

Managing Obsessive Compulsive Disorder Using Meta Cognitive Therapy: A Case Study

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Abstract: Obsessive-compulsive disorder (OCD) is characterized by obsessions, which are intrusive and recurring thoughts, and compulsions; repetitive and ritualistic behaviours which the individual is forced to do at an attempt to neutralize the anxiety accompanying the obsession, contrary to the person's will. In an Indian study the point prevalence rate of OCD was found to be 3.3%. The role of the individuals' beliefs in development of OCD is associated to people's misleading metacognitions, implying that their views about their own thinking that are the distorted beliefs are causing maladaptive coping styles which subordinates to psychological symptoms. A number of studies confirming that the specific metacognitions of OCD (thought fusion beliefs, beliefs about rituals and stop signals) as suggested by the Metacognitive Model of OCD are linked to the severity of OCD. Metacognitive therapy was applied to a 32 year old male who was brought to the psychiatry outpatient department with the chief complaints of repeated, unpleasant thoughts about perverse sexual images involving women for the past 10 years. Metacognitive therapy was successful in reduction of OCD symptoms, severity of anxiety and depressive symptoms, unhelpful metacognitions and increase thought control.

Keywords: Obsessive-Compulsive Disorder, Beliefs, Metacognitive Therapy, Case Study.

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I. INTRODUCTION

Obsessive-compulsive disorder (OCD) is characterized by obsessions, which are intrusive and recurring thoughts, and compulsions; repetitive and ritualistic behaviours which the individual is forced to do at an attempt to neutralize the anxiety accompanying the obsession, contrary to the person's will [APA, 2013]. The community prevalence estimates of obsessive compulsive disorder in adults range from 0.5% to 3% (Gururaj et al; 2016). In an Indian study the point prevalence rate of OCD was found to be 3.3% (Jaisoorya et al; 2017). According to the reported statistics by WHO, OCD is deemed as the sixth disabling factor leading to loss of performance and poor standard of living.

The OCD guidelines by NICE (2005) that the misleading metacognitions are associated to the individuals beliefs in development of OCD. It implies that one's own views about their own thinking are that the distorted beliefs are causing maladaptive coping styles which subordinate to the psychological symptoms (Wells, 2009).

A number of studies confirming some of the specific metacognitions of OCD (thought fusion beliefs, beliefs about rituals and stop signals) as suggested by Wells and Mathews model of OCD are linked to OCD severity (e.g.; Myers,

Fisher, & Wells, 2009). Hence the beliefs play a pivotal role in terms of the development of psychological disorders such as OCD (Wells, 2000).

II. CASE REPORT

A 32 year old male of average built, belonging to middle socioeconomic class and urban background was brought to the psychiatry outpatient department with the chief complaints of repeated, unpleasant thoughts about perverse sexual images involving women for the past 10 years, co-morbid with depressed mood and sleep related problems for the past 2 years with significant findings in the personal histories; especially early childhood experiences and attitude towards parental figures. Strict patterns of parenting and environmental conditioning were found in his history. He fell into bad company with the intention to seek protection from the bullies. During this phase he was introduced to pornographic videos to which the patient got addicted which in turn augmented his obsessions.

The failure at occupational front as a result of obsessions, the patient had low mood, reduced and disturbed sleep patterns, hopelessness about future with suicidal ideations. He had failed to respond effectively to medication as he got addicted to benzodiazepine for relieving his anxiety

and sleep related difficulties. The patient was started on Risperidone 15mg 1 HS, Pregabalin 75mg 1 HS and Venlafaxine 10 mg 1 B.D. Following the intake in the clinical psychology unit, he made an remarkable response to a cognitive behavioural and exposure therapy programme, and his improvements were subsequently well maintained at his home. Onset was insidious, course was progressive, 1st continuous episode with no significant precipitating factor. The patient has been receiving pharmacological treatment but there was no significant improvement. Pre-morbid temperament revealed that the patient was stubborn and rigid in his views, sensitive to criticism and failures and exceedingly moralistic.

III. INTERVENTION

Metacognitive Therapy with Mindfulness Meditation and Cognitive behaviour Therapy (Activity Scheduling and Cognitive Restructuring) was conducted for 18 sessions of 1 hour each for a duration of 7 months.

A. Locus of the Therapy Process

Hospital-based set up with the patient and his family.

B. The Focus of the Therapy Process:

➤ Short-Term Goals:

- Decrease ruminations
- Reduce distress and anxiety
- Improve Functioning in occupational and social functioning

➤ Long-Term Goals:

- Increase self-confidence
- Improve coping and self-regulation skills
- Generation of alternative stress management strategies.
- Improve family environment.

C. Types and Techniques of Intervention Used:

➤ Psycho-Education:

The family members were educated and made aware about the nature of illness, course, treatment, outcome any misconceptions about the illness were also addressed.

➤ Metacognitive Therapy:

- *Modifying Beliefs about Obsessive Thoughts through Brain lock* developed by Jeffery Schwartz. The technique is called response prevention because the patient learns to prevent the compulsive responses that come habitually and replaces them with novel and more helpful behaviours. This approach has four basic steps “Relabel, Reattribute, Refocus and Revalue”.
- *Cognitive De-fusion*: Since the present patient was suffering from a long-standing illness, primarily maintained by obsessive ruminations, maladaptive metacognitions, low thought control and worrying tendencies, therefore metacognitive therapy seemed appropriate.

➤ Mindfulness Meditation

- Body scan
- Sitting meditation.

The aim of mindfulness was to become more alert of bodily sensations, feelings, and thoughts in the moment rather than dwelling on the past feelings.

➤ Cognitive Behaviour Therapy

- Activity Scheduling
- Cognitive Restructuring

➤ Good Prognostic Indicators:

- Adaptive capacity to think logically and coherently, reaching reasonable conclusions.
- Good educational background with supportive parents.

➤ Poor Prognostic Factors:

- Poor interpersonal skills and social support
- Maladaptive level of introspection
- Severity of symptoms leading to high likelihood of terminating treatment.
- Reasonably open and flexible style of thinking-personality asset for therapy.

IV. THERAPY PROCESS

➤ Session 1-5

The first two sessions began by establishing rapport and a provisional diagnosis was arrived at based on the clinical interview. The patient along with his caregivers were psycho-educated regarding OCD. The nature of anxiety symptoms and its associated safety behaviours and the maladaptive coping strategies that lead to temporary reduction of anxiety was explained to him. Behavioural management of the patient was done. To improve the functioning, activity scheduling was done collaboratively with the patient. He was asked to maintain a record of the daily activity schedule and pleasurable activities were included in the schedule. The patient agreed to incorporate a physical activity in his routine and to help his mother in the daily household chores.

A pre-assessment was done using “Yale-Brown Obsessive Compulsive Scale (Y-BOCS), Becks Depression Inventory-II (BDI-II) and Hamilton Anxiety Rating Scale (HAM-A)”. Shallow and deep breathing was first taught to the patient followed by Sitting Meditation.

➤ Session 6-10

The patient was explained the Metacognitive model of OCD. The way in which emotions of anxiety and sadness are the core indications of inconsistency in regulating oneself and threatens ones well being was explained to the patient.

They way they are maintained because of the individual’s thinking style and strategies, which engulfs apprehension/contemplation, risk monitoring, unaccommodating thought regulating strategies, and other forms of behaviour that prevent adaptive learning. The therapist highlighted the idea that it is the patient’s

convictions about these events and the way the patient associates to them is one of the root causes of OCD.

The patient was then taught the 4 step model “Brain Lock” developed by Jeffery Schwartz. The patient had made the record as follows:

Table 1 The Patient

Situation (Trigger)	Thoughts	Re-Label	Re-Attribute	Re-Focus
Saw an image of a girl.	Intrusive sexual thoughts	These are not my thoughts.	These are the thoughts of my OCD, and caused due to the chemical imbalance in my brain. Hence these are the false messages.	To focus back on the work one was engaged in or distract oneself with some pleasurable activity.

The patient also reported benzodiazepine dependence/addiction along with withdrawal symptoms involving severe head ache and sleep related difficulties and was asked to consult the psychiatrist In-Charge and to taper the medicine in small doses instead of completely stopping to avoid facing withdrawal symptoms.

His sleep was fragmented and sleep latency was increased. Sleep hygiene was explained and methods which could help him to sleep were arrived at.

The patient was also taught “Body Scan” meditation. The instruction was simply to pay attention to each sensations in every part of the body, rather than trying to change them in any way.

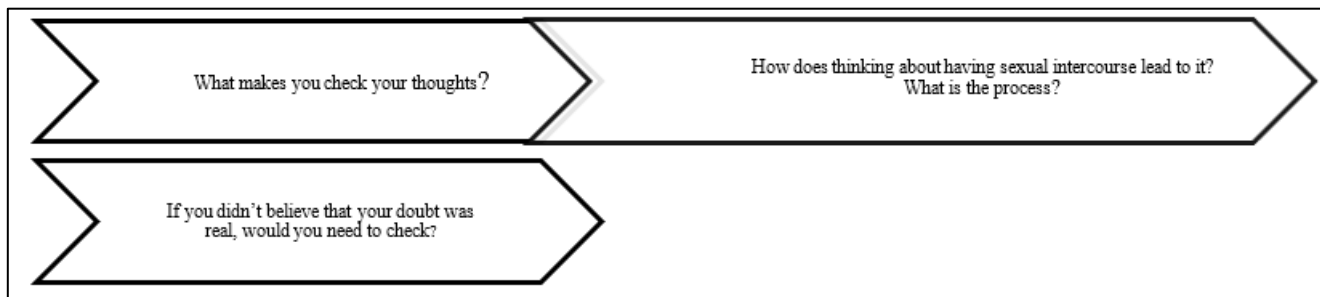
➤ *Session 11-14*

Traits of schizotypal personality added to his difficulties in social functioning. The patient was encouraged to attend social gathering weekly. The patient was also explained the importance of confronting his problems instead of avoiding them which only enhance the problem. The patient was encouraged to be autonomous in decision taking since he depended on his parents for all his major to minor decisions.

The next target of the sessions was cognitive de-fusion. The following thought fusion was found to present in the patient’s thought processes:

- Thought-Action fusion (TAF) – “If I have thoughts about sexual intercourse, I will do it”.

Verbal reattribution methods were used. Some instances of the queries asked are:



These verbal strategies thus questioned and highlighted the misinterpretation of the patient’s beliefs which led to distress and maintenance of symptoms and drew his attention to his misappraisals of thoughts.

❖ *End Phase (Session 15-18)*

➤ *Session 15-17*

The next few sessions focused on reducing the re-assuring tendency in the patient by means of problem solving skills. The problem solving skills were explained to the patient to help him to increase the flexible style of thinking in the patient but also independence in decision making thereby reducing the re-assuring tendency. The problem solving skills will help the patient broaden his thinking pattern, improve his

communication and understanding skills and increase the acceptance of the problems that are unsolvable to be less avoidant when the problems occur.

➤ *Session 18*

The patient reported an overall 90% improvement in his social and occupational functional improvement and 95% reduction in his thoughts. He also reported 80% improvement in his sleep disturbances due to mindfulness meditation which reduced his benzodiazepine dependence. As a part of relapse prevention the patient was advised to continue to implementation of the skills that he had been taught during the therapy sessions in order for symptoms to alleviate. The post assessment of the patient was done on Y-BOCS, HAM-A and BDI-II.

Table 1: Table Showing the Scores Obtained by the Patient on YBOCS, BDI-II, and HAM-A, Pre-Treatment and Post-Treatment.

	Y-BOCS	BDI	HAM-A
PRE-TREATMENT	33	32	27
POST-TREATMENT	5	8	4

Table 2: Showing the Subjective Ratings by the Patient for the Improvement in Symptoms Taken During 2 Sessions i.e.; Session 2 and Session 18.

	PRE-ASSESSMENT	POST-ASSESSMENT
Benzodiazepine Dependence	10	3
Obsessive Thoughts	9	2
Sleep Disturbances	10	2
Impairment In Social Functioning	10	1
Difficulty In Decision Making	8	2
Impairment In Social Functioning	9	2
Self Confidence	2	8

V. CONCLUSIONS AND OUTCOME

Metacognitive therapy was successful in reduction of OCD symptoms, severity of anxiety and depressive symptoms, unhelpful metacognitions and increase thought control. Increased cognizance of the role that metacognition plays in preserving symptoms helped the patient evaluate his obsessions. The levels of rumination and worry can be reduced by modification of metacognitive beliefs about obsessions and rituals.

To sustain recovery by enhancing independence in thinking by collaboratively working with the patient and his parents in his problem-solving skills, by not reinforcing his re-assuring tendencies along with further refining the communication skills as the patient faces mild difficulty in expressing his views clearly and precisely, to reduce the dependency on the therapist by encouraging the patient to solve his day-to-day concerns independently.

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