

COGNITIVE-BEHAVIORAL THERAPY WITH EXPOSURE AND RESPONSE PREVENTION FOR CONTAMINATION-RELATED OBSESSIVE-COMPULSIVE DISORDER: A CASE STUDY

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ABSTRACT

This case study describes the assessment, formulation, and cognitive-behavioral treatment of Ms. A, a 26-year-old married mother of two young children from Lahore, Pakistan, who presented with a 3-year history of contamination obsessions, excessive handwashing and cleaning, checking, avoidance, and repeated reassurance seeking from her husband. Symptoms began after her infant son was hospitalized with gastroenteritis and intensified after the birth of her daughter. Assessment comprised a detailed clinical history from the client and her husband, mental status examination, risk screening, 1 week of self-monitoring, the Yale-Brown Obsessive Compulsive Scale (Y-BOCS), and the Rotter Incomplete Sentences Blank (RISB). Baseline Y-BOCS severity was 27, and the RISB adjustment score of 143 exceeded the conventional cutoff, with themes of responsibility, guilt, and fear for her children's health. A DSM-5-TR diagnosis of obsessive-compulsive disorder, with good or fair insight, was established through clinical interview against diagnostic criteria. The case was conceptualized using a 5Ps framework and Salkovskis's cognitive-behavioral model of inflated responsibility. Treatment consisted of 12 weekly sessions of cognitive-behavioral therapy centered on graded exposure and response prevention, supported by psychoeducation, reduction of family accommodation, cognitive restructuring, and relapse prevention. At post-treatment, the Y-BOCS score fell to 14 (a 48.15% reduction), daily handwashing decreased from about 27 to 9 episodes, and reassurance seeking fell from about 12 to 2 requests per day, although residual symptoms remained. The case highlights the value of formulation-driven exposure and family involvement in treating contamination-related obsessive-compulsive disorder in young mothers.

I. INTRODUCTION

Obsessive-compulsive disorder (OCD) is characterized by obsessions, compulsions, or both that are time-consuming or cause clinically significant distress or impairment; insight is specified as good or fair, poor, or absent (American Psychiatric Association [APA], 2022). Contamination fears accompanied by washing and cleaning rituals are among its most recognizable presentations. Because these rituals are usually performed at home, family

members are frequently drawn into the cycle through reassurance and accommodation, and young mothers may experience their symptoms as directly tied to the safety of their children. Cognitive-behavioral accounts propose that intrusive thoughts are almost universal, but become obsessional when a person appraises them as signaling harm for which they are personally responsible (Salkovskis, 1985). Washing, checking, and reassurance seeking reduce distress in the short term, yet they prevent the person from discovering that the feared outcome is unlikely, so the responsibility appraisal is maintained.

Exposure and response prevention (ERP), usually delivered within cognitive-behavioral therapy (CBT), is regarded as the first-line psychotherapy for OCD (Hezel & Simpson, 2019; McKay et al., 2015). In ERP, the person approaches feared cues in a planned, graded way while refraining from the compulsions that usually neutralize distress. Cognitive techniques that target inflated responsibility and intolerance of uncertainty may improve distress tolerance, adherence, and retention when delivered alongside ERP (McKay et al., 2015), and contemporary CBT for OCD places deliberate emphasis on exposure rather than on cognitive restructuring alone (Spencer et al., 2023). A meta-analysis of 36 randomized controlled trials involving 2,020 participants found a large pooled effect for CBT with ERP against control conditions ($g = 0.74$), although effects were smaller in studies without suspected researcher allegiance (Reid et al., 2021). The present case study describes the history, assessment, diagnosis, formulation, and 12-session CBT with ERP of a young mother with contamination-related OCD. It aims to show how diagnosis was established, how a cognitive-behavioral conceptualization guided the choice of ERP targets, and how family accommodation and childcare-related exposures were addressed.

II. CASE PRESENTATION

1) Identifying Information

Ms. A (pseudonym) is a 26-year-old married woman, the second of four siblings, with a bachelor's degree. She previously worked as a primary school teacher and has been a homemaker since her first pregnancy. She lives in a joint family system in Lahore with her husband (31 years, bank officer), her son (3 years), her daughter (1.5 years), and her parents-in-law. The family belongs to a middle socioeconomic class, speaks Urdu and Punjabi, and is Muslim.

2) Referral and Setting

Ms. A was referred to the outpatient clinical psychology service of a tertiary care hospital in Lahore by a general physician whom she had consulted for cracked, inflamed skin on her hands. The physician noted excessive handwashing and recommended psychological assessment. She attended with her husband, who served as the second informant. Both informants were judged reliable, and the information they provided was consistent. Assessment and therapy were conducted by a clinical psychologist under supervision.

3) Presenting Complaints

Client's Account

Ms. A reported the following complaints, in order of distress, with duration: (a) "I keep thinking that there are germs on my hands and everything I touch, and that my children will get sick because of me" (3 years); (b) "I wash my hands again and again, sometimes 25 or 30 times a day, and I cannot stop until it feels clean" (3 years); (c) "I clean the floors, kitchen, and the children's things many times" (2.5 years); (d) "I keep asking my husband if things are clean" (2 years); and (e) "I feel tired, irritated, and guilty all the time" (1.5 years).

Informant's Account

Her husband reported that she spent 2 to 3 hours a day washing and cleaning, avoided touching shoes, doorknobs, and money, and asked him 10 to 15 times a day whether her hands or the children's things were clean. He described increasing family tension because household routines and meals were delayed, and because his mother criticized the time Ms. A spent cleaning. He also reported that he had begun removing his shoes outside the house, washing items on her behalf, and repeatedly reassuring her to keep the peace.

4) History of Present Illness

Ms. A had always been neat and particular about hygiene, but she did not experience distressing obsessions or time-consuming rituals before the age of 23. When her son was 7 months old, he was hospitalized for 3 days with acute gastroenteritis. During the admission, a pediatrician advised the family about careful hygiene during bottle preparation. Ms. A recalled feeling intensely guilty and thinking, “This happened because I was careless.” After the child’s discharge, she began washing his feeding bottles and utensils several times and boiling them repeatedly. Over the following months, the washing extended to her hands, the kitchen, the floors, and items brought into the house from outside. She began to avoid touching shoes, doorknobs, currency notes, and public washrooms, and she showered for about 40 minutes after returning from the market. Symptoms increased about 18 months before referral, after the birth of her daughter, as childcare demands rose and her daughter began to crawl on the floor.

At presentation, she washed her hands about 25 to 30 times a day, each episode lasting 3 to 5 minutes with repeated soap applications, and spent an additional 45 minutes a day, on average, cleaning surfaces with disinfectant. She washed her children’s clothes separately and twice. She repeatedly checked that her children’s hands, toys, and feeding items were clean and sought reassurance from her husband. Symptoms worsened when visitors came with children, after outings, and when she was tired, and they lessened temporarily when her husband took over feared tasks. She recognized that her fears were excessive and wished to stop, but felt unable to resist washing. Before referral, Ms. A had consulted a religious scholar about whether her repeated ablutions were necessary. He advised that a single ablution was sufficient, which reduced her guilt about prayer-related washing for a short time but did not affect her contamination fears. She had not received any psychiatric or psychological treatment. The general physician prescribed an emollient for hand dermatitis; no psychotropic medication had been prescribed.

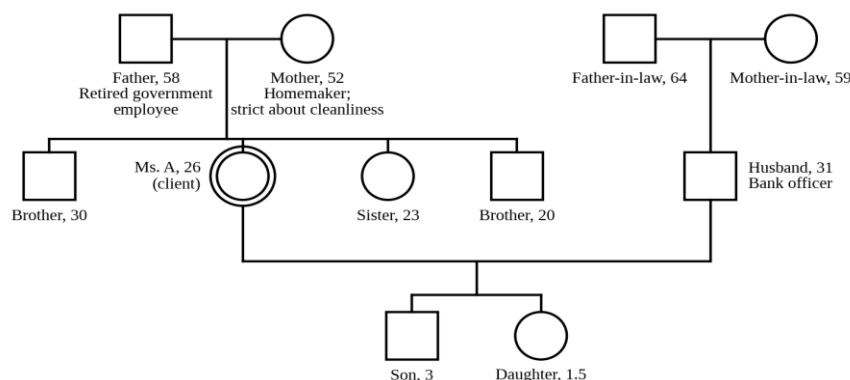
5) Past Psychiatric and Medical History

There was no history of previous psychiatric illness, hospitalization, self-harm, or substance use. Her medical history was unremarkable apart from contact dermatitis of both hands related to frequent washing. Both pregnancies and deliveries were reported to be uncomplicated. There was no history of head injury, seizures, or thyroid disease.

6) Family History

Ms. A’s father (58 years) is a retired government employee, described as calm and reserved. Her mother (52 years), a homemaker, was described as “very strict about cleanliness,” often insisting that the children wash their hands and change clothes on returning home, although she had never sought psychiatric help. Ms. A has an elder brother (30 years), a younger sister (23 years), and a younger brother (20 years); all were reported to be in good health. No family member had a diagnosed psychiatric disorder. Relationships within her family of origin were described as warm. Since marriage, she has lived with her husband and her parents-in-law; her relationship with her father-in-law was cordial, whereas her mother-in-law was critical of her cleaning routines. The family structure is shown in Figure 1.

Figure 1: Genogram of Ms. A’s Family



Note. Squares represent males and circles represent females; the double circle indicates the client. Ms. A lives in a joint family with her husband, children, and parents-in-law.

7) Personal History

Birth and Early Development

Ms. A was born by normal delivery at full term. Developmental milestones were achieved at the expected ages, and there was no history of serious childhood illness.

Childhood and Education

She was described as an obedient, sensitive, and responsible child who became upset when she made mistakes or when things were untidy. She was a consistently good student, completed her bachelor's degree with good grades at the age of 20, and had a small circle of close friends.

Occupational History

After graduating, she worked as a primary school teacher for 2 years, from the age of 20 to 22, and was regarded by colleagues as punctual, conscientious, and organized. She left her job during her first pregnancy by choice and reported no work-related difficulties.

Marital History

Ms. A married at the age of 22 through an arranged marriage with her consent. She described her husband as caring and supportive and the marriage as satisfactory. Over the past 2 years, however, her reassurance seeking and the time she spent cleaning had led to frequent arguments, especially when meals were delayed or visitors were expected.

Religious and Sociocultural Background

Ms. A is a practicing Muslim who prays regularly. She distinguished between ritual ablution, which she performed according to religious guidance, and her compulsive washing, which she described as driven by fear of germs rather than by religious obligation. Cleanliness is highly valued in her family and community, which made it difficult for relatives to recognize her washing as a problem at first.

8) Premorbid Personality

Before the onset of symptoms, Ms. A was described as organized, conscientious, responsible, and caring. She set high standards for herself, disliked uncertainty, and tended to worry when things were not under her control. She was sociable with close friends and relatives, enjoyed cooking and reading, and coped with stress mainly by working harder and seeking reassurance from family members.

9) Mental Status Examination

Ms. A was appropriately dressed and well groomed. Her hands were red and dry, with visible cracking over the knuckles. She was cooperative, maintained good eye contact, and established rapport easily. Psychomotor activity was normal, although she appeared tense and avoided touching the door handle and the arm of the chair. Speech was coherent and relevant, with normal rate, tone, and volume. She described her mood as "anxious and fed up"; her affect was anxious and congruent with her mood. Thought process was logical and goal-directed. Thought content was dominated by contamination-related obsessions and fears of harm to her children; there were no delusions, overvalued ideas, or suicidal or homicidal thoughts. There were no perceptual disturbances. She was oriented to time, place, and person; attention, concentration, and memory were intact. Insight was good to fair, as she recognized that her fears were excessive, and judgment was intact.

10) Risk Assessment

A structured risk interview identified no suicidal ideation, self-harm, homicidal ideation, psychotic symptoms, or neglect or safeguarding concerns regarding the children. Her children were well cared for, although meals and play were sometimes delayed by her rituals.

III. ASSESSMENT AND DIAGNOSIS

11) Informal Assessment

Clinical Interview and Behavioral Observation

Separate and joint interviews with Ms. A and her husband were used to obtain the history, identify triggers and rituals, and assess family accommodation. During the first session, she wiped the chair with a tissue before sitting and asked whether the clinic's water was clean, which reflected the rituals she described.

Baseline Self-Monitoring

Ms. A recorded her washing episodes, cleaning time, and reassurance requests for 7 days before treatment began. Her baseline record is summarized in Table 1.

Table 1: Baseline Self-Monitoring of Rituals Over 7 Days

Behavior	Daily Mean	Range
Handwashing episodes	27	24–31
Duration per handwashing episode	4 minutes	3–5 minutes
Cleaning of surfaces and objects	45 minutes	35–60 minutes
Reassurance requests to husband	12	9–16
Total ritual time	2.5 hours	2–3 hours

12) Formal Assessment

Yale-Brown Obsessive Compulsive Scale

The Y-BOCS is a clinician-rated, semi-structured interview that measures OCD severity independently of symptom content. It comprises a symptom checklist and 10 severity items, each rated from 0 (*no symptoms*) to 4 (*extreme symptoms*), yielding a total score of 0–40 with obsession and compulsion subtotals of 0–20 each (Goodman, Price, Rasmussen, Mazure, Fleischmann, et al., 1989). The scale has shown excellent interrater reliability and internal consistency, as well as convergent validity and sensitivity to treatment-related change (Goodman, Price, Rasmussen, Mazure, Delgado, et al., 1989). On the symptom checklist, Ms. A endorsed contamination obsessions (concern with germs and dirt, and fear of causing illness in her children), excessive or ritualized handwashing, cleaning of household items, checking related to cleanliness, and reassurance seeking. She did not endorse aggressive, sexual, religious, symmetry, or hoarding obsessions. Her baseline severity ratings are presented in Table 2.

Table 2: Baseline Y-BOCS Severity Ratings

Item	Rating (0–4)
1. Time occupied by obsessions	2
2. Interference due to obsessions	2
3. Distress associated with obsessions	3
4. Resistance against obsessions	3
5. Degree of control over obsessions	3
Obsessions subtotal (0–20)	13
6. Time spent performing compulsions	2
7. Interference due to compulsions	3
8. Distress associated with compulsions	3
9. Resistance against compulsions	3
10. Degree of control over compulsions	3
Compulsions subtotal (0–20)	14
Total score (0–40)	27

Note. Y-BOCS = Yale-Brown Obsessive Compulsive Scale. Item 4 and Item 9 ratings reflect the effort the client made to resist; higher scores indicate less resistance.

The total score of 27 indicates clinically significant OCD of marked severity. The compulsions subtotal was slightly higher than the obsessions subtotal, reflecting the large amount of time and the interference caused by washing and cleaning.

Rotter Incomplete Sentences Blank

The RISB is a semi-projective measure in which the respondent completes 40 sentence stems. Each response is scored as conflict (C3 = 6, C2 = 5, C1 = 4), neutral (N = 3), or positive (P1 = 2, P2 = 1, P3 = 0), and the weighted sum yields an overall adjustment score; omissions are prorated (Rotter et al., 1992). A score of 135 or above is conventionally interpreted as indicating maladjustment (Rotter & Rafferty, 1950). Ms. A completed the adult form in about 30 minutes without omissions. Responses were scored by the therapist and cross-checked by the supervisor. The scoring summary is shown in Table 3.

Table III: RISB Scoring Summary

Response Category	Weight	Frequency	Weighted Score
C3 (severe conflict)	6	4	24
C2 (moderate conflict)	5	8	40
C1 (mild conflict)	4	10	40
N (neutral)	3	8	24
P1 (mildly positive)	2	6	12
P2 (moderately positive)	1	3	3
P3 (strongly positive)	0	1	0
Total	—	40	143

Note. RISB = Rotter Incomplete Sentences Blank. No items were omitted, so no proration was required.

Ms. A's adjustment score of 143 exceeded the cutoff, indicating overall maladjustment. Qualitative analysis showed four recurring themes. The first was fear for her children's health and personal responsibility, as in "My greatest fear... is that my children will get sick because of my carelessness" (C3) and "I feel... responsible for everything at home" (C2). The second was guilt and self-criticism, as in "I failed... to keep my son safe when he was small" (C3). The third was exhaustion and frustration with her rituals, as in "I suffer... because I cannot stop washing" (C2). The fourth was a supportive marital relationship alongside tension with her mother-in-law, as in "My husband... is patient with me" (P2) and "Other people... think I waste time cleaning" (C1). Responses about the future, such as "I want to be a calm and happy mother" (P1), indicated motivation for change. These themes were consistent with the clinical interview and supported the role of inflated responsibility and guilt in the formulation.

13) Summary of Assessment Findings

The history, self-monitoring, and Y-BOCS indicated contamination obsessions and washing, cleaning, checking, and reassurance compulsions of marked severity, occupying more than 2 hours a day and interfering with childcare and family life. The RISB indicated overall maladjustment, with prominent themes of responsibility, guilt, and fear for her children. Insight was good to fair, and no risk to self or others was identified.

Diagnosis

14) Diagnostic Reasoning

The diagnosis was made through clinical interview with the client and her husband, using DSM-5-TR criteria (APA, 2022). The Y-BOCS was not used to make the diagnosis; it was used to describe symptom content and to quantify severity, so that change could be measured over treatment. The RISB was used to understand personality functioning, conflicts, and adjustment, which informed the formulation rather than the diagnosis. Table 4 shows how the history met each criterion.

Table IV: Evidence for DSM-5-TR Criteria for Obsessive-Compulsive Disorder

Criterion	Requirement	Evidence From the Case
A: Obsessions	Recurrent, persistent, intrusive, unwanted thoughts causing marked anxiety, which the person tries to suppress or neutralize	Repeated, unwanted thoughts that her hands, home, and children are contaminated and that her children will fall ill; she tries to neutralize them by washing
A: Compulsions	Repetitive behaviors performed in response to an obsession or according to rigid rules, aimed at reducing distress or preventing a feared event, and excessive	Handwashing 24–31 times a day, repeated cleaning, checking, and reassurance seeking aimed at preventing illness in her children
B: Time or impairment	Time-consuming (e.g., more than 1 hour a day) or clinically significant distress or impairment	Rituals occupy 2–3 hours a day; delayed meals and childcare, marital conflict, and hand dermatitis
C: Not due to substances or medical condition	Symptoms not attributable to a substance or another medical condition	No substance use; no medical condition explaining the symptoms
D: Not better explained by another disorder	Not better explained by another mental disorder	Excluded through differential diagnosis (Table 5)
Specifier	Insight	Recognizes fears as excessive: with good or fair insight

15) Differential Diagnosis

Table 5 summarizes the alternative diagnoses that were considered and the reasons they were excluded.

Table V: Differential Diagnosis

Alternative	Distinguishing Feature	Reason for Exclusion
Generalized anxiety disorder	Worry about several real-life concerns, without ritualized neutralizing	Fears were focal and met by washing and checking rituals
Specific phobia	Fear of a defined object or situation, managed mainly by avoidance, without obsessions or compulsions	Avoidance was present, but intrusive thoughts and compulsive washing predominated
Illness anxiety disorder	Preoccupation with having or acquiring a serious illness, with bodily checking or medical reassurance seeking	Fear centered on contamination and harm to her children rather than on an undiagnosed illness in herself
Obsessive-compulsive personality disorder	Pervasive, ego-syntonic perfectionism and rigidity from early adulthood, without true obsessions or compulsions	Symptoms were ego-dystonic, began at age 23, and were recognized as excessive; premorbid traits were conscientious but not disabling
Major depressive disorder	Pervasive low mood or loss of interest, with neurovegetative symptoms	Tiredness and irritability were secondary to rituals; mood was anxious rather than depressed, and interest and sleep were preserved
Normative religious practice	Washing performed according to religious guidance and experienced as meaningful	She distinguished prescribed ablution from fear-driven washing, which far exceeded religious requirements

16) Final Diagnosis

Obsessive-compulsive disorder, with good or fair insight (F42.2), according to DSM-5-TR (APA, 2022).

IV. CASE FORMULATION AND CONCEPTUALIZATION

17) 5Ps Formulation

The factors contributing to the development and maintenance of Ms. A's difficulties are summarized in Table 6.

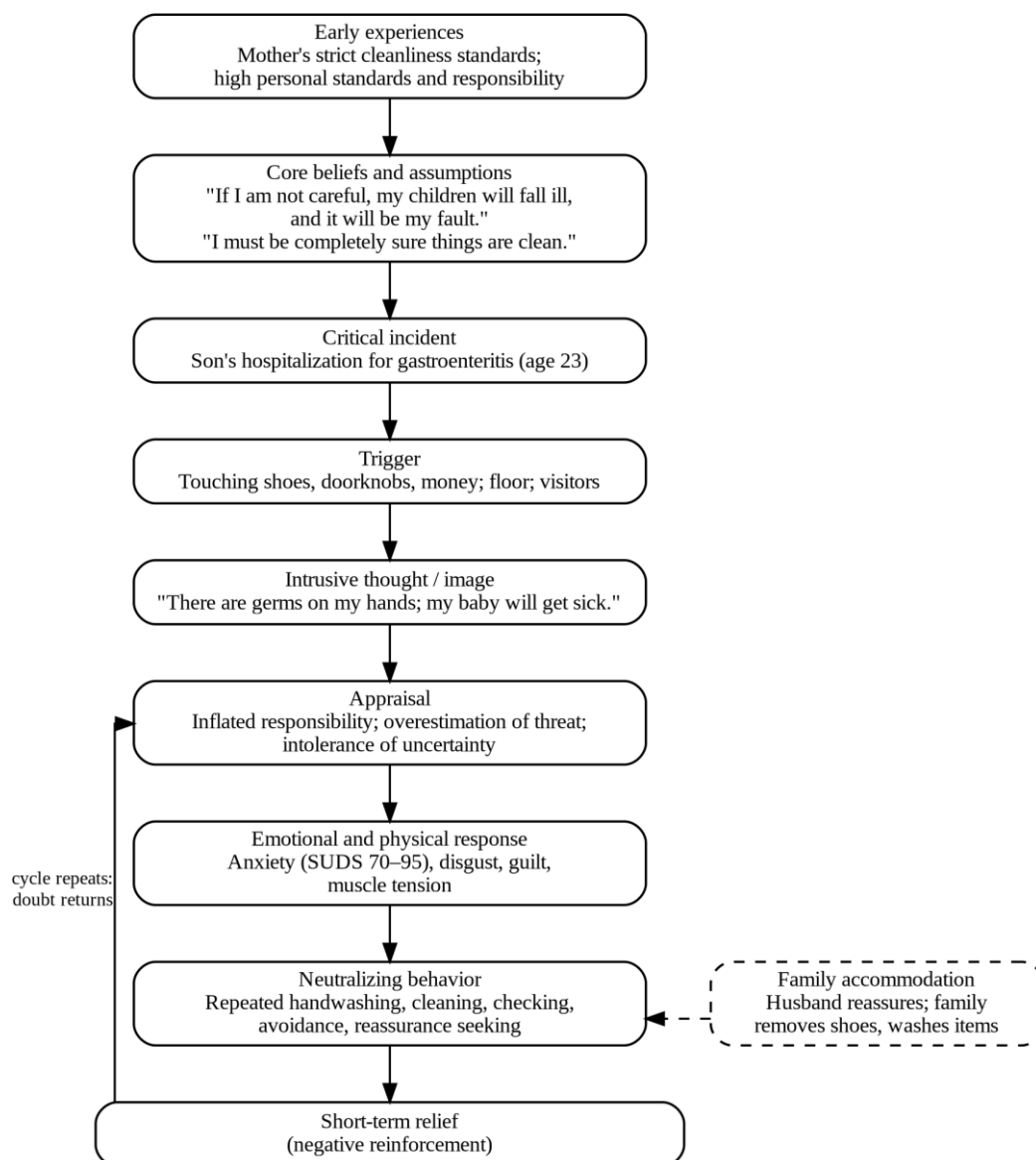
Table VI: 5Ps Case Formulation

Domain	Factors
Presenting	Contamination obsessions; handwashing (about 27 times a day), cleaning, checking, avoidance, reassurance seeking; anxiety, disgust, guilt; hand dermatitis; delayed childcare and marital conflict
Predisposing	Mother's strict cleanliness standards; conscientious, perfectionistic premorbid personality; heightened sense of responsibility; low tolerance of uncertainty
Precipitating	Son's hospitalization for gastroenteritis at 7 months, with hygiene advice and intense self-blame
Perpetuating	Washing and avoidance reinforced by relief; reassurance and accommodation by husband; responsibility and threat appraisals; increased childcare demands after daughter's birth; mother-in-law's criticism adding stress
Protective	Good to fair insight; high motivation; supportive husband; educated and articulate; religious coping; no comorbidity or risk

18) Cognitive-Behavioral Conceptualization

Following Salkovskis's (1985) model, Ms. A's early experiences with a mother who emphasized cleanliness, together with her conscientious temperament, contributed to beliefs such as "If I am not careful, my children will fall ill, and it will be my fault" and "I must be completely sure that things are clean." Her son's hospitalization activated these beliefs. Since then, everyday triggers, such as touching shoes, money, or the floor, produce intrusive thoughts about germs and illness. She appraises these intrusions as signs of real danger for which she is responsible, which produces anxiety, disgust, and guilt. Washing, cleaning, checking, avoidance, and reassurance seeking bring short-term relief, which negatively reinforces them, while preventing her from learning that the feared outcome rarely follows. Her husband's reassurance and the family's accommodation strengthen the same cycle. This conceptualization is shown in Figure 2.

Figure II: Cognitive-Behavioral Conceptualization of Ms. A's Obsessive-Compulsive Disorder



Note. Based on Salkovskis's (1985) cognitive-behavioral model. SUDS = Subjective Units of Distress Scale (0–100). The dashed box shows family accommodation, which maintains neutralizing behavior.

V. MANAGEMENT PLAN

19) Treatment Goals

Short-term goals were to (a) understand OCD and the maintenance cycle, (b) reduce handwashing to normal hygiene occasions, (c) reduce reassurance requests, and (d) reduce avoidance of feared household items. Long-term goals were to (e) restore confidence and functioning in childcare and household tasks, (f) reduce family accommodation and conflict, and (g) develop a relapse-prevention plan.

20) Treatment Rationale and Techniques

ERP was selected because the formulation identified washing, avoidance, and reassurance as behaviors that maintained the threat and responsibility appraisals (Hezel & Simpson, 2019). Exposure tasks were designed collaboratively and graded using the Subjective Units of Distress Scale (SUDS; 0–100). Each exposure was followed by response prevention, meaning that she refrained from washing, cleaning, checking, or seeking reassurance. Cognitive techniques, including Socratic questioning, a responsibility pie chart, and probability estimation, were used to support exposure rather than to replace it (McKay et al., 2015; Spencer et al., 2023). Before childcare-

related exposures, a reasonable hygiene standard was agreed: one normal 20-second handwash before preparing food, after using the toilet, and after changing diapers. This distinguished ordinary care from ritual and ensured that the children were never placed at real risk. Her husband attended one joint session to learn supportive, non-accommodating responses.

21) Exposure Hierarchy

The exposure hierarchy, with SUDS ratings at Session 3 and Session 12, is presented in Table 7.

Table VII: Exposure Hierarchy with SUDS Ratings

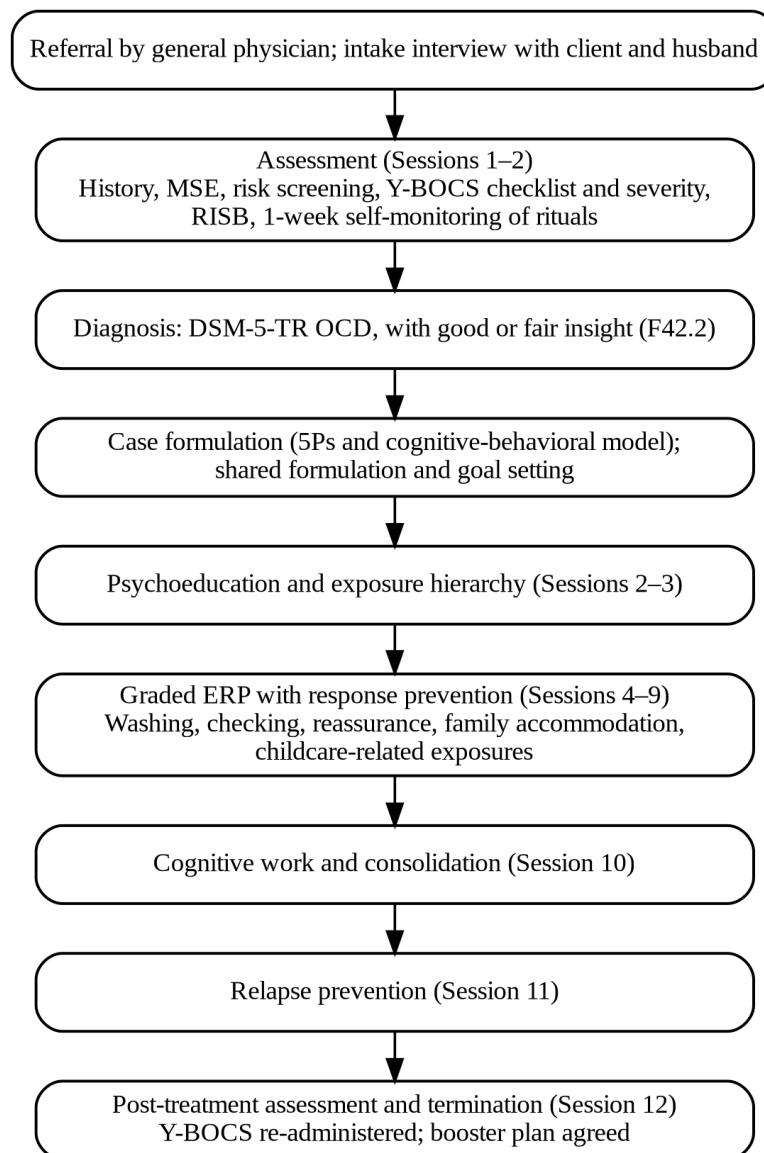
Step	Exposure Task	SUDS Session 3	SUDS Session 12
1	Touching the main-door handle and delaying handwashing for 10 minutes	30	5
2	Handling currency notes, then continuing household work without washing	40	10
3	Using a towel shared by other family members	45	10
4	Sitting on the sofa after returning from the market without changing clothes	55	15
5	Touching the living-room floor, then touching the kitchen counter	60	20
6	Touching shoes, then preparing her own food after one normal handwash	70	25
7	Allowing visitors' children to play with her children's toys without washing the toys	75	25
8	Touching shoes, then preparing her children's food after one normal handwash	85	30
9	Using a washroom at a relative's house with one normal handwash	90	35
10	Letting her daughter play on the floor, then feeding her after one normal handwash	95	40

Note. SUDS = Subjective Units of Distress Scale (0 = *no distress*, 100 = *extreme distress*).

22) Course of Therapy

Ms. A attended 12 weekly individual sessions of 45 to 50 minutes. Homework, including daily exposure practice of 45 to 60 minutes and self-monitoring, was assigned after every session. The overall course of treatment is shown in Figure 3, and the session-wise plan is summarized in Table 8.

Figure III: Flow of Assessment and Treatment



Note. MSE = mental status examination; Y-BOCS = Yale-Brown Obsessive Compulsive Scale; RISB = Rotter Incomplete Sentences Blank; ERP = exposure and response prevention.

Table VIII: Session-Wise Treatment Plan

Session	Objectives	Techniques	Homework
1	Rapport, history, risk screening	Clinical interview, MSE, Y-BOCS	Begin 7-day self-monitoring
2	Assessment and psychoeducation	RISB; psychoeducation on OCD and maintenance cycle; shared formulation	Read handout; continue monitoring
3	Goal setting and hierarchy	Collaborative goals; SUDS training; exposure hierarchy	Delay handwashing by 5 minutes
4	First exposure	In-session ERP (Steps 1–2)	Daily practice of Steps 1–2
5	Reducing washing	ERP (Steps 3–4); agreed hygiene standard	Limit washing to agreed occasions
6	Checking and reassurance	ERP (Step 5); reassurance-reduction plan	Reassurance diary
7	Family accommodation	Joint session with husband; supportive non-accommodation responses	Husband to respond with agreed statement
8	Childcare-related exposures	ERP (Steps 6–7)	Daily practice of Steps 6–7
9	Higher-level exposures	ERP (Steps 8–9); generalization across settings	Practice at home and relatives' houses
10	Cognitive work	Socratic questioning; responsibility pie chart; ERP (Step 10)	Thought record; Step 10 practice
11	Relapse prevention	Early warning signs; coping card; self-directed exposure plan	Write relapse-prevention plan
12	Termination	Post-treatment Y-BOCS; review of goals; booster plan	Continue self-directed ERP

Note. MSE = mental status examination; Y-BOCS = Yale-Brown Obsessive Compulsive Scale; RISB = Rotter Incomplete Sentences Blank; SUDS = Subjective Units of Distress Scale; ERP = exposure and response prevention.

Sessions 1–3: Assessment, Psychoeducation, and Engagement

The first sessions focused on building rapport, completing the history and assessment, and explaining the maintenance cycle using Ms. A's own examples. She was relieved to learn that intrusive thoughts are common and that washing kept her fears alive. Initially, she worried that reducing washing would make her a careless mother; this concern was addressed by agreeing on a reasonable hygiene standard before exposure began.

Sessions 4–9: Graded Exposure and Response Prevention

ERP began with low-level tasks in session and progressed weekly up the hierarchy. During the first exposure, her SUDS rating rose to 45 and fell to 15 within 35 minutes without washing. She found Session 5 difficult and washed once after an exposure at home, which was reviewed without blame and repeated the next day. In the joint session, her husband learned to respond to reassurance requests with an agreed statement, "I know this is hard, and I trust you to handle the uncertainty," instead of reassuring her. By Session 9, she was completing childcare-related exposures and using a relative's washroom with one normal handwash.

Sessions 10–12: Cognitive Work, Relapse Prevention, and Termination

Cognitive work focused on her belief that she alone was responsible for her children's health. Using a responsibility pie chart, she allocated responsibility for her son's illness to several factors, including common childhood infections, and her estimated personal responsibility fell from 90% to 30%. The final sessions focused on identifying early warning signs, preparing a coping card, planning continued self-directed exposure, and agreeing on booster sessions.

VI. OUTCOME

Ms. A's Y-BOCS total score decreased from 27 at baseline to 14 at post-treatment, a 13-point (48.15%) reduction. The obsessions subtotal fell from 13 to 7 and the compulsions subtotal from 14 to 7 (Table 9). Her daily handwashing decreased from about 27 to 9 episodes, and reassurance requests from about 12 to 2 a day (Table

10). SUDS ratings for all hierarchy items fell substantially (Table 7), and the dermatitis on her hands had healed by the final session.

Table IX: Pre- and Post-Treatment Yale-Brown Obsessive Compulsive Scale Item Ratings

Item	Pre-Treatment	Post-Treatment
1. Time occupied by obsessions	2	1
2. Interference due to obsessions	2	1
3. Distress associated with obsessions	3	2
4. Resistance against obsessions	3	2
5. Degree of control over obsessions	3	1
Obsessions subtotal	13	7
6. Time spent performing compulsions	2	1
7. Interference due to compulsions	3	2
8. Distress associated with compulsions	3	2
9. Resistance against compulsions	3	1
10. Degree of control over compulsions	3	1
Compulsions subtotal	14	7
Total score	27	14

Table X: Pre- and Post-Treatment Behavioral Indicators

Indicator	Pre-Treatment	Post-Treatment
Handwashing episodes per day	27	9
Duration per handwashing episode	4 minutes	Less than 1 minute
Total ritual time per day	2–3 hours	45–60 minutes
Reassurance requests per day	12	2
Avoidance of feared items	Moderate	Mild
Interference with childcare and household tasks	Marked	Mild to moderate

Note. Pre-treatment values are 7-day means from baseline self-monitoring; post-treatment values are means from the final week of treatment.

These results were interpreted against published benchmarks. An international expert consensus defines treatment response as a Y-BOCS reduction of at least 35%, together with a Clinical Global Impression–Improvement rating of 1 or 2, and remission as a Y-BOCS score of 12 or below (Mataix-Cols et al., 2016). Ms. A’s 48.15% reduction meets the Y-BOCS criterion for response, but her post-treatment score of 14 remained above the remission threshold. Her outcome is therefore best described as a clinically meaningful partial response with residual symptoms.

23) Client and Family Feedback

Ms. A reported, “I still get the thoughts, but now I know I don’t have to obey them.” She described feeling more relaxed with her children and able to let her daughter play on the floor. Her husband reported that household routines had become more regular and that arguments about cleaning had decreased.

VII. PROGNOSIS

The prognosis is fair to good. Favorable factors include good to fair insight, high motivation, active engagement in exposure homework, a supportive husband, absence of comorbidity, and a relatively short duration of illness before treatment. Factors that may increase the risk of relapse include residual symptoms, perfectionistic personality traits, high childcare demands, and continuing criticism from her mother-in-law.

VIII. DISCUSSION

This case study describes CBT with ERP for contamination-related OCD in a young mother whose symptoms began after her infant son's hospitalization and became entwined with childcare and family routines. Over 12 sessions, her Y-BOCS score fell by 13 points, her washing and reassurance seeking decreased markedly, and her functioning improved. These findings are consistent with the established role of ERP as the first-line psychological treatment for OCD (Hezel & Simpson, 2019; McKay et al., 2015). Several features of the case are clinically important. First, the onset is consistent with Salkovskis's (1985) proposition that OCD develops when ordinary intrusive thoughts are appraised in terms of personal responsibility for harm. Her son's illness, followed by hygiene advice and intense self-blame, converted an existing tendency toward cleanliness into a belief that she alone was responsible for preventing illness. The RISB themes of guilt and responsibility supported this formulation. Second, the treatment targets were drawn from the perpetuating factors rather than from the symptom list alone; washing, avoidance, reassurance, and accommodation were the behaviors preventing her from testing her threat appraisals. Third, family accommodation was treated as part of the maintenance cycle. In a joint family system, relatives may reassure or take over tasks out of care, and involving her husband was central to reducing reassurance seeking. Fourth, childcare-related exposures required an explicit distinction between reasonable infant-care hygiene and ritualized washing, which protected both the children's safety and the integrity of response prevention.

The case also highlights the role of cultural and religious context. Cleanliness is highly valued in Ms. A's community, which initially delayed recognition of her symptoms. Her own ability to distinguish prescribed ablution from fear-driven washing, supported by religious guidance, helped her engage with exposure without feeling that it conflicted with her faith. The residual score deserves as much attention as the improvement. A post-treatment Y-BOCS of 14 falls short of the consensus remission threshold (Mataix-Cols et al., 2016), and residual ritual time approaching an hour a day indicates continuing symptoms. Booster sessions and continued self-directed exposure were therefore planned rather than full discharge.

Limitations

As a single case, these findings cannot be generalized, and the improvement cannot be attributed with certainty to treatment alone. Assessment was limited to pre- and post-treatment, without repeated baseline measurement or follow-up data. The Y-BOCS was administered by the treating clinician, which may have introduced expectancy bias, and Clinical Global Impression ratings were not obtained. The RISB is a semi-projective measure whose interpretation depends partly on clinical judgment, and it was not re-administered after treatment. Behavioral indicators relied on self-monitoring, which may be affected by reporting bias.

Recommendations

Ms. A was advised to continue daily self-directed exposure, to attend booster sessions at 1, 3, and 6 months, and to use her relapse-prevention plan when early warning signs appear. Continued involvement of her husband, and psychoeducation for her mother-in-law, were recommended to reduce accommodation and criticism. If symptoms do not improve further or relapse occurs, a psychiatric referral to evaluate pharmacotherapy was recommended. Future case work should include repeated baseline measurement, an independent rater, Clinical Global Impression ratings, a measure of family accommodation, and follow-up assessment.

Ethical Considerations

Before assessment, Ms. A was informed about the nature and purpose of assessment and therapy, confidentiality and its limits, and her right to withdraw at any time, and she provided written informed consent for treatment and for the use of her anonymized case material for academic purposes. A pseudonym is used, and identifying details have been changed. Exposures were collaborative and graded; no genuine hazards, coercion, or flooding were used; her husband was involved only with her agreement; and childcare exposures were bounded so that the children were never placed at risk.

IX. CONCLUSION

Ms. A's contamination-related OCD developed after her son's hospitalization and was maintained by washing, avoidance, reassurance seeking, and family accommodation, underpinned by an inflated sense of responsibility for her children's health. Twelve sessions of formulation-driven CBT with ERP, combined with husband involvement and cognitive work on responsibility, reduced her Y-BOCS score from 27 to 14, decreased handwashing from about 27 to 9 episodes a day, and restored much of her confidence as a mother. Although residual symptoms remained, the case demonstrates that graded ERP, carefully adapted to childcare and the family context, can produce meaningful improvement in a young mother with contamination-related OCD, and that continued self-directed exposure and booster sessions are needed to consolidate gains.

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