

Mia, aged 35, remembers the time when she was 7 years old and reading in bed, when her mother told her an elderly neighbour had died.

From that time on, Mia never read in bed as she was afraid that her reading would cause someone to die. As an adult, she described being assailed by thoughts of her children dying. To help herself feel better, she repeated the phrase 'my children are okay' twelve times in her head. She repeatedly checked the locks and doors in her house to ensure that nobody could come in and harm the children. If she saw anything associated with death (for example, a hearse), she was afraid that it was an 'omen' and she immediately checked on her children to seek reassurance that they were well.

Over time, Mia began to worry that she may accidentally harm her children, for example by giving them chicken that had not been cooked properly. She avoided cooking raw meat as it caused her so much anxiety and she was constantly disinfecting all the kitchen surfaces and her hands. Mia's anxiety and compulsive behaviour made her think that she was going mad.

She knew that she didn't make any sense but she was too afraid to stop, thinking that if she did so then one of her children would die.

Obsessive-compulsive disorder (OCD) is a relatively common disorder with a lifetime prevalence of approximately 2% in the general population. It often has an early onset, frequently in childhood or adolescence and can become chronic and disabling. Reviews demonstrate that a lot of health care service and expense is spent on helping people to cope with OCD.¹ Further, people with OCD may be unable to work, making the illness an economic burden to themselves and their families, employers, and society.

Approximate Lifetime Prevalence: 2%

Diagnostic Criteria for Obsessions:

Recurrent and persistent thoughts, images or impulses that:

- 1 Are experienced as intrusive/unwanted.
- 2 Cause significant distress.
- 3 Are not excessive worries about real-life problems.
- 4 The person tries to ignore, suppress or 'neutralize'.
- 5 Are recognized as a product of the person's own mind.

Diagnostic Criteria for Compulsions:

Repetitive behaviours or mental acts that:

- 1 The person feels driven to perform in response to an obsession or according to rigid rules.
- 2 Are aimed at preventing or reducing distress or at preventing a dreadful event from occurring.
- 3 Are not realistically connected to what they are designed to neutralise or prevent, or are clearly excessive.

In adults, the obsessions or compulsions must:

- 1 Have been recognized as excessive or unreasonable at some point by the individual.
- 2 Cause interference in functioning, cause significant distress or take up excessive amounts of time.

In the 1950s, OCD was seen as a form of 'madness' and practitioners were told that people would have a psychotic breakdown if they were prevented from performing their compulsive behaviour. In the preceding example, Mia's repeated checking of locks and doors is compulsive behaviour.

In the decade that followed, a form of behavioural therapy intended for other kinds of anxiety disorders, called systematic desensitization, gave practitioners hope that people with OCD might be helped with behaviour therapy as well. In the 1960s and 1970s, the ground-breaking work of psychologists Victor Meyer and subsequently Jack Rachman and colleagues, led to the development of behaviour therapy for OCD that offered people an effective treatment for a previously “untreatable” problem. These investigators understood that the unwanted and disturbing obsessive thoughts made people immediately anxious and that the role of the compulsions was to reduce anxiety.

Consequently, they developed a form of treatment that involved gradual exposure to the triggers of the obsessional thoughts, and paired this with ‘response prevention’ (preventing the compulsive behaviours). This became the gold standard treatment for OCD. The ‘cognitive revolution’ of the 1980s led to the development of Cognitive-Behavioural Therapy (CBT) for the disorder. Today, practice guidelines recommend CBT as the psychotherapy of choice for OCD.²

1.0 The Content of the Therapy

A core ingredient of CBT for obsessional problems is exposing the individual to the situation (either real or imagined) that they fear or avoid, and preventing them from performing the compulsive behaviour. This treatment strategy, called ‘exposure and response prevention’ (ERP), appears to change behaviour as well as the beliefs people have about their compulsive behaviour.³ In the example of Mia, she might be helped by encouraging her to go to sleep without checking the doors and locks repeatedly. With treatment, not only does she change her behaviour (that is, stop repeated checks of the doors and locks) but, by realizing that no harm comes to her or her children, she changes her belief that repeated checking is necessary to ward off harm.

Core ingredients of CBT treatment for OCD are:

- Exposing the individual to their feared situation/person/object for example, touching a door handle that is seen as 'dirty'. Exposure is usually gradual and frequently demonstrated first by the practitioner;
- Asking the person not to engage in the compulsion for example, washing hands; and
- Discussing with the person what they find out when they engage in exposure and response prevention for example, they discovered that their anxiety decreased within a couple of hours even though they didn't wash their hands or they discovered that nobody became ill from not washing their hands.

The treatment also typically involves explaining that everyone has unwanted intrusive thoughts, and that a key factor is how the person interprets these normal but intrusive thoughts. For example, interpretations such as 'this thought means that I'm responsible for preventing harm' or 'this thought means I'm dangerous' may lead to anxiety which the person tries to cope with by suppressing the thoughts, engaging in other thoughts or behaviours to counteract the thoughts, and avoiding or monitoring the environment for potential harm and danger. These coping efforts are usually unsuccessful and result in more persistent and frequent intrusive and misinterpreted thoughts.^{4, 5}

CBT has been successful treating people with OCD individually and in groups. Group treatments can be successful whether individuals in the group have the same (for example, all with checking rituals) or different (for example, a variety of pure obsessions, washing compulsions and checking rituals) obsessions and compulsions.⁶

There is some evidence that individual CBT is superior to group CBT. Two large studies indicate that behaviour therapy (which focuses primarily on exposure and response prevention) and cognitive-behavioural therapy (which focuses on the interpretation of thoughts as well as the behaviour) are equally effective for OCD although cognitive-behavioural therapy may be better at treating co-occurring depression.^{3, 7}

2.0 Effects on Symptoms in Different Populations

A recent study of 122 adult outpatients reported that 86% of those who completed treatment benefited from exposure and response prevention.⁸ At least half of adults with OCD report that their disorder began in childhood. The childhood form of OCD is strikingly similar to that in adults. The Pediatric OCD Treatment Study of 112 volunteer outpatients aged 7-17 years, found that symptoms remitted for 53% of those in the combined CBT and medication treatment and for 39% of those undergoing CBT alone. Unlike with adults, there is some suggestion that a group CBT intervention that includes families is as effective in reducing OCD symptoms for children and adolescents as individual treatment.⁹ Little is known about late-onset OCD or OCD in older adults.

OCD can take different forms and it may be worth distinguishing among different types or subtypes of the disorder. Compulsive hoarding appears to be a distinct subtype of the disorder. OCD with co-occurring tics also appears to be a distinctive subtype in which the disorder has an earlier onset, has a unique symptom picture, and does not respond as well to antidepressant medications.

3.0 Long-Term Outcome

There has been little good research on the long-term outcome of people with OCD who have been treated with CBT. A synthesis of studies (meta-analysis) of childhood OCD found that the younger the child when OCD began, the longer the child has lived with OCD, and whether the child required hospitalization predicted that the disorder would be more persistent. The presence of other psychiatric illness and a poor response to initial treatment also predicted worse outcomes.¹⁰

4.0 Pharmacological Options

Classes of medications (such as tricyclic antidepressants and selective serotonin reuptake inhibitors, or SSRIs) have demonstrated benefit in long-term treatment trials (at least 24 weeks) with some that can be used with children and adolescents. Available treatment guidelines recommend that an SSRI be tried first and continued for a minimum of 1-2 years before being very gradually withdrawn. Relapse is very common when medication is withdrawn, particularly if the person has not had the benefit of CBT (<http://www.psychguides.com/oche.php>).¹¹

Other research reports that there are possible side effects, including apathy and increased suicide risk, associated with children and adolescents taking SSRIs; it is therefore important for individuals and families to weigh the risks and benefits of treatment with SSRIs carefully for children and adolescents.¹²

5.0 Combined CBT and Pharmacological Treatment

Combined treatments do not appear to be better or worse than CBT alone. However, combined CBT and medication does appear to be better than medication alone. For children and adolescents, CBT works as well as combined CBT and medication treatment and works better than medication alone. This latter finding has led to the conclusion that children and adolescents with OCD should begin treatment with CBT alone or with the combination of CBT plus medication. There is some evidence that the combined treatment reduces relapse when medication for OCD is withdrawn.¹³

6.0 Comparison with Non-Specific Interventions and Other Psychological Therapies

In studies of people with obsessions, where those receiving CBT have been compared to those on a waiting list (not receiving any treatment, or only receiving support and attention), CBT has led to a superior outcome. These findings indicate that the effects of CBT are not merely a function of non-specific factors such as providing support and attention. Compared to other interventions, CBT has been found to be superior to relaxation training¹⁴ but otherwise there have been few comparisons between CBT and other psychological interventions.

7.0 Brief Therapy and 'Rapid Responders'

Research comparing brief CBT treatment for OCD with a longer version of CBT has not yet been conducted. Anecdotal evidence suggests that while there are differences in individual responses to treatment, there are a small number of 'rapid responders' (people who respond rapidly to CBT). It may be that as CBT for OCD becomes more specific (for example, in targeting certain behaviours), shorter treatments can be developed.

8.0 Treatment Refractory OCD

Although the proportion of people classified as responders has been found to vary between 60-80%, this still leaves some who do not respond to treatment or who respond and do not experience a complete remission of their symptoms.¹¹ Furthermore, many people do not wish to engage in CBT as the prospect of exposure and response prevention is understandably frightening to them. In some cases, CBT delivered in a day-treatment program is necessary to treat severe and persistent OCD. In these programs, exposure can be provided for longer periods, which may be better for symptom reduction.

9.0 Self-Help and CBT

Self-help using the computer or interacting with an automated response system on the telephone has the potential to help when direct access CBT is not viable. A computerized program 'BT STEPS' has been designed by John Greist in the USA and Isaac Marks in the UK. BT STEPS is a self-therapy system to assess and treat OCD through exposure to the feared situation and prevention of obsessive and/or compulsive responses. It appears that this computer-guided, self-therapy program is effective in treating OCD, although clinician-guided behaviour therapy is likely to be even more effective. It also seems that a person's motivation to improve, and how quickly they completed the self-assessment, determines how much they are helped by the BT STEPS programs.¹⁵

10.0 What Predicts a Better Response to CBT?

There are few good quality research studies investigating prognostic indicators of a good response to CBT. Predictors of good outcome have included how much effort the individual puts into the treatment and how much insight they develop with regard to their difficulties. It has been suggested that people with a long history of poor response to medication may have poor insight into their disorder and/or not put sufficient effort into treatment, which could diminish treatment outcome.¹⁶ Mataix-Cols and colleagues (2002) report that those who engage in hoarding tend to drop out prematurely and improve less.¹⁷ The strongest predictor of outcome in this study was pre-treatment severity.

11.0 Role of the Family

It seems sensible to recruit relatives and family members (with the individual's permission) as helpers to treat OCD. One study demonstrated the benefits of family assistance in CBT treatment for OCD, as demonstrated by 61% reduction in symptoms for the family-aided group, versus 29% symptom reduction for the individual group.¹⁸ Benefit from family involvement was not found, however, in another study that randomized 50 OCD patients to ERP (exposure to response prevention) homework with or without their partner being involved, where OCD severity fell by 33% in both groups.¹⁹ These outcomes demonstrate possible benefits to involving family members in treatment (with individual's consent).

12.0 Summary

- CBT is the psychological treatment of choice for OCD.
- CBT requires specialized training to deliver.
- CBT is as effective as medication in treating OCD, although caution should be exercised when prescribing medication for children and adolescents.
- Individual treatment may be more effective than group treatments for adults, but this is not necessarily true for children (more research is warranted).
- Different therapies may be warranted for distinct subtypes of OCD for example, those with hoarding or tic disorders.
- Lack of insight may predict poor outcomes.
- Computerized and telephone-based versions of CBT may be useful first steps in the treatment of OCD.

Although she had lived with her disorder for many years, Mia decided to seek psychological treatment after a medical illness meant that she could no longer take her medication. The first group of sessions focused on exploring the bases of her beliefs; she was asked to recall past experiences that were both consistent and inconsistent with her view that she could cause harm to family. Gradually, she developed enough trust in her practitioner to attempt some of the exposure and response prevention tasks. These tasks included reading in bed, not repeating phrases and not seeking reassurance. The practitioner then came to Mia's home and touched all objects that she was afraid to touch due to her concerns that they somehow may be a 'bad omen'. On this visit, he also took her to a cemetery and asked her to touch a hearse. Doing these tasks and discussing the meaning of her concerns led her to gradually realize that she was not in danger of causing harm to her children. After such a long duration of illness, some behaviours were particularly difficult to change but overall she was able to overcome the most disabling features of her OCD.