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Journal of Psychology and Mental Health Care

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Research Article

Effectiveness of Cognitive Behavioural Therapy on the Single Case Study Obsessive Compulsive Disorder

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Received date: March 09, 2022; Accepted date: April 13, 2022; Published date: May 07, 2022

Citation: Shabina N., Abid H. Zaidi, Rani S. (2022) Effectiveness of Cognitive Behavioural Therapy on the Single Case Study Obsessive Compulsive Disorder.*J. Psychology and Mental Health Care*, 6(4): DOI: 10.31579/2637-8892/166

Abstract

This study is a single case therapeutic intervention based report; we have to design pre and post assessment with the help of some psychological rating tools. The present study examined to the effectiveness of cognitive behavioral and some techniques used of same therapeutic relational approaches, this is a pure or predominant obsession is a subtype of obsessive compulsive disorder case according to **(ICD-11 under the categories "Obsessive Compulsive Disorder with fair to good Insight, 6B20.0. Depressive Disorder, GA 34.41. Generalized Anxiety Disorder, 6B00").** This study used based of cognitive behavior, CBT Model, ERP and used multiple therapeutic techniques of Cognitive behavioral therapy. The present study W, 23 yrs old married male came with chief complaints of the multiple blasphemous thoughts, unwanted sexual images running in the mind, unseen images of sexual area of mother and God since 12 years and seen multiple symptoms of the generalized anxiety or depressive psychopathology. Studying in graduation and belong to middle SES according to kuppuswamy scale. He brought by his parents in IMHH, Agra in OPD and done pre assessment before the applied therapy session. His result showed high severity of OCD symptoms. After 3 months again applied same tools, and seen approximately 50% to 55% major reduction his symptoms that further gradually decreased his symptoms and sessions continued till 2 months. Follow-up continued and patient no longer meet the criteria for OCD, Generalized Anxiety disorders and Depressive symptoms.

Keywords: obsessive compulsive disorder; anxiety; depression; cognitive behavioral therapy; jacobson's progressive muscular relaxation

Introduction:

OCD is currently considered to be one of the five most prominent psychiatric disorders according to ICD-11. OCD characterized by the presence of obsessions is a multiple types of Obsessive compulsive thoughts which affects approximately1-3% with lifetime prevalence and leading the cause symptoms of other psychiatric illness (Reddy et al., 2017). Cognitive behavior therapy (CBT) involving exposure and response prevention is the high standard for the base of 3rd generation of psychotherapeutic intervention for obsessive-compulsive disorder (OCD). And twenty-seven patients with Diagnostic and Statistical Manual of Mental Disorders. Fourth Edition diagnosis of OCD. Overall integrated the findings indicating of the 27 patients, 18 (67%) achieved remission (55% reduction in the YBOCS severity score) at 3-month follow-up of the OCD population categories. (Kumar et al., 2016). Conducted other dimensions of obsessive-compulsive disorder (OCD) is a leading cause of mental or behavioral disorder emergencies with Mind with Body Reaction. Sexual obsessions are perhaps the least understood manifestation of OCD. Common themes include obsessions about sexual orientation, infidelity, sexual deviations, incest, pregnancy, and blasphemous thoughts combining religion and sex and This book describes new techniques for addressing sexual-OCD (S-OCD) using the cognitive sematic association splitting techniques and helps towards the multiple Obsessive-Compulsive Disturbances. (APA., 2021). In this literature showed that the having the difficulty related neurotic disturbances and seen multiple Obsessive-Compulsive symptoms and

presented multiple anxiety traits with depressive disorder with solved the case of primary symptoms then secondary multiple other active psychopathology. CBT is the helps of primary symptoms then reduced gradually other symptoms.

Presenting Complaints:

- Headache, disturbance in sleep Since 12 years
- Blasphemous thoughts, low mood, low PMA
- Anxiousness, incresed heart rate, shortness of breathing
- Seeing images of sexual area of mother and God
- Violent and aggressive thoughts and images Since 4 years
- Checking doors and taps repeatedly
- Excessive concern with moral fear

Case Summary:

❖ Onset was insidious; Course is continuous and Progress is improving.

Index patient was functioning well apparently 12 years back when he fell from a height of 8 ft and had a back injury followed which he started complaining of headache. This continued for many years. At about 13 years of age he started engaging in various philosophical thoughts like- "who made Allah, how his face looks like?" Subsequently by 16 years of age, he started masturbating and the act used to often be guilt provoking. Few years later, he started getting involved in a relationship which was unacceptable by family members and since he broke his promise with the girl, he started remaining tensed most times of the day, until one day while sleeping he had thought of having sex with God (Hazrate Fatima). This created a state of intense guilt, anxiety shame and self-blame for which he apologized to God many times. He tried to resist but was unable to do it and started remaining preoccupied with such thoughts. Subsequently, he also started having sexual thoughts for his mother, father and even his own child. In 2010, he got married, after 5 years of marriage he started having images of female vagina. Later, he also started having images of various other sexual organs of female like breast, buttocks etc. However, he remains preoccupied with thought and image of vagina so much that his activities of daily living were hampered such that it become s very difficult to make a decision while sitting or standing as he fears that he will kill Allah or will have sex with his mother if he performs certain acts. Since last 1 year he has also started controlling his thoughts by either replacing image with less threatening image or saying a mental prayer or just avoiding the activities he faces difficulties in performing.

His persistent and pervasive mood has been anxious and irritable. He has difficulty carrying out activates of daily living because of the preoccupation with these thoughts and images.

Mental Status Examination:

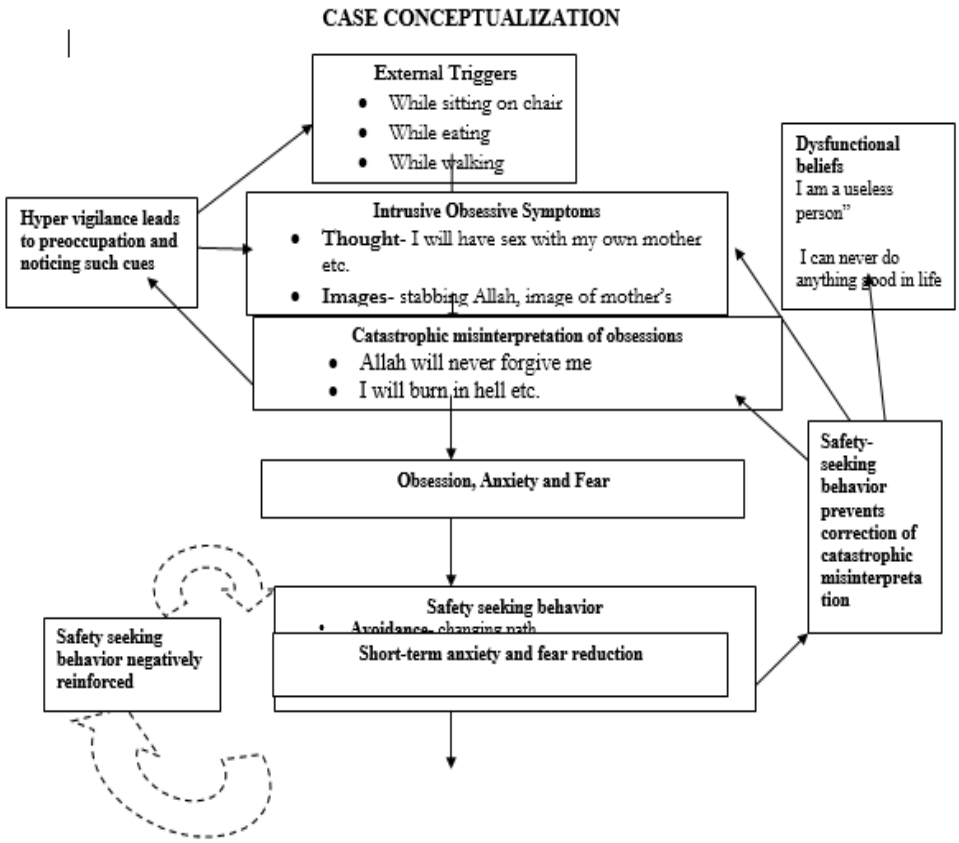
On M.S.E. patient was kempt and tidy, in touch with surrounding, eye contact maintained and had a cooperative attitude. His affect was anxious or depressed with normal range and reactivity. In thought possession he reports obsessive thought, increased suicidal wishing and images about sex and aggression as well as checking compulsions. Psychomotor activity was increased during interview time. No abnormality could be elicited in perception with intact judgment and grade IV insight.

Diagnostic Formulation:-

Index Patient X, 23 yrs old unmarried male, studying in graduation, belongs to urban background of Agra. The chief complaints were blasphemous thoughts, Seeing images of sexual area of mother and God, Violent and aggressive thoughts and images, checking doors and taps repeatedly and excessive concern with moral fears Since 4 years.The significant findings in MSE indicating obsessions and compulsions, sad mood, insight is grade IV. History and MSE finding suggests that patient is provisionally diagnosed with **ICD-11 "(Obsessive Compulsive Disorder with fair to good Insight, 6B20.0. Depressive Disorder, GA 34.41. Generalized Anxiety Disorder, 6B00)".**

Psychotherapeutic Formulation:-

He is a member of a joint family, living with his wife, children, parents and brothers. He is a nominal head and his father is a functional head of the family. His family environment is strained because of her obsessive and compulsive behavior. But his primary and secondary support system is good.



Pre Assessment for Psychotherapy:-

- **Yale Brown Obsessive Compulsive Checklist:**
  - ✓ **Aggressive obsessions** (Fear of harming others, Violent or horrifying images and Fear of acting on such obsessions);
  - ✓ **Religious obsessions** (Blasphemous thoughts and Excessive concern with morality);
  - ✓ **Sexual obsessions** (Forbidden or unacceptable sexual thoughts and images and Content involving children sometimes),
  - ✓ **Checking compulsion** (checking locks and taps);
  - ✓ **Mental compulsion** (Special prayers) and
  - ✓ **Past somatic obsessions** (Excessive concern with body parts)

Impression

Raw Score= 31 (Severe Range of Obsessive Compulsive Symptoms)

- **Hamilton Rating Scale For Depression:** Raw Score= 16 (Moderate Depression)
- **Beck Depression Inventory(BDI):** Raw score= 24 (Major Depression) chiefly in the domains of Pessimism, Past failure, Guilt , Loss of pleasure, Self-dislike and Self-critical
- **Hamilton Rating Scale For Anxiety:** Raw Score= 32 (Sever Anxiety) chiefly in the domains of Anxious mood, Tension, Depressed mood and Autonomic symptoms

Model of Therapy:

- Cognitive Behavior Therapy for Obsessive Compulsive disorder

Goals or the Therapy:

Short term goals :

- Psych-education
- Exposure and response prevention for compulsion
- Family therapy for strained relationship with her family

Long terms goals:

Cognitive behavior therapy for obsessive thoughts.

- To modify specific cognitive processes and behaviors that is maintaining the obsessive compulsive symptoms
- To improve his underlying depressive symptoms
- To improve his somatic concerns

Techniques Used

Psychoeduaction

Cognitive bio-behavioral self treatment

Relabel

Re-attribute

- **Behavioral techniques**

- Exposure and response prevention
- **Cognitive techniques**

For obsessive ruminations

- ✓ Courtroom play technique
- ✓ Cognitive continuum
- ✓ Thought suppression test
- ✓ Calculating probability estimates

For depressive symptoms

- ✓ Socratic questioning
- ✓ Down arrow technique
- ✓ Verbal challenging
- ✓ Evidence in favor against of the core beliefs

Duration of sessions: 40-50 minutes, period or total time duration: 6 months to 8 months Number of sessions: 35 to 40 sessions.

❖ **Target based therapy :**

❖ **Initial Phase**

Detailed history was taken from patient. Conversation was carried out to build therapeutic alliance. Detailed psycho-education was given to the patient which included:

- The session began with discussion on differences between intrusive thoughts that we counter in our day to day life and obsessions
- Nature and form of obsessions were discussed as repetitive, unwanted thoughts, images, or impulses that a person finds unacceptable and/or repugnant. They are involuntary, harmless, and the opposite of their actual values and desires. People experiencing obsessions recognize that the thoughts are their own production, and find them to be ego-dystonic (contrary to their view of themselves).along with examples of classical obsessional themes usually elicited, example, aggressive, sexual, and blasphemous, including the patient's obsessional theme as well.
- Similarly, the nature of compulsions were also introduced as repetitive, intense, stereotypic actions, such as cleaning or checking, that the person carries out in order to remove a perceived threat (e.g. of being contaminated) or to prevent a future threat (e.g. of causing a fire) along with the most common themes elicited as that of contamination, cleaning, symmetry etc. Patient was then asked to define his compulsions.
- Then the details about the lifetime prevalence of from 2 to 3% equally common among males and females were discussed.
- The course of the illness as waxing and waning course was explained. In a small minority, perhaps 5%, symptoms will undergo a complete, or near-complete, spontaneous remission; in such cases, however, relapses generally occur in the following years. In another minority of cases, perhaps 10 to 15%, the course is progressively downhill until patients' lives are consumed by obsessions and compulsions and their responses to them.
- All the theories explaining the etiology of OCD, along with emphasis on biological, behavioral and cognitive perspectives were explained
- Then a detailed discussion was also held on the reasons behind the persistence of symptoms and here the case formulation of development and maintenance of OCD was explained to him to develop insight over his own illness.
- The efficacy of cognitive behavior therapy in the treatment with the rationale given above. Then, the need and rationale for psychotherapy was explained including the details of number of session etc.

❖ **MIDDLE PHASE:**

Middle phase of the therapy was divided into two phases:

PHASE I:

In the first phase, the focus was on introducing various cognitive techniques to reduce the self-blame and to initiate a process of challenging over-beliefs and mis-interpretations associated with OCD. This was done in following way:

- First the patient was asked to **Relabel, i.e.,** label fear-producing cognitive activity, such as intrusive thoughts and images, as obsessions than anything else. For Example: *"This thought of stabbing Allah is just an obsession and this urge to pray immediately after that is just a compulsion that my OCD brain thinks will reduce my fear"*. Re-labeling was done for various other such beliefs and patient was practiced enough for each of these beliefs. Thereafter, a process of **Re-attributing** the cause of obsessions and compulsions to the neurobiological condition of OCD rather than calling them a product of the"self" was initiated. For example: "*Its not me, it's just OCD, a neurobiological disorder".*
- Then, four domains of **cognitive distortions** were identified in the patient for which various cognitive techniques were applied**.**
  - ✓ First being sense of **Excessive Responsibility** for the sexual and blasphemous content. Here, **Courtroom play technique** was used where therapist acted as judge and patient as prosecuting attorney who presented arguments to prove his guilt for causing a feared consequence. Therapist subsequently challenged these beliefs to reduce the responsibility.
  - ✓ The second domain of cognitive distortion is the **Over importance of thoughts for which the technique of** Cognitive continuum was used. Here patient was asked to assess his moral fears and guilt feelings for having sexual thoughts on a visual analogue scale (0-10) which was compared to a individuals who have committed acts of varying degree of immorality (e.g. serial rapist) to modify his moral thought action fusion.
  - ✓ Thirdly, **Need to control thoughts** was identified as another domain of error where **Thought Suppression Test** was applied**.** Patient was instructed to think of a animal as frequently as he can and report it followed by instruction to not to think of an animal and report it. Comparison was made to demonstrate that attempt to suppress distressing obsession thoughts is counter-productive.

- ✓ Lastly, **Overestimate of threat** or **catastrophic misinterpretation** was targeted by using **Calculating probability estimates** . here aatient was asked to provide an estimation of feared consequences (e.g.- having sex with mother). Then he was asked to list a chain of events that will be needed for his feared consequences to occur and the probability of occurrence of each of these events. A comparison was made between gut level estimate and the actual mathematical probability required to perform sex with mother

The next phase of therapy began with a elaborate discussion on the rationale of using ERP (exposure and response prevention) which basically targets the anxiety relieving ability that safety seeking behavior or compulsions produces is very short lived and counter-productive. And as proposed, each of these ERP sessions were followed by various cognitive techniques mentioned in phase I to enhance understanding. For the purpose, Anxiety graph was made and explained to the patient and discussed about rating of subjective unit of distress (SUDS). Then the patient was asked to tell about the anxiety provoking situation & thereafter asked to provide the associated SUDS with each of the situation on 0-100 point visual analogue scale.

Phase II:

Activities	**Rating**
While putting his hands in the pocket, it feels as if he is putting his hands in the vagina	20%
While wearing Chappal, he thinks he is putting his foot in the vagina	25%
While Chaining the bag he thinks he is going to cut the God into two pieces	30%
While taking water from container, he thinks he is putting his hands in vagina	35%
While sitting he thinks he'll sit on mother's vagina	40%
While singing songs, if he sings he will have sex with mother	45%
While buttoning up his Kurta he thinks that he is putting buttons on vagina	50%
While wearing pajaama he thinks he is putting his legs over vagina	55%
While speaking he thinks that if he speaks he will have sex with mother and if not he will have sex with Goddess Sita.	60%
While entering Auto he thinks as if he is entering vagina	65%
If two chairs are kept together, he thinks if he sits on one, he will have sex with mother and if another, he will kill Allah	70%
While plugging up, he thinks he is putting plug in the vagina or is killing Allah.	75%
When he walks, he thinks it become vagina or Allah's name comes and he will have sex or will them	80%
While wearing clothes, he thinks he is folding his mother and calling Goddess (Hazrate Fatima) to have sex with him	85%
While wearing or taking out his ring he thinks he is having sex with mother	95%
While praying, he thinks of verbally abusing God and having sex with them	100%

In this phase, brief conversation was carried out about previously discussed matters. Then the patient was exposed to least anxiety provoking situation i.e. putting his hands in the pocket. Before the start of the session therapist did the task to show the patient that it was doable after that patient was made to do it. In this sessions patient was very much distressed & anxious though this task was least anxiety provoking for him. He gave discomfort rating that was started with 35 & then gradually increases to 80 then decreases to 15. The duration of her distress was 1 hour 15 minutes after the exposure he was prevented from engaging in the neutralizing behaviour i.e. compulsive saying of mental prayer.

Immediately after the ERP session, revision of various cognitive techniques discussed previously, were introduced again in order to help patient understand the irrationality of thought. This subsequently helps in challenging the dysfunctional assumption and distortion to generate alternative explanations for the problem behavior. The technique of reattribution was again highlighted to make him understand that it the "OCD Brain" thought rather than his personal responsibility. He was asked to practice all these session at home also. Same task was practiced for another sessions. After the 3rd session his distress score was 50. In the 5th session hiss distress score was 25. His distress was decreased within 30 minutes & also prevented from compulsive behavior. In this way patient were exposed to least anxiety provoking situation to the most anxiety situation one by one manner.. Remaining sessions of this phase of treatment will be spent exclusively for ERP. This phase will last for approximately 10 more sessions till he was exposed and subsequently habituated to highest anxiety provoking activities.

Phase III:

- Here the main goal is to Increase patient awareness of distorted appraisal of unwanted thoughts through Cognitive restructuring chiefly to target the associated depressive symptoms. Here through Socratic questioning and down-arrow technique, an attempt was made to reach his core beliefs. Hence the process of cognitive restructuring was initiated using the technique of verbal challenging and pros-cons analysis.

❖ **Termination Phase**:

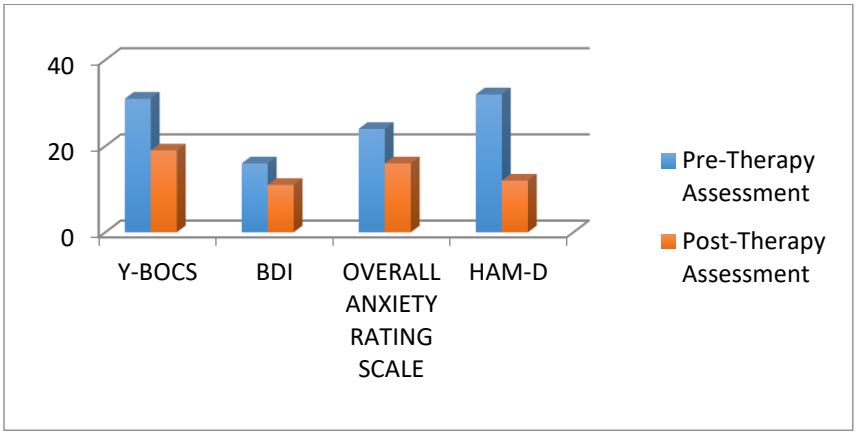
All previous session were revised. He was able to perform the task well. He was performing all of these with a mild degree of subjective anxiety, & without the following compulsive acts or if performed, within acceptable limits. A health perspective over his illness was also generated which could tackle both his obsessive ruminations and resulting depressive symptoms. Thus, the session was terminated. Patient was then asked to come for booster session.

Result:

Post-Therapy Assessment:

At the end of the final session all previously used tools were re-administered to monitor progress or client on Y-BOCS, there was a score of 19 indicating moderate range of obsessive compulsive symptoms. On BDI, OARS and HAM-D, there was mild depression indicated by score of 11 and 12 respectively. On OARS, a score of 16 was obtained indicating mild range of anxiety symptoms. The improvement obtained can be graphically depicted like this:

Y BOCS- SYMPTOMS	**Pre-Therapy Rating**	**Post-therapy Rating**
While putting his hands in the pocket, it feels as if he is putting his hands in the vagina	20%	10
While wearing Chappal, he thinks he is putting his foot in the vagina	25%	10
While Chaining the bag he thinks he is going to cut the God into two pieces	30%	20
While taking water from container, he thinks he is putting his hands in vagina	35%	20
While sitting he thinks he'll sit on mother's vagina	40%	15
While singing songs, if he sings he will have sex with mother	45%	25
While buttoning up his Kurta he thinks that he is putting buttons on vagina	50%	20
While wearing pajaama he thinks he is putting his legs over vagina	55%	15
While speaking he thinks that if he speaks he will have sex with mother and if not he will have sex with Goddess Sita.	60%	20
While entering Auto he thinks as if he is entering vagina	65%	25
If two chairs are kept together, he thinks if he sits on one, he will have sex with mother and if another, he will kill Allah	70%	30
While plugging up, he thinks he is putting plug in the vagina or is killing Allah.	75%	20
When he walks, he thinks it become vagina or Allah's name comes and he will have sex or will them	80%	35
While wearing clothes, he thinks he is folding his mother and calling Goddess (Hazrate Fatima) to have sex with him	85%	40
While wearing or taking out his ring he thinks he is having sex with mother	95%	40
While praying, he thinks of verbally abusing God and having sex with them	100%	35



Anxiety hierarchy was re-plotted to see the difference between the SUDS rating after therapy and the scores obtained are as follows:

Discussion and Conclusion:

Index patient's problem of blasphemous thoughts, Seeing images of sexual area of mother and God, Violent and aggressive thoughts and images, checking doors and taps repeatedly and excessive concern with moral fears was improved with therapy. Now patient is able manage himself and able to facing any situation.

The current study understand the OCD, especially sexual obsession towards the own members of the family, this is very stressful situation sometime happened. First of all understand the symptoms and elicited the situation. CBT or JPMR is the best combination of this treatment for the helps of reduced the active psychopathology. **Cognitive bio-behavioral self treatment (Schwartz, 1996):** Since patient has less knowledge about his illness, he has inflated sense of responsibility and self-blaming towards causing his own illness and hence always remains guilt prone. Thus, these techniques would target at his attribution style which will facilitate better adherence to standard CBT approach. **Behavioral technique (ERP):** Though ERP has been more standardized for overt compulsive behavior, in the present module patient presents with various covert compulsions. Moreover, Religious patients suffering from blasphemous thoughts often refuse ERP, since they experience such instructions sinful. However, Evidences supporting its efficacy (Abramowitz et al., 2002) proposes that if cognitive techniques immediately follow ERP sessions, especially with mental compulsions, behavior therapy can lead to successful outcome (Gordon 2005; et al., 1992). **Cognitive Therapy:** It has been suggested as standard treatment approach for altering both strongly held beliefs associated with OCD symptoms and interpretations of intrusive mental experiences change responsibility beliefs and appraisals and thereby to reduce distress and eliminate neutralizing responses, which usually occurred as covert neutralizing (mental) rituals **(Rachman & Hodgson, 1980; Salkovskis, 1998).**

Future Plan:

Urgent care:

- Contact your doctor if your symptoms worsen or don't respond to treatment. OCD typically has periods when symptoms become worse no apparent reason. Seek help at such times to adjust your medication or for help in modifying your behavior.
- If your symptoms don't respond to treatment, you may need to be hospitalized. Many psychiatric facilities provide varying levels of care, such as day care, evening care, and residential programs.

Self Care:

- You and your organization should learn as much as possible about OCD. OCD sufferers may wish to join the Obsessive-Compulsive Foundation or a local support group if available.
- Symptoms can sometimes be brought under control with medications or behavioral therapy. Even with appropriate treatment, most people with the disorder experience symptoms that wax and wane throughout life

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DOI: 10.31579/2637-8892/166