

Treating Obsessive-Compulsive Disorder with Cognitive-Behavioral Therapy

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Disclosure

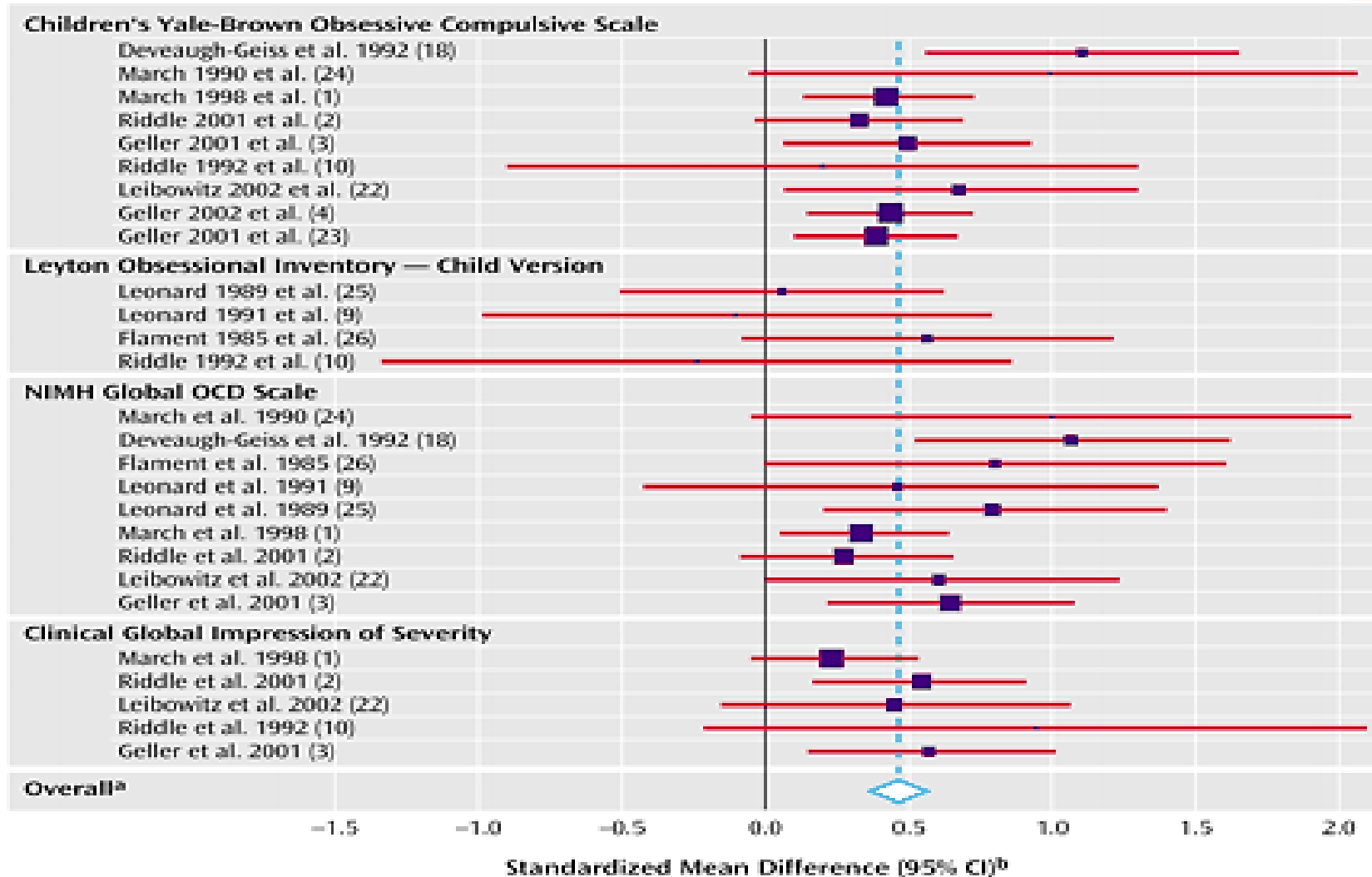
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- Applicable CME staff have no relationships to disclose relating to the subject matter of this activity.
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Treatment

2 primary treatment approaches with empirical support:

- Cognitive-Behavioral Therapy (CBT)
- Psychotropic Medications

Medication Efficacy



Effect size = 0.46, 95% CI = 0.37 to 0.55.

Geller DA, et al. *Am J Psychiatry*. 2003;160(11):1919-1928.

When you think of psychotherapy,
what comes to mind?





Effectiveness of Exposure and Response Prevention Therapy Alone

- Overall, 80% to 85% significantly improve with ERP (dozens of research trials)
- Produces roughly 60% symptom reduction
 - Produces on average an 11.8 point reduction in Y-BOCS scores
- Very low relapse rates
- Key to medication discontinuation

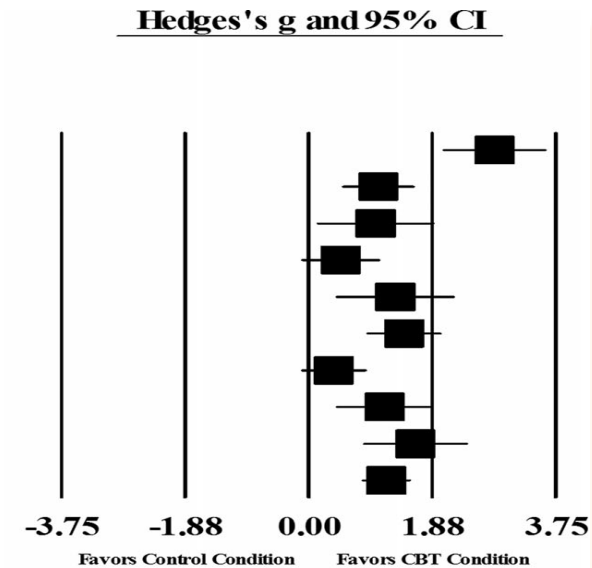
ERP = Exposure and Response Prevention; Y-BOCS = Yale-Brown Obsessive Compulsive Scale.

Foa EB, et al. *Am J Psychiatry*. 2005;162(1):151-161. McGuire JF, et al. *Depress Anxiety*. 2015;32(8):580-593. Olatunji BO, et al. *J Psychiatr Res*. 2013;47(1):33-41.

Meta-Analysis of Pediatric OCD Treatment

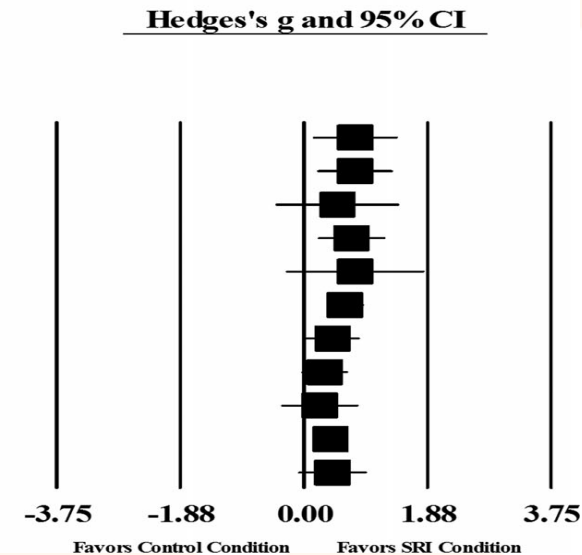
A

<u>Study name</u>	<u>Statistics for each study</u>		
	Hedges's g	Lower limit	Upper limit
Barrett et al. 2004	2.82	2.03	3.61
POTS, 2004b	1.06	0.51	1.61
Bolton & Perrin 2007	1.02	0.12	1.91
Freeman et al. 2008	0.49	-0.12	1.09
Williams et al. 2010	1.31	0.40	2.23
Bolton et al. 2011	1.45	0.87	2.02
Piacentini et al. 2011	0.38	-0.12	0.88
Storch et al. 2011	1.15	0.41	1.89
Lewin et al. 2014	1.62	0.82	2.42
Freeman et al. 2014	1.18	0.80	1.55



B

<u>Study name</u>	<u>Statistics for each study</u>		
	Hedges's g	Lower limit	Upper limit
Flament et al. 1985	0.78	0.13	1.43
Leonard et al. 1989	0.78	0.20	1.36
March et al. 1990	0.51	-0.43	1.45
DeVaugh-Geiss et al. 1992	0.73	0.21	1.24
Riddle et al. 1992	0.78	-0.28	1.84
March et al. 1998	0.62	0.33	0.92
Geller et al. 2001	0.44	0.02	0.85
Riddle et al. 2001	0.31	-0.04	0.67
Liebowitz et al. 2002	0.24	-0.35	0.83
Geller et al. 2004	0.40	0.13	0.68
POTS, 2004a	0.43	-0.09	0.96



Cognitive-Behavioral Therapy

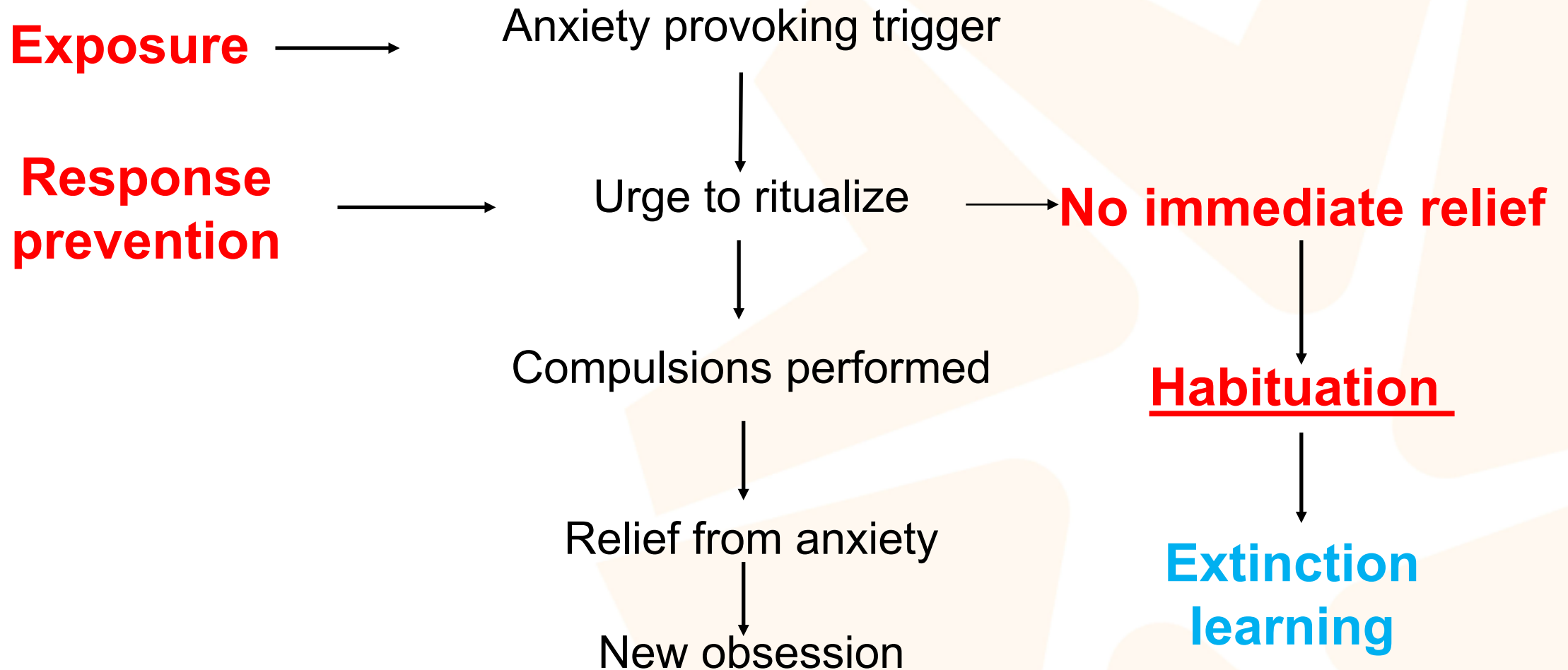
- CBT for OCD can be broken down into 2 general components
 - ERP
 - Cognitive Restructuring



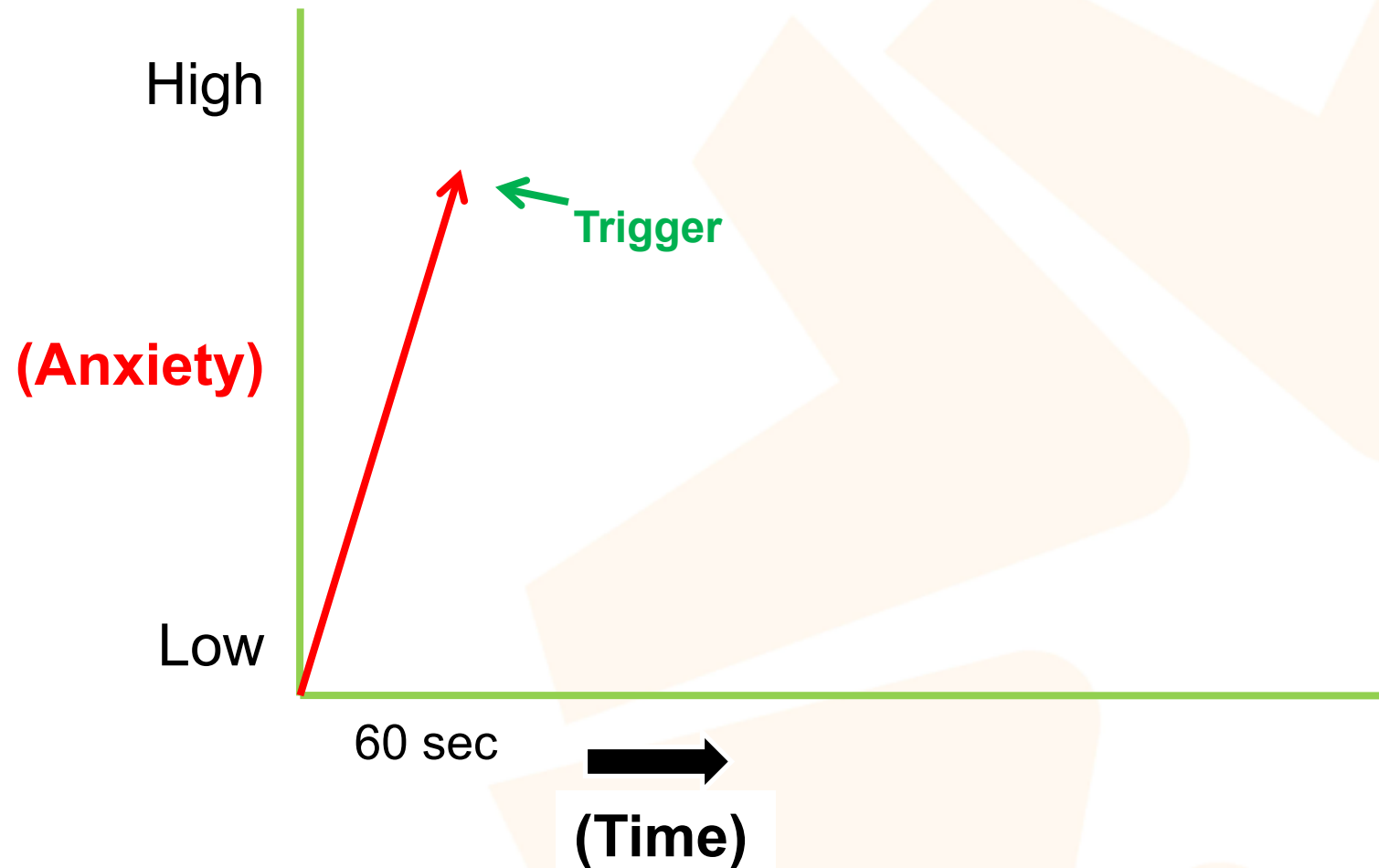
Cognitive-Behavioral Therapy: ERP

- A specific behavior therapy technique
- Meyer published first study in 1966
- Based on the principle of habituation
- Habituation is the decrease in anxiety experienced with the passage of time
 - Within trial habituation
 - Between trial habituation

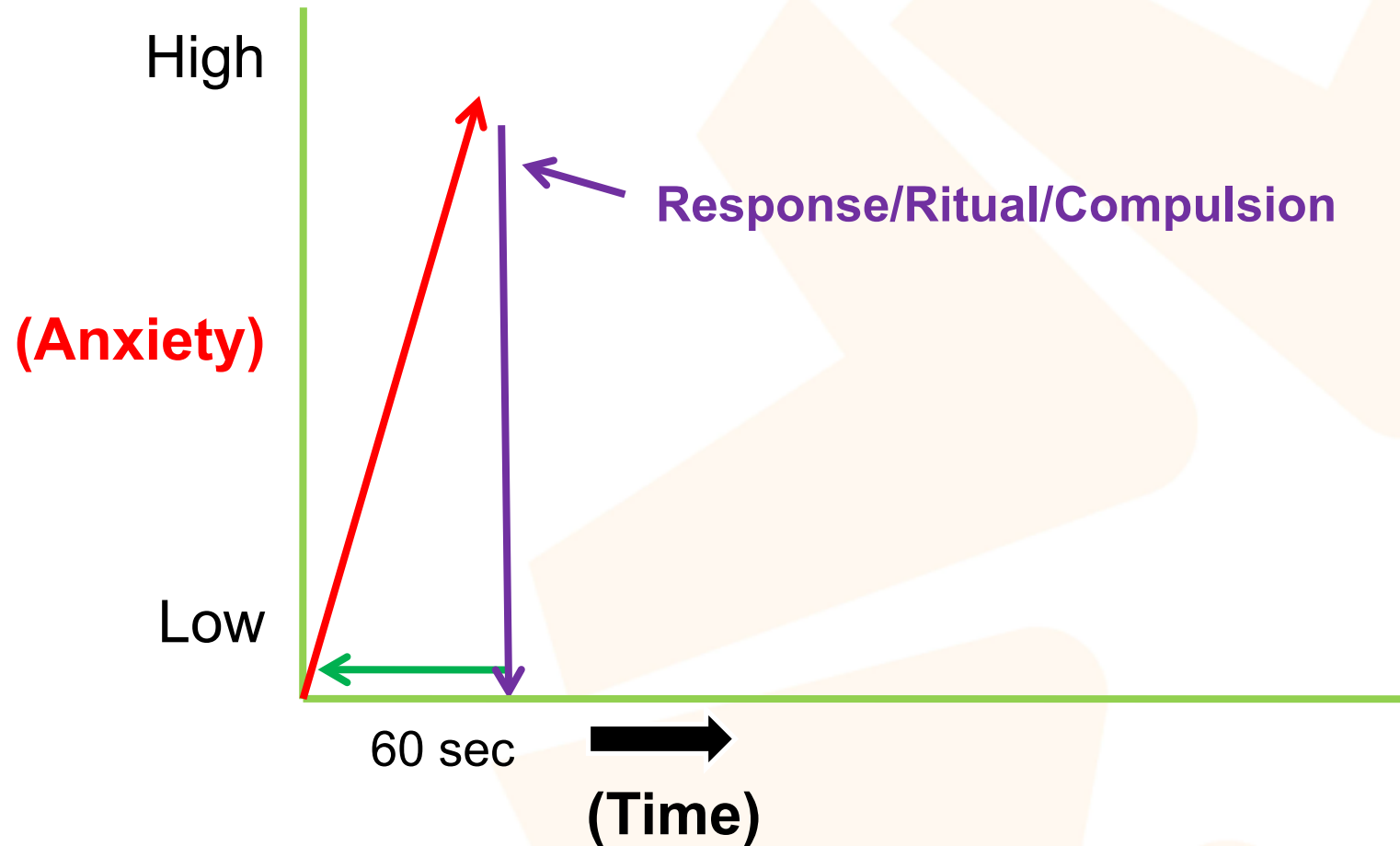
Theoretical Basis of Cognitive-Behavioral Therapy



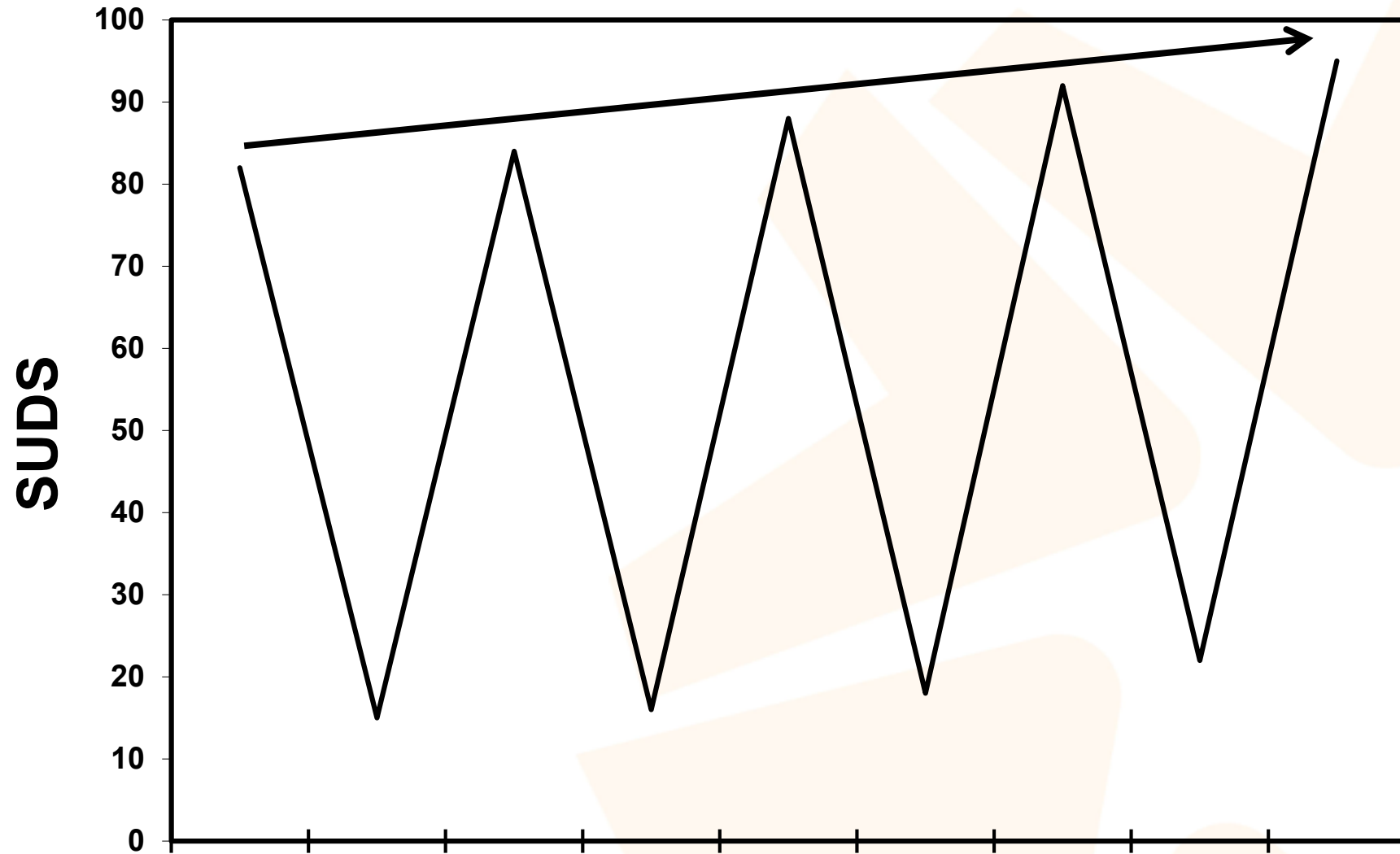
Typical OCD Scenario



Typical OCD Scenario



What happens to anxiety...



SUDS = Subjective Units of Distress Scale.

Psychoeducation

- Psychoeducation is important – takes ~1 session
 - Education about OCD and treatment
 - Goal setting
 - Enlisting supports/coaches



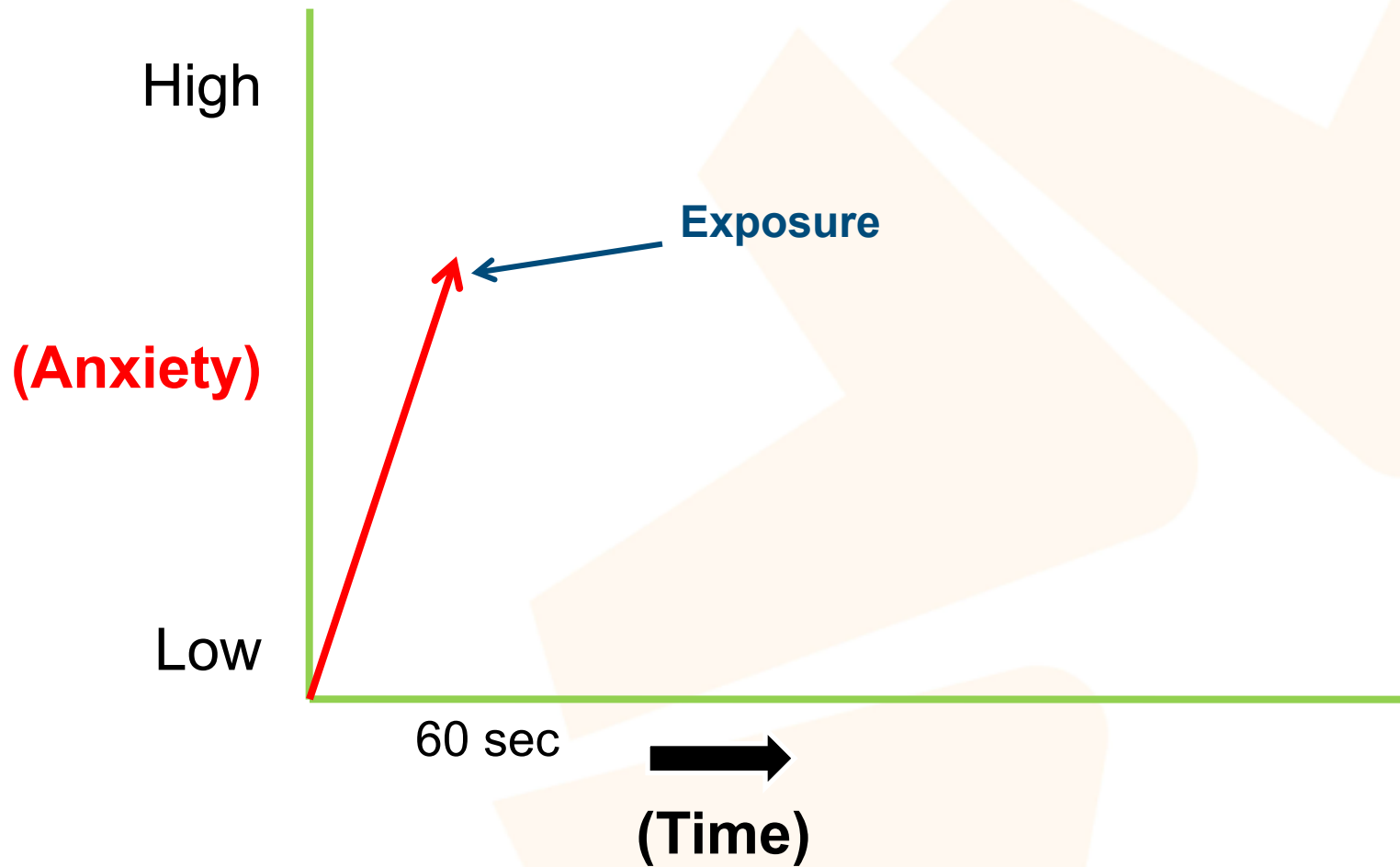


Exposure Therapy

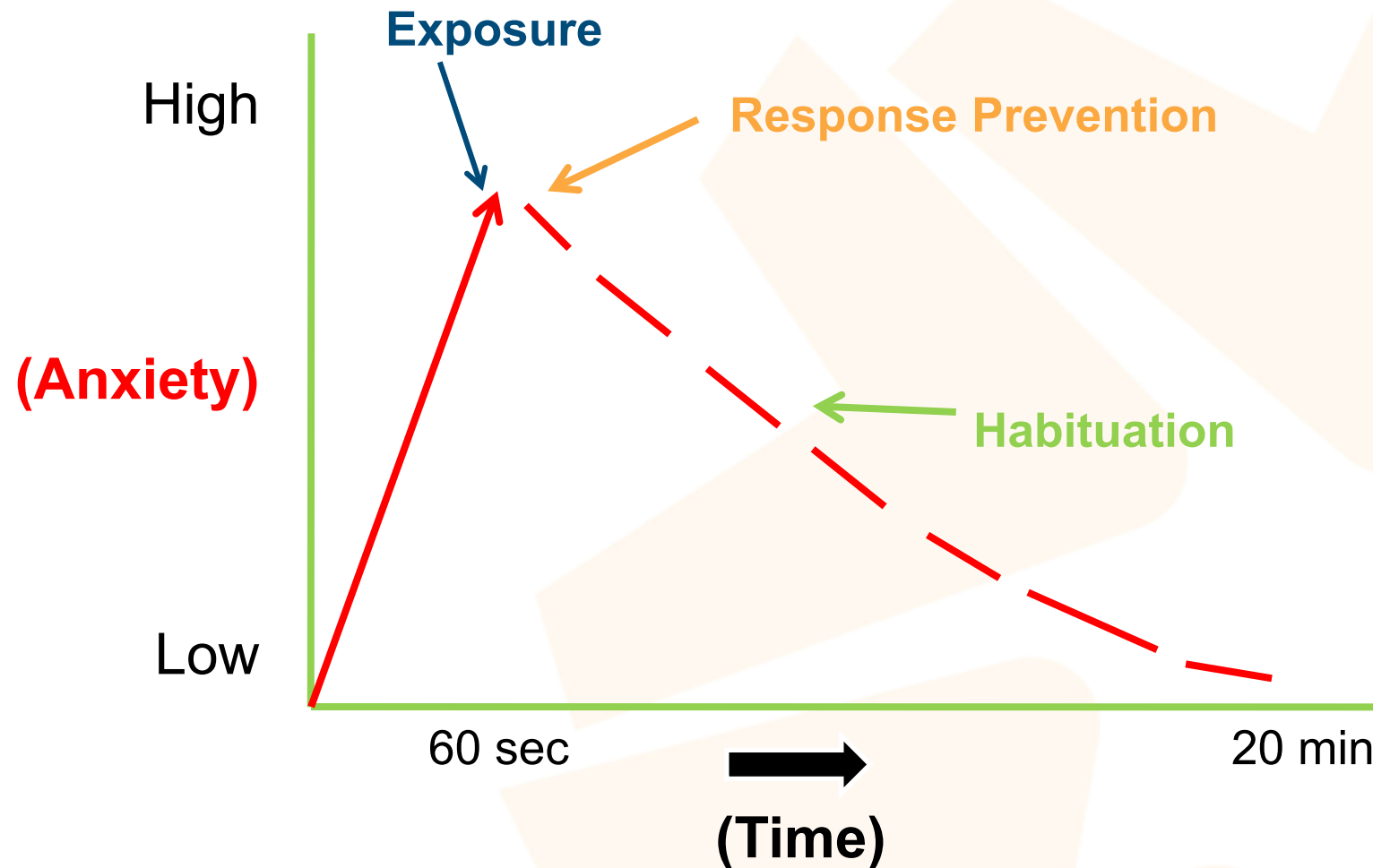
Exposure Therapy

- Placing an individual in feared situations without ritual engagement
 - Needs to be prolonged enough to lead to within trial habituation (at least 50% reduction in anxiety)
 - Needs to be repetitive enough to lead to between trial habituation (until causes minimal to no anxiety)
 - Needs to be graduated (increases compliance)

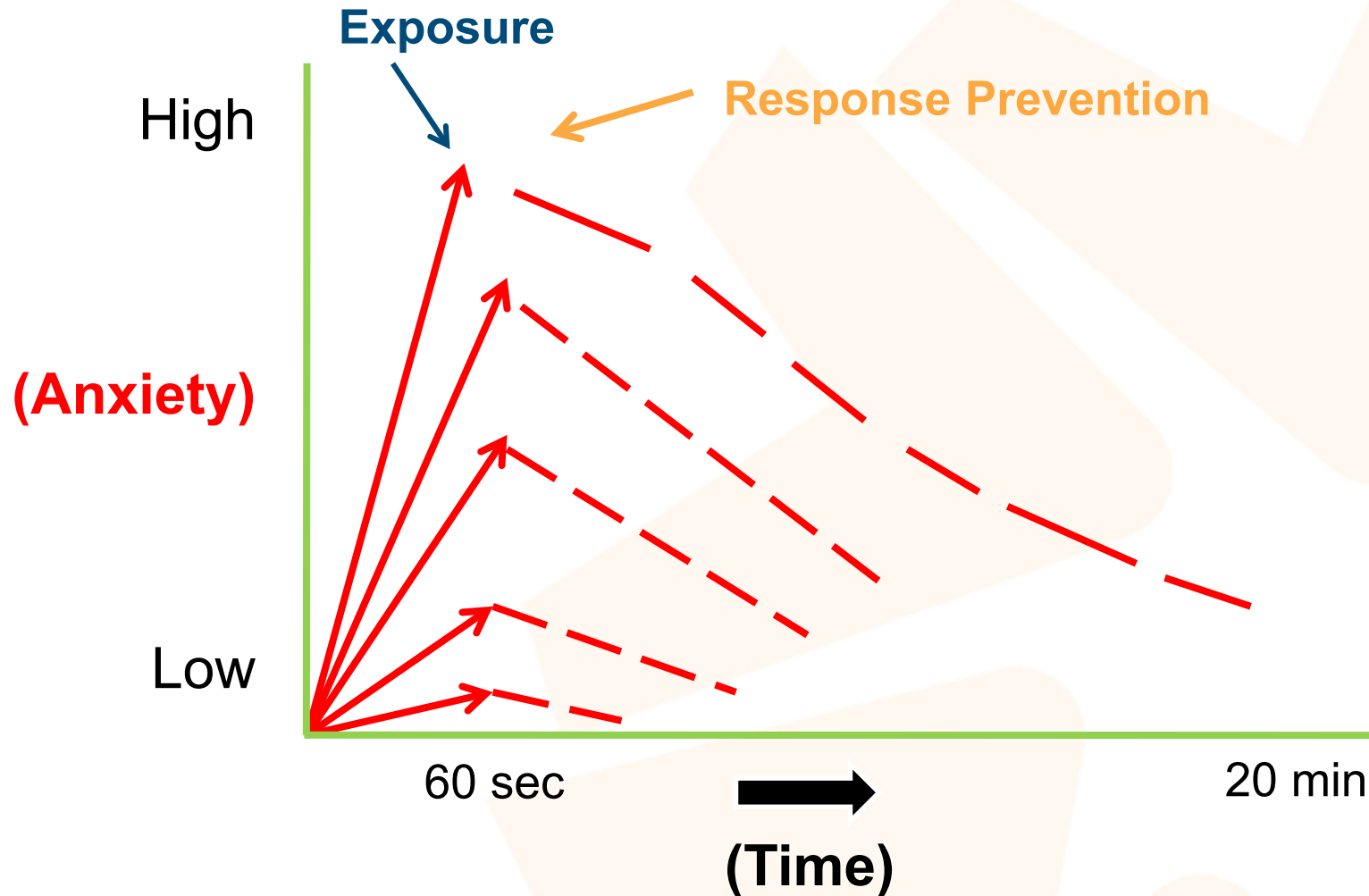
Exposure Therapy



Exposure Therapy within Trial Habituation



Exposure Therapy between Trial Habituation



Treatment Steps

- Initial Evaluation
 - Confirm diagnosis of OCD
 - Identify major problem areas (eg, contamination, doubting)
 - Assess for common comorbid diagnoses
 - Educate patient and family about OCD and treatment options

Treatment Steps (cont'd)

- Detailed Assessment Phase
 - Y-BOCS checklist and severity rating scale
 - Generate specific exposure exercises
 - Patient rates each exercise on scale of 0–10 on perceived difficulty
 - Create exposure hierarchy

Importance of Exposure Hierarchy

Feared Situation	(Session 1)	(Session 7)	(Session 14)
Holding sharp objects near parents/siblings	10	10	3
Standing next to traffic with parents/siblings	8	8	2
Holding sharp objects near friends	7	7	1
Holding sharp objects near strangers	6	6	0
Reading a detailed script about stabbing people with a sharp object	6	4	0
Standing next to traffic near friends	5	2	0
Reciting the thought that he/she is going to stab someone with a sharp object	5	3	0
Standing next to traffic near strangers	4	2	0
Reading a detailed script about shoving people into traffic	4	1	0
Reciting the thought that he/she is going to punch/shove someone near him/her	2	1	0

Sample Hierarchy: Harm

Exposure	SUDS
Holding a knife to mom/dad/sister's throat	10
Holding pencil against mom's throat	9
Holding a knife to therapist's throat	9
Holding knife on lap with mom close	9
Standing behind person with hands on shoulders ready to push (balcony)	8
Pushing your brother's head under water in <u>pool</u>	7
Holding pencil against Dr. S's throat	7
Mother cooking dinner while leaving knives out	7
Holding a handful of medication that could kill	7
Holding knife to wrist	7
Sitting with regular knife	6
Script about killing mother	5
Being near a knife in a room	5
Seeing a picture of a knife	4
Playing b-ball with brother	3
Sitting with butter knife	2
Seeing a picture of a knife	1

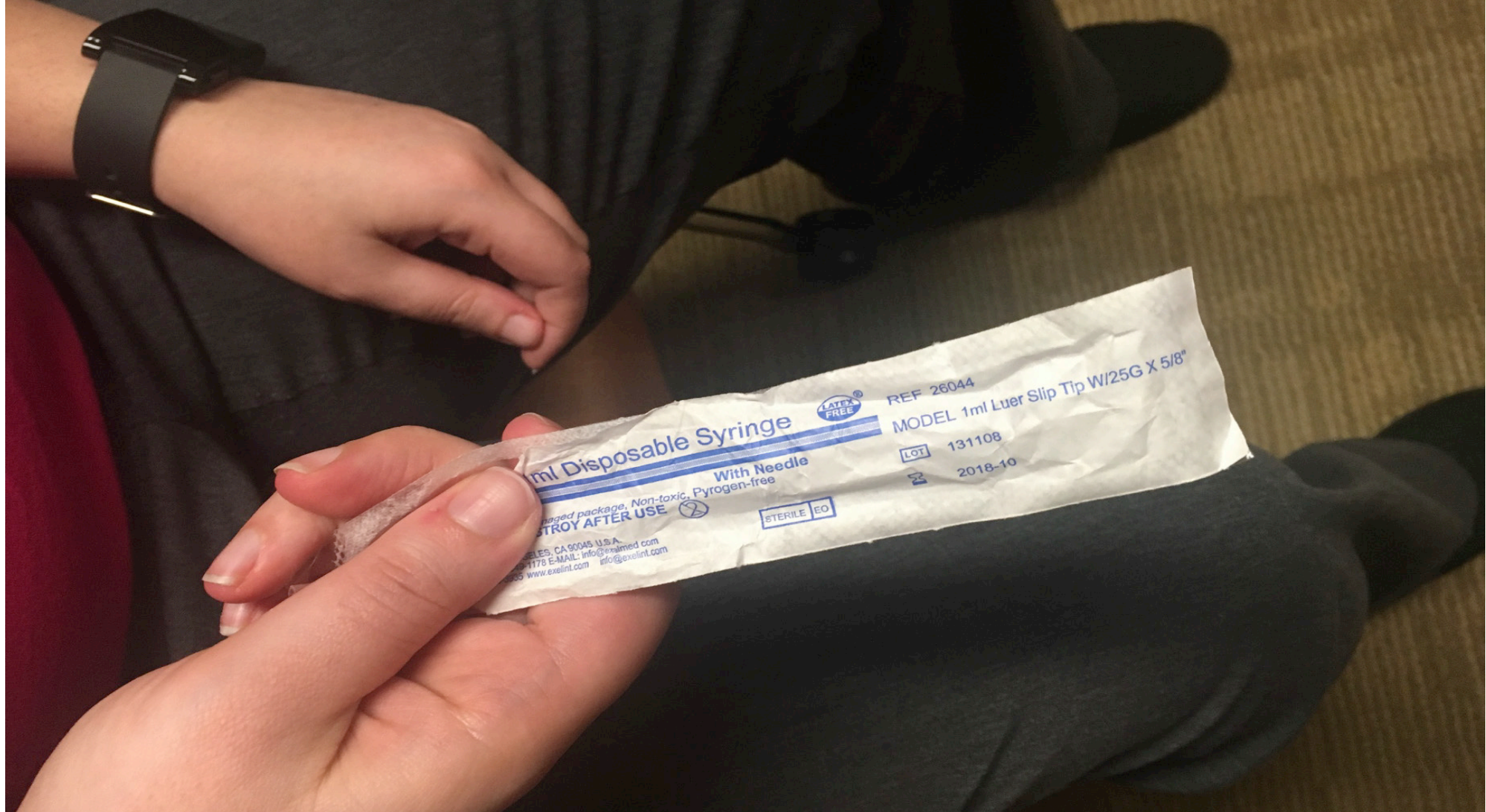
Exposure and Response Prevention

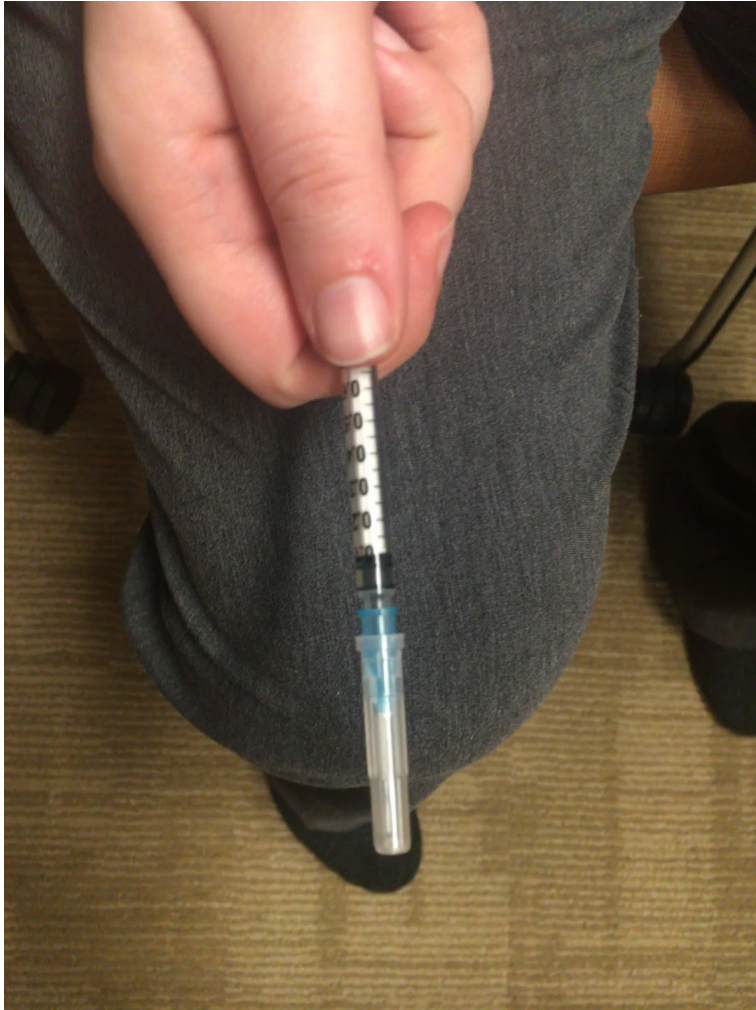
- How does it work?
 - Create a list of events that cause rituals and/or things that the person cannot do because of OCD
 - Easiest to hardest
 - Be creative and “intense”
 - Identify subtle changes in SUDS ratings
 - Incorporate reductions in family accommodation
 - Progress up that list slowly where the person does not engage in rituals
 - First exposures should have high likelihood of success

Exposure and Response Prevention (cont'd)

- How does it work?
 - Tackle things one at a time
 - Therapist should model exposure
 - *In vivo* works best (but can do it through imagination)
 - Don't leave the situation until anxiety drops

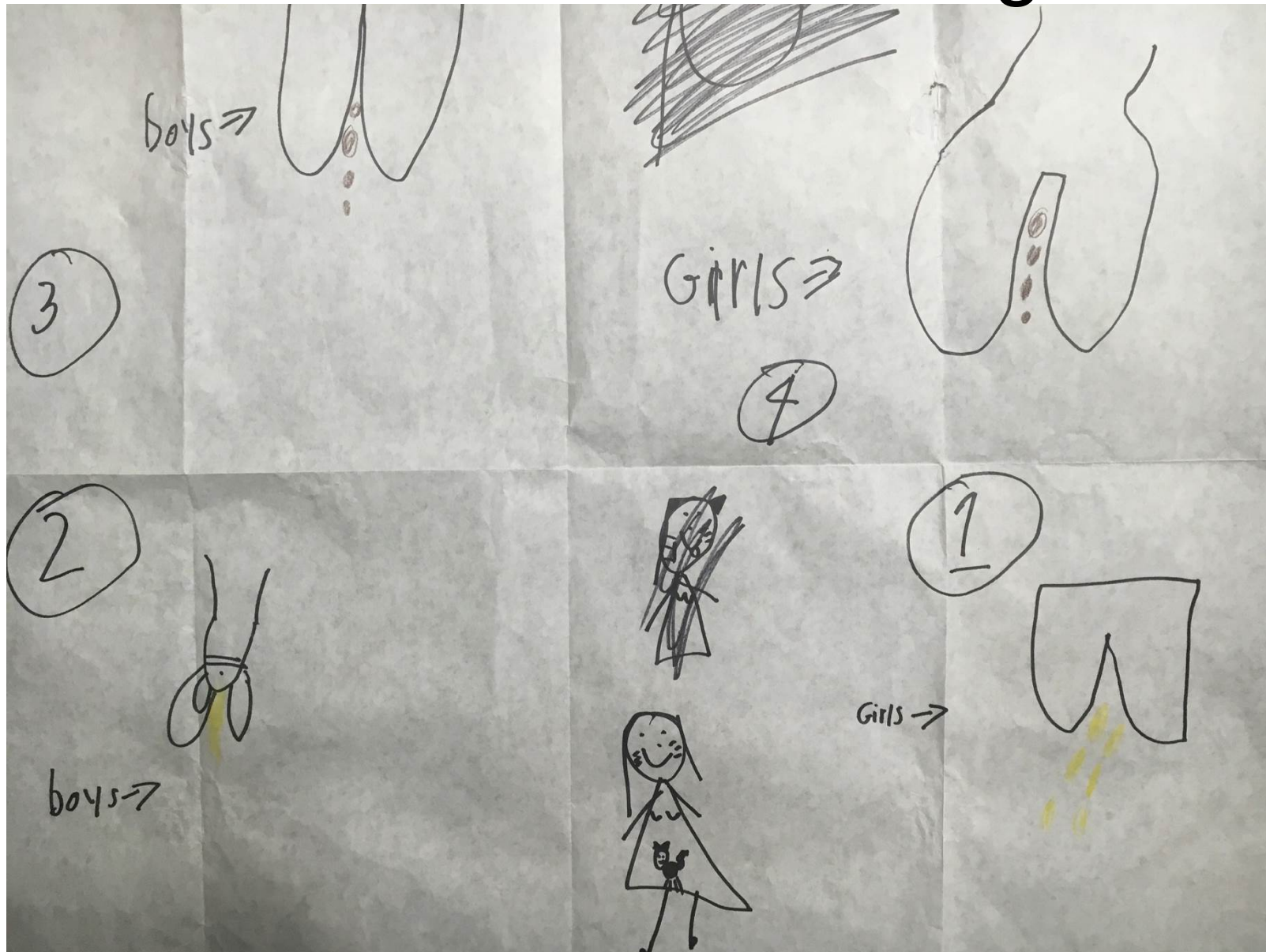
Hierarchical Progression of Fear of Harm Exposures







Draw the Intrusive Images

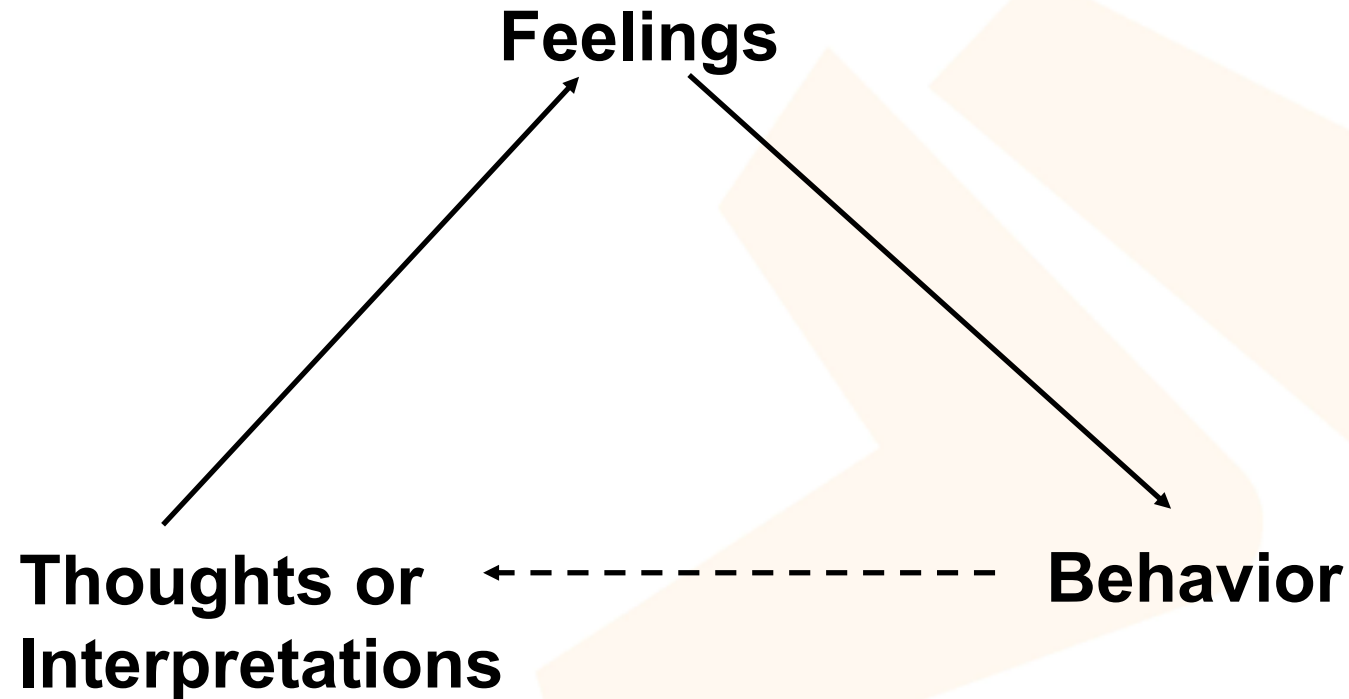


Cognitive Therapy

Cognition and Anxiety Disorders

- People with anxiety disorders have biased information processing
- Heightened level of attention to potential threat
- View situations as being unrealistically dangerous or likely to cause harm
- Underestimate ability to manage or cope with feared situations

Cognitive Model



Thoughts predict feelings which predict behavior.

Common Cognitive Errors

Doubt/Uncertainty

- “I can’t remember if I checked my door lock.”

Thought Action Fusion

- “If I think about having sex with my cat, I must want to do it.”

Overestimating Probability

- “I could get HIV from sitting on a public toilet seat.”

Catastrophic Thinking

- “I’ll get sick and die if I go near sick people without washing afterwards.”

Inflated Sense of Responsibility

- “If my mom develops cancer, it is my fault.”

Family Involvement

- Include
- Address problematic family dynamics
 - Anxiety, OCD, distress, etc.
 - Expressed emotion
- Train family as therapists
 - Teach them the skills (eg, CT, ERP, etc.)
 - Enhances compliance/generalization
- Have them conduct ERP tasks
 - Model first and gradually allow parents to take over

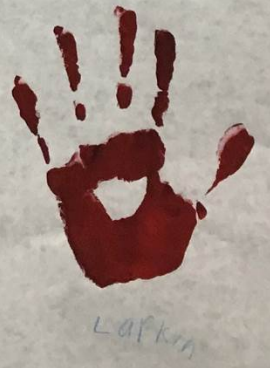


Other Considerations in Treatment Implementation

Have Fun!

- Doesn't change that the exposure is being completed
- Make games or contests out of exposures
- Laugh!
- Involve family members
 - Models tasks
 - Allows you to address any “undesirable” family behaviors

Lost Hands





Additional Resources

International OCD Foundation

- Search the IOCDF for OCD resources near you:
 - Therapists
 - Clinics
 - Support groups
 - Online resources
- Visit: <https://iocdf.org/find-help/>



International
OCD
Foundation

Self-Help Resources

- **Self-Directed Treatment**
 - Exposure Ritual Prevention and Awareness Exercises
 - <https://iocdf.org/expert-opinions/expert-opinion-self-directed-erp/>
- **Internet-Based Programs**
 - OCD Challenge: www.o cdchallenge.com
 - BT Steps
 - For more information about the program, please contact Revere Greist at rgreist@centerforpsychconsulting.com or (608) 556-0766
- **Smartphone Apps**
 - Live OCD Free
 - iCounselor OCD

Thank you!

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