Obsessive-Compulsive Disorder: Treating the Untreatable using CBT

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Obsessive-Compulsive Disorder

- OBSESSIONS
  - Recurrent
  - Thoughts, ideas, images, impulses
  - Invade consciousness
  - ANXIOGENIC
  - Senseless
  - Try to ignore or suppress them
Obsessive-Compulsive Disorder

- **COMPULSIONS**
  - Repetitive
  - Acts or thoughts
  - Seemingly purposive
  - Performed according to certain rules
  - ANXIOLYTIC
  - Behaviour is not an end in itself but is designed to reduce or prevent obsessive fear
  - Either not really connected or is clearly excessive
Two main clinically proven effective approaches to treatment

- Psychological Therapy
- Drug Therapy
Psychological Treatment of OCD.

Gold Standard = ERP

– Prolonged graduated exposure in real life to the feared situation with self-imposed response prevention
Education about the role of Compulsions/ Reassurance/ Rituals (Adapted from Stern and Drummond, 1991)
Education about the role of Compulsions/ Reassurance/ Rituals (Adapted from Stern and Drummond, 1991)

- Anxiety initially rises
- Breaking the cycle - self-imposed response prevention
- Anxiety eventually reduces - it falls higher than when ritualisation occurs
Outcome for Exposure Treatment of OCD

• 75% improved by at least 50%
  – Marks, Hodgson and Rachman, 1975

• 80% improved following I.P treatment
  – Foa and Goldstein, 1978
Cognitive Therapy
## Outcome of Exposure Treatment

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<td>Anholt et al.</td>
<td>Psychother Psychosom, 2008:77(1):38-42</td>
<td>ERP vs CT</td>
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<td>Whittal, Thorarson and McLean</td>
<td>Behav Res Ther, 2005:43(12):1559-76</td>
<td>ERP vs CBT</td>
<td>EQUAL (CBT&gt;ERP? no significant differences)</td>
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Outcome of Exposure Treatment

• Despite many theories and many studies over the years

• THERE IS NO EVIDENCE that cognitive therapy is generally any more effective than ERP
CBT versus ERP

• Cognitive therapy is:
  – More expensive
  – Needs higher level of training/supervision
  – Intellectually attractive
CBT versus ERP

• Exposure therapy is:
  – Relatively cheap
  – Easy to learn
  – Can be easily used by the patient themselves
Maybe we should use Cognitive Therapy in a targeted way???
### Possible Reason why ERP has not worked | Possible Solution
--- | ---
Treatment seems worse than current problem | Medication with Serotonin Reuptake Inhibiting drugs +/- dopamine blockade
Depression | • Medication with Serotonin Reuptake Inhibiting (SRIs)drugs  
• Cognitive Therapy for depression
Overvalued Ideation | • Medication with dopamine blockers  
• Cognitive Therapy  
• Psychoeducational approaches  
• High intensity ERP
Anxiety too high | • Revisit hierarchy and renegotiate  
• Optimise SRIs  
• Psychoeducation and cognitive reattribution  
• Waning dose of anxiolytic drug
Just too much and cannot cope | • As above  
• ? What for the future???
What else can we do to improve ERP???
Exposure & response prevention (ERP)

- Prolonged rather than short duration (Stern and Marks, 1973)
- Real life rather than fantasy (imagined) exposure (Emmelkamp and Wessels, 1975)
- Regularly practised with self-exposure homework tasks (McDonald et al., 1978)
Steps to ERP

- EDUCATION
- Construction of hierarchy/treatment contract
- Exposure task
- Feedback
- Preparation for discharge
Educate about anxiety

• Explain (and demonstrate) the:
  – Physical
  – Cognitive
  – Behavioural

  symptoms of anxiety.
Educate about anxiety

Three “Golden Rules” of ERP:

• Anxiety is unpleasant but it does no harm.
• Anxiety does eventually reduce.
• Practice makes “good enough”
Educate about anxiety

The OCD sufferer needs to agree and accept the ‘risks’ of inducing and tolerating anxiety without neutralising or engaging in compulsive behaviours.
Construction of hierarchy/treatment contract

• Establish the life-style that the OCD sufferer would like to achieve
  — “If I had a magic wand and could get rid of your OCD, what would your life be like? Where would you be living? What would be your job? Et c.

• Identify what are the current obstacles to this

• Develop hierarchy based on this
Exposure Tasks

- Choose a task initially that causes anxiety BUT AT A LEVEL THE SUFFERER CAN TOLERATE without performing compulsions
- Prescribe chosen task 3 x /day
- Duration is until anxiety is reliable 50% - usually 1-2 hours initially
- Task should be obviously beneficial to overall goals.
Habituation using ERP

Anxiety

Time
Feedback

• Review progress

• Positive Reinforcement +++ where due
  – Remember you have just asked someone to face their worst fears!!

• If progress is satisfactory, move up the hierarchy
Preparation for Discharge

• Increasingly expect OCD Sufferer to plan treatment programme themselves
• Less frequent sessions
• Start to ensure over-learning and plans for future maintenance
TREATMENT PENDULUM

SLOB  "NORMAL"  OB

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But what if this is not working??
Reassess the situation and confirm ……

- Has the OCD Sufferer understood the treatment?

- Does he/she agree with the treatment or is the treatment worse than the disorder at present?
Reassess patient and......

• Has exposure been done for long enough and without compulsive activity?

• Has the exposure been repeated often enough?
Other problems that may occur...

- Depression (Foa 1979 found SEVERELY depressed individuals did not habituate within sessions)
- Overvalued Ideation (Foa 1979 found these individuals did not habituate between sessions)
- Obsessive Ruminations
- Obsessive-Compulsive Slowness
- Thought-Action Fusion
Depression
Depression

- Most patients with severe OCD are depressed but most improve as the OCD improves but if not habituating....

- Change Medication to an alternative SSRI
- +/- Cognitive Therapy for depression
61 severe, refractory OCD patients outcome with inpatient admission

Overall this represents:
40% reduction on BDI p<0.001
31% reduction in YBOCS p<0.001
61 severe, refractory OCD patients on inpatient admission

Overall 79% had evidence of significant depression prior to treatment

No significant differences in depression between men and women
61 severe, refractory OCD patients on inpatient discharge

Overall 45% had evidence of significant depression at discharge
Overvalued Ideation
Overvalued Ideation

• All severe OCD patients will claim to believe in the obsession if there has been recent exposure but for some this goes further......

• Add Dopamine blockade to SSRI
• Cognitive therapy - Psychoeducation
Psychoeducation and Normalisation

• Many OCD sufferers have been brought up with parents who also suffer from OCD and thus are unaware of “normal” behaviour

OR

• Many OCD sufferers have had the problem so long they have forgotten “normal” behaviour

• Need to educate the patient about “normality” using psychoeducation e.g. DIRT programme

• Also worth looking at “normalisation”
Danger Ideation Reduction Therapy = D.I.R.T
Developed by Jones and Menzies 1998 in Sydney, Australia
D.I.R.T.

- Corrective Information
- Microbiological Experiments
- Possibility of Catastrophe
- Filmed Interviews
  - Filmed interviews with workers in a range of relevant occupations
- Attentional Focussing
- Cognitive Restructuring
  - Identify unrealistic thoughts related to contamination/illness and teach to re-evaluate these. Rote learn reappraisals
Normalisation

- Educating the person about the range of normal behaviours  E.g
  - It is normal for men to find underage teenage girls attractive (the problem is with acting out on this)
  - All of us have violent thoughts from time to time…even ones which are truly abhorrent
  - All of us have blasphemous thoughts
Obsessive Ruminations
Obsessive Ruminations

- ANXIOGENIC obsessions
- ANXIOLYTIC compulsive thoughts
- EXPOSE to ANXIOGENIC
- PREVENT ANXIOLYTIC
Obsessive Ruminations – techniques to aid ERP

- Exposure using:
  - Deliberately provoking thoughts
  - Writing
  - Loop tape
  - Cue cards
Obsessive Ruminations – techniques to aid ERP

- High intensity and or frequency exposure
- Doubt a major issue?
  - Replace by exposure certainty
- Perfectionism a major issue
  - Deliberately being “wrong”
Obsessive Compulsive Slowness
Obsessive Compulsive slowness

• Usually is due to PERFECTIONISM

  “If a thing’s worth doing it is worth doing absolutely completely correctly at all times and despite whatever else”
Causes of obsessional slowness

• Doubting actions
  – Self-observation
  – Repeating
  – Breaking down complex tasks
  – Counting

• The “just right” feeling
Interventions

- PERFECTIONISM
  - deliberately do things incorrectly
Interventions

• Prompting & pacing
  – *I.e.* talking the patient through speeding up their actions…usually with modelling to begin with…can then be recorded so that patient can use on their own until new routines are established
Interventions

• Taking the risk
  – Encourage the patient to take the risk that things may not be done perfectly
Thought-action fusion
Thought-action fusion

– Thought is morally equivalent to deed
– Thinking about a negative outcome will cause a negative event to occur to self or others.
– Belief that the thought is evidence that this deed has or will be
Thought-action fusion

• Test out the belief
  – E.g lottery tickets to start with and then move on to wishing harm befalls therapist before moving onto family.
Thank-you for listening; Any Questions???
and have a good day!!