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The Effectiveness of Cognitive Behavioral Therapy (CBT) to Reduce Anxiety in the Patients of Obsessive-Compulsive Disorder (OCD)

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Abstract

This research aims to find out the effect of behavioral cognitive therapy on obsessive-compulsive disorder and how effective this therapy is for patients with compulsive obsessive disorders. This research method used an experimental research design with a single case. A questionnaire was used as a data collection technique. The results of this study indicated that behavioral cognitive therapy could overcome obsessive-compulsive disorder. The therapeutic techniques in cognitive therapy of behavior could provide changes in the obsessive-compulsive symptoms experienced by the subjects.

Keyword : *anxiety*, *behavioral cognitive therapy, obsessive-compulsive disorder*

1. Introduction

Generally, every individual has anxiety. The anxiety is the most common response which states the condition “alert” and encourages someone to prepare to deal with possible dangerous situations. Anxiety is a form of a person’s response to certain threatening situations. Anxiety can be a nuisance if the levels are excessive. If people experience high functioning anxiety, they will be less able to control themselves. Oltmans

and Emery (2012) stated that anxiety was normal at a low level because it serves as a signal that people must prepare for future events. Conversely, anxiety becomes a nuisance at a high level since it reduces the ability to concentrate so that people inappropriately responds to a given stimulus. According to Davidson, Naele, and Kring (2004), anxiety disorders differed from reasonable anxiety in terms of intensity, duration, and their impact on individuals.

The obsessive-compulsive disorder is an anxiety disorder characterized by the emergence of an urgent idea and an irresistible urge to do something and it is repeatedly done. The fear or anxiety which emerges in someone's mind can affect someone's behavior. The obsessive-compulsive disorder is a condition in which people are unable to control themselves of an unexpected obsession of their thoughts, and they repeat several specific actions to be able to control their thoughts to decrease their anxiety level.

Cognitive-behavioral therapy can be applied to children, adolescents, and adults. Several studies have proven the effectiveness of cognitive-behavioral therapy. Nindita (2012) examined the effectiveness of cognitive-behavioral therapy for aggressive children in managing anger. Mauna (2012) examined teenagers who experienced excessive fear of being in the bathroom and the bedroom alone. Some researchers use cognitive-behavioral therapy to overcome obsessive-compulsive disorder. Oppen (2004) intervened cognitive behavioral therapy on a 31-year-old woman with the obsessive-compulsive disorder. This therapy is proven to provide significant clinical changes in overcoming obsessive-compulsive symptoms.

Other researchers such as (Martin, et al., 2007; Abrahamowits, et al., 2005; Sahin, et al., 2004; Rosqvist, Thomas, Egan & Haney, 2002; Wihall & O'neill, 2003) provided a proof of success of cognitive-behavioral therapy in treating obsessive-compulsive disorders since it helped sufferers with a comprehensive form of therapy. Cognitive-behavioral therapy is an intervention focused on the cognitive process of clients, and how its relationship to their emotional changes and behavior (Stallard, 2005). Somers (2007) stated that cognitive-behavioral therapy helped individuals to identify the cognitive patterns or thoughts and emotions related to behavior.

2. Theoretical Framework

2.1. Anxiety

Definition of Anxiety

Anxiety is a natural condition experienced by every human being. Anxiety is considered a part of everyday life. Anxiety is a common feeling in which someone feels fear or loss of self-confidence which the source and the form are unclear (Wiramihardja, 2005). According to Kaplan, Sadock, and Grebb (in Fauziah & Thistle, 2007), anxiety is a response to certain threatening situations, and it is a normal condition when people cope with developments, changes, new experiences, as well as finding self-identity and meaning of life. According to Duran (2006), anxiety is a condition of mood characterized by negative affect and symptoms of physical tension in which a person anticipates the possibility of danger or misfortune in the future with an anxious feeling.

Anxiety Components

Anxiety consists of several components, namely physiological, cognitive, emotional, and behavioral. The description of each component is as follows:

- Physiological component
  When experiencing anxiety, a person experiences physiological shifts. These shifts include abdominal pain, sweating, hard breathing, feeling hot or cold, headache, numbness or tingling hands and feets, chest

pain, nausea, sore or tense muscles, increased heartbeat, irregular bowel movements, blushing, digestion disorder, and trembling (Beidel & Turner, 2005; Friedberg & Mc Clure, 2002; Barrios & Hartmann, in Kendall, 2012).

- Cognitive Components
  The cognitive component of anxiety is in the form of ways of thinking or perceiving something incorrectly. According to Barret et al., Bogels and Zigterman (in Stallard, 2005), anxiety emerged if someone tended to perceive ambiguous situations as threatening situations. Meanwhile, according to Barrios and Hartmann (in Kendall, 1991), anxiety arose due to focusing too much attention on the danger or threatening situation.
- Emotional Components
  Emotional components are an emotion which occurred when someone experiences anxiety such as feelings of worry, fear, panic, and irritability (Friedberg & Mc Clure, 2002).
- Behavioral Components
  There are several behaviors displayed by someone when he or she experiences anxiety. Kendall (2012) mentioned that avoidance behavior is the common behavior response which frequently occurs when experience anxious situations. Besides, a person also looks agitated, avoids eye contact, and speaks in a low voice when feeling anxious (Kendall, 1991).

Causes of Anxiety

Kaplan, Sadock, and Grebb (1997) stated that there were three main areas in the theory of psychology which contributed to the causes of anxiety. They are:

- Psychoanalysis Theory
  Freud said that anxiety is a signal to the ego that unacceptable impulse pressure to gain representation and conscious release. As a signal, anxiety awakens the ego to take defensive action against internal pressure.
- Behavioral Theory
  Social learning theory explains anxiety as an accustomed response toward the specific environmental stimulus. Someone can learn to have an internal anxiety response by imitating other's anxiety response.
- Existential Theory
  The core concept of this theory is that a person becomes aware of a prominent emptiness within himself. Anxiety is someone's response toward the emptiness of existence.
- Biological Theory
  The biological theory also has a perspective on the causes of anxiety. In this theory, several biological conditions relate to causes of anxiety, including the autonomic nervous system which causes pain reactions.

2.2. Obsessive-Compulsive Disorder (OCD)

Definition of Obsessive-Compulsive

Based on DSM IV, the obsessive-compulsive disorder is a part of anxiety disorder. This disorder is characterized by the emergence of obsessive thoughts, impulses, or images. Consequently, individuals who experience it feel anxious and show repetitive behaviors (compulsive) (APA, 2000).

The obsessive-compulsive disorder is a form of anxiety disorder which comes from the existence of an obsessive mind and cannot be controlled, and the individual is forced to continuously repeat the certain actions (Davison, Neale & Kring, 2006). Obsession is defined as persistent and disturbing thought which

cause anxiety and cannot be controlled by the individual who experiences it (Nevid, et al., 2005). In contrast with obsessive, the form of compulsive behavior is repetitive behavior (such as washing the hands or checking the door key) or repetitive mental actions (such as praying, repeating certain words, or counting) felt by the individuals as compulsory or compulsive to do (APA, 2000).

Compulsions often emerge to overcome anxiety caused by the obsessive thought. OCD disorder is a condition in which people are unable to control the unexpected obsession of their thoughts, and they repeat certain actions several times to be able to control their thoughts to reduce their anxiety level. The obsessive-compulsive disorder is an anxiety disorder in which an individual's life is dominated by repetitive thoughts (obsessions) followed by repeated actions (compulsions) to reduce his anxiety (UIN-Maliki Press, 2013).

Obsessive-compulsive symptoms

The obsessive-compulsive disorder is an anxiety disorder characterized by the existence of an urgent idea and an irresistible urge to do something, and it is done repeatedly. The obsessive-compulsive disorder consists of two elements, namely obsession interpreted as an idea that urges into the mind and compulsion interpreted as an irresistible urge to do something. In its manifestation, each individual can be different. For example, anxious feelings about cleanliness will be manifested by repetitive handwashing behavior, or anxious feelings about home safety are manifested by checking the doors of the house repeatedly (Maramis, 2005).

Factors Causing Obsessive-Compulsive Disorder

- Biological Factors

  Genetic and biological factors eventually have an important role in the development of anxiety disorders, including panic disorder, total anxiety disorder, obsessive-compulsive disorder, and phobic disorders (Gorman, et al., 2000; Hettema, Neale, & Kedler, 2001, in Nevid, et al., 2005).

  The obsessive-compulsive disorder can cause high stimulus or stimulation from the anxious circuit in the brain in which the neural network participates in giving danger signals. In obsessive-compulsive disorder, the brain constantly sends messages when something wrong happens and needs immediate attention. It leads to obsessive anxiety and persistent compulsive behavior (Nevid, et al., 2005).
- Psychological Factors

  Obsessive-compulsive disorder is a form of anxiety disorder. Beck's anxiety model (1976, in Blackburn, & Davison, 1990/1994) is a model that connect the factors of emotional and thought with anxiety disorders.

  According to Beck (in Beck & Weishaar, 1989), individuals experience psychological distress when they respond to situations considered threatening as their primary concern. Excessive and rigid beliefs and assumptions make non-functional automatic thoughts appear. It causes damage to the cognitive process function.
- Epidemiology (Travel History of Disorders)

  The lifetime prevalence of the obsessive-compulsive disorder in the general population is estimated to be between 2% - 3%. The rate places the obsessive-compulsive disorder as the fourth-order of psychiatric diagnosis after phobic disorders, substance-related disorders, and severe depression (Kaplan & Sadock, 1997).

  In the history of obsessive-compulsive disorder of individuals in adulthood, likely both men and women are equally affected by this disorder. In adolescence, the emergence of this disorder is more commonly found in male, and the form of compulsive behavior is hygiene situation (Kaplan & Sadock, 1997; Devison, et al., 2004).

2.3. Cognitive Behavior Therapy (CBT)

Definition

According to Somers and Queree (2007), CBT is a psychological intervention which involves interactions, namely way of thinking, feeling, and behaving of a person. CBT helps a person to identify cognitive patterns or thoughts and emotions which relates to his/her behavior. CBT is developed based on behavioral and cognitive approaches. Therefore, CBT involves some behavioral and cognitive intervention techniques in its application (Gosch, Flannery-Schroder, Mauro & Compton, 2006). Based on the behavioral approach, what a person does will affect both his feelings and thoughts. The application of this theory in CBT practice is to guide a person to learn new behaviors and ways to deal with an irritating situation by involving certain skills learning (Somers & Queree, 2007).

According to Dobson, cognitive-behavioral therapy has three fundamental propositions in perceiving a disorder (Sundberg, et al., 2007). The three propositions are as follows:

- The cognitive activity influences behavior
- The cognitive activity can be monitored and changed
- The desired behavior changes can be influenced by cognitive changes.

The Purpose of Cognitive Behavioral Therapy (CBT)

Stallard (2002) explains that the overall goal of CBT is to increase self-awareness, increase the better ability to self-understanding, and improve self-control by developing the cognitive ability and better behavior accepted by the surroundings. CBT helps clients to identify dysfunctional thought and negative beliefs. The clients' understanding of the surroundings which produces negative emotions will be replaced by more positive emotions. At last, the clients are expected to be able to deal with difficult situations through cognitive ability and more adaptive behavior. CBT aims to encourage clients to oppose the wrong thoughts and emotions by presenting the evidence that contradicts with their beliefs about the problem at hand (Oemarjoedi, 2003).

Basic Principles of Cognitive Behavioral Therapy (CBT)

According to (Ledlyey, Mark & Heimberg (2005), the basic principles of CBT are divided into several principles, namely:

- Cognitive Principles
- Emotional reaction and behavior of a person are strongly influenced by cognition. Cognitions are thoughts, beliefs, and interpretations about themselves, or fundamentally, it is the meaning given to the life events. Everyone can react differently to the same event.
- Principles of Conduct
- What we do affects how we think and feel. CBT helps individuals to learn new behaviors and new ways to deal with situations, including learning specific skills such as social skills (Sommers, 2007).
- The Principle of Continuum
- CBT believes that mental health problems are better to view as an extreme version of a normal process, rather than to view as a qualitatively different pathological condition. In other words, psychological problems are in continuity, not in different dimensions.
- The principle of "here and now"
- Successful treatment has to expose the process of development, hidden motives, and unconscious conflicts as the root of the problem. Behavioral therapy considers the target of appropriate treatment is the symptom itself by observing what process that maintains it and then changes the process. The focus of therapy is the

current occurrence, and the main concern is the process that makes individual problems last to this day than the development process which occurred many years ago (Westbrook, Kennerly & Kirk, 2007).

- The principle of system interaction
- CBT identifies four systems, namely cognition, emotion or affection, behavior, and physiology. These systems interact with each other reciprocally and also interact with the surroundings. These surroundings are not only cover the physical environment but also the aspect of social, family, culture, and economy (Westbrook, Kennerly & Kirk, 2007).
- Empirical Principle
- CBT believes the importance of evaluating theory and treatment by using not only clinical evidence but also scientific evidence. The reasons why it is important are as follows:
  Scientifically, it aims that the handling conducted is based on established theories
  Ethically, it aims that CBT practitioners can have confidence in informing the clients who are given therapy that this therapy is effective
  Economically, it aims that CBT practitioners are confident that they can provide many benefits in spite of limited resources (Westbrook, Kennerly & Kirk, 2007).

3. METHODOLOGY

3.1. Research Design

The research design used in the study was a single case experimental design in which there is only a single case in the study. This study focused on examining the behavioral change of an individual or several individuals (Zechmeister & Zechmeister, 2012). The single-case experimental design enables the client to be examined. Besides that, there is an experimental evaluation of the treatment given to a participant. Single case experimental design provides practical solutions to problems by examining cause and effect when there are only a few participants (Zechmeister & Zechmeister, 2012).

In the study, the data analysis used was a qualitative analysis using visual inspection techniques on the Subjective Units Disturbance Scale by comparing the subject's anxiety level from the initial condition before getting therapy (pre-therapy / baseline assessment) until the follow-up session. Visual inspection technique was used to see the effect of an anxiety intervention and a compulsion behavior experienced by the participants.

3.2. Research Variables

In this research, the variables in the study were :

- Dependent Variable: Anxiety
- Independent Variable: Cognitive Behavior Therapy (CBT)

3.3. Operational Definition of Research Variables

- Anxiety
  Anxiety is a form of someone's response which involves an emotional reaction to anticipating the possibility of dangerous and disproportionate things and a kind of threats from the environment. This

variable will be measured by a clinical scale using the Subjective Units of Disturbance Scale (SUDS) with a range of 0-100, and this scale is generally used as a measuring tool by the subjects themselves to determine how much anxiety they feel (Rosqvist, Thomas, Egan & Haney, 2002).

- Cognitive behaviour therapy
  Cognitive behavior therapy (CBT) is a therapy that emphasizes the cognitive dimension. This therapy is used to change the way of the view of individuals through automatic thoughts since it provides ideas for restructuring irrational thoughts and beliefs (in Oemarjoedi, 2003).
- Research Subject
  The participant of the study was a 23-year-old woman who had obsessive-compulsive disorder since her teens when the subject was in class VIII (with criteria according to the DSM-IV-TR compiled by the American Psychiatric Association / APA). The subject also had never followed a CBT intervention to overcome the obsessive-compulsive disorder she suffered.

3.4. Data Collection Technique

This research used questionnaire, interview, observation, and self-monitoring as the data collection technique. The following are the explanation of the method used in the study:

- Questionnaire
  The questionnaire in this study consisted of a clinical scale as a measure of anxiety with the obsessive-compulsive disorder. The form of a clinical scale for obsessive-compulsive disorder is the Subjective Units of Disturbance Scale (SUDS) with a range of numbers from 0-100, and this scale is generally used as a measuring tool by the subjects themselves to determine how much anxiety they feel (Rosqvist, Thomas, Egan & Haney, 2002).
  In this study, the researcher used the Subjective Units of Disturbance Scale (SUDS) with a range of numbers from 0-100, with the following information: 0 = Not feeling anxious; 10-30 = a little worried; 40-70 = Quite anxious; 70-90 = Anxious; 100 = Very worried.
- Interview
  Interviews were conducted as a method for conducting assessments at the pre-therapy stage, during the therapy process, post-therapy and follow-up. The pre-therapy assessment stage interview was to find out in more detail / in-depth about the obsessive-compulsive disorder of the subject which would eventually be used as data before therapy.
  Interviews during the therapy process were conducted primarily to find out the development of the subject's obsessive-compulsive disorder during therapy to identify changes and obstacles that might arise from the subject during therapy.
  Post-interview therapy was conducted to find out what changes occurred after the therapy was given compared to the subject's condition before therapy and to find out the factors that cause a lot of changes.
  At the follow-up stage, interviews were conducted to determine the development of subject anxiety after therapy was stopped.
- Observation
  Observations in the study were non-participant which means the researcher was not involved in the activities he observed (Purwandari, 2001). The observation was done by the researcher and the subject themselves regarding the behavior which was being a focus of therapy.
  The observation was mainly done by the researcher during the implementation of exposure in therapy settings.

Observation also was done by the subject in the form of self-monitoring on exposure during the therapy process and at the follow-up stage.

- Self Monitoring
  According to Martin and Pear (2003), self-monitoring is a direct observation done by the participant itself to examine her behavior. In this study, self-report was made by the participant during the implementation of cognitive restructuring tasks, after exposure and follow-up stage.

3.5. Assessment and Measurement

In this study, researchers used the Subjective Units of Disturbance Scale (SUDS) with a range of numbers from 0-100, with the following information:

0	:	Not feeling anxious
10-30	:	A little anxious
40-70	:	Quite anxious
70 – 90	:	Worried
100	:	Very worried

Assessment of compulsive behavior was based on the number or the average number of compulsive behaviors that the subject experienced at each of her activities such as cleaning and performing ablution and prayer. Assessment and measurement were carried out at three stages, namely before the therapy (baseline), after therapy (post-therapy) and the follow-up phase. This was done to find out how obsessive thought patterns, anxiety levels and the frequency of compulsive behavior of subjects that have been experienced.

4. RESEARCH RESULTS AND DISCUSSION

4.1. Result

In this study, based on the assessment, it was known that anxiety experienced by the participant was an obsession with cleanliness, health, and anxiety. This obsession made the participant thought that if she did not maintain her health because she touched the dirty objects, it will bring germs, as well as her anxiety in taking ablution water (wudhu). She tends to think that if it is not clean then the dirt is still attached to her skin, it is not valid for her to pray.

Based on the results of the therapy, it could be seen that the participant experienced significant changes, in which the changes she experienced changes from irrational thoughts into more positive thoughts, and the participant emotionally became calmer because she was able to control and reduce the anxiety she experienced. Besides, the participant's compulsion behavior has decreased in terms of frequency so that the participant felt no need to perform her rituals. Therefore, the aims of the intervention given to the participants were:

- Helping the subject change her rational mindset into a more rational mindset
- Reducing anxiety levels
- Reducing the level of frequency of compulsive behavior

The anxiety level

At the level of anxiety, it could be seen that there was a decline in anxiety scores of the participant. This happens gradually in every activity undertaken by the participant. The decrease occurred was relatively stable, although there was an increase during exposure-1 independently. When the therapy process ended, it was followed by a follow-up phase, it could be seen that there was still a decrease in anxiety scores. This showed that the influence of cognitive-behavioral therapy on anxiety was experienced by the participant.

Table 1. The Changes in Anxiety Level of Subject at Pre Therapeutic, Therapeutic and Follow Up

Situation	Activity	Anxiety Level													
		Pra-therapy	Session 1	Session 2	Session 3 exposure 1			Session 4						Session 5	Follow up
					I	II	III	I	II	III	IV	V	VI		
Holding dirty/dusty objects	Washing hands	75	75	75	75	70	60	50	40	30	20	10	5	5	2
See the dirty and dusty floor	sweeping and mopping	70	70	70	70	60	50	40	30	20	10	10	5	5	2
See dirty clothes	Wash thoroughly	75	75	75	75	75	70	65	60	50	40	30	10	10	3
Enter the dirty-floor bathroom	Brushing the bathroom floor	70	70	70	70	65	60	50	40	30	20	10	5	5	2
Tangled or worn-out clothing	ironing until neat	70	70	70	70	65	60	50	40	30	20	10	5	5	2
The rooms are messy and dirty	Clean them up	70	70	70	60	45	30	20	15	10	10	10	5	5	2
Performing ablution	Performing ablution	80	80	80	80	75	75	65	55	45	35	25	15	15	5
Praying	Praying	80	80	80	80	75	75	65	55	45	35	25	15	15	5

Note :

Anxiety level based on Subjective Units Disturbance Scale (SUDS)

0 : Not feeling anxious
10-30: a little anxious
40-70: quite anxious
70-90: worried
100 : very worried

Exposure-1 is done independently for 3 days
Exposure-2 done independently for 6 days

Based on the table above, it shows the decrease in anxiety scores of the participant. This happened gradually in every activity she did. This decrease occurred relatively stable, both when she was conducting exposure-1 and exposure-2 independently. After the therapy process has ended, it was followed by a follow-up phase. It can be seen that there was still an agreed score. It revealed that cognitive therapy affected anxiety experienced by the participant.

The frequency of compulsive behaviour

Table 2. The frequency of subject studies each time the activity starts from the pre-therapeutic, therapeutic and follow-up phases

		Level Of Anxiety													
Situation	**Activity**	**Pra-therapy**	**Session 1**	**Sesson 2**	**Session 3 exposure 1**			**Session 4**						**Session 5**	**Follow up**
					I	**II**	**III**	**I**	**II**	**III**	**IV**	**V**	**VI**		
Holding dirty/dusty objects	Washing hands	5	5	5	5	4	4	3	3	3	2	2	2	2	1
See the dirty and dusty floor	sweeping and mopping	5	5	5	4	3	2	2	2	1	1	1	1	1	0
See dirty clothes	Wash thoroughly	5	5	5	5	5	4	3	3	3	2	2	1	1	0
Enter the dirty-floor bathroom	Brushing the bathroom floor	4	4	4	4	3	2	2	2	1	1	1	1	1	0
Tangled or worn-out clothing	ironing until neat	4	4	4	5	5	4	3	3	3	2	2	1	1	0
The rooms are messy and dirty	Clean them up	4	4	4	4	3	2	2	2	1	1	1	1	1	0
Performing ablution	Performing ablution	5	5	5	5	5	4	3	3	3	3	3	2	2	1
Praying	Praying	5	5	5	5	5	4	3	3	3	3	3	2	2	1

Note :
Exposure-1 was carried out independently for 3 days
Exposure-2 was carried out independently for 6 days

4.2. Discussion

Based on the results of the research above, it suggested that cognitive-behavioral therapy could reduce and change obsessive-compulsive symptoms experienced by the participant. This was inseparable from the therapeutic techniques given to the participant, in the form of relaxation exercises, cognitive restructuring, and exposure with ritual prevention that referred to the limitation of the principal symptoms of obsessive-compulsive disorder namely obsession mind, and the existence of anxiety and compulsive behavior.

Relaxation and cognitive restructuring in this therapy were based on the characteristics of obsessive-compulsive symptoms that the compulsive action of the subject was always based on obsessive thoughts and anxiety which was initially appeared. Therefore the two techniques done before giving exposure to ritual prevention techniques were seen to be more effective. It is expected that the participant would be more helpful when she applied exposure techniques. Cognitive techniques that combine with behavioral techniques (exposure and relaxation) are very effective in dealing with anxiety disorders, one of which is an obsessive-compulsive disorder (Nevid, et al 2005).

Based on the research basis, it could be seen that there was a decrease in anxiety levels after the participant got relaxation treatment. Besides, changes also occurred in cognitive aspects and subject behavior. This is consistent with the statements of several experts (Martin & Pears, 2007; Taylor, Thordarson & Sochating, in Martin & Pears, 2007; Open, 2004) who said that a combination of cognitive and behavioral techniques (relaxation, restructuring, and exposure) can handle various forms of anxiety disorders and one of them is obsessive-compulsive disorder.

The decrease in the frequency of compulsive behavior occurred gradually in each form of activity (washing, ironing, sweeping and mopping, performing ablution, praying). The application of exposure to ritual prevention techniques was very helpful in reducing the frequency of compulsive subjects.

The technique of exposure to ritual prevention is one of the techniques of behavior therapy. In this technique, individuals faced with situations which make them anxious and they are prevented from performing compulsive rituals. If the participant succeed in preventing it, it will gradually change her mind/belief of the individual from the ritual (Davison & Neale, 2006). The statement supports what was experienced by the subject, after doing and undergoing the exposure process several times and the subject finally was able to prevent all forms of compulsive rituals.

5. CONCLUSIONS AND RECOMMENDATION

5.1. Conclusion

The results of this study indicated that cognitive-behavioral therapy was able to overcome obsessive-compulsive disorder. The therapeutic techniques contained in cognitive behavioral therapy could provide changes in obsessive-compulsive symptoms experienced by the participant.

Obsessive thoughts that were experienced by the subject could change after the subject got restructuring techniques. The anxiety that the participant usually felt was also decreased. The decrease in anxiety score could be seen based on the Subjective Units Disturbance Scale during the administration of therapy. Likewise, the frequency of compulsion behavior of the subjects also decreased as long as the subjects followed the intervention process from the initial session to the follow-up session.

From the results of this study, the researcher concluded that by looking at the changes occurred to the participant in several sessions, namely changes in obsessive thoughts that were initially irrational to be more rational, a decrease in tension and a decrease in compulsive behavior that occurred in the subject can be

concluded that basically, CBT with relaxation techniques, cognitive restructuring, and exposure with response prevention are effective for overcoming obsessive-compulsive disorder.

5.2. Recommendations

- Further researchers are expected to be able to consider the involvement of friends as a supporting factor for research subjects.
- Future researchers are expected to use measurement which is objective and standardized properties such as the Beck Depression Inventory (BDI).
- For the research, the participant is expected to always apply the skills provided by the researcher to help the participant to overcome her obsessive-compulsive symptoms that might still be felt.

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