Cognitive Behavioral Therapy for OCD

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Current Treatments for OCD

• Serotonin Reuptake Inhibitors (SRIs)
• Behavior Therapy, i.e., Exposure and Response Prevention (ERP)
• Cognitive Interventions
• Mindfulness
• In clinical practice: CBT + Mindfulness
• For more severely ill patients, and/or patients with comorbid conditions -> CBT + pharmacotherapy
Mindfulness & Acceptance Based Interventions

1) Learning new ways to relate to internal experience
   - “Openhearted moment to moment, non-judgmental awareness” (Kabat-Zinn, 2005)
   - Paying attention to whatever arises
   - Not getting entangled/hooked by wishing things were different
Mindfulness & Acceptance Based Interventions

2) Accepting internal experience/reducing experiential avoidance
3) Valued actions (vs. behavioral constriction)
4) Self-compassion (kindness toward their own experience)
Between 50 and 60% of patients who undergo BT are much improved at the end of treatment.

Empirically supported as the most effective psychological treatment.

Foa et al. (1983)
Clomipramine and ERP

FIGURE 2. Yale-Brown Obsessive Compulsive Scale (Y-BOCS) Scores of Patients With Obsessive-Compulsive Disorder in a 12-Week Randomized, Placebo-Controlled Trial Comparing the Effects of Treatment With Exposure and Ritual Prevention, Clomipramine, and Their Combination.

- Exposure and ritual prevention
- Clomipramine
- Exposure and ritual prevention plus clomipramine
- Placebo

* Linear mixed-effects model analyses.

Foa et al. (2005)
CBT for OCD: A systematic Review and Meta-analysis of Studies published 1993-2014

Meta-analysis Comparison (Öst et al., 2015)

- All studies: 80%
- CBT vs. WLC: 37%
- CBT vs. placebo: all: 72%
- CBT vs. placebo: psychological: 77%
- CBT vs. all active tx: 49%
- Individual vs. group tx: 0%
- ERP vs. CT: 0%
- ERP/CBT vs. medication: 69%
- ERP/ERP + Med. vs. ERP + Pla.: 0%

Effect size (Hedges g)
Predictors and Moderators of CBT Outcomes for OCD

Table 1
Demographics and Descriptive Statistics by Treatment Type and Site

<table>
<thead>
<tr>
<th>Treatment Type</th>
<th>N</th>
<th>Treatment Type (n)</th>
<th>Age</th>
<th>% Women</th>
<th>Years Education</th>
<th>Number Sessions</th>
<th>Pre Y-BOCS</th>
<th>Post Y-BOCS</th>
<th>Pre BDI</th>
<th>Post BDI</th>
</tr>
</thead>
<tbody>
<tr>
<td>BT</td>
<td>125</td>
<td>n/a</td>
<td>35.82</td>
<td>55%</td>
<td>14.43</td>
<td>16.00</td>
<td>24.08</td>
<td>13.86</td>
<td>17.91</td>
<td>11.09</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>(11.89)</td>
<td></td>
<td>(2.79)</td>
<td>(3.82)</td>
<td>(5.96)</td>
<td>(7.91)</td>
<td>(10.66)</td>
<td>(10.68)</td>
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<tr>
<td>CT</td>
<td>108</td>
<td>n/a</td>
<td>35.33</td>
<td>72%</td>
<td>14.77</td>
<td>17.12</td>
<td>25.20</td>
<td>12.63</td>
<td>17.71</td>
<td>9.41</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>(10.03)</td>
<td></td>
<td>(2.56)</td>
<td>(4.52)</td>
<td>(5.12)</td>
<td>(8.87)</td>
<td>(11.06)</td>
<td>(9.20)</td>
</tr>
<tr>
<td>CBT</td>
<td>126</td>
<td>n/a</td>
<td>36.57</td>
<td>54%</td>
<td>14.16</td>
<td>18.13</td>
<td>23.83</td>
<td>11.90</td>
<td>16.23</td>
<td>7.53</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(11.34)</td>
<td></td>
<td>(2.79)</td>
<td>(2.00)</td>
<td>(5.80)</td>
<td>(6.67)</td>
<td>(10.00)</td>
<td>(7.57)</td>
</tr>
<tr>
<td>All</td>
<td>359</td>
<td>n/a</td>
<td>35.93</td>
<td>60%</td>
<td>14.44</td>
<td>17.08</td>
<td>24.33</td>
<td>12.80</td>
<td>17.27</td>
<td>9.33</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>(11.14)</td>
<td></td>
<td>(2.72)</td>
<td>(3.66)</td>
<td>(5.67)</td>
<td>(7.84)</td>
<td>(10.56)</td>
<td>(9.32)</td>
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</tbody>
</table>

Predictors and Moderators of CBT Outcomes for OCD

<table>
<thead>
<tr>
<th>Treatment type</th>
<th># of participants who met criteria</th>
<th>Total number of participants (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BT</td>
<td>45 (36.0%)</td>
<td>125</td>
</tr>
<tr>
<td>CT</td>
<td>60 (55.6%)</td>
<td>108</td>
</tr>
<tr>
<td>CBT</td>
<td>60 (47.6%)</td>
<td>126</td>
</tr>
<tr>
<td>Entire Sample</td>
<td>165 (46.0%)</td>
<td>359</td>
</tr>
</tbody>
</table>

*Clinically significant improvements are defined as reliable change and posttreatment scores in the non-clinical range.

- Significantly more CT than BT participants showed clinical improvement, $\chi^2(1) = 8.95$, $p = .003$.
- Improvement rates for CBT were marginally greater than BT, $\chi^2(1) = 3.48$, $p = .06$.
- CT did not differ from CBT, $p = .23$.

Exposure and Response Prevention (ERP)

• Long-lasting improvements
  – After individual and group ERP, patients maintained gains (40% and 46% decrease in Y-BOCS score, respectively) at a 6-month follow up

• Relapse prevention techniques help maintain gains

Fals-Stewart et al. (1993)
Exposure and Response Prevention (ERP)

• Effective for children, adolescents, and adults
  – Safe, acceptable treatment for pediatric OCD

Franklin et al. (2008)
Conducting CBT for OCD
Treatment Structure

- Assessment/Goal Setting/Psychoeducation
- Cognitive Interventions, Mindfulness
- Exposure and Ritual Prevention (ERP)
- *Enhancing Motivation*
- Relapse Prevention
Treatment Duration

- Varies, depends on severity, ~12-22 sessions
- Booster sessions after treatment has ended
- Fade the frequency of booster sessions slowly
Homework

• Assign after every session
• Includes specific strategies (e.g., ERP)
• Frequency of homework varies by type of task – usually daily/several times per week
OCD Assessment

- Current OCD triggers and related obsessions
- Rituals, avoidance and other strategies to avoid painful experience
- Feared consequences if patient does not neutralize
- Circumstances related to the onset of OCD
- History of OCD
OCD Assessment

- Cultural context/religious upbringing and current religious beliefs/practices in relationship to OCD
- Patient’s explanation for the cause of OCD (often based on strategies that are no longer adaptive)
- Family history of OCD and other psychiatric problems
- Traumatic experiences, if any
OCD Assessment

• Comorbid conditions, including influence on OCD symptoms and associated beliefs
• Impairment related to the OCD (daily routine, family and social life, employment)
• Type, dosage and effects of current and past medications
• Previous psychological treatment and effects
• Coping strategies for OCD symptoms
OCD Assessment

• Motivation/readiness for change (rewards associated with making a life change/perceived obstacles)
• Goals/how can treatment aim at increasing valued life activities (intimate relationship, career, spirituality)
OCD Model

I might stab my baby with a knife
OCD Model

I might stab my baby with a knife

I’m at risk for losing control. I want to do this. Good mothers don’t think like this.
**OCD Model**

I might stab my baby with a knife

I’m at risk for losing control. I want to do this. Good mothers don’t think like this.

Anxiety
Guilt
Shame
OCD Model

I might stab my baby with a knife

I’m at risk for losing control. I want to do this. Good mothers don’t think like this.

Anxiety
Guilt
Shame

- Avoid knives, sharp objects
- Checking if baby is OK
- Ask husband for reassurance
Constructing a CBT Model for OCD

Trigger

Intrusive Thoughts

Maladaptive Interpretations

Negative Emotions
  (e.g., Anxiety, Shame, Depression)

Maladaptive Coping Strategies
  ➢ Rituals
  ➢ Avoidance

Mindfulness Skills.
Education

Monitoring,
Metaphors,
Cognitive
Restructuring,
Behavioral
Experiments

ERP, Behavioral
Experiments

Emotion Regulation Skills
  (e.g., Activity Scheduling)
Thought Form (short)

- **Situation:** Holding baby
- **Intrusion:** I am going to smash her head against the wall
- **Interpretation:** If I am thinking that I’m going to smash her head, I secretly want to do it.
- **Emotion:** Anxious
- **Compulsion/Avoidance:** Give baby to husband right away
• Use Cognitive Therapy strategies flexibly
Socratic Dialogue

- Show curiosity about patient’s thinking
- Ask questions
- Follow the patient’s logic (“do you mean that if X, then...?”)
- Ask about logical inconsistencies (“so if that were true, then...?”)
- Be collaborative, exploratory, patient
- Avoid arguing
Thought Form

- **Situation:** Holding baby
- **Intrusion:** I am going to smash her head against the wall
- **Interpretation:** If I am thinking, I’m going to smash her head, I secretly want to do it.
- **Emotion:** Anxious
- **Compulsion/Avoidance:** Give baby to husband right away
- **Rational Response:** This is just a thought. I have had this thought over a thousand times and I never acted on it...This shows me that thoughts cannot cause actions
Acceptance of Intrusive Thoughts

- Clouds in the sky
- Leaves floating down the river
- Fish swimming in the ocean
- Wiley Coyote and train tracks
- Allow the train to arrive and leave the station
Integrating CT and ERP

- Start with CT
- Then move on to ERP
- Then combine both in session/at home
Exposure and Response Prevention

- Identify triggers for anxiety/avoidance behavior (people, places, situations)
- Identify rituals (times, frequency)
- Design ERP hierarchy (but don’t get too focused on working your way up in a step by step fashion)
- Conduct ERP
Explain How Exposure Works

• T: “Exposure will help you go into situations you currently avoid, like...[give examples]. You might be anxious at times, but you can learn to tolerate the anxiety.”
Explain How Exposure Works

• T: “During the exposure practices, you can find out if the outcomes you fear really occur. You get first hand experience if your predictions are accurate or not.”
Troubleshooting: Motivate Your Patient To Tolerate The Anxiety

• Discuss the short-term and the long-term consequences of avoidance

• Discuss reinforcement circuits as shown in the patient’s CBT model.

• Review the costs (how it robs the patient of enjoyment or achieving things) and the benefits that come along with reducing avoidance.
Exposure Situations
## Sarah - Contamination

<table>
<thead>
<tr>
<th>Distressing Situations Worksheet</th>
<th>Distress (0-100)</th>
<th>Avoidance (0-100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Door handles and elevator buttons</td>
<td>45</td>
<td>70</td>
</tr>
<tr>
<td>2. Sitting in a bus</td>
<td>55</td>
<td>60</td>
</tr>
<tr>
<td>3. Shaking hands with strangers</td>
<td>67</td>
<td>60</td>
</tr>
<tr>
<td>4. Touching money (esp. coins)</td>
<td>70</td>
<td>60</td>
</tr>
<tr>
<td>5. Touching trash cans at home</td>
<td>72</td>
<td>60</td>
</tr>
<tr>
<td>6. Touching garbage cans outside</td>
<td>78</td>
<td>90</td>
</tr>
<tr>
<td>7. Touching curtain in gym locker room</td>
<td>80</td>
<td>90</td>
</tr>
<tr>
<td>8. Images of becoming terribly ill</td>
<td>85</td>
<td>100</td>
</tr>
<tr>
<td>9. Public bathrooms</td>
<td>90</td>
<td>100</td>
</tr>
</tbody>
</table>
Sarah’s Response Prevention Plan

- No contact with water except for one 10-minute shower and 2 X 2-minute tooth brushing each day, after using bathroom (30 sec) and when hands are visibly dirty
- Do not use hand sanitizer
- Do not change clothes even if you think they are contaminated
- Do not ask family members to change when they come in the house
Response Prevention Strategies

- Stimulus control (making it difficult for the ritual to occur)
- Selective ritual prevention (picking your battles)
- Restricting your rituals (watching the clock)
- Postponing a ritual (when procrastination is a good thing)
- Using competing actions
## Sonja - Harming

### Distressing Situations Worksheet

<table>
<thead>
<tr>
<th>Distressing Situations Worksheet</th>
<th>Distress (0-100)</th>
<th>Avoidance (0-100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Turn light switch on and off</td>
<td>45</td>
<td>50</td>
</tr>
<tr>
<td>2. Turn faucet on/off</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>3. Open and close window</td>
<td>55</td>
<td>50</td>
</tr>
<tr>
<td>4. Open/close car door and</td>
<td>65</td>
<td>50</td>
</tr>
<tr>
<td>enable/disable parking break</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Turn coffee maker on and off,</td>
<td>70</td>
<td>90</td>
</tr>
<tr>
<td>go upstairs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Turn iron on and off, leave</td>
<td>80</td>
<td>100</td>
</tr>
<tr>
<td>house</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Turn stove on and off, leave</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>house</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Sonja’s Response Prevention Plan

- Don’t check (ask her to leave room/house)
- Don’t seek reassurance (family members might need to be involved in treatment plan)
- Don’t listen to news/call police.
# Olivia’s ERP Hierarchy

<table>
<thead>
<tr>
<th>Distressing Situation</th>
<th>SUD (0-100)</th>
<th>Avoidance (0-100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buttering bread while alone</td>
<td>30</td>
<td>35</td>
</tr>
<tr>
<td>Listening to loop tape on stabbing son, do not start praying</td>
<td>50</td>
<td>60</td>
</tr>
<tr>
<td>Cutting fruit while kids are in the house, do not ask husband to watch me</td>
<td>60</td>
<td>65</td>
</tr>
<tr>
<td>Cutting fruit with kids at the table, do not ask husband to watch me/do not ask for reassurance</td>
<td>80</td>
<td>100</td>
</tr>
<tr>
<td>Hold son and knife at the same time, do not pray</td>
<td>90</td>
<td>100</td>
</tr>
<tr>
<td>Hold son while cutting fruit, do not ask husband for reassurance</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>
Select A Moderate Anxiety Level Situation For The First Exposure

• Begin with exposure to situations that provoke distress and avoidance ratings near 40.

• Make patient active participant in deciding on ERP
Behavioral Experiments

• Design experiment to test validity of hypothesis
  – e.g., “I will show signs of illness in the upcoming week if I touch this door knob”
  – “My bad thoughts can harm others”

• Compare feared and actual consequences

• Identify what you learned from experiment
Moving Forward

- Practice exposures and ritual prevention daily
- Work on increasingly challenging ERP’s
- Be creative, leave office, change context
- Shift responsibility for designing ERP’s gradually to patient (parents)
Things to remember

- Patients may feel anxious, disgusted or “not right”
- Okay for the patient to feel anxious during ERP
- Patient should conduct some exposures by him/herself
- Watch out for subtle avoidance strategies and mental rituals
- Complete exposure practices without using mental rituals, distraction, anti-anxiety medication, etc.
Other things to remember

• Promote generalization: phone sessions, bring “contaminated” items to office
• High intensity exposures are okay; walk the line (exposure scripts)
• Have fun – make games out of exposures (sing, musical spoons)
Involving Family Members

• Highly recommended when working with children
• Educate family members about OCD
• Suggest reading
• Ask for the family’s/partner’s observations
• Explain what the treatment will involve
Involving Family Members

- Ask parents to be helpers/co-therapists, involve them in designing ERPs & CT, homework (praise them often!)
- Reinforce small gains (for children: gummy bears, screen time, tickets)
- Reassurance seeking and accommodation
- Maintain a normal routine
Activity Scheduling

- To introduce healthier behaviors that result in feelings of pleasure and mastery
- Guided by values
Relapse Prevention

- Residual problems are addressed
- Unrealistically optimistic or pessimistic thoughts about treatment termination are evaluated
- Review CBT techniques with handouts
- Decrease session frequency
- Schedule self-sessions/patient as therapist
- Plan time without symptoms/Activity Scheduling
Relapse Prevention

- Anticipate possible symptom recurrence and its relationship to stress, mood, and other variables
- Learn to differentiate between lapses and relapses; counter negative thoughts about setbacks; and handle lapses and setbacks
- Schedule booster sessions
OCD Therapy Manuals
