Cognitive-Behavior Therapy for OCD:
An Update for Consumers and Families

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Outline

- Cognitive-behavioral perspective on OCD
- Exposure and response prevention
  - What is it?
  - How is it conducted?
  - How well does it work?
  - What does NOT work?
  - Cognitive therapy
  - ACT
  - Inhibitory learning
  - Technology
- How to find a competent therapist

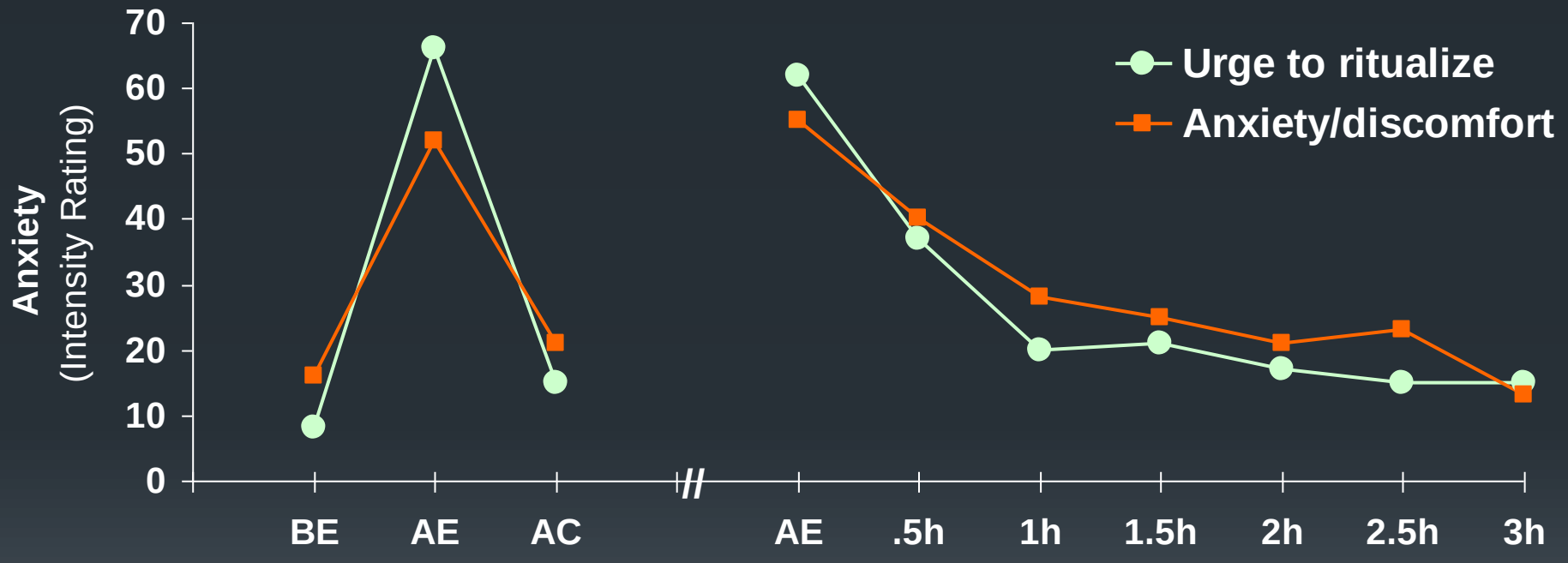
CBT perspective on OCD

- Conceptual model
- Treatment

Conceptual View of OCD

- Obsessional stimuli evoke fear, anxiety, distress
- Compulsions produce an immediate reduction in obsessional anxiety
- Compulsions and avoidance are reinforced by the immediate reduction of anxiety they engender
- The performance of avoidance and compulsions prevents:
  - Learning that obsessional anxiety is temporary
  - Learning that obsessions, anxiety, and uncertainty are tolerable
  - Learning that feared consequences are unlikely

Empirical Basis for the Conceptual Model and for ERP



BE - Before exposure to anxiety-evoking stimulus
AE - After exposure
AC - After compulsion

Rachman, de Silva, & Roper, 1976

Cognitive Factors in OCD

- Exaggerated thinking patterns that lead to obsessional fear
  - Overestimates of threat
  - Inflated sense of responsibility
  - “Bad” thoughts are significant, meaningful, threatening
  - Need to control thoughts
  - Intolerance of certainty
  - Need for perfection

Exposure therapy is:

A set of techniques to help patients confront situations that elicit excessive or inappropriate fear and anxiety so they can learn new information about danger/safety

Exposure and Response Prevention for OCD Includes:

- Procedures that evoke obsessional anxiety
  - Exposure to obsessional cues (floors, driving)
- Procedures that eliminate the contingency between performing compulsions and anxiety reduction
  - Response prevention (refrain from washing or checking rituals)

Exposure

- OCD symptoms are reduced when the person comes to believe his/her fears are unfounded and acts accordingly
- Simply talking about probabilities of danger is not as convincing as direct evidence from experience
  - Patients need to directly confront their fears to truly master them
- Exposure is a behavioral intervention, but it changes beliefs about external cues, obsessional thoughts, and the experience of anxiety and doubt

What Happens During Exposure?

- We don’t “unlearn” a fear, we acquire new learning that competes with previous learning
- The central task in ERP is to create learned safety
- Habituation
  - What is it?
  - Why it doesn’t matter so much

Basics of Exposure

- ERP is a set of “experiments” that test the accuracy of anxious predictions, such as:
  - Obsessions are signs of disastrous consequences
  - I can’t tolerate anxiety/uncertainty
- Patients practice confronting their fears in a planned and systematic manner (often using a hierarchy)
- Exposures are practiced without the use of compulsive rituals (i.e., response prevention)

Types of Exposure used for OCD

- In vivo exposure - confronting feared stimuli in the environment
- Imaginal exposure - confronting feared mental stimuli such as thoughts, images, impulses, worries, and memories

Response Prevention

- Rationale: weaken the pattern of using rituals to control anxiety
  - Learn that rituals are unnecessary
- Goal is to refrain from all ritualizing and avoidance
  - May have to start with partial RP
- Washers: 1 daily 10-minute shower otherwise no contact with water
- “Effortless” rituals: do them incorrectly
- Counting: count to the wrong number

Response Prevention (cont'd)

- If a ritual is performed: re-expose
- Self-monitoring of rituals
  - Situation or thought that evoked the ritual
  - Anxiety level
  - Time spent ritualizing
- Violation of RP means we have to work harder on that particular area

ERP Treatment Program

Detailed Investigation of OCD Symptoms

- “Functional (behavioral) analysis”
- Guided by the conceptual framework
- Gather specific information about the antecedents, behaviors, and consequences
  - External fear cues
  - Intrusive obsessional thoughts and beliefs
  - Feared consequences associated with cues and obsessions
  - Avoidance and rituals
  - Consequences of avoidance and rituals
- Leads directly to the treatment plan

Setting Up the Treatment Plan

- Generate list of situations and thoughts for exposure
  - Realistically safe
  - Evoke obsessional distress and urges to ritualize
- Patient rates subjective units of discomfort (SUDS) for each situation or thought
- Collaborative effort in generating exposure list
- Generate a list of rituals to target

Sample Exposure List

- Public surfaces (doors, buttons)
- Floors
- Garbage cans/dumpsters
- “Buggy” room
- Clothes from “buggy” dresser
- Bugs
- Home bathroom
- Public bathroom

Stylistic Considerations

- Therapist as coach and cheerleader
- Therapist and patient *vs.* OCD
  - *not* therapist *vs.* patient + OCD
- Focus on “choosing to be anxious” and “increasing risk tolerance”
- Discourage reassurance-seeking or analyzing
- Use of humor
- Providing treatment outside of the office
- It’s OK if anxiety doesn’t subside – fear tolerance

Why Imaginal Exposure?

- Helps patients access experiences that cannot be confronted with situational exposure
- Helps weaken mistaken beliefs about intrusive thoughts
- Helps with tolerance for uncertainty
- Helps the patient confront and accept (rather than attempt to fight) obsessional thoughts

ERP: How well does it work?

- Hundreds of studies around the world
- Comparisons between ERP and:
  - Credible psychotherapies (anxiety management, relaxation)
  - Medications (Clomipramine)
- Meta-analyses of controlled studies
  - Olatunji et al. (2013): *ES* = 1.39
  - Ost et al. (2015): *ES* = 1.33

- Short- and long-term improvement for most patients
- Not everyone responds
- Not everyone stays better after treatment

ERP + Medication

- Many people use ERP and medication in combination
- Adding medication to ERP does not seem to improve or detract from the effects of ERP (Foa et al., 2005)
- Types of medications
  - SSRIs (Prozac, Zoloft)
  - Benzodiazepines (Xanax, Klonopin)
  - Ketamine, experimental medications (not enough data)

ERP: Modes of Delivery

- Individual therapy
- Intensive treatment
- Residential programs
- Group therapy
- Couples therapy
- Over the Internet
- Smartphone apps

Cognitive therapy for OCD

Cognitive Model of OCD

- Obsessions
  - Intrusive unpleasant thoughts are universal
    - A thought about stabbing my child at dinner
  - "Obsessive beliefs" lead to misinterpretation of normal intrusions as anxiety-provoking
    - *"Only bad people have bad thoughts"*
    - *"I am a bad person for thinking about this"*

Rachman, 1997; Salkovskis, 1999

Cognitive Model of OCD

- Compulsions
  - Rituals and avoidance reduce obsessional fear
    - Avoidance of child, keep knives locked up
    - Asking for reassurances, checking, repetitive praying
  - Avoidance and rituals prevent the correction of obsessive beliefs and misinterpretations

Rachman, 1997; Salkovskis, 1999

Cognitive Therapy for OCD

- Psychoeducation
  - Intrusive unpleasant thoughts are universal
  - How do avoidance and rituals maintain obsessions
- Cognitive restructuring
  - Identify and modify mistaken beliefs about intrusive thoughts
- Behavioral experiments
  - Test out new beliefs about obsessional thoughts

ACT Model of OCD

- Relational frame theory (RFT): psychological theory of human language
  - Language specifies the strength, type, and dimension of relations between stimuli
  - Implication: Rigidity of relations → psychopathology
- ACT promotes *psychological flexibility*

Hayes, Barnes-Holmes, & Roche (2001)

ACT Model of OCD

- It's not whether or not we have the thoughts, it's *how* we interact with them
- Distress and impairment from anxiety and OCD result from psychological inflexibility/experiential avoidance
- Three parts:
  1. Unwanted internal experiences
  2. Behavioral responses (rituals, avoidance) as attempts to control thoughts
  3. Negative effects on quality of life

ACT for OCD

- Basic techniques
  - Metaphors to address six core processes
  - Learn to respond differently even if situation doesn't change
    - Acceptance
    - Defusion
- Ultimate goal: Increased psychological flexibility

ACT for OCD

- Research
  - Some open trials suggest that it works
  - Some comparison trials suggest that ACT works as well as CBT for OCD
  - No studies suggest that ACT is more effective than CBT
  - One study suggests that ACT does not add anything to exposure

ACT for OCD

- Potential benefits of ACT
  - May improve adherence and tolerance
  - May enhance patients' understanding of OCD and its treatment
  - Provides an alternative to the habituation model

What does NOT work for OCD?

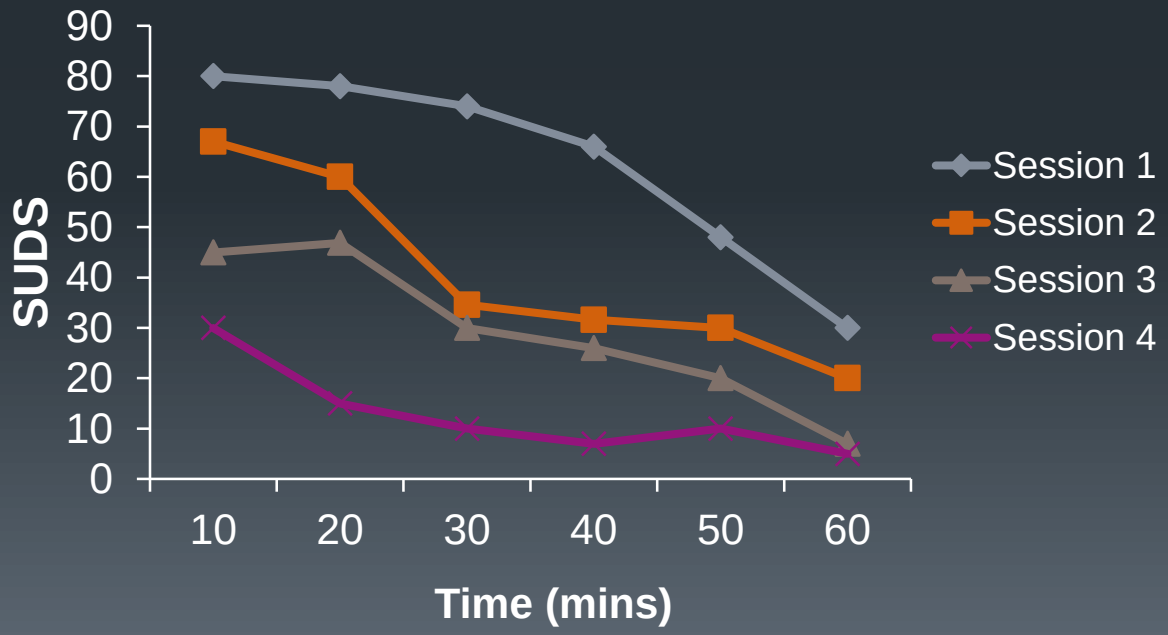
- Relaxation
- Biofeedback
- Reassurance
- Deep breathing
- Thought-stopping
- Rubber band snapping

Inhibitory Learning ERP

- The best of ERP, cognitive therapy, and ACT

Emotional Processing Theory (EPT), Habituation, and Exposure Therapy

- EPT emphasizes the importance of within- and between-session habituation
  - Provoke initial anxiety (SUDS)
  - Remain exposed until anxiety subsides naturally



Implications of EPT

- It is assumed that patients improve if
  - Self-reported anxiety (SUDS) decline during exposure trials
  - Exposure to the same stimulus evokes less anxiety from one trial to the next

Is Performance During Exposure a Reliable Indicator of Learning?

- Although habituation usually occurs during exposure, it's not a good predictor of outcome
- Decline in anxiety across similar exposures may predict, but is not necessary for, long-term improvement
  - Successful response to exposure can occur in the absence of habituation
- Therapists are over-relying on habituation

Perils of the Habituation Model

- Over-reliance on habituation can contribute to return of fear and relapse
  - Patients continue to view anxiety/fear/arousal as a problem
  - Exposure used to control anxiety
    - *"I know I'll be OK because anxiety will go down eventually"*
  - Inevitable surges of anxiety and arousal viewed as a failure

Using Exposure to Foster Anxiety Tolerance

- If exposure can instill greater *fear tolerance*, the return of fear (and relapse) can be avoided
  - OCD patients: "*Make anxiety go down*"
  - IL approach: "*Learn that you can tolerate anxiety*"
- Doing exposure practice
  - Importance of using exposure to learn fear tolerance
  - Label the occurrence of anxiety, and uncertainty as opportunities to practice fear tolerance (as opposed to signs of failure)
  - "Bring it on" attitude!
  - Don't use exposure to control anxiety

1. Frame exposure to mismatch expectancies

- When you confront a trigger and expect that a negative outcome will occur, but it doesn't, a new "non-threat" association is generated (i.e., when we are "surprised") = corrective learning
- What are negative outcomes for people with OCD?
  - Fairly immediate (fires, mistakes, bad luck, act on thoughts)
  - Long-term (diseases, personality change)
  - Unknowable (am I saved?, sexual preference?)
  - Inability to handle emotions (uncertainty, imperfection, disgust, anxiety)

Clinical Implications: Expectancy Tracking

- Set up exposure to violate expectancies about uncertainty
  - Instead of tracking SUDS, track length of time you can manage without rituals while being exposed to the possibility of the feared outcome
  - Consolidate learning by summarizing what you learned (i.e., the discrepancy between what was predicted and what occurred)

2. Combine Fear Cues

- When an expected negative outcome fails to occur despite the presence of multiple fear cues, inhibitory learning is greater than when only a single fear cue is present
  - “Deepened extinction” (Rescorla, 2006)

- What are fear cues for people with OCD?
  - External (contaminants, driving, religious icons, horror movies)
  - Cognitive (obsessional thoughts, doubts, images)
  - Physiological (arousal-related sensations)

Clinical Implications: Multi-Media Exposure

- Include multiple fear cues and multiple media in exposures
  - External fear cues along with imaginal exposure to the feared consequences of (or uncertainty about) doing so
    - Ex: Touch public toilet and imagine getting AIDS one day
  - External, cognitive, and physiological cues
    - Ex: Look at pictures of children, imagine touching them, notice arousal sensations

3. Maximize Exposure Variability

- Introducing variability into exposure makes short-term learning more difficult, but enhances long-term retention (Bjork & Bjork, 2006)
  - The more diverse the conditions under which learning takes place, the greater the number of retrieval cues that are generated
    - Greater retention, transfer, and generalization of learning

Clinical Implications:

- Vary intensity of anxiety during exposures (instead of hierarchy)
  - Teaches fear tolerance
  - Similar to what happens in real life
- Practice exposure in different contexts
  - enhances retrieval of new safety learning
  - Examples of contexts
    - Situations and stimuli, emotions (anxiety level), others present, (therapist), other treatments (medication), time of day/week

Technology-Based Interventions for OCD

- Internet, telehealth, and smartphone app platforms can help improve treatment dissemination
- One trial suggested that Internet-based CBT superior to a control condition (Andersson et al., 2012)
- CBT for children delivered via web-camera was superior to a waitlist (Storch et al, 2011)
- ICBT + phone guidance may enhance outcomes (Kenwright et al., 2005)
- Research is needed on technology-augmented CBT

An App For That?
Mobile Apps for Obsessive-Compulsive Disorder

	GGOC: OCD Relief	nOCD	OCD Understood	iCounselor: OCD
Credibility Out of 5.00	4.28	3.21	1.43	1.43
User Experience Out of 5.00	3.42	4.74	Not Available	Not Available
Data Transparency	Questionable	Acceptable	Unacceptable	Unacceptable
Platforms Available				
Cost	Free	Free	Free	$0.99

How to find a competent ERP therapist

- What kind of treatment approach do you use for OCD?
- Can you tell me what CBT involves? What would the therapy be like?
- What formal training have you had in treating OCD using CBT?
- About how many people with OCD have you worked with using CBT and what kinds of results do you get?
- How long will it take me to start feeling better with CBT? How long does treatment usually last (how many sessions, weeks, or months will it take)?

How to find a competent ERP therapist

- Will we do exposure therapy together during the treatment sessions, or will I do it for homework?
- Are you able to leave your office to help me do exposure therapy?
- Do you use imaginal exposure along with situational exposure?
- Will you work with my family to help them help me with treatment? Is it OK if I being a family member (or close friend) who has volunteered to help me with treatment?
- Is it OK if I bring in some self-help materials I've been using so you can see where I'm at with working on this problem?

Thank you!