CBT Treatment

Obsessive-Compulsive Disorder
OCD DEFINITION AND DIAGNOSIS

• NORMAL WORRIES & COMPULSIONS
• DYSFUNCTIONAL/ABNORMAL OBSESSIONS
• DSM IV DIAGNOSIS
OCD DIAGNOSIS

DSM IV & ICD 10

A significant source of distress and/or interference

OBSESSIONS

Recurrent, persistent thoughts, images or Impulses experienced, at some point, as intrusive and senseless

Attempts to ignore and/or suppress and/or neutralise.

Recognition of ownership of thoughts, yet perceived as ego-dystonic; content unrelated to another Axis 1 diagnosis.
OCD DIAGNOSIS

COMPULSIONS

Repetitive, purposeful and intentional behaviour

Performed in response to an obsession or according to certain rules

Designed to neutralise or prevent discomfort and/or catastrophe.

Awareness of their unrealistic and/or excessive nature.
OCD: DIFFERENTIAL DIAGNOSIS

MAJOR DEPRESSIVE DISORDER
GENERALIZED ANXIETY DISORDER
HYPOCHONDRIASIS
SPECIFIC ILLNESS PHOBIA
ANXIETY DUE TO A GENERAL MEDICAL CONDITION
APPETITIVE DISORDERS
BODY DYSMORPHIC DISORDER
DELUSIONAL DISORDER
OCD DIFFERENTIAL DIAGNOSIS

OBSESSIVE-COMPULSIVE PERSONALITY DISORDER
ABSENCE OF OBSESSIONS AND/OR COMPULSIONS
PERVASIVE PATTERN OF:

– ORDERLINESS
– PERFECTIONISM
– CONTROL
– ONSET BY EARLY ADULTHOOD
BEHAVIOURAL MODEL OF ANXIETY

BEHAVIOURAL TREATMENT INVOLVES EXPOSURE TO FEARED STIMULI/SITUATIONS (CS) WITHOUT THE MALADAPTIVE RESPONSE TO PERMIT THE EXTINCTION OF THE CONDITIONED RESPONSE (CR)

ADVANTAGES
• EXPLICIT PREDICTIONS
• DEMONSTRABLE
• PLAUSIBLE
• PRACTICAL/DIRECT TREATMENT

DISADVANTAGES
• PREPAREDNESS
• INDIVIDUAL DIFFERENCES
• DEVELOPMENTAL INFLUENCES
• LACK OF TRAUMATIC ONSET
• SOCIAL & SYMBOLIC ACQUISITION OF ANXIETY
OCD TREATMENT APPROACHES

BEHAVIOUR THERAPY

Rationale & Behavioural Assessment – see Figure 1

Exposure and Response Prevention

Maintenance and Generalizability

Relapse Prevention
Typical Steps in the Behavioural Assessment of OCD

Specify the rituals and obsessions in detail

What situations evoke the rituals or obsessions (e.g., do the rituals occur only at home)?

Are there any fluctuations in the symptoms (e.g. are they worse if the patient is alone)?

What situations does the patient avoid as a result of OCD?

Fig. 1
Typical Steps in the Behavioural Assessment of OCD (Contd.)

Do any thoughts, images, or impulses trigger (eg sacrilegious images, aggressive impulses) rituals or obsessions?

Construct hierarchy of target situations based on the amount of anxiety (SUDS scale), ritualising, or obsessing they evoke.

What does the patient believe will occur if he or she does ritualise? How strong is this belief?

Are the patient’s symptoms being maintained by family interactions?

Is the patient severely depressed? If so, consider trial of medication.

Fig. 1
### Typical OCD Fear Hierarchy

<table>
<thead>
<tr>
<th>Items in fear hierarchy</th>
<th>Level of anxiety^a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting in a friend’s apartment</td>
<td>10</td>
</tr>
<tr>
<td>Wearing the same clothes for two consecutive days</td>
<td>15</td>
</tr>
<tr>
<td>Vacuuming the apartment and coming in contact with dirt</td>
<td>25</td>
</tr>
<tr>
<td>Noticing dust on furniture at work</td>
<td>30</td>
</tr>
<tr>
<td>Handling books that other people probably handled</td>
<td>30</td>
</tr>
<tr>
<td>Touching doorknobs in public buildings</td>
<td>50</td>
</tr>
<tr>
<td>Seating on a park bench</td>
<td>55</td>
</tr>
<tr>
<td>Having one’s pyjamas come in contact with the apartment floor</td>
<td>65</td>
</tr>
<tr>
<td>Wearing clothes that fell on the floor</td>
<td>65</td>
</tr>
<tr>
<td>Washing clothes in a public laundromat</td>
<td>75</td>
</tr>
<tr>
<td>Using a public pay phone</td>
<td>90</td>
</tr>
<tr>
<td>Shaking hands with a unfamiliar person</td>
<td>90</td>
</tr>
<tr>
<td>Using a public toilet</td>
<td>100</td>
</tr>
</tbody>
</table>

^a = no anxiety to 100 = maximum anxiety/panic.
OCD: Client Exposure Guidelines

Prepare to feel anxious. It is normal to feel uncomfortable during exposure practice. In fact, if you feel anxious it means you are doing exposure correctly. The object is to provoke obsessional fear and urges to ritualize, which you will practice resisting. Your job is to remain in the situation until your anxiety subsides on its own.

Try not to fight your fear. Fighting the anxiety during exposure will make you even more anxious. Instead, just let yourself be uncomfortable. Remember that the worst thing that will happen is temporary distress.

Do not use avoidance, rituals, or reassurance seeking during exposure. In order to reduce your fears, exposure practices must be completed without compulsive rituals, reassurance seeking, avoidance, distraction, medications, alcohol, or other strategies that make you feel safer or that prevent you from becoming anxious.

Test out negative beliefs about the consequences of facing your fear. Before beginning an exposure, ask yourself what you are afraid might happen if you confront this situation. Then, like a scientist, test out whether your fearful prediction is true by doing the exposure. Afterwards, consider what the experience has taught you. What evidence did you gain? What do you now think about the exposure situation?

Keep track of your SUDS. During exposure practices it is important to monitor how distressed you are feeling using the SUDS scale from 0 (calm) to 100 (extremely anxious). Pay attention to whether your level of fearfulness changes as time goes by.

Each exposure practice should continue until you feel a significant reduction in anxiety. Remain exposed to the feared situation until your anxiety subsides, no matter how long this takes. If you leave the situation when you are still very anxious, you are convincing yourself that the situation is dangerous and you will not reduce your fear.

Repeat exposures until they no longer make you very anxious. The more an exposure is practiced, the more your feelings of anxiety will decrease and the easier it will be to feel comfortable with the feared situation.

Practice exposure in different settings. Confronting your fears in new and different settings helps to solidify your improvement. Practice exposure with your therapist, with family members (if applicable), on your own, and in various places that trigger obsessions.
ERP Session by Session Habituation

Ratings of subjective distress for an individual with OCD during four sessions of exposure to “bathroom germs.” The figure illustrates the reduction of distress within individual sessions as well as across treatment sessions.
Stimuli and situations
(Internal or external)
Including external triggers, intrusive thoughts and information

COGNITION
DANGER, THREAT

Safety seeking Behaviours (including Avoidance, escape, and neutralising)

Biological and Psychophysiological reactions
CBT Model of OCD from Salkovskis (1985)

- Potential Stimuli
- Extrinsic Mood Disturbance
- Schematic Activation: accessibility of loss, threat or blame ideation
- Increased Acceptance
- Automatic Thoughts Ego syntonic
- Mood Disturbance, discomfort, dysphoria, anxiety
- Neutralising Response
- Escape Behaviour
- Reduced Discomfort
- Perception of Responsibility
- Rewarding Non-punishment
- Avoidance

Triggering Stimuli (Internal/External)
A COGNITIVE THEORY OF OBSESSIONS

A postulated sequence of descriptions, interpretations and actions (from S.J. Rachman)
Cognitive Obsessions and Covert Rituals

- Intrusive Thought
  - Negative Appraisal
    - Increased Anxiety and Worry
      - Overcontrol
        - Vigilance (Could I really do it?)
        - Covert Rituals
          - Testing
            - Temporary Anxiety Reduction
              - Cycle starts all over again
EXAMPLE OF THOUGHT/ACTION FUSION AND OC METACOGNITION

“I’m having a bad thought – that must mean I’m bad.”

“I wouldn’t be having these thoughts if I wasn’t truly bad!”

“The more bad thoughts I have, the more proof I have that I’m bad.”

“Because I’m thinking so much about doing bad things, it must mean that I’m highly likely to do something bad.”

“If I don’t try hard to prevent harm from happening, it is as bad as doing something bad on purpose.”

“Since it is likely that I’m going to do something bad, I’d better watch out for it. I may even have to make sure that others are protected from my bad actions.”
OCD: COGNITIVE TREATMENT APPROACHES

– Psychoeducation of CBT Model of OCD
– Shared Formulation
– Identification of Intrusions & Appraisals
– Cognitive Restructuring of Appraisals & Beliefs
– Role of Compulsions, Neutralization & Avoidance: ERP
– Behavioural Experiments
– Modifying Metacognitive Beliefs
### OCD: Examples of Behavioural Experiments

<table>
<thead>
<tr>
<th>Thought-action fusion (TAF)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Premonitions experiment.</strong> The client thinks about people and records every time he or she hears from these individuals.</td>
<td></td>
</tr>
<tr>
<td><strong>Intrusions survey.</strong> The client surveys trusted friends and family on the types of unwanted ego-dystonic intrusive thoughts they experience.</td>
<td></td>
</tr>
<tr>
<td><strong>Power of thoughts.</strong> Begin by having the client form a specific thought about a positive or neutral event and record whether the event occurs. The client then proceeds to thinking about bad things happening to therapist, friends, or self, and records the outcome.</td>
<td></td>
</tr>
<tr>
<td><strong>Cognitive risk.</strong> The client increases the frequency and duration of ruminating on unwanted thoughts and records any evidence of increased tendency for negative outcomes.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inflated responsibility</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responsibility manipulation.</strong> The client records the frequency and distress of the obsession during a week in which he or she focuses on his or her personal responsibility for any negative consequences of the obsession (high responsibility condition). In the following week responsibility is temporarily shifted to the therapist through a written contract, and the client records frequency and distress of the obsession for a week, during which the client reminds him or herself that the therapist is responsible for the possible negative outcome (low responsibility condition).</td>
<td></td>
</tr>
<tr>
<td><strong>Responsibility gradient.</strong> The client is exposed to a hierarchy of successively greater responsibility for tasks involving the primary obsessional concern.</td>
<td></td>
</tr>
</tbody>
</table>
### TABLE 12.2. Therapeutic Elements Used to Promote Relapse Prevention in CBT

- Educate client on the nature and course of OCD.
- Ensure realistic treatment expectations, including presence of residual symptoms.
- Identity situations that trigger obsessions and compulsions.
- Ensure a clear understanding of the CBT model.
- Provide written instructions on response to a relapse of obsessions.
- Instruct client to be vigilant about re-emerging avoidance, reassurance seeking, or other compulsive and neutralizing responses.
- Instruct client to take a problem-solving approach to episodes of unwanted intrusive thoughts or obsessions.
- Teach coping skills for stress and other life difficulties.
- Fade therapy sessions, providing continued access and support.
Susan: OCD Case Formulation

External Triggers
- e.g. bathrooms, ‘dirty’ pupils, marking schoolwork, sharp objects, bathing the baby

Intrusive Obsessional Thoughts
- Ideas: e.g. I am contaminated
- Doubts: e.g. I might assign the wrong mark
- Images: e.g. Stabbing and drowning baby

Catastrophic Interpretations of Obsessions
- I will get ill & make my family ill
- I can’t take the chance this will happen
- The more I think it the more likely it is.
- I can & should control my thoughts or I am fully responsible for the outcome
- These thoughts mean that I’m a terrible mother

Dysfunctional Beliefs
- Overestimates of the probability and severity of danger
- Inflated sense of responsibility for danger
- Certain thoughts should be controlled

Hypervigilance
- Increases preoccupation and salience of cues

Lack of Correction of Beliefs
Safety behaviours prevent correction of catastrophic beliefs

Negative Reinforcement
- Of safety behaviours by distress reduction

Safety-Seeking Behaviours
- Avoidance: e.g. pupils, public toilets, baby
- Rituals: e.g. washing, checking, mental health
- Neutralising: e.g. concealment, suppression

Short-Term Anxiety/Fear Reduction

Thought Suppression
- Leads to more unwanted thoughts
Susan: An Exposure Hierarchy

<table>
<thead>
<tr>
<th>Description of the exposure</th>
<th>SUDS</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.  SIT: Public surfaces</td>
<td>50</td>
<td>1</td>
</tr>
<tr>
<td>IMAG: Germs on self, contamination of family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.  SIT: Grading papers and recording grades</td>
<td>55</td>
<td>2</td>
</tr>
<tr>
<td>IMAG: Possibility of mistakes, ruining students’ career</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.  SIT: Leave appliances plugged in/on</td>
<td>65</td>
<td>2</td>
</tr>
<tr>
<td>IMAG: Responsibility for causing fires</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.  SIT: Hand papers back to students (no checking)</td>
<td>65</td>
<td>3</td>
</tr>
<tr>
<td>IMAG: Uncertainty over mistakes in assigning grades</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.  SIT: Use knife while Jennifer is nearby</td>
<td>65</td>
<td>3</td>
</tr>
<tr>
<td>IMAG: Thoughts of stabbing Jennifer with a knife</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.  SIT: Give Jennifer a bath</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>IMAG: Thoughts of drowning Jennifer in the bathtub</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.  SIT: Shaking hands</td>
<td>65</td>
<td>4</td>
</tr>
<tr>
<td>IMAG: Germs possibly on self, passing germs to family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.  SIT: Sweat</td>
<td>65</td>
<td>4</td>
</tr>
<tr>
<td>IMAG: Germs possibly on self, passing germs to family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.  SIT: Saliva</td>
<td>65</td>
<td>4</td>
</tr>
<tr>
<td>IMAG: Germs possibly on self, passing germs to family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. SIT: “Contaminated” student from class</td>
<td>70</td>
<td>5</td>
</tr>
<tr>
<td>IMAG: Germs possibly on self, passing germs to family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. SIT: Garbage cans, dumpsters</td>
<td>75</td>
<td>6</td>
</tr>
<tr>
<td>IMAG: Germs possibly on self, passing germs to family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. SIT: Public bathrooms</td>
<td>80</td>
<td>7</td>
</tr>
<tr>
<td>IMAG: Germs possibly on self, passing germs to family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. SIT: Faculty bathroom at school</td>
<td>85</td>
<td></td>
</tr>
<tr>
<td>IMAG: Germs possibly on self, passing germs to family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. SIT: Urine</td>
<td>90</td>
<td>8</td>
</tr>
<tr>
<td>IMAG: Germs possibly on self, passing germs to family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. SIT: Contaminate family members with urine</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>IMAG: Responsibility for illness</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FIG. 10.2. Susan T.’s fear hierarchy.
OCD: Client Ratings

1: DESCRIPTION
Brief description of the most troublesome mental thought, image or impulse, and the most troublesome physical ritual (at the start of therapy):

THOUGHT: .............................................................................................................................................

THOUGHT/ RITUAL: .................................................................................................................................

2: SPECIFIC RATINGS
Please rate the above thought, the above ritual, and your obsessional problems as a whole, on each of the following scales, according to how they have been IN THE PAST WEEK.

(a) Discomfort experienced:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absent</td>
<td>Slight</td>
<td>Moderate</td>
<td>Marked</td>
<td>Extreme</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Thought: ...........
Ritual: ...........
All Obsessional Problems: ...........

(b) Interference caused in your life:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Slight</td>
<td>Moderate</td>
<td>Marked</td>
<td>Extreme</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Thought: ...........
Ritual: ...........
All Obsessional Problems: ...........

(c) Please estimate how long each day you are troubled by the obsessional problems as a whole:

......hrs ......mins
Obsessive Compulsive Inventory (OCI)

The following statements refer to experiences which many people have in their everyday lives. In the column labelled DISTRESS, please CIRCLE the number that best describes HOW MUCH that experience has DISTRESSED or BOTHERED YOU DURING THE PAST MONTH. The numbers in this column refer to the following labels: 0 = Not at all  1 = A little  2 = Moderately  3 = A lot  4 = Extremely

<table>
<thead>
<tr>
<th>Statement</th>
<th>DISTRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unpleasant thoughts come into my mind against my will and I cannot get rid of them</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>2. I think contact with bodily secretions (perspiration, saliva, blood, urine, etc) may contaminate my clothes or somehow harm me.</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>3. I ask people to repeat things to me several times, even though I understood them the first time.</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>4. I wash and clean obsessively.</td>
<td>0 1 2 3 4</td>
</tr>
</tbody>
</table>
Responsibility Interpretations Questionnaire (RIQ)

If I don’t resist these thoughts it means I am being irresponsible
I could be responsible for serious harm
I can not take the risk of this thought coming true
If I don’t act now then something terrible will happen and will be my fault
I need to be certain something awful won’t happen
I should not be thinking this kind of thing
It would be irresponsible to ignore these thoughts
I’ll feel awful unless I do something about this thought
Because I’ve thought of bad things happening then I must act to prevent them
Since I’ve had this thought I must want it to happen
Now I’ve thought of bad things which could go wrong I have a responsibility to make sure I don’t let them happen
Thinking this could make it happen
I must regain control of these thoughts
This could be an omen
It’s wrong to ignore these thoughts
Because these thoughts come from my mind, I must want to have them
The Responsibility Attitudes Questionnaire (RAS)

1. I often feel responsible for things which go wrong.

2. If I don't act when I can foresee danger, then I am to blame for any consequences if it happens.

3. I am too sensitive to feeling responsible for things going wrong.

4. If I think bad things, this is as bad as doing bad things.

5. I worry a great deal about the effects of things which I do or don't do.

6. To me, not acting to prevent disaster is as bad as making disaster happen.
OCD for CBT: Some Tips

Use Multi-faceted Assessment
Psychoeducation & Motivational Interviewing
Work to an Agenda
Stay focussed and calm
Homework, homework, homework!
Recognise Roadblocks
‘The perfect is the enemy of the good’