

Mr. George must check everything: A Case Report

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Abstract

The evidence shows that OCD responds preferably to the drug with powerful inhibition of synaptic serotonin reuptake and to the cognitive behavioural therapy. The case report describes the CBT therapy with 56 years old patients suffering with serious checking and reassuring. Case conceptualization help to understand, why typical symptoms developed and which factors maintains the OCD course. The most important experiences probably connecting with onset of OCD symptomatology were the family environment during childhood, especially mother perfectionist influence, and traumatic event during military service. The first three sessions take place in patient's house and patient's wife was invited to collaborate with the therapy. They were targeted to the exposure in imagination and exposure in vivo with response prevention. After improving of the symptoms in patient home, therapy focussed to the exposure in vivo with response prevention in patient's job. We elaborated the relation with patient's mother in parallel. In the last 3 sessions of the therapy we started to work on a problem related to troubles George had after promotion at work. We did around 5 role plays every session. In the final session we drew up a plan for future difficult situations he may encounter. In this case we can demonstrate that CBT can works also with situations from history and with actual life situation, which influence the development of OCD.

INTRODUCTION

Obsessive-compulsive disorder (OCD) is now recognized as a common, treatable illness with a distinctive pathophysiology and pharmacology. The evidence shows that OCD responds preferably to the drug with powerful inhibition of synaptic serotonin reuptake (e.g., clomipramine and serotonin reuptake inhibitors) and to the cognitive behavioural therapy (CBT). CBT is based on the principle that emotional and behavioural responses are formed by a pattern of thought and anxiety is precipitated by a stimulus appraised as dangerous. Key elements of CBT include identification of target symptoms, mutual understanding of the disorder shared between patient and therapist, and development of specific cognitive and behavioural strategies to cope with symptoms. CBT trains skills and strategies that help the patient manage his obsessions, compulsions, anxiety, and avoidant behaviour more effectively.

Psycho-education is the first critical step in the treatment of obsessive-compulsive disorder. It is essential for patients to understand their thoughts affect emotions, bodily reactions, and avoidance behaviour. Patients often feel better when understanding simple patterns of their symptoms. So the initial phase of treatment focuses on identifying patterns that are specific to patients. Psychoeducation and support from family members can be crucial for success in cognitive behavioural therapy. Dysfunctional families are very widespread and most parents or spouses are accustomed to patients' rituals or even become the part of them. Perhaps that is how they reduce anxiety or anger patients direct at them or other family members.

After the initial phase of therapy, patients use core CBT principles and skills in the real world, performing exposure exercises and behavioural experiments. The first step is to allocate fear or obsession evoking situations on the scale from the least to the most anxiety provoking. The therapist emphasizes exposure combined with response prevention. The patient can be exposed to a feared situation or stimulus using various techniques (e.g., imagery exposure, systematic desensitization, flooding) in order to prevent the execution of compulsive behaviour that usually follows. For instance, a compulsive washer may be asked to hold "contaminated" objects (e.g., dirty tissues) and afterwards prevented from washing his/her hands. Success with low-anxiety stimuli reinforces self-confidence and provides an opportunity for practicing the technique further.

Towards the end of treatment, which typically takes approximately 12 to 18 sessions in OCD patients, the patient and the therapist draw a follow-up plan.

This is to help the patient profit from cognitive and behavioural skills he learned during the treatment. Booster sessions are often useful to review the therapeutic process and to address relapses.

A CASE REPORT

Mr. George was referred with the diagnosis of obsessive-compulsive disorder to the outpatient clinic of Prague Psychiatric Centre, a specialised psychiatric institution. The first meeting focused on taking his detailed history and making a behavioural, cognitive, and functional analysis and thus a case formulation of this patient. Mr. George was a carefully and well groomed man. He came dressed in a suit (although there was tropical heat outside), quite in contrast to my dress (cotton trousers and a T-shirt). I felt bad to be dressed informally when I noticed he was inspecting me cautiously. Maybe he expected a different outfit and my desk to be tidier. But it was really hot outside. At that moment I said to myself I am going to be thoroughly observed and I must avoid any joking I tend to use in my speech to ease up the situation. I felt uneasy, being aware of external control. I was thinking about whether to explain that I was dressed like that due to the heat, but then I realised that was my problem. So I did not worry about the mess on my desk either, even though I saw his eyes roaming all over it. I had several half-opened bags scattered around. Nevertheless, after I asked what brought him to me, he started to talk freely. He introduced himself and said he came because he had heard a lot about me as one of the best specialists for obsessive-compulsive disorder. If I do not help him he does not know what might happen to him. When I am praised I begin to feel uncomfortable. It flatters me and at the same time I feel embarrassed to admit it (and of course the patient gets me on his side). It was also a compliment I wanted to be true (not being very modest). Feeling insecure and embarrassed, I murmured something about exaggeration, although I truly have a lot of experience with OCD. My insecurity and embarrassment calmed him down straightaway. As if he did not have to control me anymore. For a moment, I thought that he needed to see my weakness, but I left those thoughts behind to pay full attention to him. He started to talk about his symptoms and became so immersed in his own story that I started to feel relaxed and with no control from outside. I could stop thinking about myself, how I regarded his compliment, or controlling the situation, and was able to get absorbed by his life story.

Mr. George was 56 years old and worked at the City Council as a clerk. He began to talk about his repeatedly coming back to check everything well. He had to do it at work as well as at home. He checks drawers, computers, taps, window and door handles, a kitchen stove, and a gas heater. Everything must be checked repeatedly. I obviously pleased him asking about details of his checking. He wanted to describe everything exactly, so I could understand him completely. It encouraged me to enquire about all possible details (in patients with OCD or hypochondria I do this often, as my impression is the more I ask the more I earn patient's confidence). Upon leaving his home he usually checks things for more than one hour; upon leaving his workplace it can be approximately one hour. The reason is he needs reassurance that he did it thoroughly, while remembering what he already did. While checking he often feels unsure whether he turned the taps or the kitchen stove off or not, restarted the computer, etc. I asked him what drives him to check so thoroughly. Mr. George constantly thinks about all the possible disasters that might happen if the checking is not done 100%. Burglars could get into the house, the house could be on fire, or some unauthorised trespasser could get access to information he is not supposed to know. I am interested what happens if he does not check, just in case it had happened to him. Yes, it had. When he tried to skip some checks he felt extremely tense, irritable, and upset quite often. If some external circumstances prevented him from checking, he usually had strong heart palpitations and sweating. This drove him to check things at least five times and frequently even more often. He interrupted his journey to work repeatedly, returning home to perform more checks. I expressed my empathy, telling him how difficult and time consuming it must be for him. He agreed, and nodded. My sympathy made him feel good, while his wife does not understand, and blames him. I could see how he devoured my acceptance and understanding. It was clear to me I should let him indulge in his feelings. Besides, I like to do it as I do it well. I asked what amplifies or reduces his urges. Urges were amplified by stress, loneliness, his wife nagging him, and during days he felt less rested after sleep. He felt less tense when doing something interesting, e.g., watching an ice-hockey match on TV or an interesting documentary. His urges were also smaller when the responsibility for office or home security was on someone else, who would leave after him. However, he felt driven to make a phone call to make sure everything was alright. Then I briefly summarized what I learned about his checking. He seemed to be fine with it as I listened to him and wanted him to specify few more things. Then we carried on with his history starting from childhood.

A history: Mr. George had a difficult and prolonged birth with forceps and was resuscitated. He was pretty happy as a child, though excessively stubborn and obstinate. I asked him about it, as I have seen it much more in patients who had prolonged birth. I also asked if he still has to do things his way. He answered yes, it has been there his whole life and he is aware of it and tries to control it. He easily gets upset when he feels he is right or someone disagrees with him. The relationship with his parents was OK. He had enough friends; he studied well at school, and had no conflicts with teachers. His mother has always been too caring. She can hardly stand any disorder, and she cleans far too often. She used to check his school bag very often, whether he had forgotten to sharpen his pencils and get things ready for school. He had to report to her that he had everything ready and checked. Yet she had to check it one more time herself. He was fed up with it all that time but now he has realised she wanted him not to become a slacker. I asked him if he might have inherited this cleanliness from her and he responded he is just the same as she. Everything must be in order and "in lines," otherwise he feels uncomfortable. Sometimes he is aware he overdoes things, but feels more comfortable with it. After graduating from business college, he started his compulsory military service at 19 years old. He joined the infantry, where soldiers were called "bigosi". He had some traumatising experiences there and one of them has haunted him since. Just before the end of his service, he witnessed as one soldier shoot another one inadvertently. George saw the soldier dying in pain. I was interested in this story, and I wanted him to tell me more about it. I experienced something similar myself when joining the army and it comes to me sometimes as a flashback. He said it came back sometimes but did not disturb him. He talked about it for a while and shed a tear. I thought about deepening my exploration, but I wanted to continue taking his history as well. I had to be on time and needed more information, so this was perhaps my craving related to my own experience. It would be early to do so at this time, and could block other important things out and anyway; there is plenty of time to get back to it.

George got married after completing his military service. They had a baby boy first and a girl was born two years later. At that time, he used to have dreams reminding him of his experience in the army. He was tense and irritable during the day it occurred and got easily upset. He divorced 12 years ago. He decided to do so after finding out his wife cheated on him. At this time he started to be worried about petty things. He felt insecure about house security, work, and children. This period of his life seemed to be very important to him, therefore I questioned him more thoroughly. I wanted to know whether he could identify any connection between stress (wife had a lover and left him) and symptoms (checking), then or now. He described his symptoms again and did not respond to my hypothesis on symptoms related to stress. He was just not sure if he locked the door, switched the kitchen oven off or turned off running tap water. This uncertainty started to harass him. I was a bit impatient at that moment and asked him again whether the onset of symptoms is related to stress he experienced. It must have been a very difficult time for him after his wife left him (now, when I am writing this paper I feel ashamed of my “empathetic intrusiveness”). He admitted he had less time to think about his wife when preoccupied with checking. According to his voice I realised that I forced him a bit to acknowledge this connection. My guilty feelings led to listening to him much longer and asking no further questions.

It seemed that he gradually got used to the break-up with his wife and his uncertainties and checking started to occur less frequently. One year later, when he met his second wife, his compulsive checking was so minimal he almost did not notice it or did not mind it at all. Then 2 years ago he was promoted at work and although it pleased him, the new position turned out to be very stressful. He did not know how to delegate work to his subordinates, or say no, as he was worried he would be criticised. He started to check their work very precisely, all papers, computer records, correspondence, and locks. A number of job duties he did himself to be sure they were done correctly. He started to be more and more overloaded. He brought his checking home soon. Here I did not hold myself back and inquired about the relation between stress and the recurrence of symptoms. He replied he was sure about it. There was a prominent increase of checking since the promotion, as he had responsibility for other people as well.

At the end of our first session we went through all the factors that might have theoretically contributed to the development of his problem. We hypothesised about what could have had greater or lesser importance. George enjoyed our discussion very much (so did I as I like case conceptualisation), even if we said there are only hypotheses as we did not know how to measure particular factors between each other. It was a sort of a “primordial soup,” and more accurate contours were yet to appear during treatment.

Factors increasing sensitivity to stress: One of them is a difficult and prolonged labour, which enhanced George’s sensitivity during childhood and manifested as being stubborn and obstinate at preschool age. As a child, he also learned from his mum how to check things more than other children. He experienced a traumatic event during military service which had been recurring as flashbacks and dreams for a period of time. Since then he tended to worry much more. His first wife left him, which contributed to his life sense of insecurity. He could not put up with it for a long time. He began to be worried about everyday issues, home, and children. These worries allowed him automatically to divert his attention from a painful and hurtful emotional reaction to his wife’s infidelity and break up.

Triggering factors: Promotion at work required new responsibility from George, combined with higher emotional demands. He was worried about managing the situation and started to have doubts about himself. These doubts transferred from work-related issues to those about being able to check the kitchen stove, windows, doors, computer, etc., “responsibly” enough. The more he was checking up the less he was thinking whether he could manage his job requirements.

It was a bilateral formulation and seemed to be logical to George. I emphasised this formulation was made by himself in fact, based on my questions and our joint discussion. I praised him for having things logically arranged and well communicated. We continued with identifying maintenance factors which are usually not obvious to most people. I always prefer when a patient identifies them rather than when I do it myself during psycho-education. However, it happens quite often that I do not manage this guided discovery and there is hardly any other way other than education. This happened with George as well. He learned that after compulsion there is a relief of tension, but it was hard for him to find out why this repeated relief leads to maintenance of obsessions. I drew a picture and he understood. I praised him again for good cooperation (I was a bit disappointed in my mind that he did not make it himself. I hope it was not visible, but hopefully not, as he looked very happy.). Finally, we mapped all maintenance factors as follows:

Maintenance factors: When an urge to check comes, strong tension arises. If Mr. George executes checking, the tension decreases quickly and there are no unpleasant physical symptoms. He does not have to think about catastrophes that could supposedly happen. This is the reason he performs compulsions and gets reassurance from his secretary or wife. But this neutralisation manoeuvre results in him being less sure and able to resist his urges. Therefore they grow and take more time of his day. A long-term consequence is his compulsive behaviour getting stronger and his self-confidence (whether he got things checked) getting lower. When his wife teased him it increased his anxiety (he feels she does not respect him anymore so she may leave him as his first wife did).

Before completing the first session we discussed how to define problems and goals in therapy so we can measure them and assess objectively. Initially Mr. George said he wants to be less fearful at work as well as at home, so he would not have to check things so much. Subsequently we succeeded in finding a more specific formulation: see Table 1.

Afterwards I asked about the traumatic event and flashbacks which happened during military service. Mr. George was not interested in working on it as he considered it not to be a problem, but the old past. Flashbacks have occurred very rarely and he does not mind them at present. He could not see any problem in his marriage to be worked on. My impression was that something from the relationship with his mother has transferred into the relationship with his wife and asking her for reassurance is related to it. However, I could not find enough evidence supporting this in his account of problems. He rejected my proposal about parallels between his wife and mother. It is possible it will come up during therapy later on, which sometimes happens, and I did not want to be pushy with my hypothesis. I do not have to always be right and besides, this was not something I came up with.

At the end of the first session we negotiated the *treatment framework*. I offered to begin with the treatment at home where he performs most of his compulsions. We discussed the idea of his wife being a co-therapist, which is something he liked. Then, after making first steps there, we will move the treatment to the clinic (My suggestions were a fresh result of my recent arrival from the world congress in Kobe, where I heard many times that the treatment of OCD in a home environment proves to be more efficient. I wanted to try it out, although I was not experienced in home treatment. I had vacation, so enough time as well, while during the term I would not be able to make such an offer as I am busy teaching. I visited a few patients at that time but then I stopped as it was very time-consuming. With hindsight I think generally it is not necessary. Unfortunately, we did not establish how many times we would stay at his house or how long one session should be and we did not set a date to move the treatment back to the clinic. These were the drawbacks of our contract.)

SESSION 2

The treatment began in his family house on the outskirts of Prague (in our country it is called “entrepreneurs’ baroque,” indicating a particularly kitschy architectural style). My patient and his wife were evidently proud of it; they showed me around. I felt bound to admire it but I thought to myself it was not tastefully decorated. I did not manage to remain congruent, seeing how proud they were. I said they must like living there and that they arranged it well according to their needs. Then we sat down in the armchairs in the living room. Mr. George’s wife was involved in the treatment as well. I explained the model of OCD, how it works, and we discussed what triggered George’s vulnerability again. It was difficult for me, as I never know what can be said in front of a partner. Although George agreed I can say anything, I was faint-hearted and eventually hid myself behind questions, so instead he said it himself. I rationalised my behaviour to myself and thought he would understand everything better this way and mention only what he wanted in front of his wife. Our conversation was as follows:

Therapist: Now we can go through origins of George’s OCD symptoms. As we have already gone through it once at the clinic, I would like to ask you, George, to explain it to your wife. I will follow you and see how you understand, so that I can help you to add something in case you forget. What do you say, can we do this?

George: Well, I am not sure if I remember it all. But it was clear to me back then. I have those pictures we drew together as well. So at least you will help me, won’t you?

Therapist: Sure, I will. You understood it very well on our previous meeting. In fact, it was you who told me everything about yourself. If you forget something, I will help you. Tell me, how does it feel to talk about your problems in front of your wife?

George: Well, it’s not very easy. Even though I trust her....I feel embarrassed...actually, I admit I have a problem. I am not sure if she’s gonna respect me afterwards (turns to his wife).

Wife: I love you very much....really...and I appreciate you. You’re a capable man. That’s why I married you. Everybody knows you are competent, that’s why you have been promoted. If you tell me your worries, I can get closer to you. Sometimes I don’t understand, sometimes I get angry and then I am ironic or call you names. I am sorry.

Therapist: I have the impression, from what I learned from George and read from your behaviour, you have a nice relationship....

Wife: We love each other. I’d like to help George and just as he would. George, if there is anything I can do for you in your suffering, I’d love to do it very much.

George: OK, I’ll start then ... (Like most patients with OCD, George has an excellent memory and remembers especially logical links. He gave a nice account of everything from his childhood vulnerability, his mother’s checking he adopted later, and his military experience. He openly talked about his first wife’s betrayal and how he developed checking afterwards. Maybe he took my interpretation as his own.)

George's wife did not have a clue about his trauma from the army and stress he experienced when his first wife left him. They never talked about it. Now she understood him with empathy. She said she would never tease him again and would not provide any reassurance anymore. At the end of the session, which lasted 1.5 hours, we all agreed on the treatment plan. The plan consisted of following steps: a) education on obsessive-compulsive disorder; b) self-assessment; c) exposure with neutralisation prevention (including no reassurance); d) cognitive restructuring; e) problem solving at work.

Then the couple was given a self-help brochure on OCD and its treatment (Praško et al 2003). George was instructed by the therapist how to interrupt a vicious circle of checking and worrying. He had to overcome tension and worries that forced him to check up on things repeatedly. At first, the situation had to be accurately described. During the first week, Mr. George's task was to record the frequency of his urges to check things (at home and work too), how often he resisted them, when, and what he was worried about). He was also supposed to write down urges to seek reassurance. His records would provide information on his behaviour at the beginning. At the end of the session we agreed on the first exposure – we left the house together, George as the last one and without any checking. Then they give me a lift to the centre. If George became too tense, they would take me only to the nearest tube station. George managed to get to the centre (approx. 30 minutes). He was tense, however he could tolerate it.

SESSION 3

For the next session, Mr. George's wife prepared an opulent dinner. It surprised me. I was not very happy about it, firstly because we would lose some time dining and secondly, for the sake of treatment, I prefer to attend to the treatment only. On the other hand, I would hurt her feelings if I strictly refused. We had dinner then and I said I do not want them to prepare anything because next time I would rather work. As I had another appointment in the evening that day, we had not enough time for the therapy either. I was like an elephant in a china shop and perceived their embarrassment. Moving on to the homework was a relief for everyone.

Exposure with prevention of compulsive neutralisation

We went through Mr. George's records first. Then I explained them the purpose of the exposure technique with prevention of compulsive neutralisation. Together we made a hierarchy of a situation which was George's task to do in his imagination before. Next he ought to imagine particular situations when he felt driven to check and then amplify his compulsive urges and try to resist them. We did one imagery exposure during the session so Mr. George could understand the technique well.

He was supposed to start with the easiest situation at home and then move on to the more difficult one once he gained more confidence in himself. His homework was also to keep records of his urges and compulsive behaviour. This week (with 4 days left), George shall work mostly on imagery exposure. From next Monday, he should leave the house as the last one and initially with his wife waiting for him. Later on she should leave at a different time, leaving him alone. The task is to reduce number of checks from the list to the minimum. George made a list of gradual steps himself and made a deal with his wife she would not provide any reassurance anymore, but would discuss achievements with him. If the plan of leaving the house failed, George could come back home, turn on the gas and water, open windows, and then switch everything off in one single go. We contemplated the option of taking antidepressants as well, but Mr. George was not interested. However he agreed he would think about them if no sufficient improvement occurred within two months.

At the end of the session we left their house without checking, just as at our first meeting. This time George had no tension and I started to think we could have subsequent sessions at the clinic again, so I would not have to commute. I let them know my position, but they tried to persuade me to have one more session in their house. I insisted on not doing so, but maybe it was too early. I decided so haphazardly as late as at the end of the session. It was mainly my priority not to lose much time, but disregarding their feelings. Now I think with hindsight that if I had had one more session there (or announced the change of place early enough), I would not have been short of anything. This day demonstrated how important a therapeutic contract (conditions of the treatment) is from the very beginning. Also, I was not prepared for home treatment at that time. The session accomplished its goals, though we went through at least two sheepish moments which could have had a negative effect on our relationship.

SESSION 4

The fourth session took place back at the outpatient clinic. Mr. George came by himself. I asked him if his wife felt offended about continuing our treatment at the clinic. He replied she understood I do not have so much time, but felt bad about it. I admitted my decision was caused by my lack of time. Certainly (I added defensively), further home visits would not meet the objective that much. How to perform exposures had been demonstrated and further ones he could do without me. At the outpatient clinic sessions we will plan and review them. After a moment of silence, George said he understood I cannot give him one whole afternoon per week. I felt ashamed a bit that I had not made myself clear. I also realised I have to make contracts more clearly not to end up in a situation like this. During the first 4 days George went in his imagination through the hierarchy of all situations. He was quite successful in walking out of the house, though he had to look at everything. He did not check it with his hand though. We went through all exposures on the list and I paid him a compliment. Then we focused on a discussion about automatic thoughts which are incorporated into obsessions (cognitive restructuring).

Therapist: As we go through all your checking, it seems that there is one idea deep underneath. Just as you put it down in your vicious circle, if you don't check taps, you flood the apartment, if you don't check windows, you get robbed, if you don't check the stove, you're gonna burn the house down. As if there is one general worry. Do you have any idea how to summarise it all in one sentence? If your wife is the last one leaving the house, you don't have to check anything even though she doesn't do it as much as you.

George: You're right, usually I am the last one and I check things. If she stays at home or goes out after me, I don't have to check, I leave it to her. But sometimes I phone her and ask if she did checks. Then she ironically replies the house is already on fire. Instead, I drove home once to check. But most of the time I trust her that she left the house alright.

Therapist: It seems you can rely on her, you remain calmer. But if it's up to you, you must check. Is it possible there is some more universal worry underneath? What do you think?

George: Yes, a worry that a disaster will happen due to my negligence.

Therapist: And if it happens due to your wife's negligence?

George: I would forgive her that.

Therapist: And what about yourself?

George: Well, that's worse. Perhaps yes, eventually, but I would feel troubled and guilty. I was brought up to do things properly since my childhood.

Therapist: Yes, just as you said in the beginning. You told me your mum used to check your schoolbag.

George: Not only that, I had to check it myself and then she checked it on the top of that.

Therapist: As if she did not trust you whether you checked it enough? ...

George: Sort of....you are right, I did mind she did not trust me to check it enough....I felt ashamed when she found I did not sharpen a pencil, for instance. As if she was right, that I did not checked things thoroughly. It was terribly embarrassing – she told me to check it which I did and then she found a mistake. As if I was unable, as if I failed. She shouldn't have done it to me, I suppose. But it was not her fault that she was so organised. She was worried I would end up in the gutter in my life. She just has always been anxious.

Therapist: I can see you understand her. Can we go back to the feelings you had then? You mentioned "terribly embarrassing."

George: Yes, my chest was constricted. As if I was going to slump to the underground, to disappear somewhere. I still have the same feeling when I don't succeed. This is the reason I always try to do my best. Even those exposures, so you don't find out I did them wrong.

Therapist: You do them brilliantly....but I have just reassured you. Well, it was a slip. I shouldn't reassure you....

George: I'm glad you're happy with me.

Therapist: When mum checked your schoolbag and everything was alright, how did you feel?

George: She praised me and it was nice. That's why I checked my schoolbag very carefully. Oh, God, I've got it now, it's so similar. Poor mum, in fact she taught me this....But I can't be angry with her. She didn't mean it...

Therapist: I also think it was due to her anxiety, as you said. I have a metaphor....it's just like you have been carrying your mum in the backpack and she were saying: "George, you have to check it carefully otherwise a disaster could happen."

George: Well, it's almost like that....

Therapist: Isn't she too heavy?

George (laughs): Mum is a big woman, so I can barely walk....

Therapist: I'm thinking what can you say to her.... turning back a bit ... so you don't have to carry her anymore...?

George: Mum, stop worrying so much....It's I who carries your fear my whole life...I don't want it anymore...get off of my back and go home. I'm happy to visit you anytime, but I don't want to discuss your worries with you anymore and worries about me at all. I can take care of myself. I don't need your supervision (his determination frightens him a bit).

Therapist: Carry on, it's perfect....

George: I'm scared of hurting her, but at the end of the day I have to take her off ... Mum, get off and hurry home. When you get there, I'll come to hug you and kiss you. And then I will run along by myself. And you can do it too. Don't be afraid. I can't even kiss you with you on my back. Go then (regretfully and resolutely)!

Therapist: I can see you don't need any therapist....you can do it on your own....

George: Well, it's funny....it hasn't come to me. Although we talked about it on our first session, now I've become fully aware of it. Thanks a lot.

Therapist: You thank yourself, it came to you, not me.... What I have in mind is what would you like to hear in such a situation from your mum?

George: Hmm, I do trust you George. I believe you can make it and I will never worry about you.... (George in tears) yes, I need her to trust me.

Therapist: And can you believe in yourself?

George: Hmm (silence)...In fact, yes, I can. I did what I wanted. Even though my first wife left me, I found myself a second one, much nicer. She cares for me and respects me. And my children love me. I enjoy respect at work. Why shouldn't I trust myself?

Therapist: I don't know either....

George: Gosh, I'd like to throw all my checking away...

Therapist: You may try ... and even if you can't do it straightaway, I believe you can do it soon ... (additional remark: maybe this was a useless sentence, it was rather my anxiety as I didn't want him to be disappointed. Actually, I didn't trust him, just as his mother didn't).

George: I'll try and everything will be alright.

Therapist: I trust you.... now when you look at the sentence: "due to my negligence, a disaster could happen," how do you see it?

George: It's nonsense. I was too scared. I can't check everything.... And I certainly cannot control my destiny. I'll try to throw all checking away.

Therapist: Fingers crossed.

Before ending this session we outlined exposures for the next week. I had to hold George back a bit as he really wanted to cope with everything. I told him it is like dieting: when done quickly, always leads to putting on weight again. It is called a yo-yo effect. He agreed to do things gradually. I realised I was in the role of his mother a bit and let him know. He laughed. "Well, I feel like you do not trust me completely. But I can do it!"

At the end of the session, George gave feedback that he was happy with himself and me too. This session stabilized our therapeutic relationship, mostly the sense of bilateral cooperation on goals. George considered cognitive reconstruction (it was like solving puzzles, finding out stuff about himself, how things are interconnected) to be the most important part for him. Also, he planned exposures almost by himself. I was very pleased to hear it as it showed one of the core principles of CBT – therapeutic alliance means that a therapist is in the role of a teacher or coach guiding a client on an individual journey.

SESSIONS 5 TO 7

In the next session we agreed he avoids checking water taps, windows, and the car lock completely when leaving home. His wife was going to support him. He felt like a little child for a moment, but essentially was happy with it. "It's like my wife checking my briefcase instead of my mother." He was right. I left it up to him. "I'm happy to go through it with her, it makes her feel good and I don't mind it. Did you know I visited her and gave her hugs and kisses? This time sort of wholly, as I haven't done in 20 years...maybe ever so spontaneously. She cried and was very happy." On the ground of George being successful in avoiding some checks he planned, the next session they added to skip checking of stove and doors, something he considered to be more difficult.

In the 2 weeks that followed we worked on rituals at work. It was more difficult for George there, as he was scared to give up responsibility and stop checking, at least in his mind (what he turned on or off while leaving). Thus he transformed a behavioural ritual into an ideation process. Strangely enough, without checking worked at home, but not at work, where gradual exposures needed to be applied. We practised the stop technique in order to block thinking rituals.

SESSIONS 8 TO 11

In the last 3 sessions of our therapy we started to work on a problem related to troubles George had after promotion at work (which he mentioned at the beginning). It was one of the goals of the therapy and we did not work on it. Mr. George had the problem of delegating work to his subordinates and insisting they do their work tasks. He was afraid that if he was strict with them, they would dislike him. He tried to do most of the job himself or to check their jobs in the computer at least. When he found out someone did not do his assignment well enough, he had a problem talking to the person. Instead, he preferred to complete things himself. I suggested training in assertive communication, which would be suitable for such a situation. Mr. George outlined several more frequent and different situations with his subordinates. Then we did role playing and tried particular roles. We evaluated them, how he felt playing them, or what impact they may have had.

An example of a practiced situation: Mr. Lamac is a manager of maintenance – repair department. Mr. Lamac tolerates his men leaving the workplace on Fridays early, though their working day ends at 4pm. He leaves early as well. If they had their job done, it would not be a problem. However, it has already happened twice that a delivery truck arrived at 3pm and had to be unloaded. There was nobody available in the department, which had a number of men. Finally, female staff members from other departments dealt with it, carrying heavy parcels. They complained to George, who as a line manager to Mr. Lamac was supposed to deal with the problem. This was against Mr. George's grain. Lamac is a short-tempered man and easily gets upset.

Therapist: Maybe we can role play this situation together. I will be Lamac and you will be yourself. Then we switch our roles, so you can experience how Lamac feels. But I suggest that we begin with you being yourself and looking for various alternatives for dealing with the problem.

Boss, you called me to your office, what do you want?

Mr. George: Mr. Lamac, I want to go through the recent situation when a truck arrived. I don't like it and I'm sorry it happened, but your men were supposed to be there until 4pm.

Therapist: But it's not a big deal, it was done by people from other departments. Next time we'll do their job.

Mr. George: You can't be serious! Everybody from your team ran away from work and you consider it nothing?

Therapist: And how am I supposed to take it? After all, nothing really happened.

Now I step out of my role: Do you like how the situation looks?

Mr. George: No, I don't. But I don't know how to explain it to him. He is short-tempered, and so am I.

Therapist: So we'll start all over again. What I think is, don't make detours – I am sorry, I don't like – try to express your requirements rather as a boss and stick with it. Shall we try?

Boss, you called me to your office, what do you want?

Mr. George: I want you and your men to stay at work until 4pm every Friday.

Therapist: It's because of that silly truck, nothing happened anyway. The job was done by others and we'll help them next time.

Mr. George: You don't take it seriously. I want all of you to be there until 4 o'clock as it's written in your job description. I won't tolerate it and I am going to check on you guys.

Therapist: Oh, anyhow, we manage to do everything earlier than 4 o'clock.

Mr. George: I want you to be there until 4 o'clock. If you have nothing to do, it's my fault, not getting more out of you. I will check your job descriptions.

Therapist: Again, I step out of my role: How do you like yourself now?

Mr. George: It's much better, even though I feel pretty aggressive. But perhaps there's no other way to subjugate him. It works pretty well.

Therapist: OK, we can switch our roles now, so you try Mr. Lamac's role. Is it OK with you?

We did around 5 role plays every session. It worked well as Mr. George kept on finding responses he was happy with more and more quickly. He ought to read particular chapters in the book "Assertively against stress" and then try situations "live." He discovered it really worked. He did not feel his subordinates rejected him. He started to feel more secure at work and relieved that they were doing their jobs. He was able to hand some of the responsibility over to them.

SESSION 12

In the final session we drew up a plan for future difficult situations he may encounter. We made a list of situations George considered to be more stressful and causing urges to check things. They were mainly the office reconstruction 4 months ahead, moving to a temporary place and then organisational changes which always come after elections. George made a list of ideas and steps, complementary to these situations, for how to deal with them. The most important aspect of this activity was that George had to come to terms with deterioration of his problems and failures in the future. They are a part of a normal course of treatment and definitely do not mean he failed in his endeavour. We set up the next meeting in 3 months' time.

SESSION AFTER THREE MONTHS

Mr. George was doing very well. Though a little deterioration occurred once, when George checked something many times, he was ready and easily got over it. At work, the situation improved for him and he delegated a number of duties not belonging to him to his subordinates. He earned more respect as he acted assertively. He cut back on checking them dramatically, something he was unable to do before. The office reconstruction was still ahead, but he was not afraid of it.

FOLLOW-UP AFTER ONE YEAR

Mr. George is alright, feels fine. He managed the office reconstruction and organisational changes without stress or recurrence of symptoms.

SUMMARY

Although the prognosis of OCD was traditionally considered poor, with the new development in cognitive behavioural or pharmacological treatment, it has considerably improved. In this case we can demonstrate that CBT can work also with situations from history and with actual life situation, which influence the development of OCD.

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