

# Obsessive-Compulsive Disorder cases with a Good Prognosis which Underwent CBT and Morita Therapy

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## Abstract

Morita therapy was found by Shoma Morita in 1919 in Japan and is psychotherapy for anxiety disorders based on Eastern psychology. 2 OCD cases were illustrated to which Inpatient Morita therapy was applied after the trial of Cognitive Behavioural therapy and showed a favourable progress. Case 1 rejected exposure. Although Case 2 engaged in Cognitive Behavioural therapy, it had a side effect that his obsession intensified. Case 1 could shorten her bathing time and engaged in occupation of taking care of animals. After Case 2 engaged in works with other patients, he could live with obsession and was aware of anger towards his parents. Morita therapy is effective for OCD patients who reject exposure and who are inclined to intellectualize their emotions.

**Keywords:** Obsessive-compulsive disorder; Cognitive-behavioural therapy; Exposure; Inpatient Morita therapy

## Introduction

In U.S., Cognitive-Behavioural therapy such as ERP has become a standard treatment for the patients with Obsessive-Compulsive Disorders (OCD) [1]. In some cases, however, trying to correct cognitive contents exacerbates obsessions. 2 OCD cases will be illustrated to which Inpatient Morita therapy was applied after the trial of Cognitive Behavioural therapy and showed a favourable progress.

Morita therapy is founded by Shoma Morita (1874-1938) in 1919 in Japan. Morita therapy was originally intended to treat the patients with anxiety disorders [2]. Morita therapy is effective for anxiety disorders, mild or moderate depressive episode, dysthymia, psychosomatic diseases, and chronic pain disorder. Morita therapy is not applied to acute phase of schizophrenia and manic episode, severe depressive episode, and dementia [3]. Therapeutic goal for the patients is to begin to manifest the desire for life behind anxiety while having the anxiety as it is [4].

The treatment system of Inpatient Morita therapy is as follows [2]. The Jikei University Center for Morita therapy has 20 beds available. Morita therapy consists of 4 phases which is shown in Table 1. Bed rest period is not completely isolated. Once a day Morita therapist sees the patient in short time, a nurse sees the patient in short time three times a day. Before admission, Morita therapist explains inpatient Morita therapy and gets consent from the patient by letter. From light work period, Morita therapist sees the inpatient twice or three times a week. It takes about 30 to 50 minutes. Morita therapist listens to the patients supportively, and recommends engaging in occupational work and interpersonal relationship as necessary.

## Case Presentation

The cases are modified to protect privacy to an extent that the context is not significantly changed.

	Therapeutic purpose
Bed-Rest Period	During the first seven days of treatment, the patients are required to remain in bed in a single room, with time permitted only to go to the toilet, wash their faces, and have meals.
Light Work Period	During this stage, which 5 days, the patient was required to go outside to experience fresh air and silently observe others working in the garden. From this period, patients start to have a 30 to 50 minute counseling session for 2 to 3 times per week, as well as daily diary therapy sessions.
Heavy Work Period	During this stage, which lasted about 3 months, the patients was to engage in more significant tasks, such as cleaning, gardening, and caring animals. For the first half of the period, the beginning patients learn about the light work from the experienced patients. For the latter half of the period, they become in charge of the work and teach the newer patients how to work. This period usually lasts for 2 to 3 months.
Training Period for Practical Living	During this stage, which lasted about a few weeks to one month, the patients prepared to return to his or her usual life in society. This period usually lasts for several weeks to 1 month.

Table 1: Therapeutic purpose of inpatient Morita therapy

### Case 1: A 30-year-old woman

**Symptom:** Obsession of contamination for various matters and compulsive washing.

#### History prior to treatment

After she started living with her husband in year X-5, she began to feel that bath room was dirty and to take a long time to take a bath, while she also began to fear that the floor was dirty. In year X-4, because she wanted to improve her symptoms, she searched hospitals with her husband. She was treated with fluvoxamine 150 mg, which was not effective. In year X-3, she visited the B medical institute which offered behavioral therapy. However, she shortly dropped out of the therapy. She was then determined to make a change in her present condition and visited our hospital to try Morita therapy that she came to know in year X. At that time, she spent 4 hours to take a bath and did not sleep well. In order to decrease her compulsive washing, she was put on pharmacotherapy at the other psychiatric department as a start. During the inpatient treatment at the psychiatric department, she became able to sleep with 50 mg of paroxetine and 10 mg of olanzapine which she took at bedtime. After 2 months; she was examined at our center again for further treatment.

#### Assessment at first examination (case formulation)

While she had *shinkeishitsu* (nervousness) character, her “*toraware* (obsession)” with symptoms was ambiguous. This personality is also similar to what Salzmänn called obsessive personality [5]. The reason why *shinkeishitsu* character is assessed is because Morita therapy is usually effective to treat those with anxiety disorders developed from this type of character [6]. It is an important index to judge whether or not Morita therapy is indicated. “*Toraware*” consists of “a vicious cycle of symptom aggravation effects” and “conflict between ideal and reality” [4].

Co-author of another therapist made the MMPI-II -measurement. As for Case 1, the analysis of MMPI-II revealed that the score F was remarkably high at 113, suggesting the possibility that the case might have dramatized her distress in the assessment, perhaps wanting others to understand her sufferings. As for the profile, Schizophrenia marked the highest score of 93, followed by Paranoia, of 92. Thus, it was considered that the case was sensitive to the behaviors of others and tended to associate happenings with herself and become a victim, while she also had a strong sense of self-doubt and was inclined to feel isolated from others, and may have consequently withdrawn from actual interpersonal relationships. It was also presumed that due to her perfectionism, nothing she did contributed to her confidence, but to more obsessive feelings of inadequateness and helplessness, resulting in somatic and depressive symptoms.

#### Progress after admission

At the last check-up during the Bed-Rest Period, she told the therapist that she worried about the long hours required to take a bath. Because the therapist said her to cut short the time for taking a bath within 1 hour, and the patient was able to cut down the bath time to around 40 minutes on her own. During Heavy Work Period, she was able to touch a dog while feeling scared and found that it felt good and warm.

On the 63<sup>rd</sup> day after rising from the bed-rest, another patient who was in charge of animals strictly told her to discipline the dogs more

properly. She was then irritated and washed her hands more. Taking up this episode in an interview, she could gain an insight that her hand washing tended to increase when irritated by something, which also occurred in the relationship with her husband. She was advised not to remove the irritated feelings by washing but to hold it as it is.

On the 74<sup>th</sup> days after rising, she stayed overnight at home as she entered the social rehabilitation period. From her husband’s point of view, the time for taking a bath shortened only to 30 minutes but her hand washing increased compared to the time prior to inpatient treatment. She was discharged on the 83<sup>rd</sup> day after rising.

The scores of the Japanese version of YBOCS were as follows. Co-author of another therapist made the measurement. As for Case 1, the scores at admission were 20 for obsession, 20 for compulsion, which totalled 40, and 4 for insight. At discharge, the scores declined to 5 and 7 for obsession and compulsion, which totalled 12, and 2 for insight.

After discharge, she overcame the “*kamae* (mental set)” that “she had to” get married, and reconsidered her way of living, to change her life to a more work-oriented one, and her symptoms disappeared.

### Case 2 A 29-year-old man

**Symptoms:** Fear of harming others, ritualistic compulsive checking, compulsive washing.

#### History prior to treatment

In year X-11, after graduating from high school and preparing for the entrance exam for University, the patient started to be worried that he might hurt others. After spending 3 years for the preparation, he passed the exam and started to live independently. Then his worry became more serious, and in year X-8, he was diagnosed to have OCD at a C local hospital. In year X-7, he left the university as he could not go to the campus due to symptoms. In the following year, he attempted to kill himself by hanging, and was admitted in the psychiatric hospital D. He then tried Cognitive behavioral therapy for a total of 4 times at the hospital E. In year X-1, however, compulsion increased as he could not refuse what colleagues of his part-time job wanted him to do. And in year X, he was referred to our hospital by the hospital D, seeking Morita therapy.

#### Assessment at first examination (Case formulation)

At the first exam, the patient was most troubled by the fact that it took him over 2 hours to take a bath. He had *shinkeishitsu* character and showed a marked “*toraware* (obsession)” that “he had to shorten the bath time.”

**Prescription at admission:** 200 mg of quetiapine, 150 mg of fluvoxamine

Co-author of another therapist made the MMPI-II -measurement. The analysis of MMPI-II for Case 2 showed that Psychopathic deviate marked the highest score of 83, followed by paranoia, of 80, and by depression, of 78. This suggested that the case had a low stress tolerance, overreacting to trivial matters, and therefore was vulnerable to depressive and hypochondriac responses as well as frustration with others. It was considered that the case had difficulty to assume responsibility, tending to be extrapunitive and become a victim, and to learn from experience. Perfectionism was obvious. In interpersonal relationships, he/she is passive and dependent, attracting attention

from others. He tends to associate the happenings in his environment with himself.

### Progress after admission

After rising from the bed-rest, he was able to cut short the bath time thinking he had to finish within 30 minutes. However, he was overly worried during the day that other patients might point out the length of his bath time. He relieved the stress of this worry by drinking a lot of water (10 litter a day at most), and on the 35<sup>th</sup> day after rising, the Na blood concentration level reached 123 mmol/l. During the light work, his feelings of inferiority intensified, and he went on one-week stay at his home from the 42<sup>nd</sup> day after rising.

From the 55<sup>th</sup> day after rising, he was encouraged to join group work as he was very conscious about others, and he was scheduled for group work in the morning. Through the group activities, he got used to communicate with other patients, which gradually resulted in a decreased water drinking and normalized the Na blood concentration level.

On the 62<sup>nd</sup> day after rising, another patient misguidedly thought and pointed out that he took too much time for bathing. He was disgusted by the happening and stayed at his home from the 65<sup>th</sup> to 69<sup>th</sup> day after rising. During the home stay, he realized that he could not say no to his parents. When the therapist asked how he felt when his parents told him to continue the inpatient treatment, he said he was angry.

From the 72<sup>nd</sup> day after rising, he started to join group work all day. On the 78<sup>th</sup> day, he said, "having worked with everyone all day, I gradually became able to live with my obsession that I had to shorten the time I took for bathing within a fixed length of time."

He was discharged from our hospital on the 101<sup>st</sup> day after rising. The scores of the Japanese version of YBOCS were as follows. Co-author of another therapist made the measurement. As for Case 2, the scores at admission stood at 12 for obsession, 14 for compulsion, which totalled 26, and 3 for insight. At discharge, they declined to 8 and 11 for obsession and compulsion, which totalled 19, and 2 for insight. Although he used to suppress his opinion in front of his parents prior to the inpatient treatment, he gained awareness about his own feelings and started to express them both at home and at work after discharge.

### Discussion

While Case 1 dropped out of the exposure therapy to treat her fear to touch floors, she retained the motivation for treatment. Her motivation was then directed not to alleviate symptoms through exposure and response prevention but to act according to the schedule of the ward, which resulted in the decrease in obsessive-compulsive behaviours. Nakamura points to the difference between cognitive behavioural therapy and Morita therapy that the former focuses on the avoidant behaviours related to symptoms while the latter focuses on the fulfilment of life in general, listening to the desire for life, rather than symptom alleviation. However, as in the above case, it is difficult to aim at fulfilment of life without treating obsessive-compulsive behaviours when they are intense [7]. To such cases, Kubota proposed a method to use time as a ruler to facilitate the change in behaviour [8]. For the patients with severe obsessive-compulsive symptoms who reject exposure therapy, Inpatient Morita therapy was considered effective as it simultaneously addresses both issues, by giving

instructions regarding the symptoms and by expanding the scope of behaviours in daily living. While the patient in Case 2 succeeded in limiting the amount of time to take a bath to 30 minutes after starting the inpatient treatment, he had difficulty diverting his attention from symptom reduction after going through cognitive behavioural therapy, which somehow led to the impulsive behaviour of water intoxication, being so concerned with how others thought about him. Referring to his attention to symptom reduction, he himself remarked, "cognitive behavioural therapy penetrated me," suggesting the possible side effect of cognitive behavioural therapy. According to Nakamura, while cognitive behavioural therapy looks into the validity of cognition, Morita Therapy brings about the change in cognition as a result of the patient's various experiences [7]. For the patients who are entirely preoccupied with symptom reduction, it was therefore considered that the Inpatient Morita Therapy, in which patients become able to deal with obsessions as a result of the fruitful efforts to expand the scope of living through the experiences of work and group activity, was effective.

The limitation of this study is discussed next. In this study, the 2 cases with favourable progress were reported among the cases of inpatient Morita therapy to which cognitive behavioural therapy had been applied previously. As the report was based on the clinical records, this is a retrospective study. Interviewing the patients about their experiences of the Inpatient Morita Therapy after cognitive behavioural therapy, and applying qualitative research methods to analyse the results can be a good way to complement.

### Conclusion

2 OCD cases were illustrated to which Inpatient Morita therapy was applied after the trial of cognitive behavioural therapy and showed a favourable progress. Case 1 could not continue the behavioural therapy due to resistance against exposure. Although Case 2 engaged in cognitive behavioural therapy, it had a side effect that his "toraware (obsession)" with the length of time for taking a bath intensified and suppressed himself to shorten the time. It is important in Inpatient Morita therapy that treatment goal is not only to relieve symptoms but also to enhance a patient's life in general. Inpatient Morita therapy is effective for OCD patients who reject exposure and who are inclined to intellectualize their emotions.

### References

1. Abramowitz JS (1996) Variants of exposure and response prevention in the treatment of obsessive-compulsive disorder: A meta-analysis. *Behavior Therapy* 27: 583-600.
2. Morita S (1998) Morita therapy and the true nature of anxiety-based disorders (shinkeishitsu). In: A Kondo, P LeVine (eds). Albany, NY: State University of New York Press. (Original work published 1928)
3. Nakamura K, Tanii K (2011) Current Morita-Shinkeishitsu and Morita Therapy. *The Journal of JPHA* 30: 28-32.
4. Kitanishi K, Azuma N (2005) Morita Therapy in Modern Times from 1995 to 2004. *Internal Journal of Counseling and Psychotherapy* 3: 67-85.
5. Salzman L (1975) *The Obsessive Personality; Origins, Dynamics and therapy*. Jason Aronson Inc, New York.
6. Nakamura K, Kitanishi K, Maruyama S (English Translation by Ishu Ishiyama) (2010) *Guidelines for practising outpatient Morita therapy (English edition)*. By Japanese Society for Morita Therapy.
7. Nakamura K (2007) New wave in Cognitive Behavioral Therapy and position of Morita Sect 18: 45-50.
8. Kubota M (2002) Morita Therapy for OCD. *Japanese Journal of Psychotherapy* 36: 17-23.