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Research Article

The application of paradox therapy for the treatment of obsessive-compulsive disorder: A case study

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Abstract

The course of treatment as well as the treatment costs/benefits are among challenges of the current psychotherapies. The purpose of the present article is to introduce a new psychotherapeutic model for the treatment of Obsessive-Compulsive Disorder (OCD). An evidence-based case study was performed based on a new paradox therapy for the treatment of OCD, called PTC (Paradox + Timetable = Cure). Three patients with OCD are presented based on the accounts of their video recorded therapy sessions. The patients participated in diagnostic interviews and self-report scales pre-, post-, and a follow-up assessment. Results indicated that the treatment of the patients was successfully done after three sessions for the first two patients and four sessions for the last one. The result of a 22 to 32 months follow-up showed that the therapeutic changes were satisfactory and stable, during which no relapse was happened. These results supported the deep and permanent effects of the PTC psychotherapeutic model in the shortest possible time. The influential mechanisms of "paradoxical timetable", as the main PTC technique, and its adjustment to the treatment outcomes of the three patients are also explained. It is concluded that the PTC psychotherapeutic model can be considered as a very short-term, effective, efficient and yet economical approach for the treatment of OCD. Simple nature of the PTC protocol, described within the present paper, allows psychotherapists and clinical practitioners to use this newly developed psychotherapy model for the treatment of anxiety disorders. The results of the present study can be applied to new developments in the field of psychotherapy theory, research, and practice.

Keywords: psychotherapy; paradox; timetable; PTC; OCD

1. Introduction

Obsessive-Compulsive Disorder (OCD) is a mental disorder characterized by obsessions (recurrent, intruding, persistent and unwanted thoughts, urges and images) and/or compulsions (recurrent behavior or mental acts that the individual feels like doing in response to an obsessive thought or does based on an irresistible ritual [1]. OCD is a persistent (resistant) disorder, usually accompanied by severe distress, high levels of dysfunction and disruption in the family, social and occupational arias for the individual and strongly influences the quality of life [2-5] In case that OCD is not treated, it usually leads to a debilitating and chronic course [6] increases the costs of health-care services [7] and eventually turns into a serious public health concern [8]. The present paper offers a paradoxical therapeutic (PT) model for treating OCD. This paradoxical psychotherapeutic model, shortly named PTC [9], is a method of treating psychological disorders that has been able to resolve many of the limitations and shortcomings of other existing treatments.

The PTC Treatment protocol

PTC has originated from psychodynamic, psychoanalytic and systemic psychotherapies, but is practically loyal to behavioral techniques. PTC therapy consists of two components or techniques: paradox and timetable. According to this dual combinational technique, the exact symptoms of the disorder are prescribed for the patient and the patient should recreate and re-experience the symptoms according to the instructions made with the help of the patient at certain times and lengths during the day (paradoxical timetable). The combination of these two techniques, as well as prescription of the exact symptoms are the main features of the PTC model.

When the details, the time, and the way of doing the tasks are determined, it's necessary that the therapist explain to the patient the possibilities that take place during the task. (Addressing the patient) You need to repeat the behaviors with the same negative feelings and emotions at the arranged times. Keep in mind that these tasks should only be done at these times, neither sooner nor later. In other words, these tasks are either done at these times or never done at all. This means that if you happen to miss one for any reasons (finding no suitable place, oversleeping, forgetting and so on)

the task should be skipped and not be compensated at other times. When you happen to successfully do the tasks, there might be some possibilities: one is that you are able to do the task exactly like the compulsive behavior; this is perfect and in this case, we will get the best results. But the perfect performance may not occur in every task and the tasks may be less similar to the obsessive behaviors, and their related feelings and emotions (the similarity may be from some 10 to 90 percent). In all these occasions, you have successfully done the tasks only if you have done your best in repeating the exact behaviors. With these explanations, you'll find the tasks very easy. Remember that you have to start the tasks tomorrow and you should not do any of them today. Another important issue is that under no circumstances should you intentionally try to stop your own compulsive behaviors. This instruction should be followed till the end of the treatment. In addition to the inseparability of paradox from timetable and prescription of the exact symptoms, beginning the tasks with a delay (a day after they are prescribed in the first session) and forbidding the prevention of OCD symptoms intentionally are other principles in the PTC psychotherapeutic model.

The first session ends with these instructions and the therapy session is usually held every other week. It's possible and sometimes necessary to make the interval between the first and second sessions shorter (at least a week); but since the effect of this psychotherapeutic model is quick, a two-week interval is preferred for the patient to evaluate and believe in his/her therapeutic changes. During this two-week interval, there is enough time for the patient to do the tasks and compare them with the occasions when he/she does not do them. Since PTC is a short-term therapy and requires the intervals between the sessions to increase (up to four-weeks), it's better to arrange a two-week interval between the sessions. In the form of behavior analysis, the patient reports his/her way of doing the tasks and the possible changes at the beginning of every session. This report determines whether or not the tasks are done, clarifying the possible limitations and problems of the prescribed tasks and giving information about the gained results. All this determines the type and amount of future tasks. The prescribed tasks are decremental. For instance, if the patient is to do the paradoxical tasks three times a day during the first week, the number of times will decrease to twice a day during the second week, once a day during the third week and every other day during the fourth week. The decremental change in the paradoxical tasks is another feature of the PTC psychotherapeutic model. When the disorder is severe and chronic, it may be necessary to increase the number of daily tasks two or three sessions in a row. In these cases, the level and number of tasks will afterword decrease too.

The special principles and features of the PTC psychotherapeutic model provide the ground for the principle of anxiety reduction or elimination (the anxiety of doing the tasks), which is the most fundamental principle in this psychotherapeutic model. All these considerations, principles, and techniques make the treatment even shorter. The number of therapy sessions is specific to each patient and is not determined beforehand. The number of sessions may be two for a patient and five for another. The therapist's intervention and management continues if it is necessary. The end of the therapy is determined by the patient's condition; when the patient no longer suffers from his/her problems and disorder for which he/she has entered the therapy; when the patient feels that he/she is no longer a patient; when the patient acquires the ability to manage his/her pathological condition; and when there is no psychological disorder. The end of the therapy is determined by the direct experience of the patient.

2. Method

Three OCD patients participated in the present study. All participants were admitted to an academic clinic center. They signed an informed consent document prior to performing the treatment sessions for both treatment and use of the anonymized case information for educational, learning, and research purposes. They also signed a written consent for video recording of all treatment sessions. For initial evaluation the patients participated in a diagnostic interview [1], the Yale-Brown Obsessive Compulsive Scale (Y-BOCS; [10], Beck Depression Inventory-II (BDI-II; [11]), the Overall Anxiety Severity and Impairment Scale (OASIS; [12]), and the Treatment Outcome Subjective Rating Scale [TOSRS; 13]. The patients met criteria for DSM-5 OCD, as well as a total score of 27.5, 26.9, and 30/3 for the Y-BOCS, respectively indicating severe OCD. A total score of 11.7, 12/5, 15.9 for BDI-II; and a total score of 9.4, 12.7, and 13.9 for OASIS, respectively indicating anxiety disorder. Subjective ratings on OCD on a scale of 0 (none) to 100 (extreme) percent were obtained at regular intervals. Obsessive-compulsive symptoms during the first session was 100 out of 100 for all 3 patients. At their last session, OCD symptoms reduced to 15/100 for the first patient, 10/100 for the second patient, and 5/100 for the third patient (see Figures 1-3). At post treatment, total scores of the Y-BOCS, BDI-II, and OASIS reduced to 10.5, 5.8, and 4.7 for the first patient: 9.6, 7/5, and 5/9 for the second patient; 8.9, 6.5, and 6.1 for the third patient, respectively.

3. Results

3.1. The application of PTC to OCD

3.1.1. Case 1

SA, a fifteen year old boy, came to an academic clinic centre with his mother. The clinical interview with the patient and his mother confirmed the existence of a series of symptoms related to obsessive-compulsive disorder including obsessive thoughts and doubts, constant washing, orderliness, rituals for going to the bathroom, rituals for taking baths, performing *Wudu*[1]and saying the prayers and constantly checking the lamps and other electronic devices. The disorder which had started two years ago, had low intensity at the beginning, but gradually became more and more severe. It turned into a worrying concern for the patient's family about a year ago. SA has no background of other physical illnesses or psychological disorders, has not taken any medication and does not take drugs at present. He has not visited any psychologist or psychiatrist before and this is his first visit to receive professional help. At the end of the first session, the following paradoxical timetable was arranged for the patient: a personal task including going to the bathroom three times (at 16:00, 19:00, and 22:00) on school days and four times (at 10:00, 14:00, 16:00, 19:00, and 22:00) on other days. It was explained to the patient that the order, routine, quality and quantity of these toilets must be exactly identical with the compulsive ones. The joint task for the mother and the son included the son asking the mother about the hygiene and purity or impurity of his underwear along with questions about religious issues: twice on school days (17:30 and 21:30) and four times on off days (11:30, 15:30, 17:30, and 21:30), each time for 10 minutes. In the joint task, the son must try to copy the obsessive questions he usually asks from his mother, and the mother must answer as she normally does. The report on the second session showed that the patient had carried out the tasks successfully, as a result of which the time the patient spent in the toilet had decreased from 50 to 10 minutes. The frequency of obsessive questions from the mother reduced close to zero. As a result of this improvement, the patient automatically spent less time with less rituals before taking baths (without any paradoxical tasks designed specifically for taking baths). At the end of the second session, it was decided that,

[1] *Wudu* is a term used for the ritual ablutions in Islam (the washing of one's face, hands and feet before the saying of obligatory prayers)

until the third session (which would be two weeks after), the patient must repeat the rituals of going to the bathroom twice a day (at 17:00 and 20:00) and do the task about questions and doubts with the mother once a day for 10 minutes (at 21:30). The report given in the third session showed that the symptoms of obsessive-compulsive disorder had disappeared completely, the treatment was complete and the patient was no longer suffering from any symptom. All the therapeutic changes and the patient's reports concerning his improvement were confirmed by the mother.

3.1.2. Case 2

Mrs. ZA, who is 27 years old, came to an academic clinic center because she was suffering from sexual impulses and conflicts that were, she believed, caused by masturbation. ZA had married three years ago with the expectation that marriage would get her rid of the need to masturbate. But, the expectation was not realized leading to further conflicts and severe religious guilt resulting from her perceived nightly masturbations. ZA's masturbation started at age 5, when she realized it gave her pleasure to press against her sexual organ. Severe religious guilt made her stop doing it 6 years ago (three years before her marriage), voluntarily. However, it reappeared as perceived masturbation that occurred nightly in her sleep. Compulsive behaviors started when she was 14, including constant washing, exaggerated concern about personal hygiene, taking long baths (for 75 minutes), doubts before and during saying the prayers and checking the gas valve and door locks. ZA visited a psychiatrist when she was 18 and took sedatives for a short period of time. She has no other history of physical illnesses or psychological disorders, and it's been about 10 years she has not taken medication. At the end of the first session, the following tasks were prescribed to the patient: the gas valve and the door locks must be checked twice a day (at 21:00 and 23:00), each time for 5 minutes; she must take a bath for 75 minutes at the maximum every day starting at 19:00; and she must masturbate three times a week similar to what she believes happens to her in her sleep (on Sunday, Tuesday and Thursday). According to the PTC model, it was explained to the patient that the tasks must be identical with the real compulsive behaviors. The patient's report on the second session showed that the obsessive checking had decreased by 70% and the baths had lessened to 30 minutes (60% decrease). The masturbation was done three times in the first week, but she had no desire to do it in the second week. Through the two weeks, she had the perceived sexual dream only once. Taking into account the improvement made, it was decided at the end of the second session that in the interval between the second and the third session, the patient must continue doing the daily baths up to 75 minutes starting at 19:00; do the checking only on even days for 5 minutes; do the masturbation twice a week (Sundays and Tuesdays); and do an extra task about obsessive doubts about the cleanliness of her body and clothes twice a day (at 17:00 and 22:00) for 5 minutes. According to the report given by the patient on the third session, the obsessive checking has totally disappeared; the baths have decreased to 20 minutes; and most important of all, the obsessive concerns that usually arose after the baths have vanished along with doubts about hygiene. The masturbation was carried out with pleasure, without any guilt or unease, as a result of which the sexual conflicts were resolved.

3.1.3. Case 3

Mrs. MK, 62 years old, with two daughters, discussed her problems and symptoms thus: the anxiety attacks started at 25 along with nausea, spasm in the neck and jaw muscles. She had visited a psychiatrist and had received medication for 15 years. She had ceased taking medicines from 10 years ago, and the physiological symptoms had disappeared. However, the patient had developed this new fear that she might, at any moment, have spasm in her neck and jaw muscles. She had severe religious guilt due to the fact that she had done things that were against her religious beliefs in the past. She had serious compulsions with checking the gas valve, door locks and the power button on the television. The anxiety symptoms included checking the possibility of breast cancer daily; extreme fear of getting blood cancer; extreme anxiety over her children's health and the fear that they may get cancer. The symptoms of compulsions and illness anxiety disorder with respect to her children started 6 years ago. Four years ago, she started taking medication under a psychiatrist, which was supposed to last for four years. At the time of visiting the therapist, she took 10 mg/day Fluoxetine. At the end of the first session, the paradoxical tasks were prescribed as follows: three times a day (at 12:00, 16:00, and 22:00) for recreating and re-experiencing the compulsive checking of the gas valve, door locks and the TV, each time for 6 minutes; two 7-minutes occasions a day (at 11:00 and 17:00) for re-experiencing the physical symptoms such as spasm in the neck and the jaw muscles, and upsetting and guilt-ridden thoughts about past deeds and the illness anxiety thoughts both about herself and about her children. The second session was held a week later with the patient giving the following report: I did the tasks about checking twice. When I was about to do them for the third time, I asked myself "am I out of my mind to do such things?" So I stopped, and I haven't done them once up to now. The task about recreating the spasm was so difficult on the first two occasions that I got a headache. I did them more easily after that, but I could not feel the spasm. As for the past and concern about diseases, I am much better." The following tasks were prescribed for the patient at the end of the second session: you must continue doing the tasks related to checking and the guilt-ridden thoughts about the past three times a day (at 12:00, 16:00, and 22:00) for 5 minutes, for three more days, but cease them on the fourth day and shift your focus to recreating thoughts and anxieties about yourself and your children. Imagine, in these tasks, that yourself and your children have contracted the worst diseases and try to make your thoughts identical to the real ones. Let there be no doubt that you have the worst disease. This task takes 10 minutes. Think about the diseases in the first 5 minutes, and in the second 5 minutes, stand before a mirror and try to create the spasm in your neck, jaw and mouth. For the next three weeks, do these tasks three times a day (at 12:00, 16:00, and 22:00), for 10 minutes. The report given by the patient on the third session showed that, following the disappearance of the compulsive checking, religious guilt had also vanished. She felt much better in this respect and said, "I feel that I have started a new life." The patient was willing to do the tasks about the diseases for one more week, since she did not have enough time to do it in the past two weeks. The patient said that she feared her chronic nausea appears again. The therapist prescribed new tasks for the patient. For the first week: a 5-minute task for recreating the diseases of the children (at 17:00) and another 5 minutes for recreating her own disease (at 23:00), every day. For the second week, allocate the first daily task to the anxiety over your own disease (at 17:00) and the second daily task to examining and checking your body (at 23:00). Do two 10-minute tasks every day during the third week: first, think of anything that can make you feel nausea (at 17:00) and then recreate the spasm in the neck, the jaw and the mouth (23:00). The tasks of the third week are of utmost importance, so they should be done carefully. At the beginning of the fourth session, which was the last session, the patient reported that she was completely treated: no compulsion had reappeared; the feelings of guilt had gone away; hypochondriac thoughts and fears had vanished; nausea along with spasm in the muscles were treated; and hope for a new better life had become dominant.

3.2. Evaluating the treatment outcomes and follow-up

The results of the treatment evaluation, which was based on the patients' comments in a graded scale of 0-100 and an open-ended question, indicated 85%, 90%, and 95% recovery for the patients at the end of therapy, respectively. A 23, 32 and 22 month follow-up evaluation indicated that the improvements gained by the PTC psychotherapeutic model have continued for all the three patients at 85%, 90%, and 90%, respectively (see Figures 1-3).

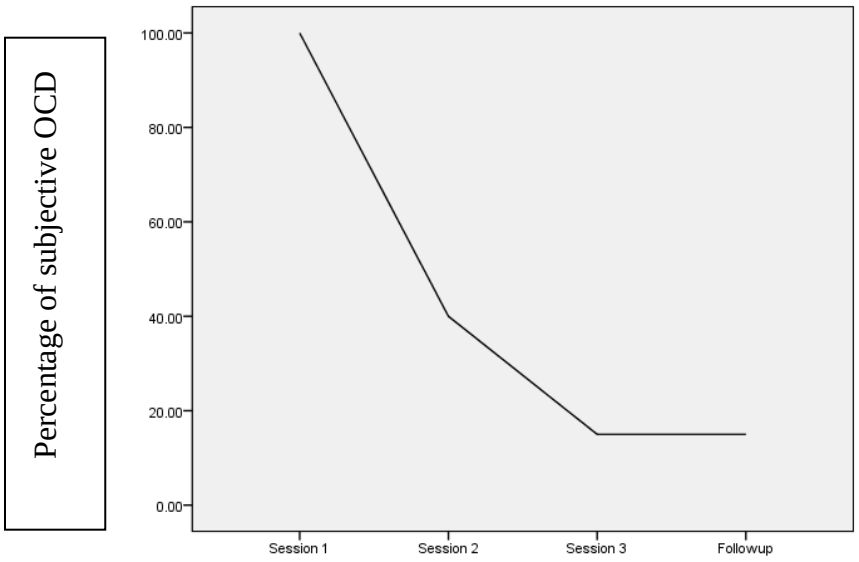

Figure 1. Subjective ratings of OCD by session

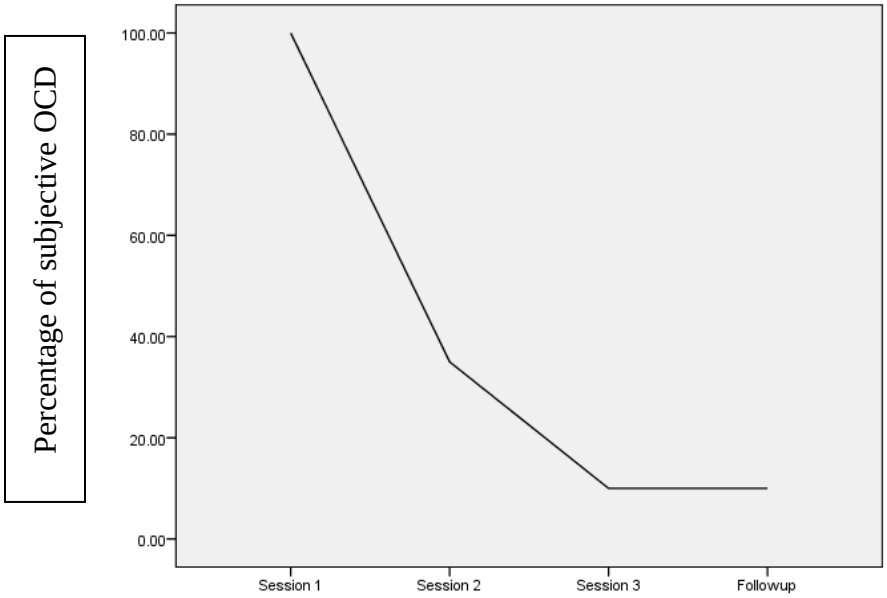

Figure 2. Subjective ratings of OCD by session

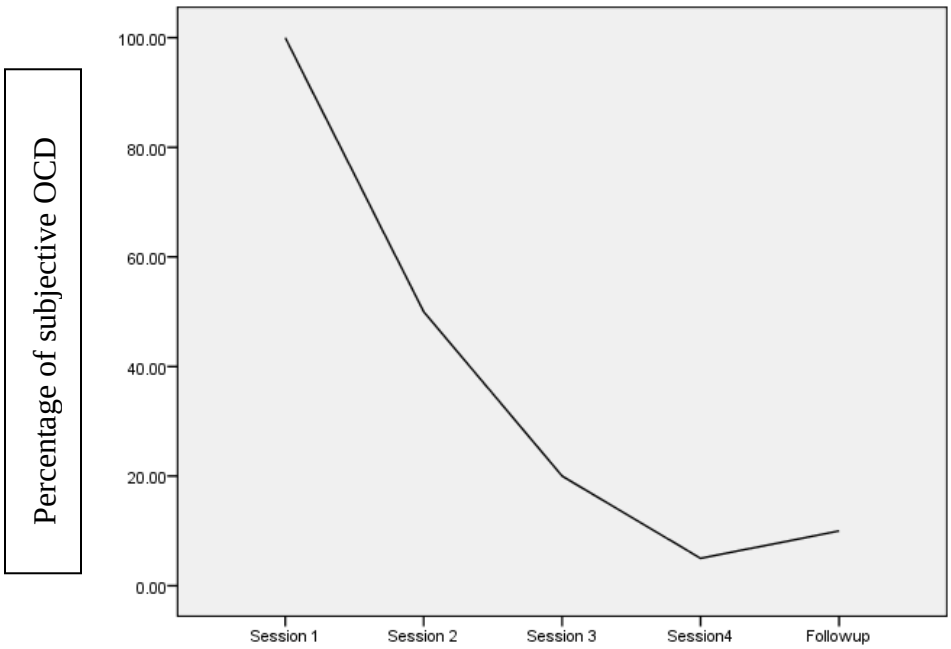

Figure 3. Subjective ratings of OCD by session

4. Discussion

How is the paradoxical timetable able to perform such a therapeutic influence by creating deep and quick long-lasting therapeutic changes? Based on the therapeutic changes reported by the patient, we will discuss the paradoxical timetable's effective mechanisms; mechanisms that explain how the therapeutic changes take place in the PTC psychotherapeutic model.

4.1. Effective mechanisms of paradoxical timetable

Ordering-artificializing: Based on the paradoxical timetable, the therapist asks the patient to intentionally recreate and re-experience, on pre-arranged occasions, the symptoms and behaviors that are out of the patient's control, and which are imposed upon the patient in an unpredictable manner, intruding his/her mind and debilitating and frustrating him/her all day long. This task necessitates a) ordering, i.e., symptoms that appear on the psychic level without the intention and willing of the patient and start annoying him/her are now experienced and recreated according to the therapist's instructions (Ordering); and b) artificializing, i.e., symptoms and behaviors that are real, are experienced and played artificially according to the therapist's instruction (artificializing). This mechanism, together with the principle of prescribing the exact same symptoms and the principle of delayed beginning of paradoxical timetable tasks, reduces or eliminates the anxiety of task performance and increases the chances of artificially recreating the symptoms of the disorder. The reports of all the three patients showed that they were able to follow the therapist's instructions and do the prescribed tasks without any problems. Under these circumstances, the symptoms are recreated but in spite of the therapist's warnings and the patient's honest endeavors, these symptoms may not be similar to the content of the symptoms of the disorder at all, though in terms of form they may sound similar. For this reason, after doing the tasks on a few occasions, the patients feel they don't have to continue doing them. As a result of performing the paradoxical timetable and by means of ordering-artificializing mechanism, the patient is able to turn the real symptoms of a disorder into artificial ones. Consequently, the connection between the symptom and the anxiety is disrupted, i.e., the second mechanism.

Breaking the symptom-anxiety relation

Symptom without the anxiety, i.e., a normal behavior without a pathological feature; is no longer accompanied by negative emotions and feelings and is not important anymore. This symptom, with these features, cannot be compulsory and annoying for the individual; it's under the control of the patient and he/she can easily eliminate it from his/her life. Keep in mind that in prescribing the paradoxical timetable task, the patient is asked to recreate the exact symptoms of the disorder with the same intensity and quality. In the PTC psychotherapeutic model, the patient is not asked to control or manage the symptoms; he is not asked to tolerate the symptoms; neither is he asked to accept the symptoms; however, he/she is asked to live just like before and only perform the prescribed tasks on pre-arranged occasions. Repeating the tasks in the interval between the two sessions provides the patient with an opportunity to test and believe in this experiential hypothesis and reality. Such practical and emotional experience modifies and changes the cognition, beliefs and expectations of the patient in the simplest way possible within and between the sessions without any special efforts on the side of the therapist and patient to change the cognitions and beliefs directly.

Changing the symptom's meaning: Disconnecting the symptom-anxiety relationship, which is done by means of a behavioral task, influences the patient's cognition automatically. The fact that the patient realizes by his/her personal and practical experience that the symptoms have no pathological feature changes the symptom's meaning and value. As the patient re-evaluates and re-experiences the ineffectiveness of the tasks by repeating them, his/her previous beliefs about the symptoms start to change. The mechanism of changing the symptom's meaning is not just limited to these changes. As soon as the therapist prescribes the exact symptoms for the patient, the symptom's meaning changes both for the patient and for the system (usually family) in which the patient lives.

By desensitizing the symptoms, the change in the meaning of the symptom has its effect before even the paradoxical timetable tasks begin. Part of the patient's anxiety stems from the negative meaning of the disorder for the patient and the system within which he/she lives. This meaning changes in the first session by prescribing the same symptoms; a positive change that directly reduces the anxiety, changing both the

meaning of the symptoms and creating a positive effect for the patient to perform his/her tasks easily. This type of change in the meaning of the symptoms is a product and feature of PTC psychotherapy. These therapeutic experiences, including "artificializing-ordering", "disconnecting the symptom-anxiety relation" and "change in the meaning of the symptom" are the beginning of the process of strengthening the ego which is stuck in the intrapsychic conflicts and has become helpless as a result of the conflicts between the Id and the Superego.

Ego strength

The core purpose of treating the psychological disorder in PTC is to make the ego powerful and strong. The principle of having intrapsychic conflict, stress and anxiety is considered not only pathological but also necessary for life. These intrapsychic conflicts and anxiety-inducing factors become troublesome and lead to psychological disorders in the absence of a powerful and strong ego, disrupting the psychic organization. When the ego weakens, the intrapsychic conflicts, which according to the psychodynamic paradigm result from the conflicts between drives of the id and standards and benefits of the superego, continue and exacerbate, disrupting the psychic organization by means of a psychological disorder. The psychopathological criteria in the PTC model revolves around the relation between the three psychic structures of the id, the ego and the superego. When the ego is placed at the top of the personality triangle and is able to control, manage and watch over the conflicts between the id and the superego, the general psychological well-being is obtained. The ego's relation with and distance from the other two psychic structures, i.e., the length of the height (the ego's status), determines the general psychological well-being. In contrast, if this distance decreases and reaches zero, with the ego standing next to the id and the superego in a horizontal line, or when the ego drops even below the horizontal line, the psychological disorder emerges [14-16].

When prescribing and performing the paradoxical tasks begin based on the patient's emotional and practical experience, the pathological relation between the ego and the unrestrained conflicts within the other two psychic structures begin to change and the countdown for regaining the ego strength starts. These reports along with the patients' satisfaction and positive feelings are all evidence of the strength of the ego. The first patient says, "after I did the tasks for a few days, I realized I was able to get out of the bathroom more quickly, I no longer listen to my thoughts and I'm able to stop hesitating and checking with my mother…"; the second patient: "It takes me only 15 to 20 minutes to finish my bath and I don't like to remain in the bath any longer… I'm not obsessed with the checking anymore… I did the personal and sexual tasks (masturbation) willingly and if I was allowed to, I could do them every day…"; the third patient: "Doctor, I used to say prayers, struggle with my conscience and do whatever I could to solve my problems with no success. But for the last twenty days, I've not thought about those issues and I feel content with my condition. I used to go around the house and check the telephone, the oven and things like that, but I don't do them anymore. As for the task about my sickness and checking myself, I did it for a couple of times but it got boring and I no longer did it because I had no more feelings about it. I felt more comfortable about my past too…"

Although ego strength is the ultimate goal in the PTC psychotherapeutic model, it starts when the therapeutic process begins during the first session, especially when the therapist prescribes the paradoxical timetable tasks; a process that quickly reaches its peak based on the four main mechanisms of paradoxical timetable. How fast the ego strength is achieved depends on several variables including the baseline ego strength/weakness, the inherent speed of emotions and emotional experience in both normal and abnormal conditions; it's a process in the PTC model which is formulated to be accomplished according to the patient's practical experience as easily as possible. The PTC therapeutic model leaves no room for the use of common techniques in psychodynamic, psychoanalytic, and cognitive-behavioral approaches. By providing a practical ground for the patient to have an emotional experience within the paradoxical timetable framework, the PTC therapeutic model quickly reaches all the goals which other approaches seek out to achieve in a long time.

5. Conclusion

The results of PTC for all the three patients with OCD, and other comorbid symptoms, indicated that the PTC psychotherapeutic model is an efficient and yet short-term therapeutic approach which suits both the therapist and the patient. The simplicity of the PTC model and its techniques is one of its advantages. The therapist's prescribed tasks and instructions are all dependent upon a principle that minimizes the task performance anxiety and maximizes the patient's compliance. Four main principles (paradox-timetable inseparability, prescribing the exact same symptoms, performing the task with delay, and resorting to the practical techniques) pave the way for an emotional and practical experience as quickly and easily as possible and facilitate the therapeutic changes. The ultimate goal in this short-term and quick therapy is to make changes on the ego level, balancing its distance and relation with the id and the superego, ultimately leading to the ego strength. This strength anticipates the stability and permanence of the therapeutic changes and reduces the relapse rate of the symptoms of the disorder. Another feature of the PTC psychotherapeutic model is that the patient turns into the therapist at the end of the treatment which can happen only in a simple approach such as the PTC model. The ending instruction of the PTC therapist for the patient at the end of the last therapy session can be explained as follows: The therapist warns the patient that the disorder might appear at any time for anyone; but there are two possibilities that may happen. Firstly, the disorder may never appear again. But the disorder may also emerge for any reasons. In case it reappears, five days must elapse to see whether it disappears automatically or not. If it continues after 5 to 7 days, the patient can either make another appointment or attempt to treat the disorder himself. To do so, the patient must arrange the same simple paradoxical timetable prescribed by the therapist and start it from the next day. When the symptoms, such as the checking, appear, one just needs to make a paradoxical timetable and do the tasks accordingly: three five-minute sessions each day for the first week; two five-minute sessions each day for the second week.

Compliance with Ethical Standards

Conflict of Interest: The authors declare that they have no conflict of interest.

Ethical Approval: All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent: Informed consent was obtained from all individual participants included in the study.

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