"I AM A TOC": PROPOSAL OF A PSYCHOLOGICAL INTERVENTION IN A CASE OF IMPULSION PHOBIAS

Massó Rodríguez A., Pérez Golarons L., Cedrón Castro C., Rodríguez Pérez I., Rodríguez Romero A.M., Polo Gómez M,
Institute of Neuropsychiatry and Addiction (INAD), Parc de Salut Mar, Barcelona, Spain

Introduction

According to the World Health Organization (WHO), the Obsessive and Compulsive Disorder (OCD) is one of the 5 most disabling psychopathological disorders because of its significant distress and marked functional impairments. Since it was first described (Esquirol, 1838) it has been a real challenge for all those who have tried to discover its causes or who have addressed the treatment (Belloch et al., 2006). SSRI medication and cognitive behavioral therapy with exposure and response prevention (CBT), either combined or alone, have been identified as efficacious initial treatments (Ponniah et al., 2014). Nevertheless, a significant number of OCD patients continue to experience symptoms so it has been proposed that providing an additional augmentation treatment following CBT could help reduce these residual symptoms and specifically, mindfulness interventions that facilitate less reactivity to thoughts and feelings may be helpful for patients suffering from OCD symptoms (Key et al., 2017).

Objectives

To present the psychological treatment from an integrative perspective in a clinical case of OCD with a predominance of obsessions with aggressive content.

Methodology

A 33 years-old male patient who is referred from Primary Care to the clinical psychologist of the Mental Health Center to assess and treat obsessive and compulsive symptomatology. **Assessment instruments:** Clinical Interview, Yale- Brown Obsessive- Compulsive Scale (Y-BOCS), Maudlsey Obsessive and Compulsive Inventory (MOCI), Patient Health Questionnaire-9 (PHQ-9), Hamilton Anxiety Rating Scale (HARS), Structured Clinical Interview for Axis II Disorders (SCID-II), Young Schema Questionnaire- Reduced Version (YSQ-RV). It highlights obsessive thoughts with aggressive content, checking rituals and pathological doubts (see table 1). **Intervention:** pharmacological treatment with Fluoxetin 20 mg (2-0-0) and a psychological integrative approach with cognitive and behavioral strategies to reduce obsessive and compulsive symptoms along with strategies focused on the individual to improve tolerance and management of discomfort, functionality and quality of life, as well to reduce the risk of relapse (see table 2).

Table 1. Pre-intervention assessment

	RESULTS
Y-BOCS	Obsessions: aggressiveness, doubts, pollution; compulsions: checking and cleaning; SST:28; SSO: 16; SSC: 12
MOCI	MOCIT: 16; Doubts: 4; Checking: 4; cleaning: 1.
PHQ-9	PHQ-9T: 4
HARS	HARST: 14
SCID-II	Maladaptive obsessive- compulsive personality features without complying criteria for the disorder
YSQ-RV	7,8. inflexible standards; 6. self-sacrifice; 5. vulnerability to damage and disease

Y-BOCS: Yale- Brown Obsessive- Compulsive Scale; Y-BOCST: Yale- Brown Obsessive- Compulsive Scale Total; MOCI: Maudlsey Obsessive and Compulsive Inventory; MOCIT: Maudlsey Obsessive and Compulsive Inventory Total; PHQ-9:), Patient Health Questionnaire-9; PHQ-9T:), Patient Health Questionnaire-9 Total; HARS: Hamilton Anxiety Rating Scale; HARST: Hamilton Anxiety Rating Scale Total; SCID-II: Structured Clinical Interview for Axis II Disorders; SCID-IIT: Structured Clinical Interview for Axis II Disorders Total; Young Schema Questionnaire- Reduced Version; YSQ-RVT: Young Schema Questionnaire- Reduced Version Total.

Table 2. Psychological interventions

INTERVENTIONS	STRATEGIES	OBJECTIVES
Therapeutic alliance	1. Positive unconditional acceptance; 2. Empathy; 3. No judgement; 4. Congruence	1. Motivate; 2. Get an active collaboration from patient
Psychoeducation	1. Anxiety and panic attack symptoms; 2. Anxiety curve; 3. Obsessive and compulsive disorder; 4. Obsessions; 5. Compulsions; 6. Cognitive schema; 7. Cognitive distortions; 8. Maintenance behaviors; 9. Treatment; 10. Exposition; 11. Habituation	1. Normalize; 2. De-stigmatize; 3. Eliminate mistaken beliefs about anxiety.
Case Formulation (Salkovskis model)	1. Iceberg Metaphor; 2. Visual Map	1. Understand; 2. Motivate
Specific cognitive strategies	1. Descending arrow; 2. Stories in favor; 3. Distorted cartesian reasoning: attentional experiments; 4. Fusion thinking probabilistic action: lottery; 5. Fusion thought moral action: choice; 6. Overestimation of the threat: assess the risk in sequences and decatastophization; 7. Personal responsibility: cheese technique and double standard; 8. Thinking control: metaphor; 9. Retrospective analysis of anxiety consequences.	1. Exposure and Response Prevention in reality; 2. Exposure and Response Prevention in imagination; 3. Slowness of rituals; 4. Ritual change; 5. Time to worry; 6. Postponement of the obsession
Motivational strategies	1. Open questions; 2. Thoughtful listening; 3. Affirmation; 4. Reflexes; 5. Summaries; 6. Show ambivalence; 7. Generate discrepancies	1. Adherence to treatment; 2. Performing prescribed tasks
Exposure and Response Prevention	1. Topographic analysis; 2. Hierarchy; 3. Identification and removal of safety and maintenance behaviors; 4. progressive exposure	1. Habituation
Emotional Conscience	1. emotional psychoeducation; 2. emotional identification, 3. validation; 4. discomfort tolerance; 5. act techniques	1. Better discomfort tolerance
Anxiety reduction strategies	1. Mindfulness; 2. Relaxation; 3. breathing	1. Better discomfort management
Relapse Prevention	1. Psychoeducation; 2. identification risky situations	1. Decrease relapse probability

Results

There has been a decrease in the frequency of intrusive thoughts, an almost complete elimination of rituals and a withdrawal of safety behaviors. The patient reported less time in the rumination, along with greater distance, less interference and less discomfort. All this have indirectly impact to his mood, improving his emotional regulation capacity, with greater ability to identify and express emotions, and his self-concept and self-esteem.

Conclusions

It has been observed the therapeutic alliance is a key element of the intervention, through which the psychoeducation could help the patient to destigmatize and diminish anxieties and fears getting like this a collaborative intervention. The classic cognitive behavioral techniques have been effective for the reduction of anxious depressive symptoms but the third-generation techniques centered on the individual have allowed the subject a greater capacity for emotional regulation and with it a clear improvement in your mood and decrease in residual basal anxiety.

References

Key, BL.; Rowa, K.; Bieling, P.; McCabe, R.; Pawluk, EJ. .(2017).Mindfulness-based cognitive therapy as an augmentation treatment for obsessive-compulsive disorder. Clin Psychol Psychother. 24(5):1109-1120.
Ponniah, K.; Magiati, I.; Steven, D. (2014). An update on the efficacy of psychological therapies in the treatment of obsessive- compulsive disorder in adults. J. Obsessive Compuls Relat Disord. 2(2): 207–218.
Belloch A., Sandrín, B., Ramos, F. (2008). Manual de psicopatologia. Vol. 1.

INAD Institut de Neuropsiquiatria i Addiccions

Parc de Salut MAR Barcelona