

# How to reduce distress and repetitive behaviors in patients with OCD

## Strategies help increase the effectiveness of CBT for obsessions and compulsions

**E**xposure and response (or ritual) prevention has been shown to be effective in improving the therapeutic outlook for patients with obsessive-compulsive disorder (OCD). Yet barriers—including patient unwillingness to enter into the intensive therapy—prevent more persons with OCD from achieving an improved quality of life.

This article focuses on the clinical picture of OCD and the multifaceted cognitive-behavioral therapy (CBT) that has received the most empirical support. We also describe initiatives to make CBT more accessible to OCD patients, such as providing twice-weekly instead of daily treatment sessions.

### OCD definition: Anxiety/distress

OCD is a relatively common, debilitating condition that often develops early in life (*Box 1, page 20*).<sup>1,2</sup> The obsessions of this disorder are not simply excessive worries about real-life problems. The compulsions are excessive or unreasonable and serve to reduce the discomfort associated with the obsessions. The Yale-Brown Obsessive Compulsive Scale (Y-BOCS) is the gold standard tool for quantifying OCD (*Box 2, page 20*).<sup>3,4</sup>

**Obsessions vs compulsions.** When diagnosing and treating OCD, it is important to ascertain the functional relationship between a patient's obsessions and compulsions and anxiety/distress:

- Obsessions give rise to anxiety/distress.
- Compulsions aim to reduce this anxiety/distress.

continued



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CBT for OCD

### Clinical Point

Many patients believe established OCD treatments won't be effective because they do not have 'classic' symptoms

#### Box 1

### OCD: A common, debilitating condition

The lifetime prevalence of obsessive-compulsive disorder (OCD) is 2% to 3%—approximately 2 to 3 times higher than that of schizophrenia. Onset of OCD often is in childhood or adolescence. OCD presents earlier in boys than girls, but by young adulthood the incidence is equally distributed in men and women.<sup>1</sup> Its course typically is chronic and is associated with substantial suffering and functional impairment.

According to DSM-IV-TR criteria, OCD is characterized by:

- **obsessions**—persistent thoughts, impulses, or images that are experienced as intrusive, inappropriate, and distressing that an individual attempts to ignore, suppress, or neutralize with other thoughts or actions
- **compulsions**—repetitive behaviors or mental acts that are aimed at reducing distress or preventing a dreaded consequence.<sup>2</sup>

#### Box 2

### Assessing obsessive-compulsive disorder: Y-BOCS

The 10-item, clinician-rated Yale-Brown Obsessive Compulsive Scale (Y-BOCS)<sup>3,4</sup> has excellent psychometric properties. It is widely used in outcome studies and clinical practice to assess and monitor change and progress.

Y-BOCS consists of 5 questions about obsessions and 5 about compulsions; each symptom is rated on a scale of 0 (least severe) to 4 (most severe). Results are combined for a total score of 0 to 40, which is interpreted as:

- 0 to 7=subclinical
- 8 to 15=mild
- 16 to 23=moderate
- 24 to 31=severe
- 32 to 40=extreme.

This distinction is important because lay people routinely use the word “obsessing” to describe being consumed by an idea or an activity. This not the same as the obsession of OCD. Similarly, repetitive behaviors often described as “compulsive” are not necessarily a symptom of OCD. “Compulsive” eating or gambling can be self-stimulating or positively reinforcing (mostly ego-syntonic). The compulsive behavior

of OCD is often viewed by the individual as inappropriate or incompatible with the perception of self (mostly ego-dystonic).

### OCD's clinical picture

**Classic vs nonclassic obsessions.** Frequently reported obsessions in OCD include fears related to:

- contamination (dirt, germs, bodily waste, chemicals)
- making mistakes (locks, appliances, paperwork, decisions)
- having unwanted impulses (violent, sexual, religious, embarrassing)
- orderliness (neatness, symmetry, numbers).

Many patients who seek treatment for OCD believe they do not have “classic” OCD symptoms. They think no one has seen or heard of their form of OCD and, therefore, they may not be good candidates for treatments shown to be effective for “classic” OCD. Examples of “non-classic” forms of OCD—which often are encountered at OCD specialty clinics and are less often described in mainstream literature or media—include:

- intrusive, irrational, or excessive worries about loss of identity, essence, or intelligence, mostly seen in teenagers or young adults
- contamination by “evil” or fear of becoming a “bad person”
- fear of harm to a newborn child by new parents
- fear of unintentionally performing socially inappropriate behaviors, such as shoplifting, molesting, or insulting someone.

**Distressed by uncertainty.** In assessing whether fears of inappropriate behaviors reflect OCD, first determine if the person has engaged in such behaviors. Clinical experience suggests that persons with OCD rarely act out their fears, and indeed are less likely to do so than those without the disorder.

A common theme among OCD patients is overwhelming distress associated with uncertainty. Patients with OCD often appraise low-probability events as extremely high-probability events, and as a result

require reassurance and guarantees that dreaded outcomes will not occur. That reassurance can come in many forms:

- searching the Internet for answers
- asking family members, friends, or experts for confirmation or disconfirmation
- mentally checking and reevaluating whether they had opportunity or propensity to perform any of those acts.

Because guarantees often are impossible to secure, persons with OCD begin avoiding places and people where they may have an opportunity to encounter triggering stimuli. Phrases such as “just in case,” “yes, but what if...?” and “how do I know for sure?” are telltale signs of an OCD obsession.

A recent model of OCD may further advance our understanding of how obsessions and compulsions frequently appear together because of their functional link. This model clusters OCD symptoms into “symptom dimensions” that include:

- symmetry/ordering
- contamination/cleaning
- sexual/religious/aggressive/checking
- hoarding.<sup>5-7</sup>

**Varying insight.** Patients differ greatly in their reports of the functional relationship between their compulsions and obsessions. Some patients clearly state that their compulsions are meant to prevent harm to others or dreaded consequences, whereas others note their compulsions are intended solely to reduce discomfort associated with obsessions. Some OCD sufferers report that they perform compulsions automatically, without an identified purpose; others are unclear about the relationship between their obsessions and compulsions.

### Multifaceted CBT

OCD is conceptualized by both behavioral and cognitive theory (*Box 3*). Cognitive-behavioral treatment for OCD includes:

- exposure in vivo—repeated, prolonged confrontation with anxiety-evoking stimuli
- repeated, prolonged imaginal confrontation with feared disasters
- ritual prevention—blocking or preventing compulsions

#### Box 3

### What causes OCD? Cognitive vs behavioral theories

The behavioral theory of obsessive-compulsive disorder (OCD) suggests that obsessions produce anxiety—and/or other forms of distress, such as disgust—and compulsions reduce obsessional anxiety. Compulsions are maintained because they are reinforced by briefly reducing obsessional anxiety; however, in the long term, they prevent the habituation of obsessional anxiety.

The cognitive theory of OCD maintains that the disorder is characterized by erroneous cognitions, including:

- unrealistic estimates of threat, and exaggerated sense of personal responsibility for harm
- the notion that absence of complete evidence of safety denotes danger
- the notion that obsessional anxiety can be reduced only by compulsions or avoidance of the triggering stimuli.

- cognitive interventions—correcting erroneous cognitions about potential consequences if confrontation with feared situations is not followed by “ritualizing” (engaging in compulsive behavior).

**In vivo exposure (EX)** consists of confronting situations, objects, and thoughts that evoke anxiety or distress because they are associated with unrealistic danger. The patient first confronts exposures that provoke moderate anxiety/discomfort, followed by exposures of increasing difficulty. The aim is for patients to face obsessional fears for a prolonged period without ritualizing, which allows them to disconfirm their feared consequences and reduce anxiety/discomfort. The goal is to weaken the association between feared stimuli and distress and between ritualizing and relief from distress, and to disconfirm mistaken OCD beliefs.

### Clinical Point

Phrases such as ‘just in case’ and ‘yes, but what if...?’ are telltale signs of an OCD obsession

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## CBT for OCD

### Clinical Point

Blocking avoidance of feared situations helps patients realize that obsessional fears are unrealistic or exaggerated

### Table

## SSRIs for OCD: Recommended dosages

Medication	Recommended dosage
Citalopram*	20 to 80 mg/d
Fluoxetine	20 to 80 mg/d
Fluvoxamine	100 to 300 mg/d
Paroxetine	40 to 60 mg/d
Sertraline	50 to 200 mg/d

\*Not FDA-approved for OCD

SSRI: selective serotonin reuptake inhibitor; OCD: obsessive-compulsive disorder

**Imaginal exposure** involves repeated confrontation (in imagination) with the disastrous consequences the patient anticipates if the rituals are not performed (eg, a parent's children will contract a disease many years from now because of failure to protect them from harmful toxins).

**Response (or ritual) prevention (RP)** is blocking avoidance of—or escape from—situations that give rise to obsessional distress. By strongly encouraging the patient to gradually approach the distressing situation and to remain in it without ritualizing, RP allows patients to realize that their obsessional fear is unrealistic or exaggerated and that anxiety or distress diminishes with time and repetition.

**Cognitive interventions** involve discussing the changes that take place during in vivo and imaginal exposure, such as:

- the patient's anxiety decreases with repeated exposure even without ritualistic behavior
- the feared consequences often do not materialize
- in some cases tolerance of uncertainty is what is being practiced.

### Evidence supports EX/RP

Several randomized controlled trials (RCTs) have demonstrated the efficacy of EX/RP for reducing OCD symptoms.<sup>8-10</sup> To address the potential generalizability of these results to typical clinical practice, Franklin et al<sup>11</sup> compared findings from 4

RCTs of EX/RP with treatment outcome data from 110 outpatients receiving EX/RP. The outpatients had varying OCD severity, treatment histories, concomitant pharmacotherapy regimens, psychiatric comorbidity profiles, and ages. Following EX/RP, they achieved substantial and clinically meaningful reductions in their OCD and depressive symptoms that were comparable with those reported in the RCTs, which suggests the benefits of EX/RP are not limited to select patient samples.

Foa et al<sup>12</sup> compared the relative and combined efficacy of clomipramine (maximum dosage 250 mg/d) and EX/RP for treating OCD in adults. At week 12, all active treatments were more effective than placebo. EX/RP and EX/RP plus clomipramine were comparable, and both were more effective than clomipramine alone. The study also suggested that with regular supervision, treatment modalities could be successfully implemented in clinics with differing expertise.

Most OCD patients who receive an adequate selective serotonin reuptake inhibitor (SSRI) trial (*Table*) continue to have clinically significant OCD symptoms. Simpson et al<sup>13</sup> studied 108 outpatients with OCD and found that augmenting SSRIs with EX/RP further reduces OCD symptoms and is more effective than stress management training. However, the now-standard 17 sessions of EX/RP were not sufficient to help most patients achieve minimal symptoms, defined as a Y-BOCS score  $\leq 12$ . Ongoing augmentation studies are examining ways to increase OCD remission rates and achieve greater palatability, accessibility, and duration of effects.

### Using EX/RP in practice

When EX/RP was developed and studied in the 1960s and '70s, it was conducted daily. However, intensive OCD treatments are not always practical or readily available. This consideration prompted us to examine—in a nonrandomized study—the efficacy of a twice-weekly EX/RP program that is otherwise identical to the intensive treatment program at 3-month follow-up. Results indicated that this less intensive program was as effective as the intensive treatment.<sup>14</sup>

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Less-intensive, once- or twice-weekly programs may be suitable for most OCD patients. Consider intensive EX/RP for:

- patients who wish to complete their treatment in a short period at expert centers
- patients for whom less intensive treatment fails to produce the desired outcome.

Although EX/RP is an efficacious treatment for OCD, factors such as patient unwillingness to enter into treatment or inadequate adherence to the program can limit its effectiveness. In a preliminary study that integrated a motivational interviewing module with EX/RP, 5 of the 6 patients experienced decreased Y-BOCS scores and increased quality of life.<sup>15</sup>

In addition to lack of adherence, other predictors of poorer outcome include:

- poor insight by the patient that the feared consequences were unrealistic<sup>16</sup>
- comorbid severe depression that interferes with utilization of EX/RP<sup>17</sup>
- family members' expressed emotion (mainly hostility).<sup>18</sup>

OCD treatment in the general clinical setting often has included prescribing an SSRI as an initial step in the care of patients of all ages. However, a published expert consensus opinion—based on a survey of a wide range of clinicians and researchers in the OCD field—recommended beginning treatment with CBT alone, particularly in younger patients and those with milder cases, and adding an approved medication when symptoms worsen or if the patient has comorbidities.<sup>19</sup>

To help patients and clinicians overcome barriers to effective OCD treatment, researchers are evaluating the cost-effectiveness and feasibility of a stepped-care model,<sup>20</sup> in which effective treatment com-

## Related Resources

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• Abramowitz JS, Houts AC, eds. Concepts and controversies in obsessive-compulsive disorder. New York, NY: Springer; 2005.

• The Obsessive-Compulsive Foundation. www.ocfoundation.org.

### Drug Brand Names

Citalopram • Celexa	Fluvoxamine • Luvox
Clomipramine • Anafranil	Paroxetine • Paxil
Fluoxetine • Prozac	Sertraline • Zoloft

### Disclosures

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ponents are offered in phases, depending on need and availability. Phases include self-directed EX/RP, therapist-assisted EX/RP, intensifying frequency of sessions, and augmenting EX/RP with SSRIs.

Despite major improvements in OCD identification, treatment, and dissemination of knowledge to clinicians, the situation is far from ideal. Future research will help uncover additional factors for improving treatment outcome and portability.

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## Clinical Point

Barriers to effective OCD treatment include nonadherence, poor insight, and comorbid severe depression

## Bottom Line

Exposure and response prevention (EX/RP) is an effective cognitive-behavioral therapy for obsessive-compulsive disorder, alone or as augmentation to selective serotonin reuptake inhibitors. For some patients, a twice-weekly form of EX/RP may be as effective as more intensive EX/RP.

continued

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