MASSACHUSETTS GENERAL HOSPITAL
PSYCHIATRY ACADEMY

COGNITIVE BEHAVIORAL THERAPY FOR OCD

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DISCLOSURES

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I have the following relevant financial relationships with a commercial interest to disclose:

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CURRENT TREATMENTS FOR OCD

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1. Serotonin Reuptake Inhibitors
2. Behavior Therapy, i.e., Exposure and Response Prevention (ERP)
3. Cognitive Interventions
4. Mindfulness
5. In clinical practice: CBT + Mindfulness
6. For more severely ill patients, and/or patients with comorbid conditions -> CBT + pharmacotherapy

EXPOSURE AND RESPONSE PREVENTION

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

ERP is empirically supported as one of the most effective psychological treatments

Foa et al. (1983)

EXPOSURE AND RESPONSE PREVENTION (ERP)

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Long-lasting improvements

- ✓ 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)

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

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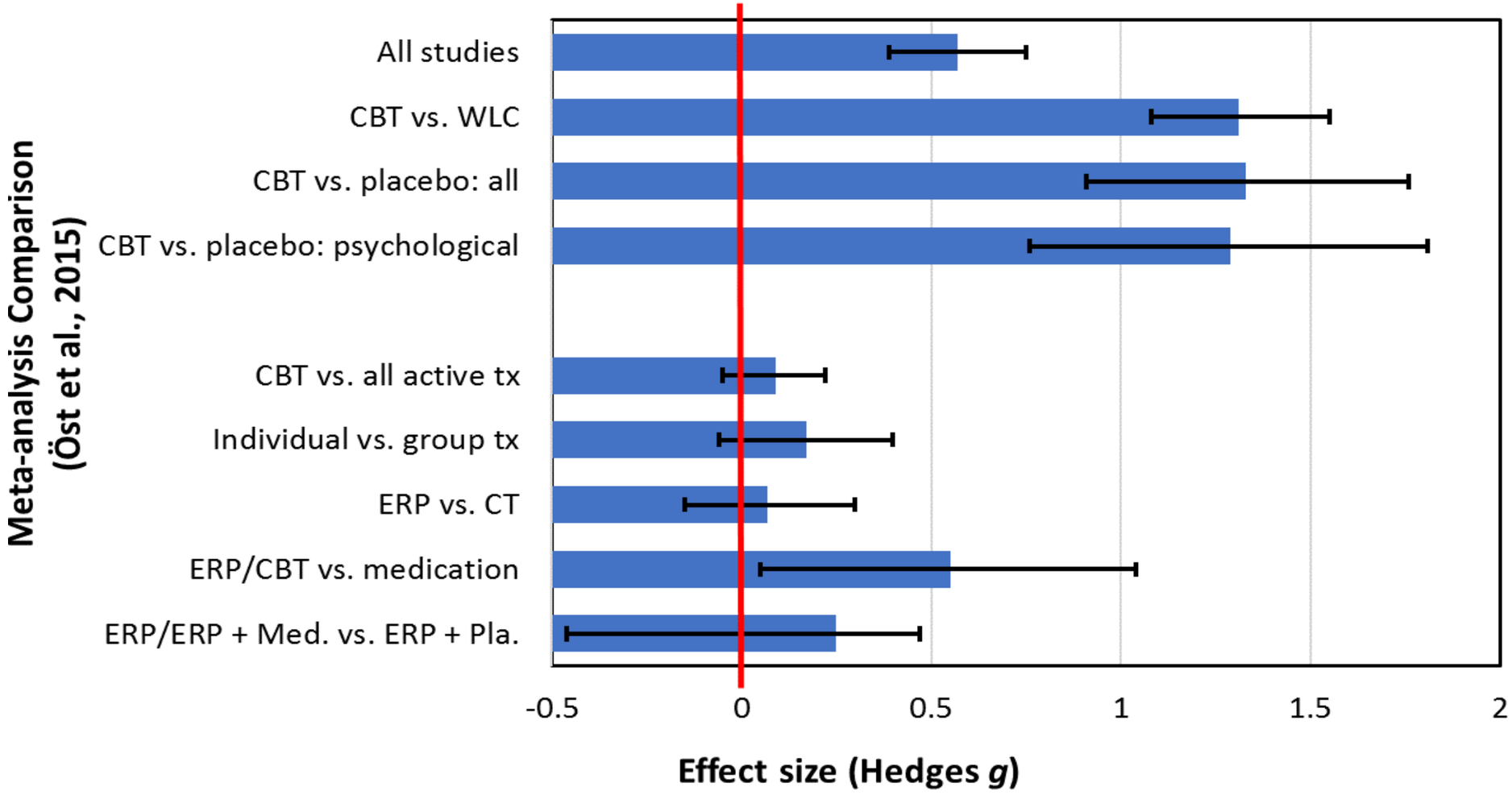

Öst et al. (2015)

CBT OUTCOMES FOR OCD

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	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

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PSYCHIATRY ACADEMY

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, $\chi2(1) = 8.95$, $p = .003$
- ✓ Improvement rates for CBT were marginally greater than BT, $\chi2(1) = 3.48$, $p = .06$
- ✓ 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

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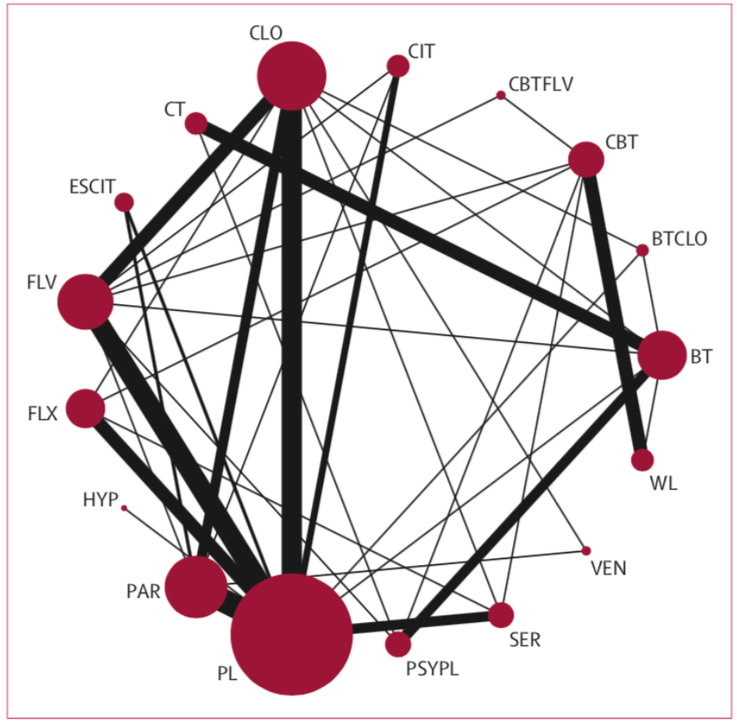

Figure 2: **Network diagram for efficacy analysis representing direct comparisons between individual treatments**

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)

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CONDUCTING CBT FOR OCD

TREATMENT STRUCTURE

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1 Assessment/Goal Setting/Psychoeducation

2 Enhancing Motivation

3 Cognitive Interventions, Mindfulness

4 Exposure & Ritual Prevention (ERP)

5 Relapse Prevention

TREATMENT DURATION

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Varies, depends on severity, ~12-22 sessions

Booster sessions after treatment has ended

Fade the frequency of booster sessions slowly

HOMEWORK

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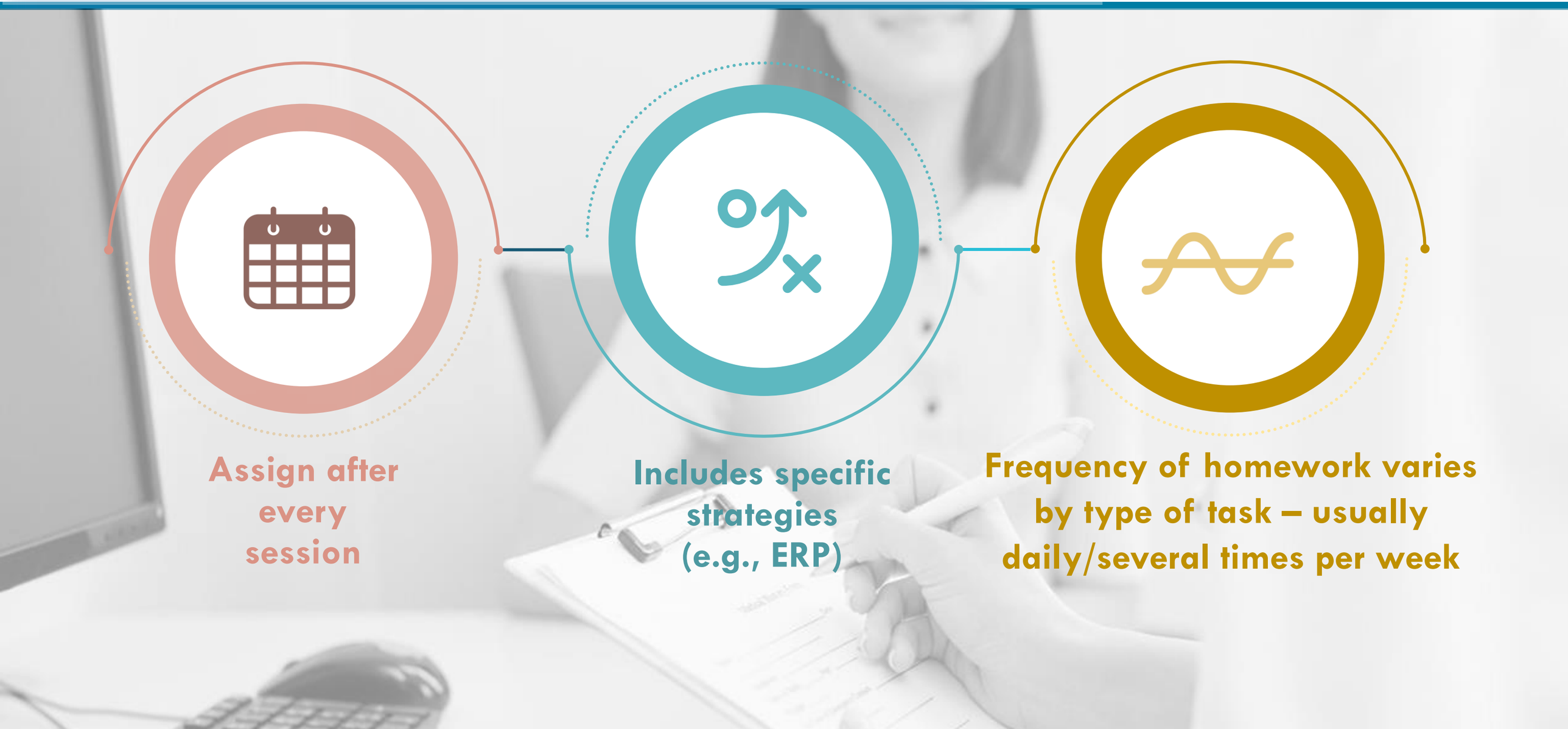

Assign after every session

Includes specific strategies (e.g., ERP)

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

OCD ASSESSMENT

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- Current OCD triggers and related obsessions
- Rituals, avoidance and other strategies to neutralize painful experience
- Feared consequences if patient does not neutralize
- Circumstances related to the onset of OCD
- History of OCD

OCD ASSESSMENT

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Cultural context/religious upbringing and current religious beliefs/practices In relationship to OCD

Traumatic experiences, if any

Family history of OCD and other psychiatric problems

Patient's explanation for the cause of OCD (often based on strategies that are no longer adaptive)

OCD ASSESSMENT

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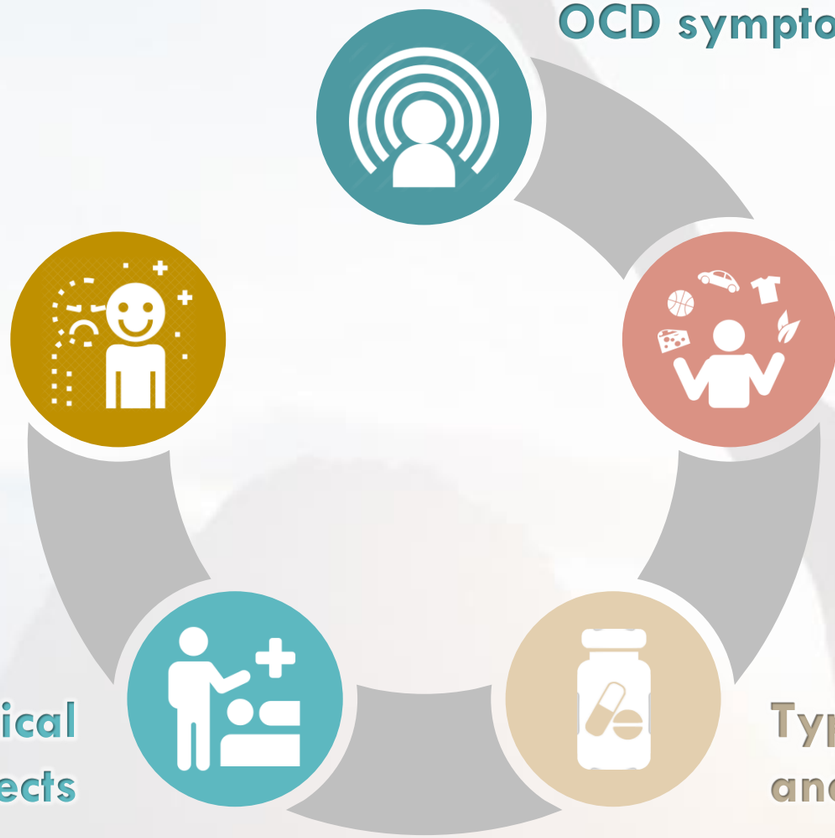
Comorbid conditions, including influence on OCD symptoms & associated beliefs

Impairment related to the OCD (daily routine, family & social life, employment)

Type, dosage & effects of current and past medications

Previous psychological treatment and effects

Coping strategies for OCD symptoms



OCD ASSESSMENT

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Motivation/readiness for change
(rewards associated with making a life change/perceived obstacles)

Goals/how can treatment aim at increasing valued life activities
(intimate relationship, career, spirituality)

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

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TRIGGER

INTRUSIVE THOUGHTS

Mindfulness Skills /Education

MALADAPTIVE INTERPRETATIONS

Monitoring, Metaphors, Cognitive Restructuring, Behavioral Experiments

NEGATIVE EMOTIONS
(e.g., Anxiety, Shame, Depression)

Emotion Regulation Skills
(e.g., Activity Scheduling)

MALADAPTIVE COPING STRATEGIES
Rituals, Avoidance

ERP, Behavioral Experiments

SESSION 3

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Use Cognitive Therapy Strategies Flexibly

THOUGHT FORM

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Name: Date:

Situation/ Trigger	**Intrusive Thought**	**Interpretation** a)write interpretation b)write belief in interpretation (0-100%)	**Emotion** a) specify emotions b) write strength of emotion (0-100%)	**Compulsions/ Avoidance** a) compulsive urge (0-100) b) what rituals or avoidance did you do?
Holding my baby	I am going to smash her head against the wall	If I am thinking that I might smash her head, I'm going to do it (90%)	anxious (85)	Urge (100) Gave baby to husband right away

SOCRATIC DIALOGUE

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SHOW	Curiosity about patient's thinking
ASK	Ask questions
FOLLOW	The patient's logic ("do you mean that if X, then…?")
ASK ABOUT	Logical inconsistencies ("so if that were true, then…?")
BE	Collaborative, exploratory, patient
AVOID	Arguing

THOUGHT FORM

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PSYCHIATRY ACADEMY

Name: _____ Date

Situation/ Trigger	**Intrusion**	**Interpretation** a) write interpretation b) rate belief in interpretation (0-100%)	**Emotion** a) specify emotions b) write strength of emotion (0-100%)	**Compulsions/ Avoidance** a) rate urge to neutralize or avoid (0-100) b) specify rituals or avoidance	**Rational Response** a) write rational response to interpretation b) rate belief in rational response (0-100)	**Outcome** a) re-rate interpretation (0-100) b) specify and rate subsequent emotions (0-100)
Holding my baby	I am going to smash her head against the wall	If I am thinking that I might smash her head, I'm going to do it (90%)	anxious (85%)	urge (100) Gave baby to husband right away.	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 (70%)	a) 35 b) anxious (20%)

Adapted from J. Beck (1995)

ACCEPTANCE OF INTRUSIVE THOUGHTS

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Examples

Clouds in the sky

Leaves Floating down the river

Fish swimming in the ocean

Wiley Coyote And train tracks

Allow the train to arrive & leave the station

INTEGRATING CT AND ERP

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STEP 1

START
With CT

STEP 2

MOVE
On to ERP

STEP 3

COMBINE
both in session/at home

EXPOSURE & RESPONSE PREVENTION

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TRIGGERS

Identify triggers for anxiety/avoidance behavior (people, places, situations)

RITUALS

Identify rituals (times, frequency)

DESIGN

Design ERP hierarchy (but don't get too focused on working your way up in a step by step fashion)

CONDUCT

Conduct ERP

EXPLAIN HOW EXPOSURE WORKS

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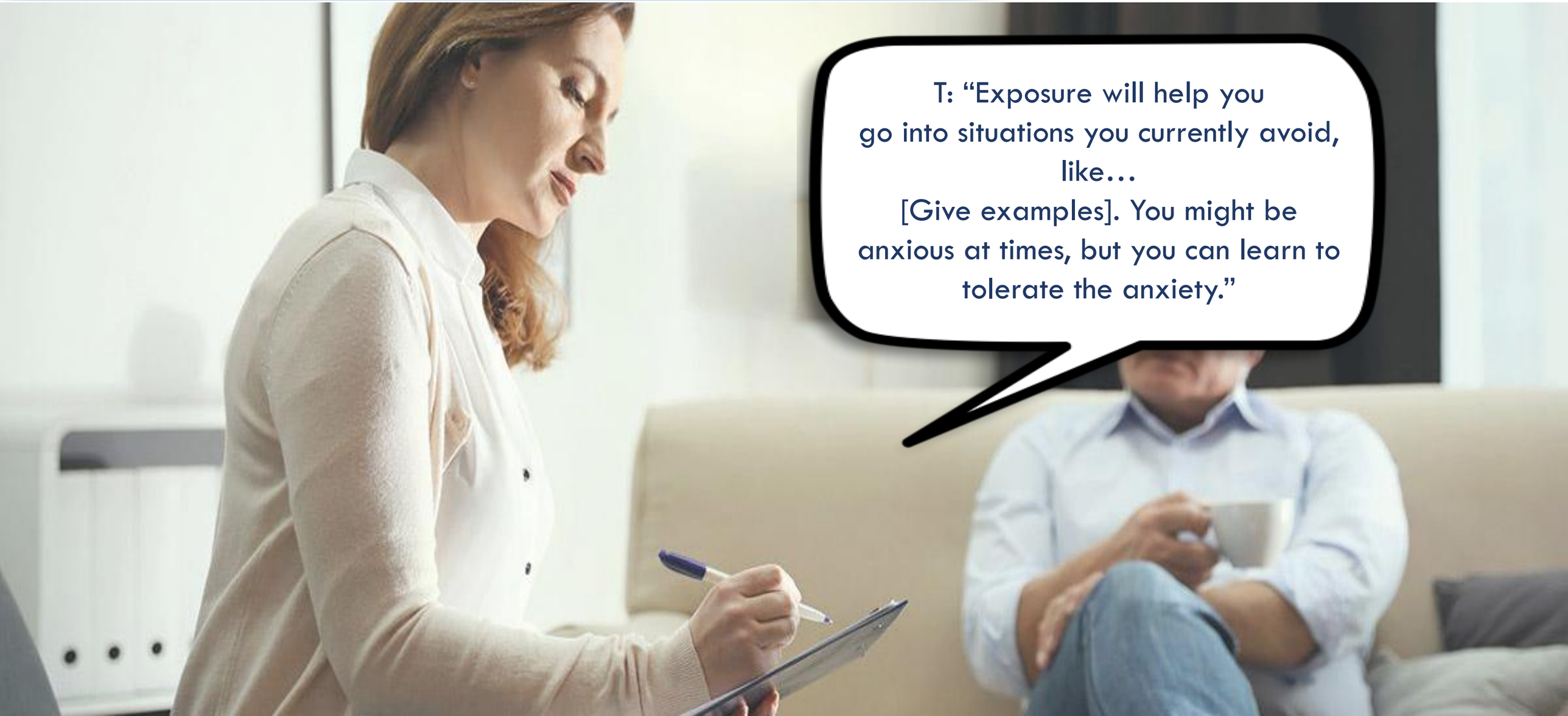

EXPLAIN HOW EXPOSURE WORKS

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TROUBLESHOOTING

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Motivate Your Patient To Tolerate The Anxiety

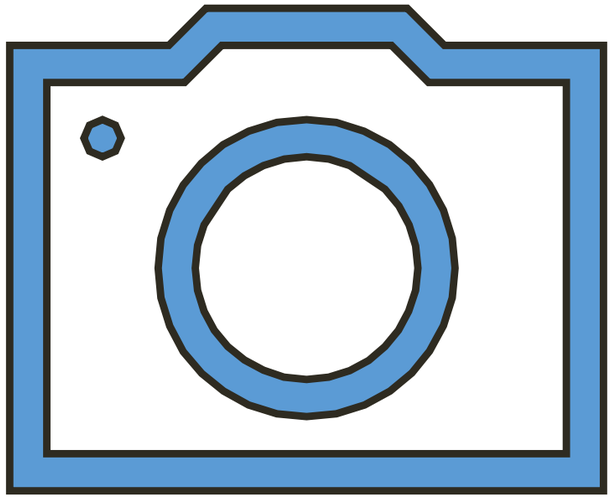
1. Discuss the short-term and the long-term consequences of avoidance

2. Discuss reinforcement circuits as shown in the patient's CBT model.

3. Review the costs* and the benefits that come along with reducing avoidance.

* How It Robs The Patient Of Enjoyment Or Achieving Things

Exposure Situations



SARAH - CONTAMINATION

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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

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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

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1. Stimulus control
   (Making it difficult for the ritual to occur)
2. Selective ritual prevention
   (Picking your battles)
3. Restricting your rituals
   (Watching the clock)
4. Postponing a ritual
   (When procrastination is a good thing)
5. Using competing actions

SONJA - HARMING

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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

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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

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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

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For The First Exposure

Begin with exposure to situations that provoke distress & avoidance ratings near 40.

Make patient an active participant in deciding on ERP.

BEHAVIORAL EXPERIMENTS

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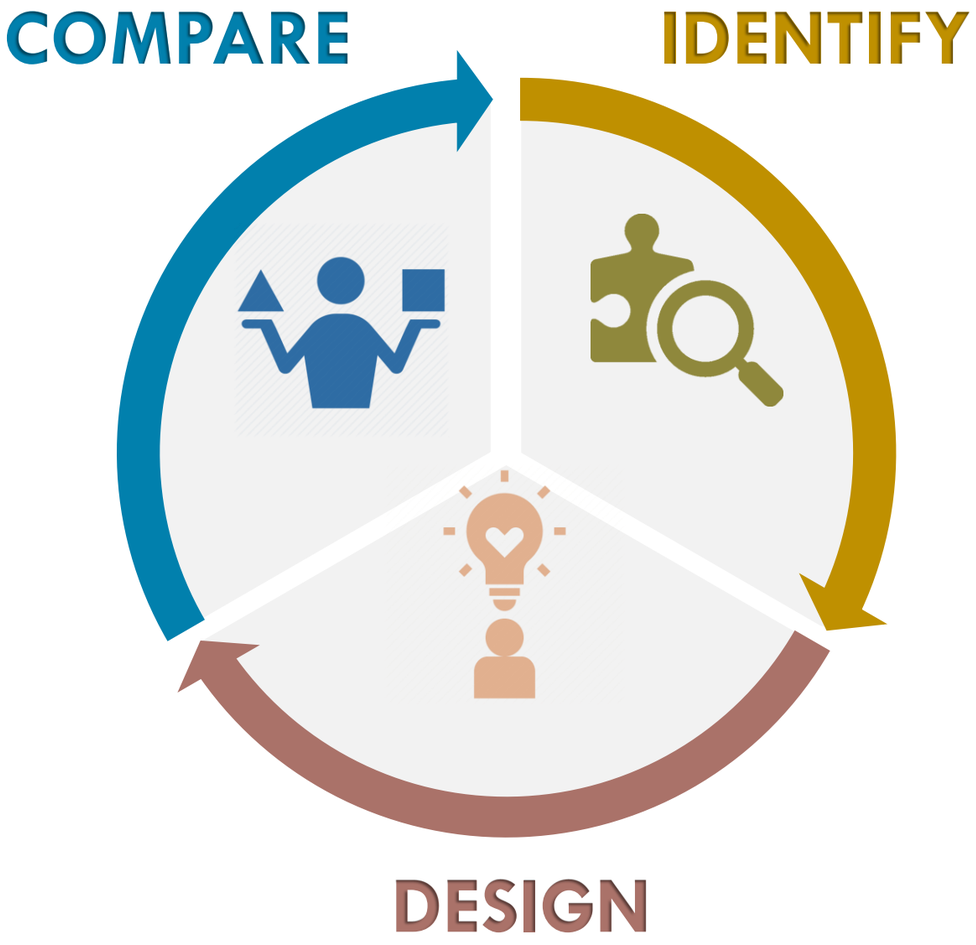

Design

An experiment to test validity of hypothesis

e.g., " I will show signs of illness in the upcoming week if I touch this doorknob"
"My bad thoughts can harm others"

Compare

Feared and actual consequences

Identify

What you learned from experiment

MOVING FORWARD

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PRACTICE

Exposures and Ritual Prevention daily

WORK ON

Increasingly challenging ERPs

BE

Creative, leave office, change context

SHIFT

Responsibility for designing ERP's gradually to patient (parents)

THINGS TO REMEMBER

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Patients may feel anxious, disgusted or "not right"

It's okay for the patient to feel anxious during ERP

Patient should conduct some exposures by him/herself

Watch out for subtle avoidance strategies & mental rituals

ACTIVITY SCHEDULING

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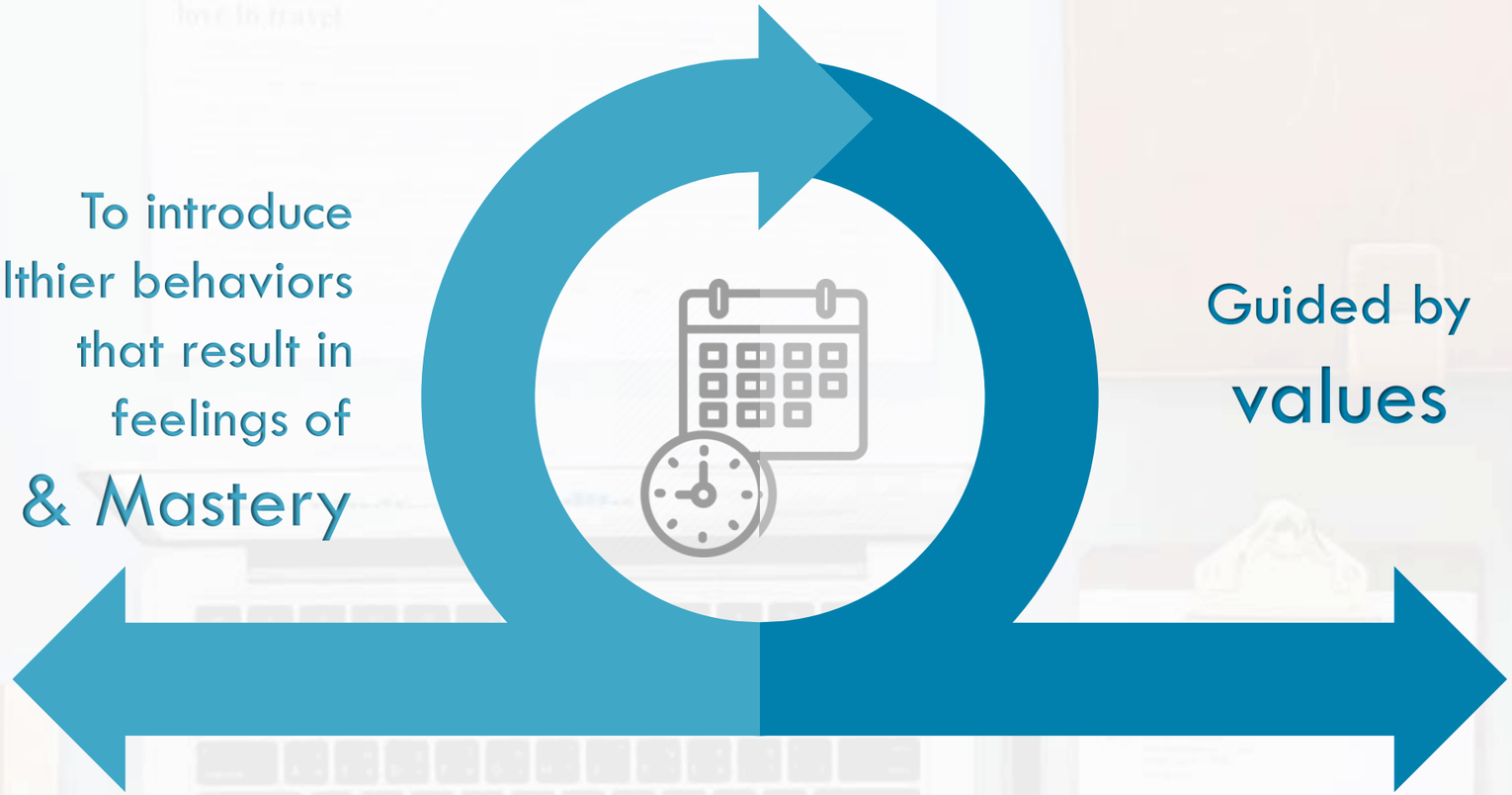
To introduce healthier behaviors that result in feelings of

Pleasure & Mastery



Guided by

values

CBT FOR OCD IN THE TIME OF COVID-19

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Image courtesy of NPR

COVID-19 & CONTAMINATION CONCERNS

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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, INTERNET USAGE, & NEWS CONSUMPTION

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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, At Johns Hopkins Center for Health Security)

Avoid "learning everything" and encourage patients to stick to the time and frequency limits on news that you both have agreed on.

RELAPSE PREVENTION

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Residual problems are addressed

Decrease session frequency

Schedule self-sessions/ patient as therapist

Review CBT techniques with handouts

Schedule booster sessions

RELAPSE PREVENTION

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Plan time without symptoms/ activity scheduling

Learn to differentiate between lapses & relapses; counter negative thoughts about setbacks; and handle lapses & setbacks

Unrealistically optimistic or pessimistic thoughts about treatment termination are evaluated

Anticipate possible symptom recurrence & its relationship to stress, mood & other variables

OCD THERAPY MANUALS

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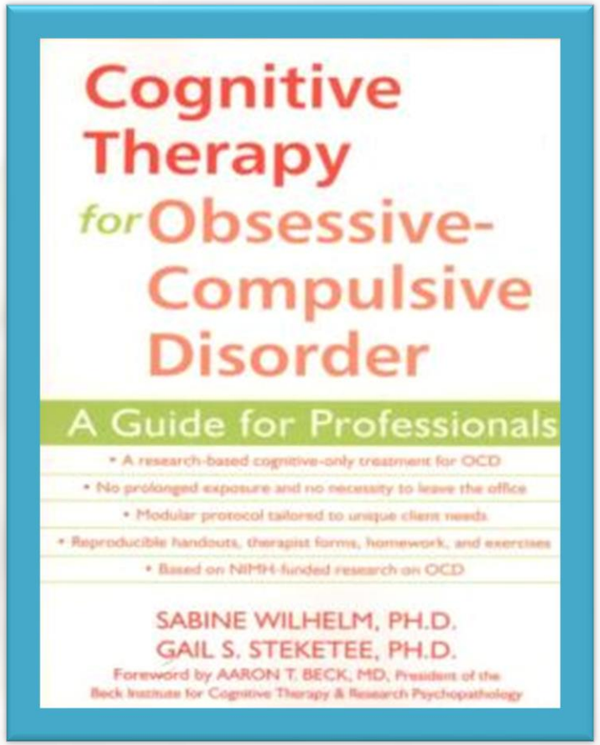

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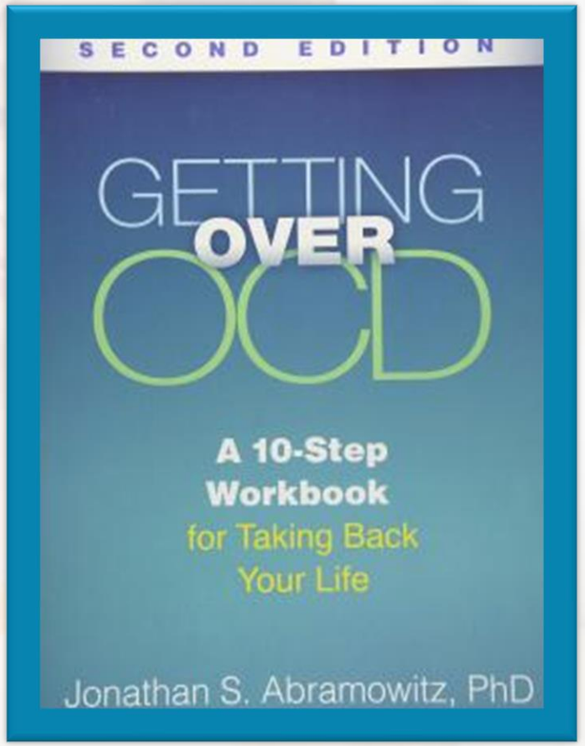

Abramowitz, J. S. (2018). Getting Over OCD, Second Edition: A 10-Step Workbook for Taking Back Your Life. The Guilford Self-Help Workbook Series

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

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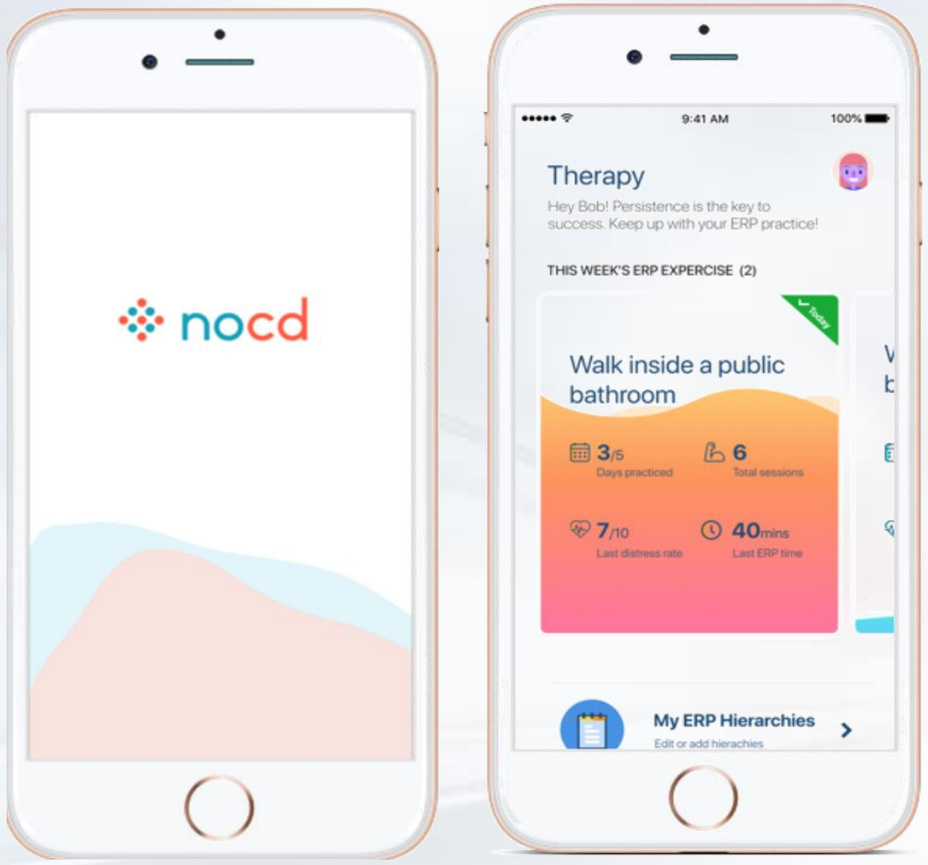

Images Courtesy Of nocd's Website (www.treatmyocd.com)

Addresses some barriers to in-person ERP/CBT
(e.g., accessibility)

NOCD Therapy includes video-based OCD therapy and in-between session support

Outcome tracking and treatment is personalized to the patient's goals & symptoms

INTERNET-BASED COGNITIVE BEHAVIOR THERAPY FOR OCD: RANDOMIZED CONTROLLED TRIALS

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	Andersson et al., 2012	Kyrios et al., 2018	Mahoney et al., 2014	Wootton et al., 2019
Sample	101 participants with a primary diagnosis of OCD.	179 participants with a primary diagnosis of OCD.	67 participants reporting significant symptoms of OCD on the DOCS.	140 participants scoring ≥ 7 on one subscale of DOCS and ≥ 14 on YBOCS.
Method	Therapist-assisted iCBT vs. online non-directive supportive therapy.	Therapist-assisted iCBT vs. therapist-assisted internet-based standard progressive relaxation training (iPRT).	Technician-administered iCBT vs. treatment as usual control group.	Self-guided iCBT vs. waitlist control group.
Results	**60% of iCBT showed clinically significant improvement at post-treatment** as compared to 6% in CC. Persistent at follow-up.	Pre-post improvements in both conditions; however, **iCBT superior for reliable and clinically significant changes** (symptom severity Cohen d: iCBT = 1.05, iPRT= 0.48).	**54% of iCBT dropped to non-clinical range by post-treatment** as compared to 17% in treatment as usual. Persistent at follow-up.	**27% in iCBT showed clinically significant change at post-treatment** as compared to 1% in the waitlist. Persistent at follow-up.

APP-BASED CBT COMPARED TO IN-PERSON CBT

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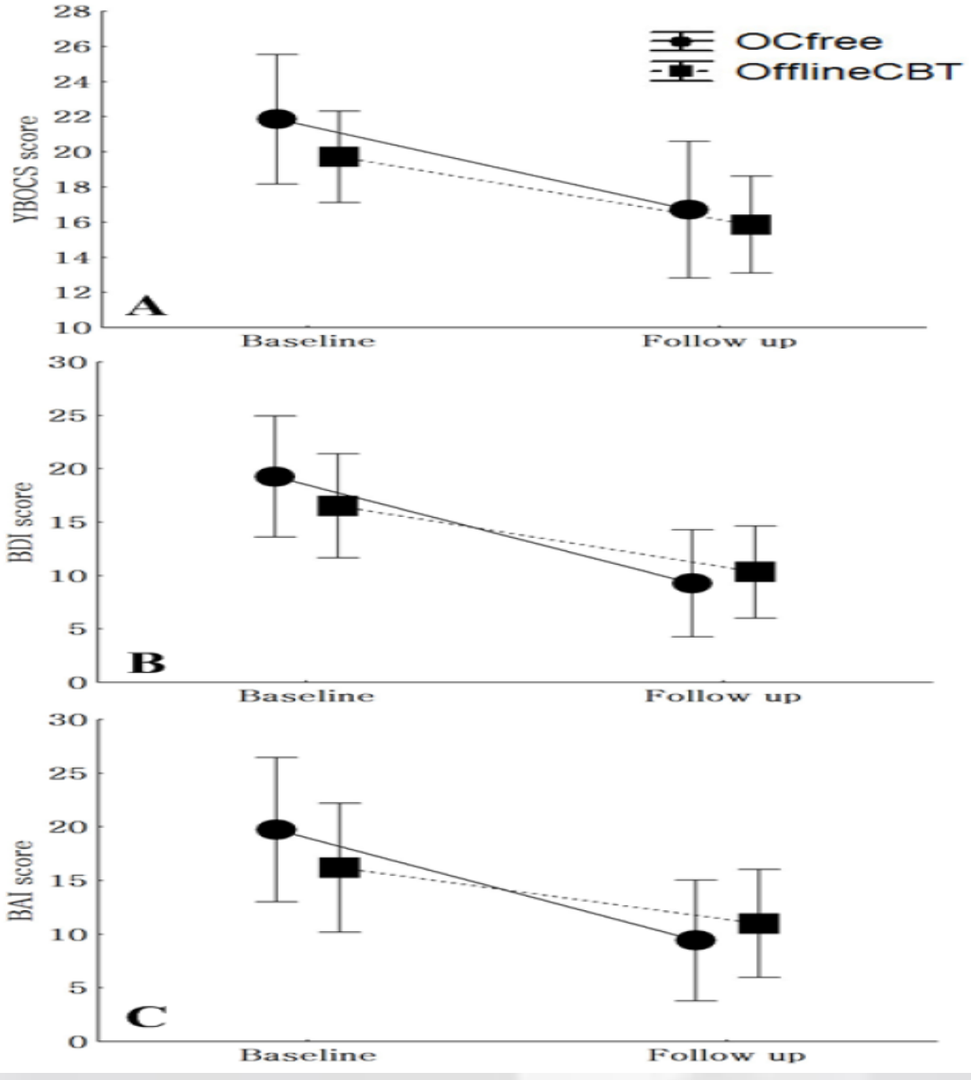
Figure 2. Comparisons of the changes of (A) Y-BOCS, (B) BDI, and (C) BAI scores between the offline CBT group and OCfree group. BAI: Beck Anxiety Inventory. BDI: Beck Depression Inventory. CBT: cognitive behavior therapy. Y-BOCS: Yale-Brown Obsessive Compulsive Scale.



Hwang et al. (2012)

PAIRING APP-BASED ERP WITH IN-PERSON CBT

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Gershkovich et al. (2021)

Table 2
Observed Outcomes for Clinical Measures

Measure	Baseline ($n = 33$)		Week 4			Week 8			Week 16		
	M	*SD*	*n*	*M*	*SD*	*n*	*M*	*SD*	*n*	*M*	*SD*
Y-BOCS	22.85	4.47	30	16.73	4.43	27	13.96	5.45	20	15.80	6.33
HAM-D	6.21	4.21	30	4.17	3.14	27	4.29	4.54	20	5.65	4.68
QLESQ-SF	48.76	6.29	27	50.48	7.40	25	51.84	7.38	18	51.83	7.82

Note. Y-BOCS = Yale-Brown Obsessive Compulsive Scale; HAM-D = Hamilton Depression Rating Scale; QLESQ-SF = Quality of Life Enjoyment and Satisfaction Questionnaire-Short Form.

8 weeks of Brief Exposure and Response Prevention Assisted by Mobile app (BEAM) with 2-month follow-up

3-5 sessions (90 min) of face-to-face EX/RP + mobile app EX/RP + 5 weekly phone calls

42% responded to treatment (Y-BOCS decreased ≥35%). At follow-up 35% met criteria for treatment response and 15% met for treatment remission

More research needs to be done to evaluate the efficacy of integrated treatment platforms for cognitive behavior therapies for OCD

ONLINE COURSES

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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 Body Dysmorphic Disorder

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

CBT for OCD in Children & Adolescents

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

CBT & 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.

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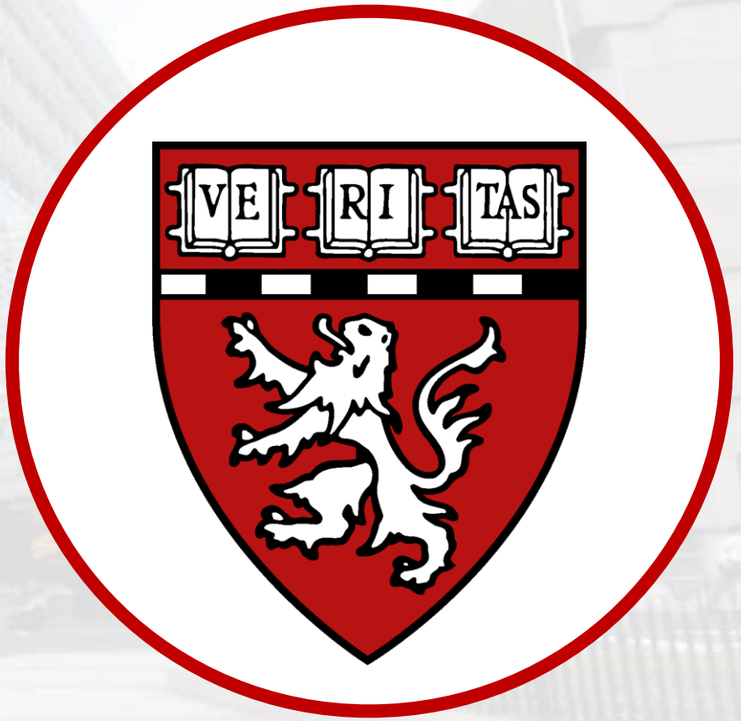

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