TREATMENT OF AN OBSESSIVE COMPULSIVE DISORDER BY DESENSITISATION

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SUMMARY

The present study reports on a successful treatment of a single case of obsessive compulsive neurosis using a behavioural technique, namely, systematic desensitisation. Much recent literature has suggested that behavioural techniques may be more helpful with this particularly difficult condition than traditional methods of treatment, such as medication. The present results suggest that the technique of systematic desensitisation may be successfully used in a non-western setting.

INTRODUCTION

The disorder known as obsessive compulsive neurosis has been known to man for many years, if not centuries. References to it occur in works of fiction, such as Lavengro (Borrow 1921) [1] and it has been the subject of serious study since Janet wrote about it in 1902. What exactly are the features of an obsessive compulsive neurosis? Perhaps the best definition is given in the third edition of the American Psychiatric Association's (1980) Diagnostic and Statistical Manual of Mental Disorders (D.S.M. III). [2]

"The essential features are recurrent obsessions and/or compulsions. Obsessions are defined as recurrent, persistent ideas, thoughts, images or impulses which are ego-alien, that is they are not experienced as voluntarily produced, but rather as ideas that invade the field of consciousness. Attempts are made to ignore or suppress them. Compulsions are behaviours which are not experienced as the outcome of the individual's own volition, but are accompanied by both a sense of subjective compulsion and a desire to resist (at least initially). Obsessions and compulsions are recognised by the individual as foreign to his personality".

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TABLE I
INCIDENCE OF OBSESSIVE COMPULSIVE NEUROSIS AMONGST GENERAL HOSPITAL OUTPATIENTS

	1978	1979	1980	1981 (to date of writing)
Total O/Ps (new and readmissions)	1577	1631	1624	1256
No. obsessive compulsives	10	3	5	4
% of total	.63	.18	.31	.32

Obsessive compulsive neurosis is a relatively uncommon disorder, with reports of its incidence ranging from 0.1 percent to 4.6 percent of the psychiatric population. [3] Its incidence in the Malaysian population is also difficult to assess. The author studied the outpatient records of the General Hospital, Kuala Lumpur, for the years 1978 to 1981 for the incidence of the diagnosis of obsessive compulsive neurosis. (Table I).

It can be seen from Table I that the frequency of obsessive compulsive neurosis in all outpatients is extremely low.

in 1980 Nemiah, [4] looking at the frequency of obsessive compulsive neurosis in the general population comments:

"It is possible that the figures given are lower than the actual incidence of obsessive compulsive

disorder . . . It is known that persons with obsessive compulsive disorders tend to be secretive about their symptoms and to avoid disclosing them to physicians, often revealing them only when some other illness has forced them to seek medical attention. Furthermore, people with obsessive compulsive symptoms are frequently able to work and earn a living despite marked limitations in their social and emotional life, their disorder may never be known except to their closest associates. Facts such as these suggest that the incidence based on figures derived from the clinical population is spuriously low".

The present figures are also low, in keeping with those of Western countries. In the present sample the complaint was evenly spread among the three racial groups, equally afflicting Malays, Chinese and Indians. In this sample twice as many males as females were sufferers, but other studies using larger populations suggest that there is no difference between the sexes in the rate of presentation with an obsessive compulsive neurosis.

Various forms of therapy have been tried with obsessive compulsive patients, generally with poor results. [5,6] Three main therapeutic approaches have been tried.

Physical Therapies

The role of physical therapies in the treatment of obsessive compulsive neurosis is limited. No drugs have a specific action on the obsessive compulsive symptoms themselves, although the use of sedatives and tranquillisers as an adjunct to psychotherapy may be helpful when anxiety is excessive. Likewise, E.C.T. and antidepressant medication seem to have no direct effect on obsessions and compulsions.

In the author's survey of the old obsessive compulsive patients' case notes, treatment consisted almost totally of medication, with some psychotherapy. The drugs most typically used were anti-anxiety agents such as Ativan, Lorazepan and Diazepan. Also used were antidepressants such as Amitriptylene hydrochloride and even some antipsychotic drugs such as Flupentixyl, which are thought to have antidepresent attributes. Generally, the response to this kind of treatment was poor. In some cases there was an initial improvement in mood as a result of the drug action, but generally the compulsive acts remained untouched.

Only one study of obsessive compulsive neurosis has been reported in the local Malaysian literature. This was by Hasan. [7] He reported on the treatment of eight obsessive compulsive patients with varying doses of Fluspirilene. Seven out of the eight reported varying reductions in rituals, but little reduction in anxiety or depression. In one there was no improvement and the author made no comment about eventual outcomes (that is if and when the patients eventually ceases the medication.)

Psychotherapy

It appears that obsessive compulsive patients do respond to psychotherapy, but no adequate studies have been conducted on its use, so one is unable to make any valid generalisations about its effectiveness.

Behaviour Therapy

Behaviour therapists have developed treatment techniques based on the application of the concepts of learning theory to the development of neurotic symptoms. According to learning theory, the obsessions represent a conditioned stimulus to anxiety. Because of an association with an unconditioned anxiety provoking stimulus, the originally neutral obsessional thought gains the capacity to arouse anxiety, that is, a new mode of behaviour has been learned. The compulsion is established when a certain action reduces the anxiety attached to the obsessional thought. The relief brought about when the anxiety is reduced by the performance of the compulsive act reinforces that act.

There has been a recent upsurge in the literature on the use of Behaviour Therapy with obsessive compulsive disorders. A number of different approaches have been tried; flooding, [8] thought stopping, [9,10] modelling, [11] aversive conditioning, [12] contingent reinforcement, [13] and desensitisation. [14] These techniques have met with varied success and so far the evidence does not point to any one technique being the most successful.

The purpose of the present report is to describe a case in which a desensitisation technique was used on a patient whose compulsive rituals had become so time consuming and destructive that they threatened her health and relations with her husband and family.

CASE HISTORY

The patient was a 24 year old Chinese female,

married for six years with two children. In appearance she was small and dainty, neat and tidy. In manner she was quiet and rather timid, softly spoken and rather girlish in appearance.

She was the fourth in a family of five. Her father was a labourer and the family was poor. Her mother was described as a "bad woman" who had affairs with other men and eventually killed herself over one of these. The father was described as kind and loving and kept the family together after the mother's death. He was killed in a car accident when the patient was three years old. The children were then split up and the patient was adopted by her father's sister. This woman was married but without children of her own.

During childhood, the patient felt that her "mother" was over strict and controlling and that she didn't love her. She would seldom allow the patient to mix with her peers outside school hours and would cane her for no apparent reason. The "mother" was not unusually clean or compulsive in her behaviour. There was no history of psychiatric illness in the family, There was no history of childhood neurotic symptoms reported. Her early childhood years were remembered with some bitterness by the patient, as she felt unloved and unwanted and never knew how to please her "mother". She blames her "mother" for making her feel inferior even to this day.

She was a good student and enjoyed school, but was not a good mixer and did not participate in games and social activities. She would have liked to continue her studies, but was taken out of school by her "mother". After leaving school the patient remained at home, helping the "mother" with housework. At 16 years she learned dressmaking at her "mother's " insistence. At this time she had few friends and rarely left the house. At 18 years the patient married. It was arranged by the "mother" with the consent of both parties. The future husband (a bank clerk) was known to the patient and they dated twice before marriage. No petting or kissing occurred and both were sexually naive. The patient describes the marriage as happy, her husband is quiet and considerate and helpful with her "problem". Their sexual relationship has always been rather poor and has deteriorated since her second pregnancy, since then they have not had sex.

History of The Present Illness

The present illness is the second episode. The first occurred when the patient was 16 years. At that time she lived in close proximity to a family with a grossly disturbed relative at home. She became afraid of this person and was troubled by thoughts that she too would go crazy. This episode spontaneously remitted after several weeks.

The present episode started in 1980, during confinement with her second child. During the latter stage of this pregnancy she had some vague depressive feelings. At about the same time she began to fear rats and things supposedly touched by rats or places frequented by rats, e.g. cupboards legs of tables or chairs, etc.

At first, she kept these fears to herself because she was afraid of being labelled as insane. During this time she began to mop the floor, wash the furniture etc. She would not allow her daughter to touch the walls, chair legs etc. If this happened the daughter would be scolded or beaten and her activities curtailed. This behaviour on the part of the patient caused some friction between her and her husband and "mother" (who lived with them). The patient often washed her own and her daughter's hands. As a result of all these rituals the patient became very short tempered and anxious.

After the birth of her second child, these behaviours gradually worsened and the patient revealed the nature of her problem to the family. She insisted that they move to a new house as the old house was dirty and had rats. She threatened to kill herself if they didn't move. The family moved to a new house, everything was scrubbed and sterilised and the patient's symptoms disappeared for a few days only to return with renewed vigour. The family tried to help her with Buddhist meditation, visits to bomohs and doctors, to no avail.

In addition to the cleaning rituals the patient was troubled by recurring thoughts that she had not cleaned things properly, that her children were getting dirty, that rats might be lurking in the background and so on. She also felt tire and irritable as a result of her frenzied cleaning activities (which occupied most of her day) and guilty over the number of beatings she gave the children whenever they got dirty. Her sleep and appetite were affected. She had difficulty getting to sleep and often woke during the night. She also had nightmares and muscular spasms during her sleep. She eventually went to a General Practitioner who prescribed Chlorpromazine hydrochloride and Imipramine hydrochloride. When these failed the

doctor referred her to the University Kebangsaan psychiatric clinic.

Treatment

A detailed history was taken from the patient herself, her sister-in-law (who accompanied her) her husband (by letter, as the family lived far away from Kuala Lumpur). She completed the questionaires on Thought Stopping Survey Schedule, S.A.D. Scale (measuring social anxiety) and the Fear Inventory, devised by Joseph Wolpe. [15] She also kept a diary recording her typical daily activities, especially rituals. The author also obtained a more objective measurement of ritualistic behaviours, by observing the patient's behaviour in ritual-provoking situations, (recommended in Turner *et al).* [16] After obtaining a thorough understanding of the patient's problems treatment was commenced. All treatment was conducted on an outpatient basis, and she received no medication.

First, the patient was taught to relax. This technique was developed by Jacobson [17] and also used in phobic patients by Wolpe. [15] She proved to be a good subject and learned how to relax quite quickly. She also practised regularly at home.

The next step was systematic desensitisation both imaginal and in vivo. In the former the patient was instructed to imagine progressively more disturbing scenes, such as touching the legs of chairs, dirty utensils, opening cupboard doors where rats have been and so on. At the same time she experience in vivo desensitisation, e.g. she practised touching these dirty things, allowing her sister's (with whom she was staying) children to play with dirty toys, put them in their mouths etc. without scolding them. She practised these in vivo desensitisation daily, both at the hospital and at home. Her "homework" was supervised by her sister.

After four sessions of imaginal desensitisation and four of in vivo desensitisation at the hospital, and more at home the patient reported herself to be almost completely symptom free. This was supported by the sister. In addition she was now sleeping soundly each night, needed no medication, had much more drive and energy and was no longer troubled by intrusive thoughts.

The patient then completed again the Thought Stopping Survey Schedule, S.A.D. Scale and Fear Inventory in order that a quantitative analysis could be made of her progress. The figures obtained here indicated a moderate improvement in all three questionnaires.

TABLE II
SCORES ON THREE QUESTIONNAIRES BY TIME

	Before Treatment	After Treatment	Follow Up
Fear Inventory	149	113	94
Thought Stopping Survey Schedule	100	52	42
S.A.D.	23	20	20

As all evidence suggested that the patient was recovered, her husband was sent for. In a final joint interview he was informed of his wife's treatment and progress and suggestions were made on how to help her maintain this progress.

RESULTS

Three months after termination of treatment the patient and her family were contacted by letter. She was asked to report on her current emotional state and to complete again the S.A.D., Fear Survey Schedule and the Thought Stopping Inventory. The patient and her husband reported that overall she was still maintaining her improvement. She was sleeping and eating well and her general behaviour was less anxious and irritable. She was still afraid of rats but this was weaker than before. She still engaged in some of her old ritualistic behaviour, such as washing, but to a significantly lesser extent than before. She was no longer troubled by intrusive thoughts. This report was corroborated by the questionnaire results. (Table II).

It can be seen from the above figures that there was a drop in the number of fears as reported by the Fear Inventory. Also the number of times the patient was troubled by obsessional thoughts decreased as well from an initial score of 100 (pre-treatment) to 42 (follow up). This seemed to be the patient's most significant behavioural gain.

The S.A.D. score did not decline as much. This suggests that she will retained a relatively high amount of social anxiety; that is, anxiety in situations which force her to relate to other people. This suggests that for future obsessive compulsive patients, treatment should focus as much on generalised social anxiety as on reducing its symptoms, such as compulsive rituals and obsessional thoughts. Thus it would seem that

systematic desensitisation has been fairly successful in the treatment of both the obsessional thoughts an the compulsive rituals. It did not seem to have such a great effect on generalised anxiety, most probably because this was not the main focus of treatment. Perhaps in future similar cases some desensitisation of anxiety alone would also be helpful.

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