COGNITIVE BEHAVIORAL THERAPY FOR OCD

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DISCLOSURES

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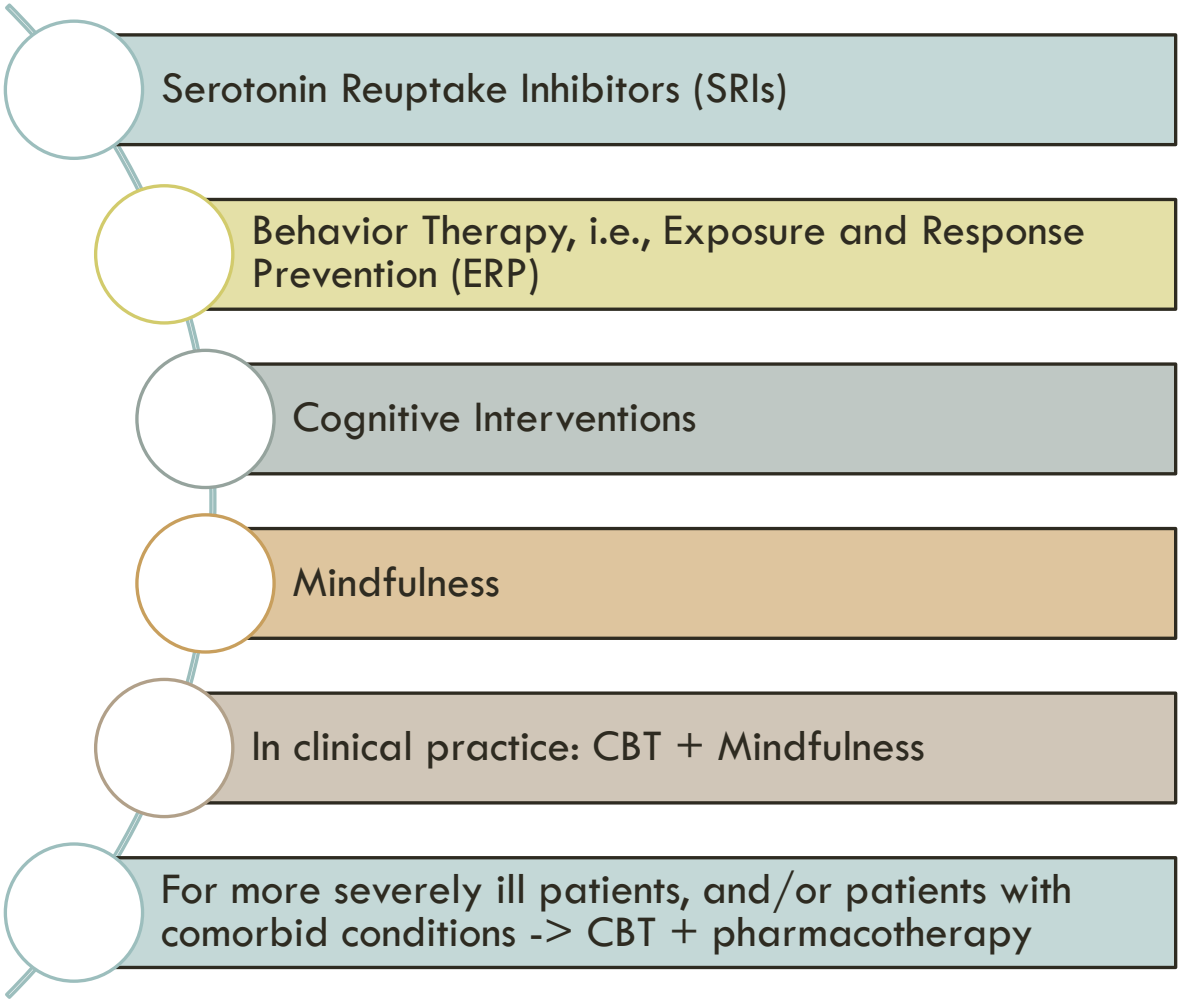
CURRENT TREATMENTS FOR OCD



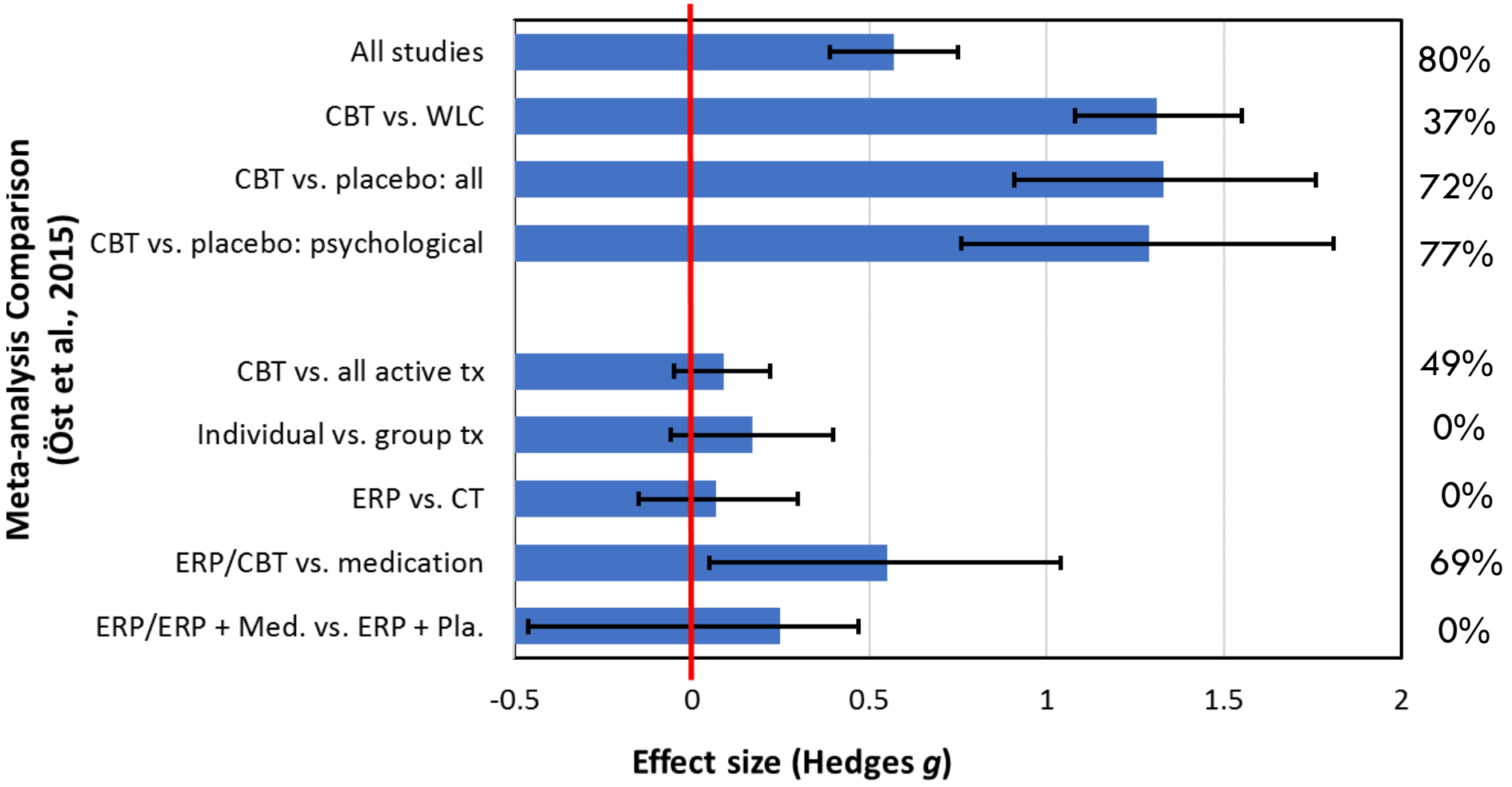
Exposure and Response Prevention

Between 50 and 60% of patients who undergo BT are much improved at the end of treatment

ERP is **empirically supported** as the most effective psychological treatment

Foa et al. (1983)

CBT FOR OCD: A SYSTEMATIC REVIEW AND META-ANALYSIS OF STUDIES PUBLISHED 1993-2014



Öst et al. (2015)

CBT OUTCOMES FOR OCD

Table 1
Demographics and Descriptive Statistics by Treatment Type and Site

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

Steketee, Siev, Yovel, Lit, & Wilhelm (2018). *Behavior Therapy.*

CBT OUTCOMES FOR OCD

Treatment Comparisons: Clinically Significant Improvements*

Treatment type	# of participants who met criteria	Total number of participants (N)
BT	45 (36.0%)	125
CT	60 (55.6%)	108
CBT	60 (47.6%)	126
Entire Sample	165 (46.0%)	359

*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, $p = .23$

Steketee, Siev, Yovel, Lit, & Wilhelm (2018). *Behavior Therapy.*

PHARMACOLOGICAL & PSYCHOTHERAPEUTIC INTERVENTIONS FOR OCD: A NETWORK META-ANALYSIS

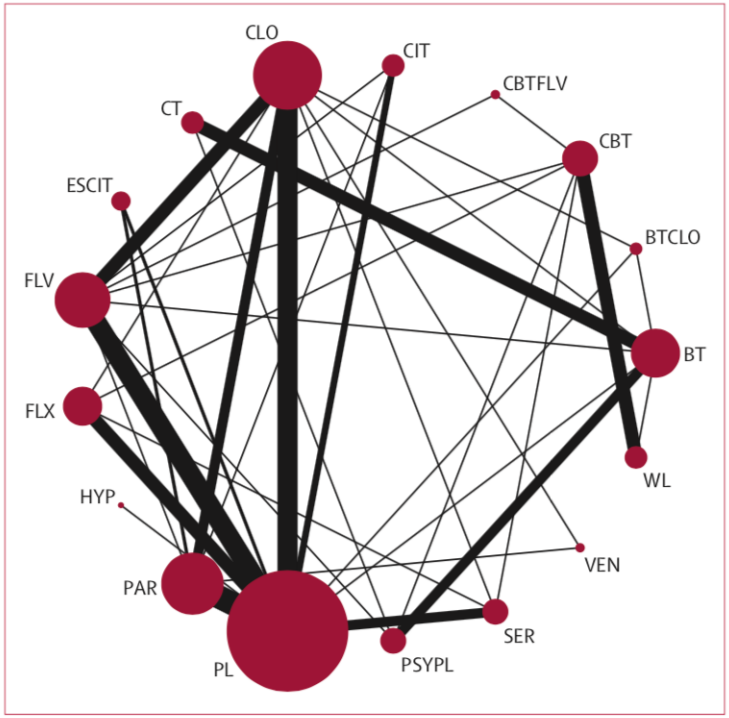


Figure 2: **Network diagram for efficacy analysis representing direct comparisons between individual treatments**

The size of each circle is proportional to the number of randomly allocated participants and the width of each line is proportional to the number of trials in each direct comparison. BT=behavioural therapy. CBT=cognitive behavioural therapy. CT=cognitive therapy. BTCLO=behavioural therapy and clomipramine. CBTFLV=cognitive behavioural therapy and fluvoxamine. CIT=citalopram. CLO=clomipramine. ESCIT=escitalopram. FLV=fluvoxamine. FLX=fluoxetine. HYP=hypericum. PAR=paroxetine. PL=placebo. PSYPL=psychological placebo. SER=sertraline. VEN=venlafaxine. WL=waiting list.

	Number of trials (n=54)*	Number of patients (n=6652)*	Mean YBOCS difference	
			Full network (n=54)	Excluding waiting list controlled trials (n=48)
Drug placebo	23	1515	Reference	Reference
Waiting list	6	97	5·62 (0·91 to 10·26)	NA
Psychological placebo†	6	196	−4·15 (−8·65 to 0·49)	−1·90 (−5·62 to 1·91)
SSRIs (class effect)	37	3158	−3·49 (−5·12 to −1·81)	−3·62 (−4·89 to −2·34)
Fluoxetine	6	633	−3·46 (−5·27 to −1·58)	−3·67 (−5·13 to −2·26)
Fluvoxamine	13	521	−3·60 (−5·29 to −1·95)	−3·66 (−4·96 to −2·37)
Paroxetine	8	902	−3·42 (−5·10 to −1·61)	−3·51 (−4·81 to −2·14)
Sertraline	7	565	−3·50 (−5·30 to −1·63)	−3·68 (−5·14 to −2·30)
Citalopram	2	311	−3·49 (−5·62 to −1·31)	−3·60 (−5·25 to −1·91)
Escitalopram	1	226	−3·48 (−5·61 to −1·23)	−3·59 (−5·25 to −1·86)
Venlafaxine	2	98	−3·22 (−8·26 to 1·88)	−3·21 (−7·01 to 0·69)
Clomipramine	13	831	−4·72 (−6·85 to −2·60)	−4·66 (−6·26 to −3·05)
BT†	11	287	−14·48 (−18·61 to −10·23)	−10·41 (−14·04 to −6·77)
CBT†	9	231	−5·37 (−9·10 to −1·63)	−7·98 (−11·02 to −4·93)
Cognitive therapy†	6	172	−13·36 (−18·40 to −8·21)	−9·45 (−13·76 to −5·19)
Hypericum	1	30	−0·15 (−7·46 to 7·12)	−0·13 (−5·93 to 5·68)
CBT and fluvoxamine	1	6	−7·50 (−13·89 to −1·17)	−8·81 (−13·75 to −3·88)
BT and clomipramine	1	31	−12·97 (−19·18 to −6·74)	−11·68 (−16·73 to −6·65)

Data in parentheses are 95% credible intervals. YBOCS=Yale-Brown Obsessive Compulsive Scale. BT=behavioural therapy. CBT=cognitive behavioural therapy. NA=not applicable. *Individual trials could be included in more than one treatment category. †Several patients randomly allocated into these psychotherapeutic interventions were allowed to take stable doses of antidepressants and remain on the same dose without further adjustments.

Table 2: **Treatment efficacy compared with drug placebo**

Skapinakis et al. (2016)

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)

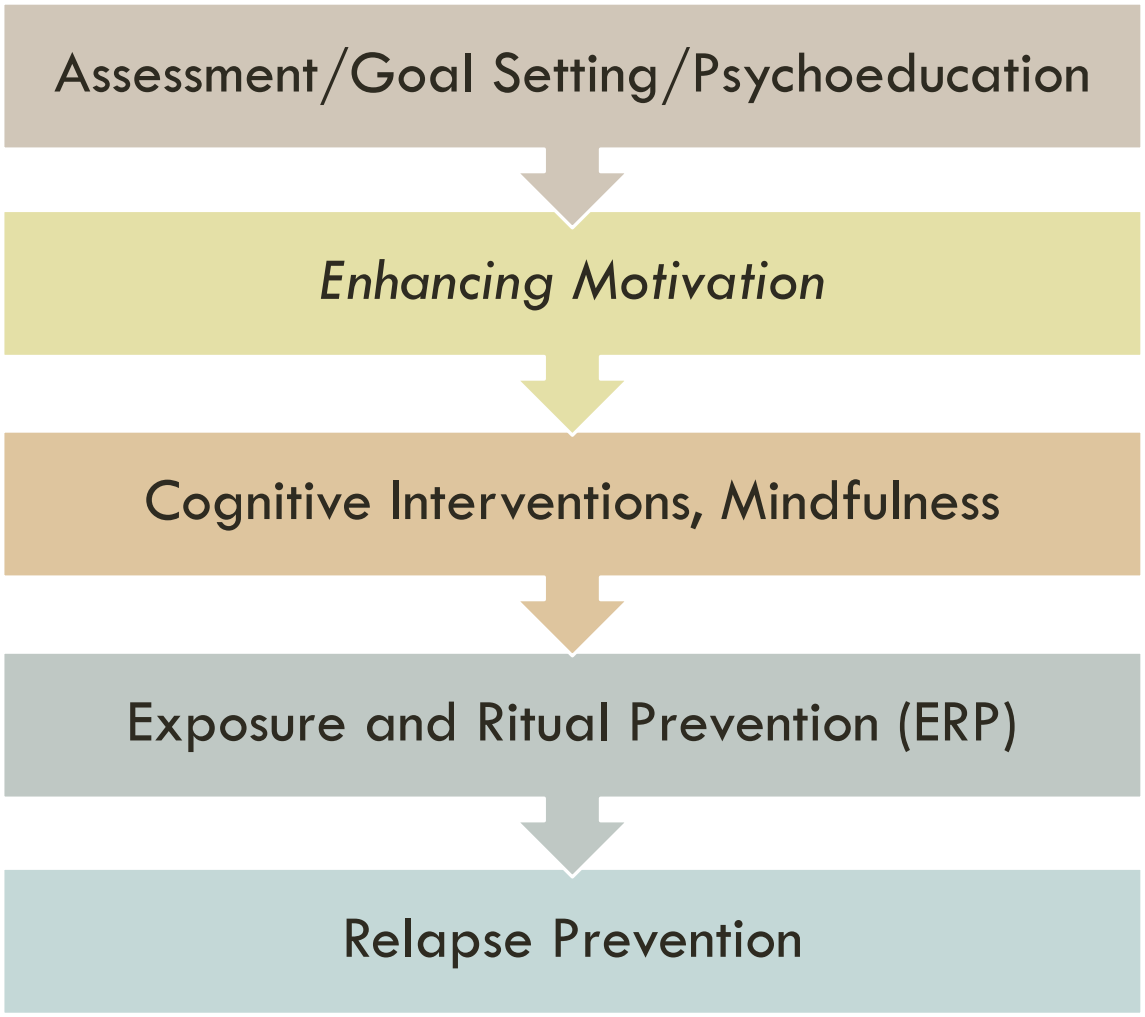
Effective for children, adolescents, and adults

- Safe, acceptable treatment for pediatric OCD

Franklin et al. (2008)

CONDUCTING CBT FOR OCD

TREATMENT STRUCTURE



TREATMENT DURATION

Varies, depends on severity, ~12-22 sessions

Booster sessions after treatment has ended

Fade the frequency of booster sessions slowly

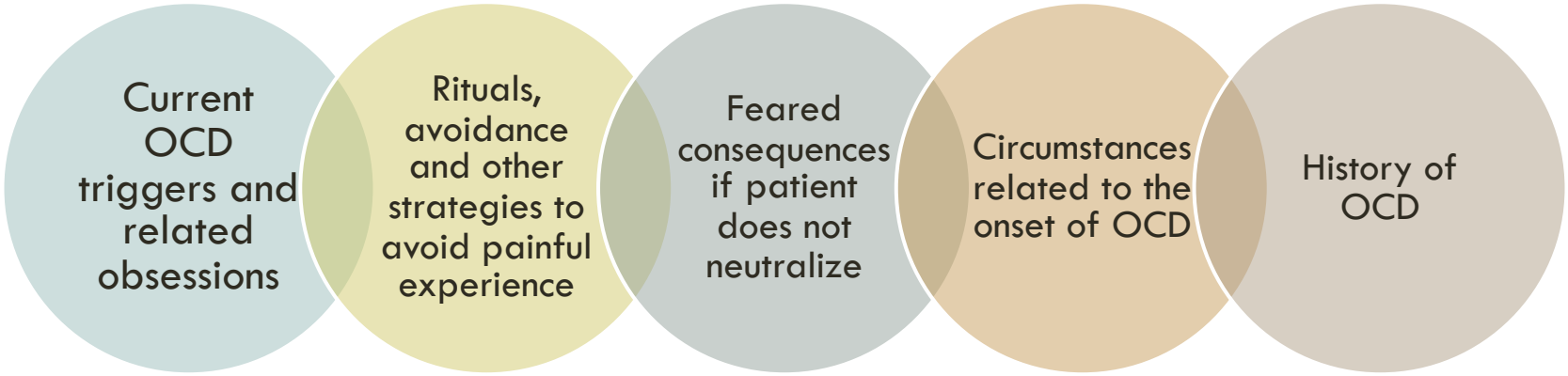
HOMEWORK

Assign after every session

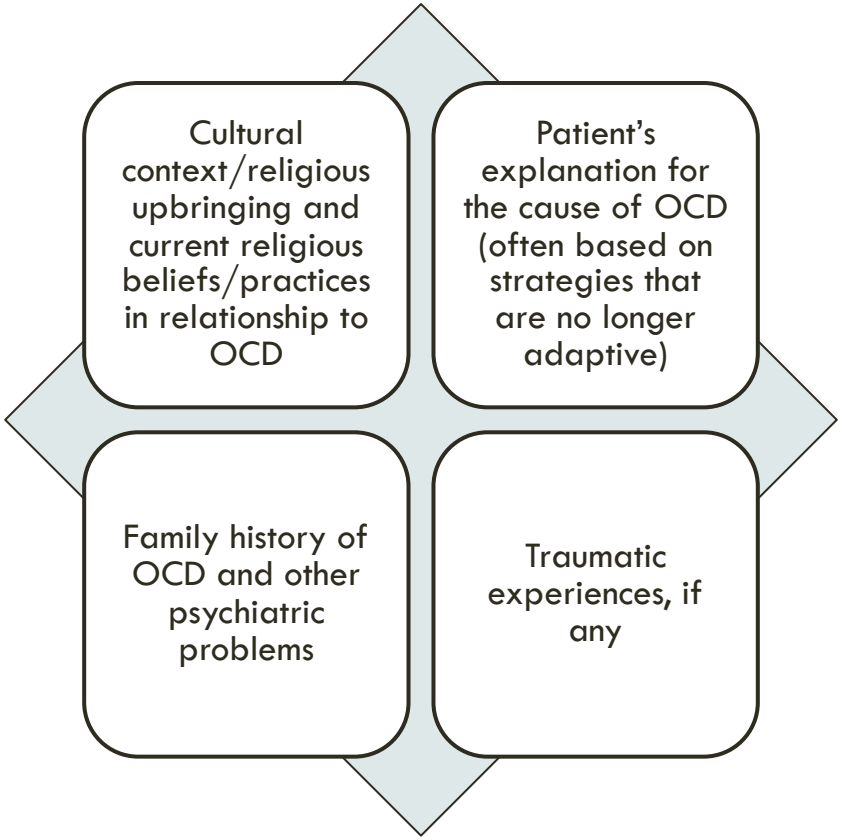
Includes specific strategies (e.g., ERP)

Frequency of homework varies by type of task – usually daily/several times per week

OCD ASSESSMENT



OCD ASSESSMENT



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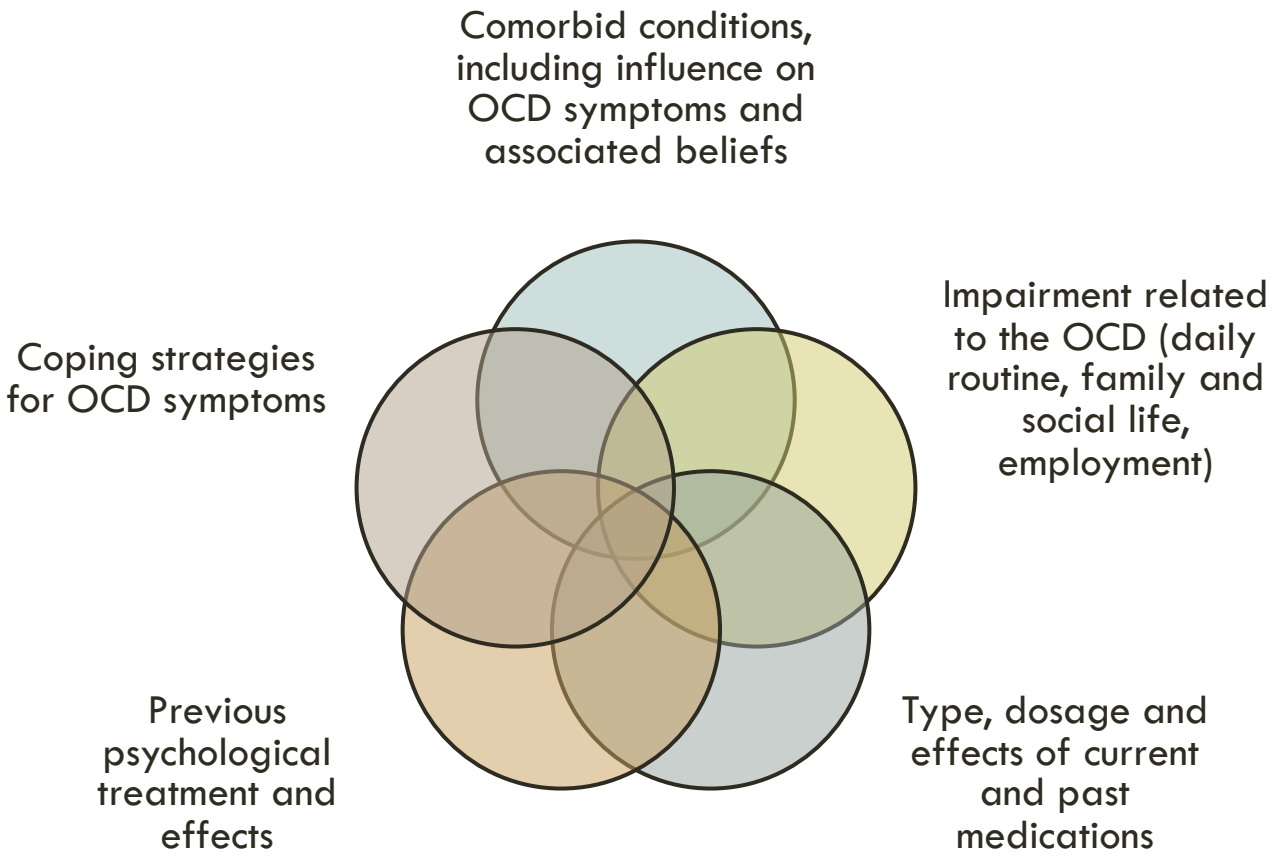
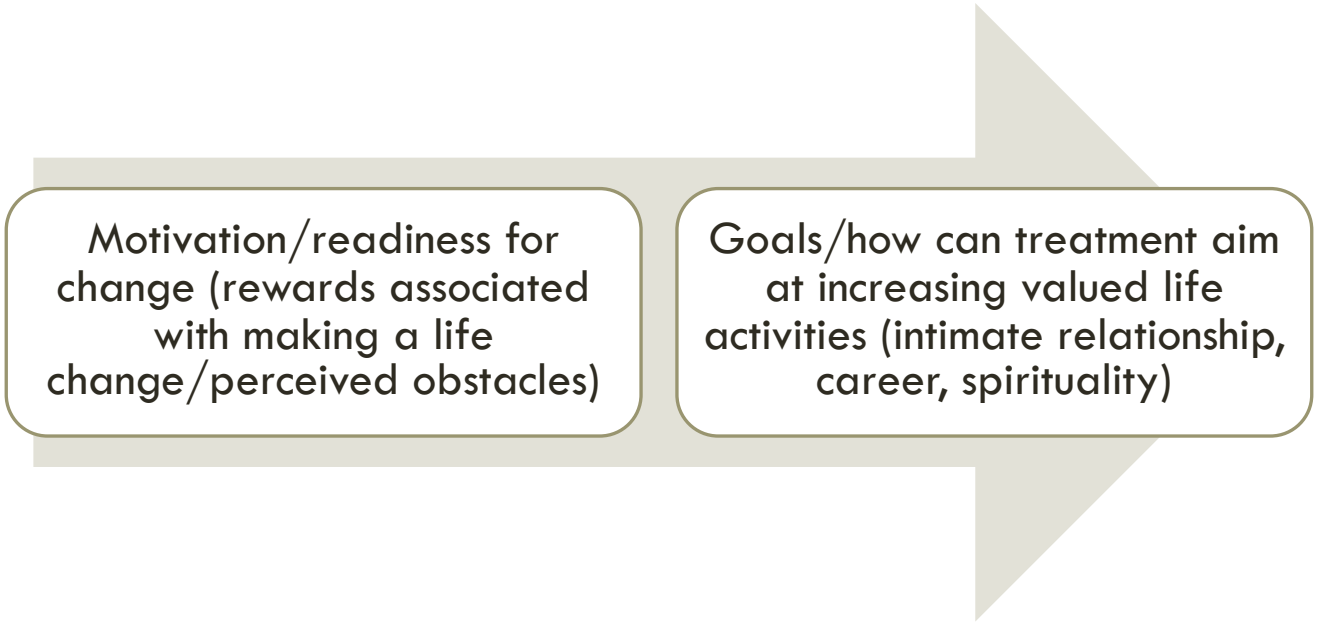


OCD ASSESSMENT



OCD Model

I might stab my baby with a knife

OCD Model

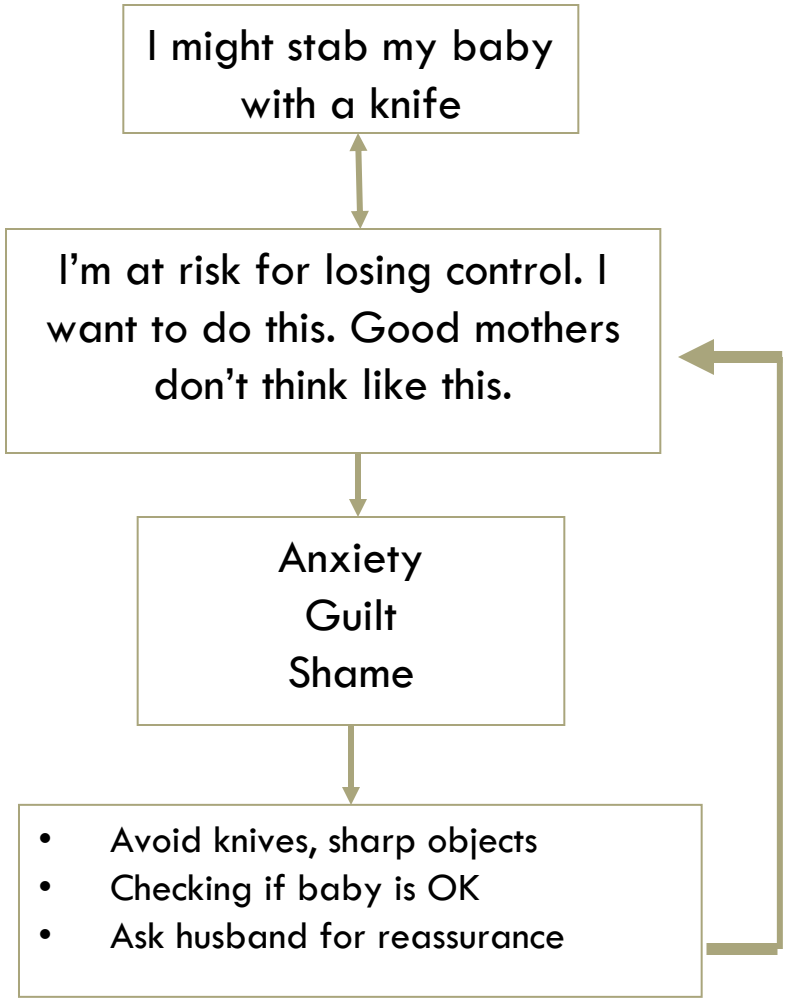
I might stab my baby with a knife

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

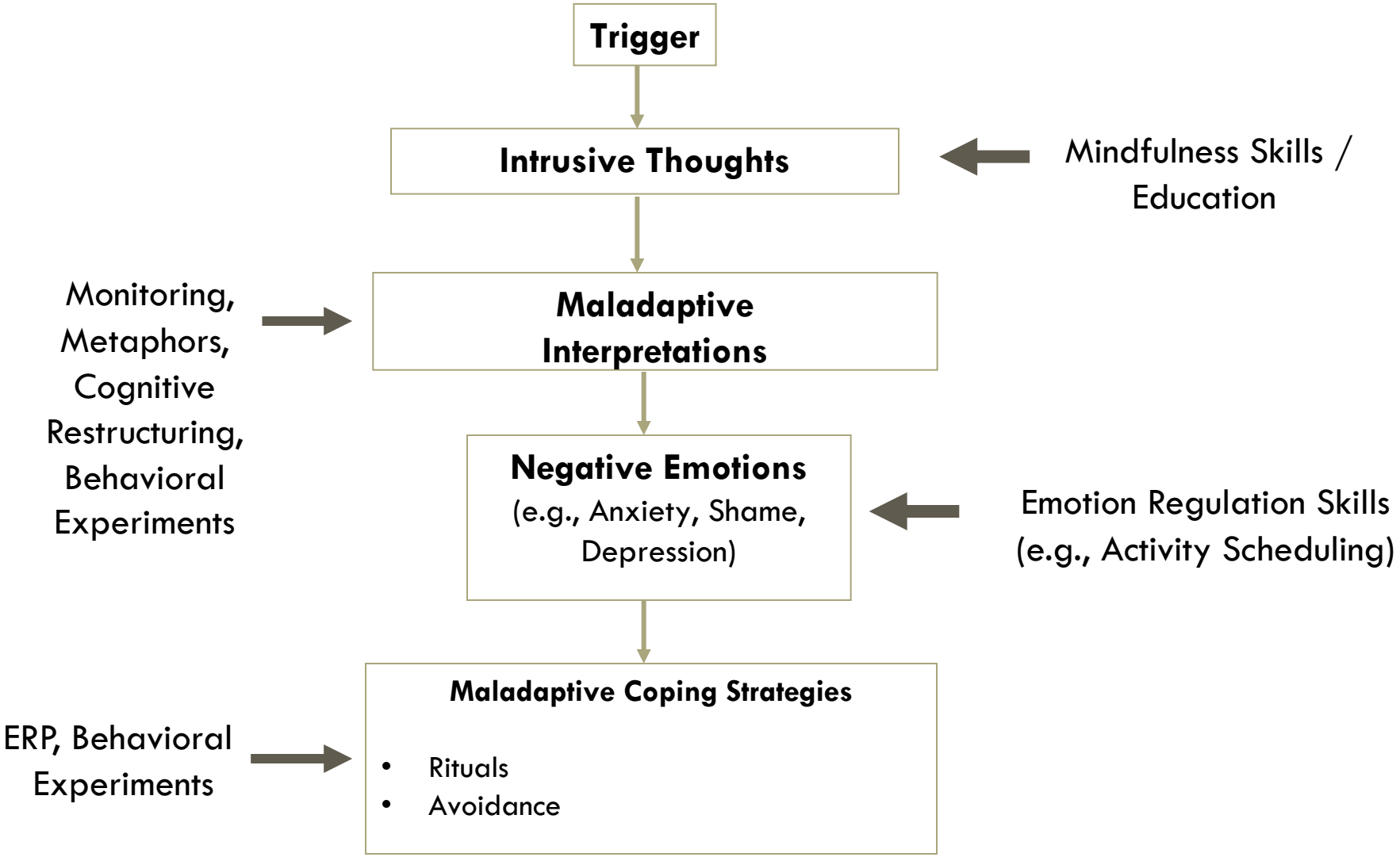
OCD Model


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

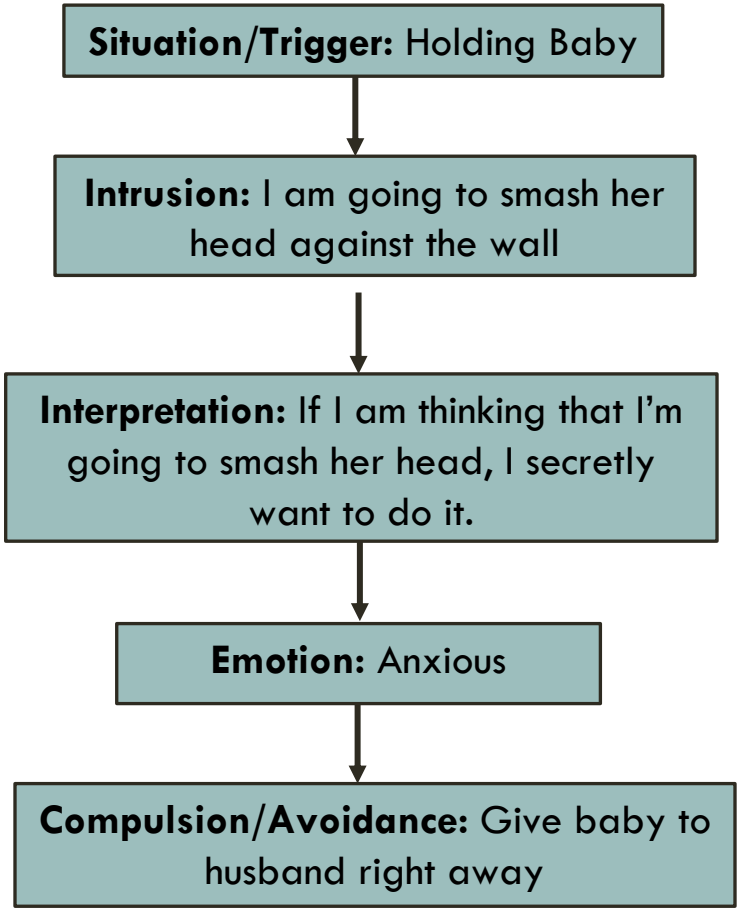
OCD Model


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



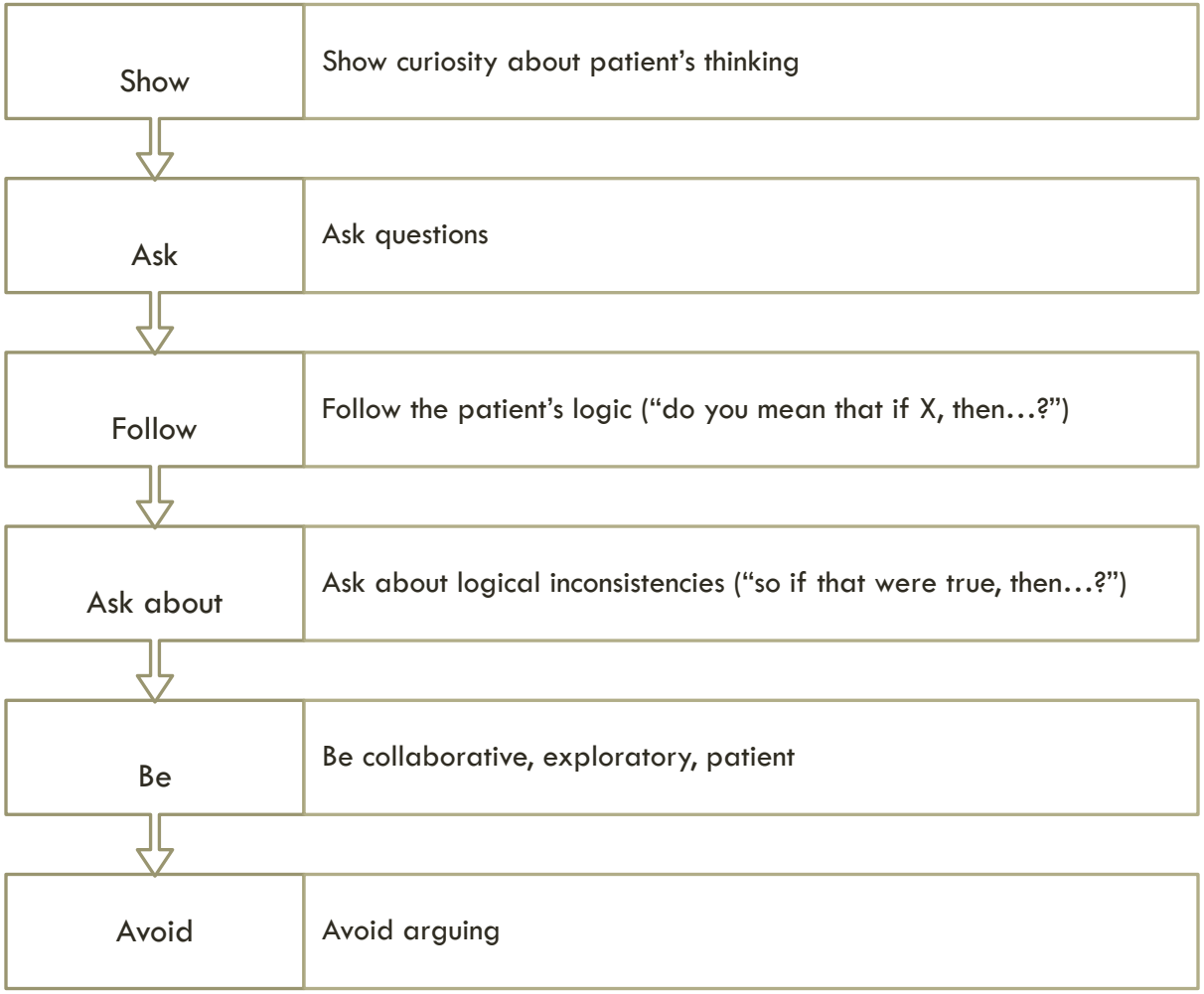
Thought Form (Short)



SESSION 3

Use Cognitive Therapy strategies flexibly

SOCRATIC DIALOGUE



Thought Form

Situation/Trigger: 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

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

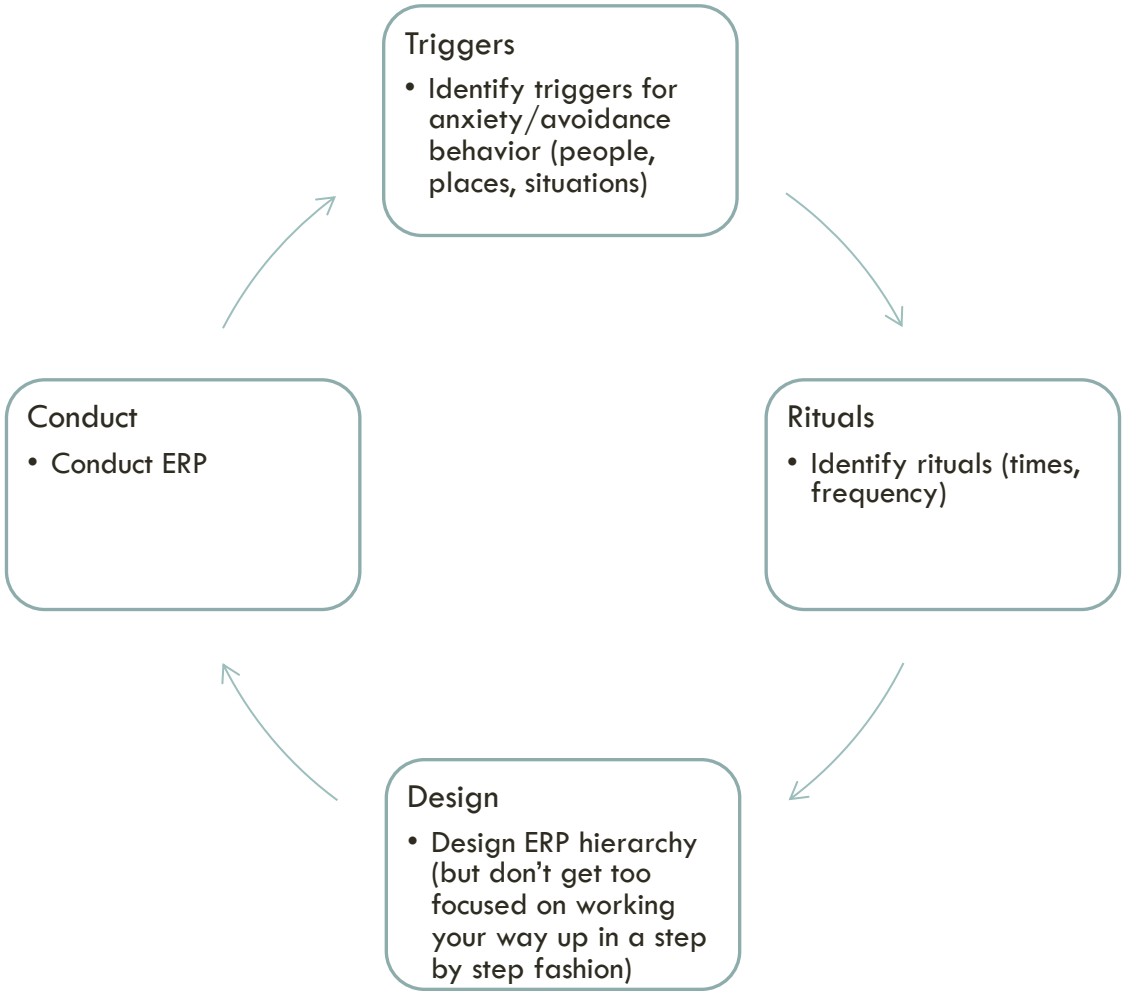
ACCEPTANCE OF INTRUSIVE THOUGHTS

- 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

- First
  - Start with CT
- Second
  - Move on to ERP
- Third
  - Combine both in session/at home

EXPOSURE & RESPONSE PREVENTION



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 firsthand experience if your predictions are accurate or not.”

TROUBLESHOOTING:

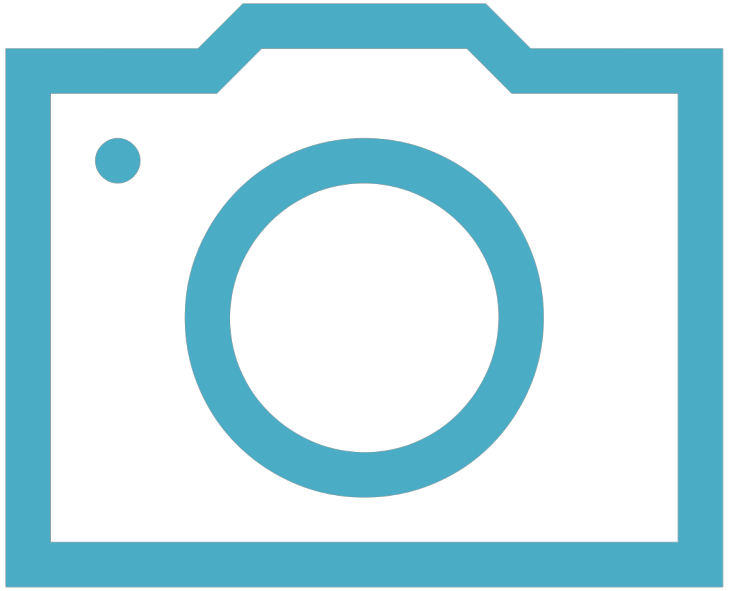
MOTIVATE YOUR PATIENT TO TOLERATE THE ANXIETY

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

Distressing Situations Worksheet	Distress (0-100)	Avoidance (0-100)
1. Door handles and elevator buttons	45	70
2. Sitting in a bus	55	60
3. Touching money (esp. coins)	70	60
4. Touching trash cans at home	72	60
5. Touching garbage cans outside	78	90
6. Images of becoming terribly ill	85	100
7. Public bathrooms	90	100

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 (20 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	Distress (0-100)	Avoidance (0-100)
1. Turn light switch on and off	45	50
2. Turn faucet on/off	50	50
3. Open and close window	55	50
4. Open/close car door and enable/disable parking break	65	50
5. Turn coffee maker on and off, go upstairs	70	90
6. Turn iron on and off, leave house	80	100
7. Turn stove on and off, leave house	100	100

SONJA'S RESPONSE PREVENTION STRATEGIES

- 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

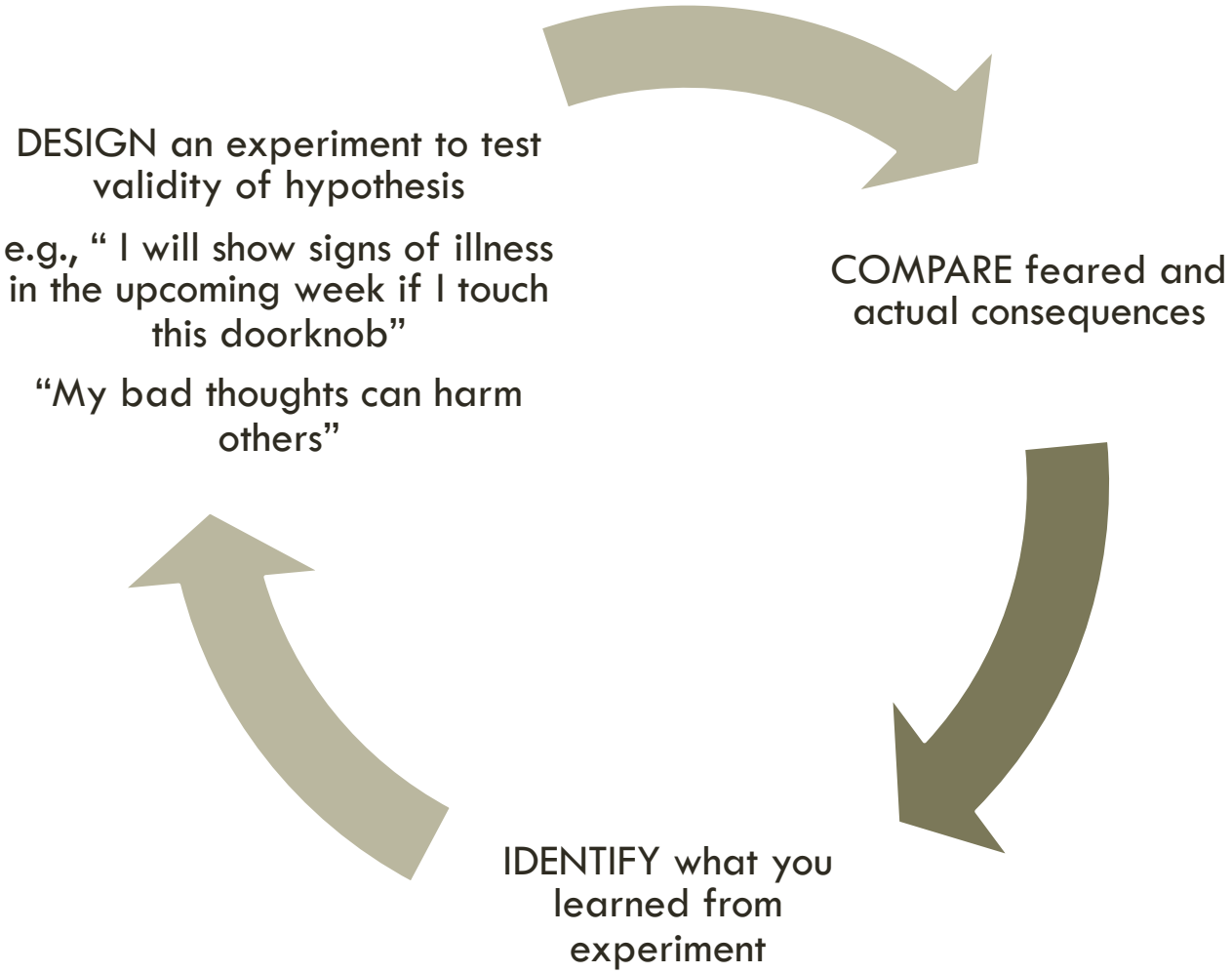
Distressing Situation	SUD (0-100)	Avoidance (0-100)
Buttering bread while alone	30	35
Listening to loop tape on stabbing son, do not start praying	50	60
Cutting fruit while kids are in the house, do not ask husband to watch me	60	65
Cutting fruit with kids at the table, do not ask husband to watch me/do not ask for reassurance	80	100
Hold son and knife at the same time, do not pray	90	100
Hold son while cutting fruit, do not ask husband for reassurance	100	100

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 an **active participant** in deciding on ERP

BEHAVIORAL EXPERIMENTS



MOVING FORWARD

Practice	• Practice exposures and ritual prevention daily
Work on	• Work on increasingly challenging ERP's
Be	• Be creative, leave office, change context
Shift	• 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.

THINGS TO REMEMBER

Promote generalization: phone sessions, bring “contaminated” items to office

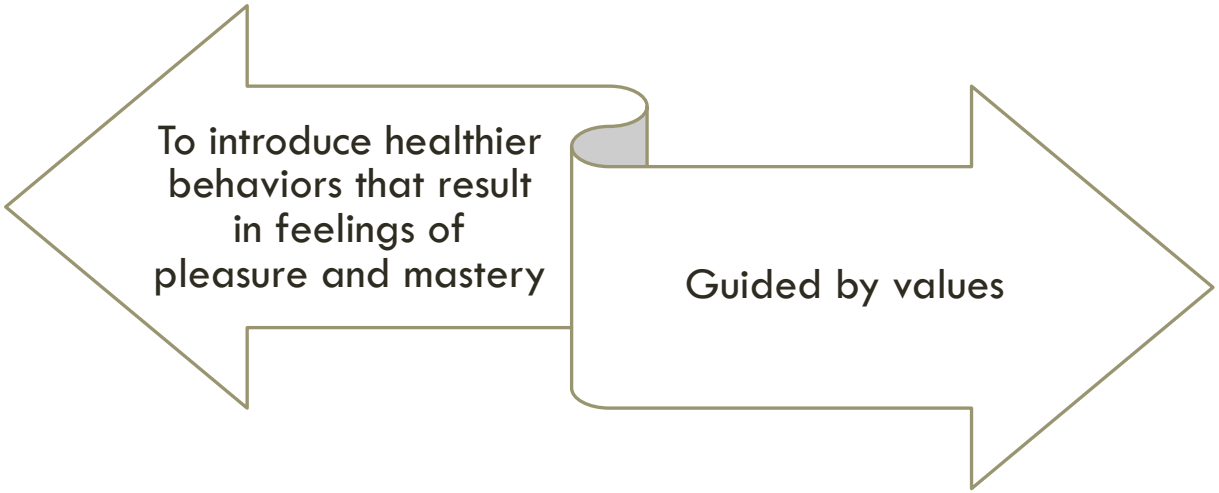
High intensity exposures are okay; walk the line (exposure scripts)

Have fun – make games out of exposures (sing, musical spoons)

Involving Family Members

Highly recommended when with working with children

- ❑ Educate family members about OCD
- ❑ Suggest reading
- ❑ Ask for the family's/partner's observations
- ❑ Explain what the treatment will involve
- ❑ Ask parents to be a 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

CBT FOR OCD
IN THE TIME OF COVID-19

Image courtesy of NPR

COVID-19 & CONTAMINATION CONCERNS

Set basic **safety plan** based on CDC guidelines

Consider **context**

Do you live alone or with others? Does your job require you to work with the public?

Differentiate **normative** vs. **OCD-related compulsions**

Are you handwashing in response to an obsession? Are your behaviors time-consuming and impairing? Are your behaviors consistent with CDC guidelines?

COVID-19 Safety Plan

1. Disinfect frequently-touched surfaces **twice a day**. Set a **5-minute timer** and stop when it has ended.
2. Wash hands **once** ONLY when the situation truly calls for it:
    1. After being in public spaces
    2. Before eating
    3. After using the bathroom
    4. After coughing or sneezing
3. Wash hands under warm water with soap and **count to 20** (no more).
4. Use hand sanitizer ONLY when soap and water are unavailable.

COVID-19, INTERNET USAGE, & NEWS CONSUMPTION

- Spending hours a day watching television or viewing online media sources can be a COMPULSION.

- Offer a **balanced approach** (e.g., spend no more than 30 mins in the morning and 30 mins at night to stay informed).

  - Suggest **trusted sources** to avoid myths (e.g., WHO, CDC, Center for Health Security at Johns Hopkins)

  - Avoid "**learn everything**"

    - Encourage patients to stick to the time and frequency limits on news that you both have agreed on.

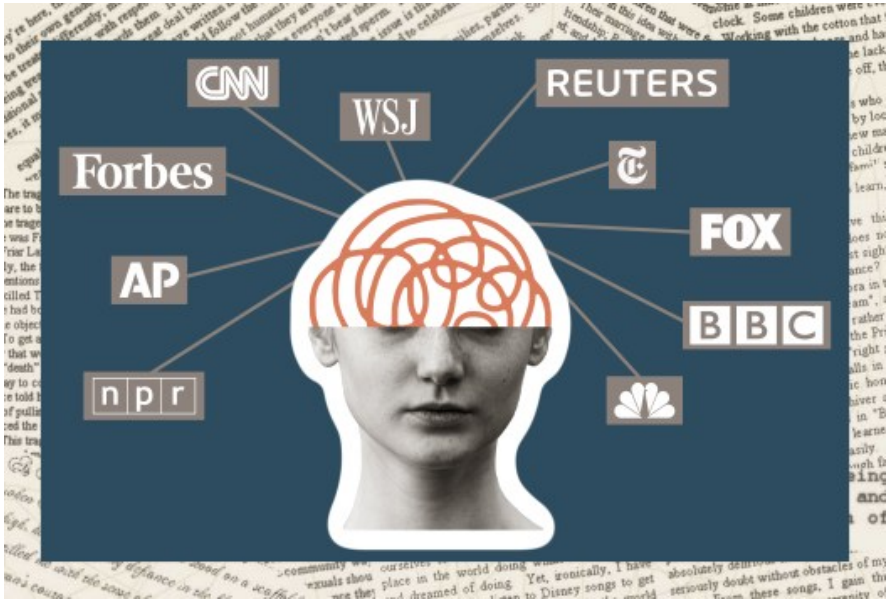


Image courtesy of Maggie Stout/TommieMedia

COVID-19 & TOLERATING UNCERTAINTY

Explain the importance of tolerating uncertainty and SET LIMITS on:

- ❑ time **considering choices,**
- ❑ how much **information** they gather before making a decision,
- ❑ and **asking for reassurance** after they have acted.

*"How can I **be certain** that …*

… I am not going to get other people sick?"
… I'm not unnecessarily putting others at risk?"
… my travel is truly necessary or essential?"

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

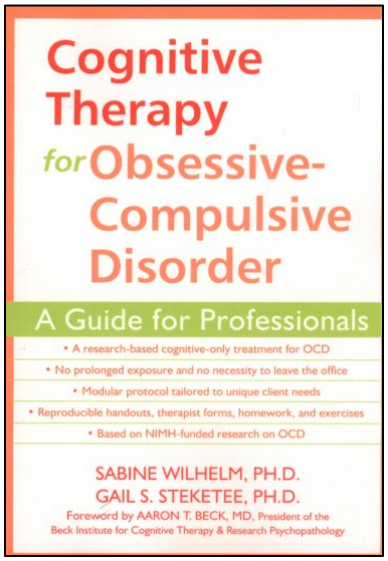
RELAPSE PREVENTION

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



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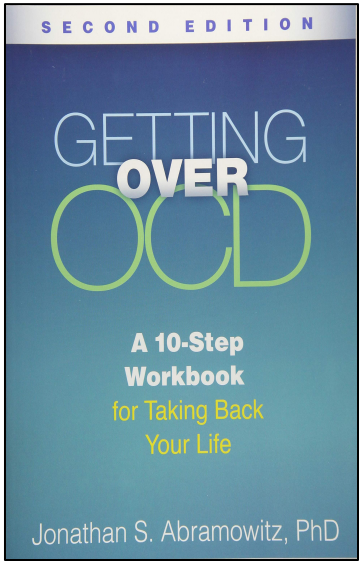

Abramowitz, J. S. (2018). Getting Over OCD, Second Edition: A 10-Step Workbook for Taking Back Your Life. The Guilford Self-Help Workbook Series

LOOKING TO THE FUTURE: APP-BASED & INTERNET CBT (ICBT)

- Addresses some barriers to in-person ERP/CBT (e.g., cost & accessibility)
- Patients can engage in self-paced, evidenced-based ERP exercises
- Personalized to the patient's goals and symptoms

Images courtesy of nocd's website (www.treatmyocd.com)

INTERNET-BASED COGNITIVE BEHAVIOR THERAPY FOR OCD: A RANDOMIZED CONTROLLED TRIAL

- 10 weeks of ICBT vs. an online non-directive supportive therapy (CC)
- ICBT resulted in larger improvements on the YBOCS when compared to the CC (Cohen's *d* = 1.12; 95% CI 0.69-1.53)
- **60%** of those in the ICBT condition showed clinically significant improvement (95% CI 46-72) as compared to **6%** in the CC (95% CI 1-17). Results were present at follow-up
- More research needs to be done to evaluate the efficacy of app-based cognitive behavior therapies for OCD

Table 2 *Continuous treatment outcome measures*

	Baseline			Post-treatment			4-months follow-up			Effect size at post-treatment		Effect size at follow-up	*p* value
Measure	*n*	Mean	S.D.	*n*	Mean	S.D.	*n*	Mean	S.D.	Within group (95% CI)	Between group (95% CI)	Within group (95% CI)	Group x time interaction
YBOCS													
ICBT	50	21.42	4.59	49	12.94	6.26	50	12.56	7.34	1.55 (1.09 to 1.98)	1.12 (0.69 to 1.53)	1.45 (1.00 to 1.88)	<0.001
CC	51	20.80	4.04	51	18.88	4.18				0.47 (0.07 to 0.86)			

Andersson et al. (2012)

International OCD Foundation

MASSACHUSETTS GENERAL HOSPITAL
PSYCHIATRY ACADEMY

Online Courses

☐ **CBT for Obsessive Compulsive Disorder: An Introductory Online Course**

Understand and identify clinical features of OCD and apply skills to treat the different OCD symptom subtypes.

☐ **CBT for OCD in Children and Adolescents**

How to use CBT for children and adolescents with OCD, including evidence-based interventions such as psychoeducation, cognitive strategies, and more.

☐ **CBT for Body Dysmorphic Disorder**

Identify clinical features of BDD, enhance patient motivation, manage treatment pitfalls , apply specific strategies for unique presentations, and much more

☐ **CBT and Medication Treatment for Body Focused Repetitive Behaviors**

How to use the latest assessment tools and treatment interventions (both CBT and medication) to help patients who suffer from BFRBs such as trichotillomania and excoriation disorder.

SEE ALL COURSE DATES AT MGHCME.ORG/CBT

ACKNOWLEDGMENTS

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- Harvard Medical School

HARVARD MEDICAL SCHOOL

OCD & Related Disorders Program

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