

Psychological treatment of obsessive–compulsive disorder

Paul M Salkovskis

Abstract

NICE guidelines recommend psychological treatment (cognitive–behavioural therapy, involving major elements of exposure and response prevention) as the first-line treatment for obsessive compulsive–disorder (OCD). In this contribution, the theory and practice of integrated cognitive–behavioural therapy is described. The use of normalizing strategies and re-appraisal of beliefs motivating compulsive behaviour are emphasized as ways of enabling patients to choose to change. Developments in terms of dissemination and delivery are considered.

Keywords cognitive–behaviour therapy; cognitive models; dissemination of psychological treatments; obsessive–compulsive disorder; OCD; treatment integrity

The psychological treatment of obsessive–compulsive disorder (OCD) is highly effective only when it takes the form of behaviour therapy or cognitive–behavioural therapy (CBT). Such treatment is closely linked to learning and cognitive–behavioural theories of the maintenance of OCD. The first published description of CBT came in 1966 from Meyer, in case series described as the ‘modification of expectations in cases with obsessional rituals’.¹ This work led to the treatment now known as exposure and response prevention,² and ultimately to cognitive–behavioural treatments.

Cognitive–behavioural understanding of obsessions

Salkovskis described a cognitive–behavioural approach to the understanding and treatment of obsessional problems,³ building on behavioural theories and treatment.^{4–8} In this approach, obsessions are conceptualized as normal intrusive thoughts, which the sufferer misinterprets as a sign that harm to themselves or to others is a serious risk and that they are responsible for such harm (or its prevention). This interpretation has several effects, such as:

- increased discomfort, including (but not confined to) anxiety and depression
- the focusing of attention both on the intrusions themselves and triggers in the environment that may increase their occurrence

Paul M Salkovskis MPhil FBPSS is Professor of Clinical Psychology and Applied Science at the Institute of Psychiatry, London, UK, and Clinical Director of the Centre for Anxiety Disorders and Trauma, London. His research interests include anxiety disorders, health psychology and communication/ethics. Conflicts of interest: none declared.

- increased accessibility to and preoccupation with the original thought and other related ideas
- behavioural responses, including ‘neutralizing’ reactions in which the person seeks to reduce or escape responsibility (such behaviours can be overt or covert).

The inflated sense of responsibility that the sufferer attaches to his or her activities leads them into a pattern of mental and behavioural effort characterized by both over-control and pre-occupation. (Figure 1 shows this cognitive–behavioural model of the development and maintenance of obsessional problems.) Efforts at over-control increase distress for a number of reasons.

- Direct and deliberate attention to mental activity can modify the contents of consciousness.
- Efforts to deliberately control a range of mental activities apparently and actually result in failure and even in opposite effects.
- Attempts to prevent harm and responsibility for harm increase the salience and accessibility of the patients’ concerns with harm, neutralizing efforts directed at preventing harm.

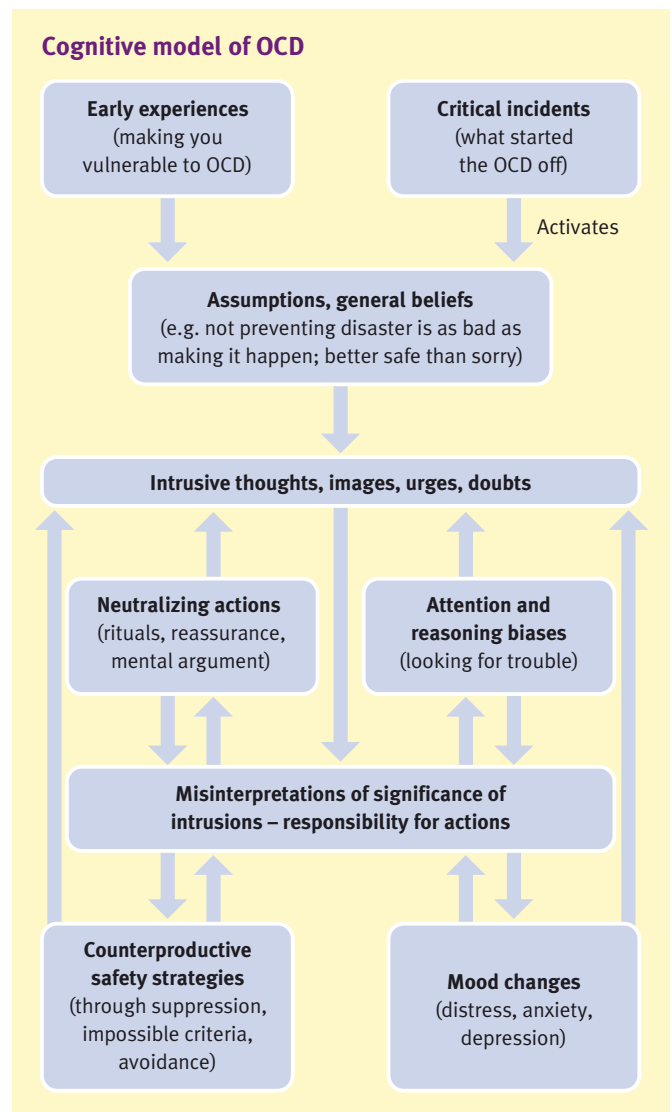


Figure 1

Modifying beliefs

Treatment requires modification of the beliefs involved in and leading to the misinterpretation of intrusive thoughts as indicating heightened responsibility, and of the associated behaviours involved in the maintenance of these beliefs. Obsessional patients are distressed because they have a particularly threatening perception of their obsessional experience; for example, that their thoughts mean that they are a child molester, or that they are in constant danger of passing disease on to other people. The essence of treatment is helping the sufferer to construct and test a new, less threatening model of their experience.

Specific elements of treatment

The treatment protocol specifies a number of stages of treatment, allowing flexibility of application.

- Working with patients to develop a comprehensive cognitive-behavioural model of the maintenance of their obsessional problems as an alternative to the fears that they have.
- Detailed identification and self-monitoring of obsessional thoughts, and patients' appraisal of them, combined with strategies designed to help modify their beliefs about responsibility.
- Discussion techniques and behavioural experiments intended to challenge negative appraisals and the basic assumptions on which these are based. The aim is modification of the patient's negative beliefs about the extent of their own personal responsibility (e.g. by asking the patient to describe all contributing factors for a feared outcome and then dividing the contributions in a pie chart).
- Behavioural experiments to directly test appraisals, assumptions and processes hypothesized to be involved in the patient's obsessional problems (e.g. demonstrating that attempts to suppress a thought lead to an increase in the frequency with which it occurs, or showing that beliefs such as 'if I think it, I must want it to happen' are incorrect). Each behavioural experiment is idiosyncratically devised in order to help the patient test their previous (threatening) explanation of their experience against the new (non-threatening) explanation worked out with their therapist.
- Helping patients to identify and modify underlying general assumptions (such as 'not trying to prevent harm is as bad as making it happen deliberately') which give rise to their misinterpretation of their own mental activity.

Exposure and response prevention strategies (see below) are used to help the patient discover the way in which neutralizing

behaviour acts to maintain their beliefs and the associated discomfort, and discover that stopping such behaviours is beneficial.

Assessment

Careful questioning and discussion about a particular episode is used to identify the particular intrusion (thought, image, impulse or doubt) and the significance that the person attached to it (i.e. the way the intrusion was interpreted/appraised). The therapist then helps the patient focus on the way their particular interpretation, at the time in question, resulted in both distress and the desire (compulsion) to prevent or put right any possible harm that the patient has foreseen. Thus, discussion helps the patient and therapist identify the specific sequence as shown in [Figure 2](#).

Changing the way intrusions are interpreted by normalizing them

Given that the focus of treatment is on helping the patient to adopt and test an alternative, less threatening explanation of their problems, most therapy techniques focus on reappraisal. A key component of this is 'normalizing' the experience of intrusions, helping the patient to change their understanding of the significance of the occurrence and content of intrusions. Guided discovery is used to help patients consider several important questions:

- who has obsessional thoughts?
- how common are intrusive thoughts?
- do they occur only in people suffering from OCD?
- why are intrusions so common?
- are they of any use?

Understanding and testing counterproductive strategies

Having worked on de-catastrophizing the occurrence and content of intrusions, the therapist then helps the patient understand and deal with responses that are involved in the maintenance of their negative beliefs. This is done through interwoven discussion and behavioural experiments designed to help the patient gather further evidence for the way in which the mechanisms identified affect them and the effects of stopping their counterproductive behaviours. For example, the patient may be asked to consider what usually happens to someone who tries to avoid thinking about something that is important to them. Have they themselves ever had the experience of trying not to think of something? Could they try now, in the office, not to think of giraffes? What happens? Why would trying not to think of something make this thing come to mind more, both now and later?

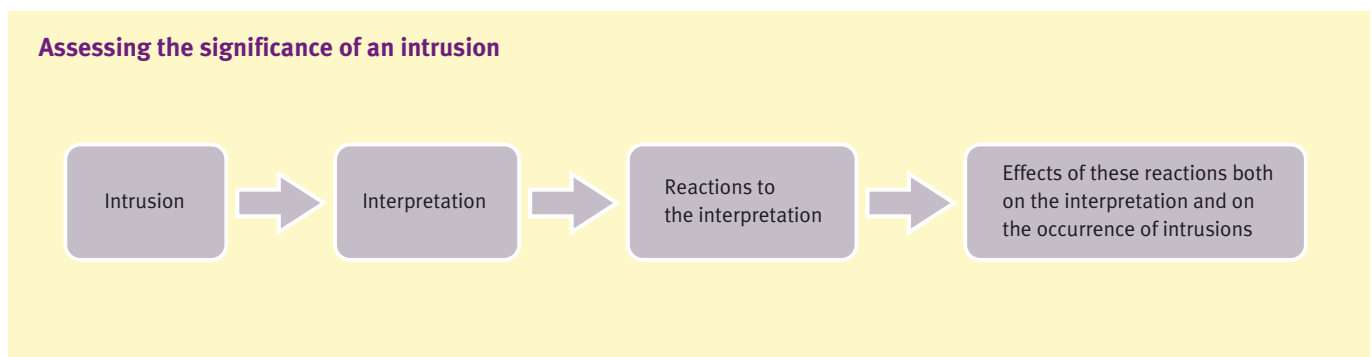


Figure 2

Follow-up homework experiments involving an alternating treatments experimental design can be helpful in gathering further evidence for the importance of the paradoxical effects of thought suppression. The patient keeps a daily diary of intrusive thoughts, and also records the amount of effort they put into suppression in the course of the day. They are then asked to try very hard to get rid of their intrusions by suppressing them on some days (e.g. Monday, Wednesday, Friday and Sunday), and to simply record the occurrence of thoughts, without making any special attempts at suppression, on the other days. The frequency of intrusions is plotted on a graph, with the two types of days interspersed. Figure 3 shows an example from an actual patient. This patient recorded their intrusions in a diary for a week, then alternated suppression/recording for a further week. Ratings of suppression were also recorded, and indicated that the patient had indeed suppressed more on the days when instructed to do this. The thought-frequency information was then plotted. The patient was shown their graph, and asked what they made of the results as a step towards helping them to stop any efforts to resist, suppress or neutralize their intrusions.

Exposure and behavioural experiments

Early in the course of CBT, the notion of exposure and response prevention (ERP) is introduced and a more planned and detailed programme initiated.⁹ Such a programme is discussed with the patient as the logical extension of the previous strategies for belief change, with an appropriate combination of explicit aims, as follows.

- To deal with compulsive/neutralizing behaviours as a factor that is particularly important in the maintenance of their negative beliefs.
- As a way of demonstrating that the formulation is indeed correct, as it predicts that reducing neutralizing behaviour will result in decreases both in anxiety and in negative beliefs.

- As a confrontation and disconfirmation of their negative expectancies where appropriate (i.e. to help the person to discover that their feared consequences do not occur when they stop their safety-seeking behaviours when such disconfirmation is possible).
- To begin the process of regaining control over those aspects of their life that have come to be dominated by compulsive and neutralizing behaviour; that is, to deal with compulsive behaviour as a problem rather than as a way of preventing harm.

Carrying out exposure tasks

Exposure tasks are planned and set up with the explicit aim of bringing about such belief changes. Early on, therapist-aided tasks are used to reveal and begin the process of challenging the negative appraisals activated by the person not neutralizing. Discussion after the task is completed is used to consolidate and extend such belief change, particularly with respect to the patient’s perception of the alternative account of their problems.

The importance of patients assuming responsibility for their own actions (rather than simply complying with the suggestions made by the therapist) is emphasized. This is best achieved by the therapist modelling exposure exercises in the early stages, before rapidly moving to having the patient do things without modelling, then having the patient assume the role of identifying and planning exposure exercises themselves. Subsequently, the patient is asked to plan and execute exposure tasks and to describe their responses without describing the task itself. Doing this removes the reassurance involved in having the therapist know about the details of the task undertaken by the patient.

Challenging assumptions

The use of techniques such as the downward arrow is tailored to the specific appraisals the person makes, which can be of the occurrence or the content of the intrusion, or both.¹⁰ Figure 4 shows a previously published version of the downward arrow,

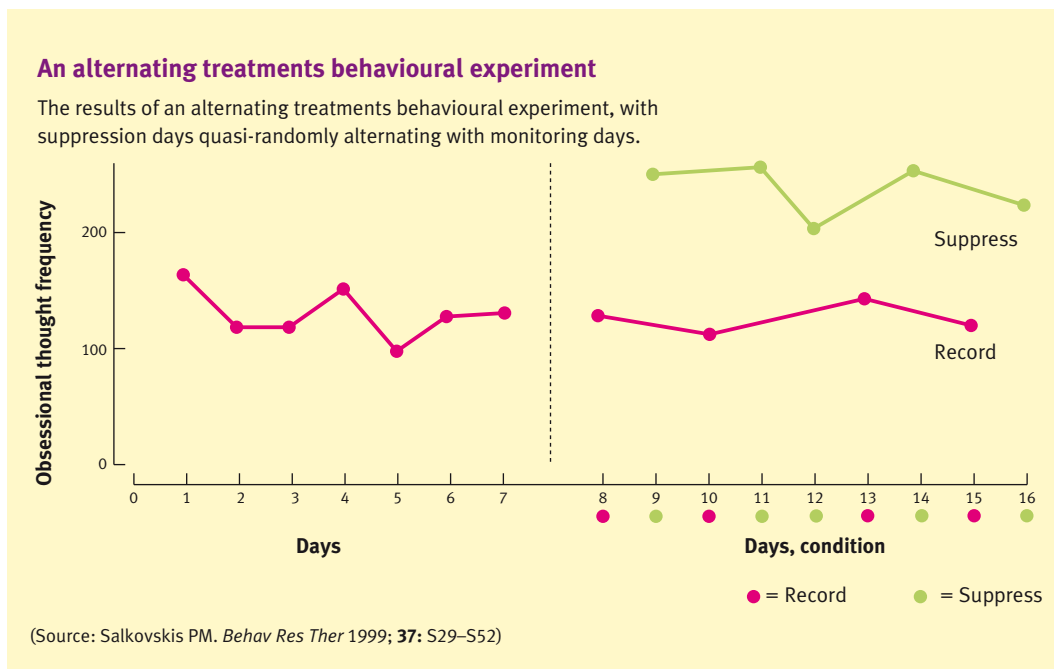


Figure 3

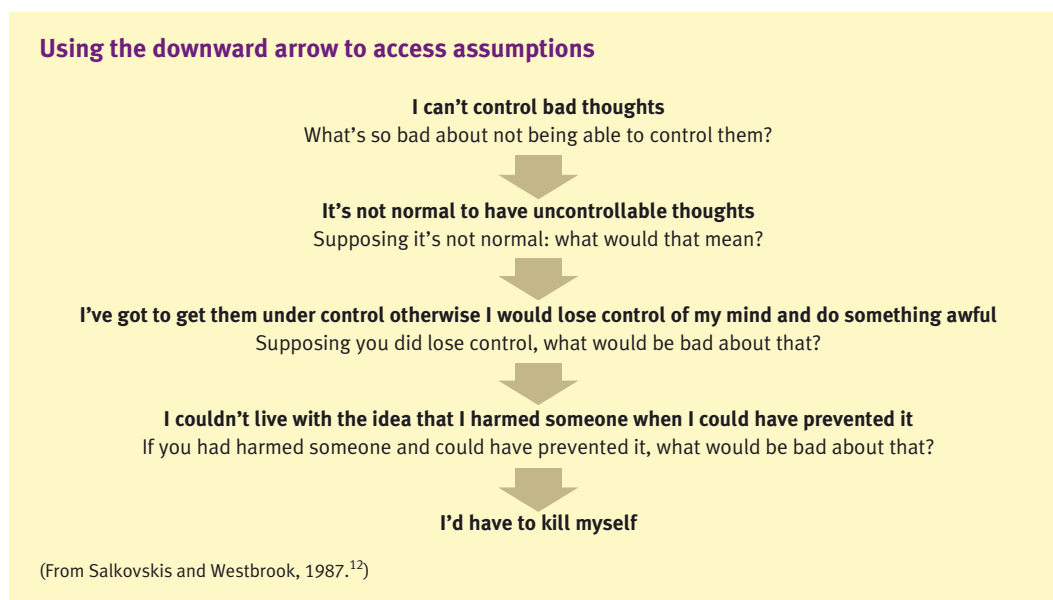


Figure 4

in which both the occurrence and content of the intrusions form the focus.¹¹

Therapy should aim to help the patient to understand the way in which an apparently innocuous thought can evoke so much discomfort and challenge the assumptions at each level. Having identified key assumptions on the basis of downward arrows and specific questionnaires such as the Responsibility Attitudes Scale,¹² therapy should seek to modify these more directly.

Effectiveness of cognitive-behavioural strategies

The effectiveness of ERP in OCD patients with a major component of ritualizing is well established: meta-analyses indicate that ERP is as effective as or more effective than treatment with serotonin-active antidepressant medication.¹³ Cognitive treatment without the incorporation of exposure is at least as effective as behavioural treatment.¹⁴ It has also been shown to be as effective as a combination of cognitive treatment with fluvoxamine or behavioural treatment with fluvoxamine.¹⁵ A number of studies are now comparing CBT with behaviour therapy; the results will help us to understand the relative contribution of explicit cognitive elements in CBT.

As dissemination of CBT becomes more of an issue, the issue of dilution of treatment integrity becomes increasingly important. For example, a UK-based study showed that although many patients with OCD were initially offered CBT rather than other treatments (43%), their recollection of what had been done during such treatment suggested that some therapists may 'badge' poor quality treatment as 'CBT' despite apparent discrepancies suggesting that this was 'not CBT as we know it'.¹⁶

Integrated CBT has been found to be effective in the treatment of obsessional ruminations when compared with a waiting-list control;¹⁷ research from the author's own group suggests that CBT is superior to an equally credible psychological control condition.

More recently, attention has turned to the delivery of CBT, with a growing interest in 'stepped care' – the idea being that patients are offered CBT-based psychological treatments at increasing levels of intensity. There is evidence that, for some

patients, receiving CBT guidance on the telephone is both helpful and highly economical.¹⁸ We await the results of work at the other end of the spectrum, where 'intensive treatments' are offered, compressing CBT normally delivered over a period of 3 months into 1 or 2 weeks. The idea is that, by doing this, patients can overcome practical barriers to attending treatment (e.g. by taking leave from work) and may gain 'momentum' in terms of their efforts to change their behaviour. ◆

REFERENCES

- 1 Meyer V. Modification of expectations in cases with obsessional rituals. *Behav Res Ther* 1966; **4**: 273–80.
- 2 Rachman SJ, Hodgson RJ. Obsessions and compulsions. Englewood Cliffs, NJ: Prentice Hall, 1980.
- 3 Salkovskis PM. Obsessional-compulsive problems: a cognitive-behavioural analysis. *Behav Res Ther* 1985; **23**: 571–83.
- 4 Clark DA, Purdon C. New perspectives for a cognitive theory of obsessions. *Aust Psychol* 1993; **28**: 161–67.
- 5 Freeston MH, Ladouceur R, Gagnon F, Thibodeau N. Beliefs about obsessional thoughts. *J Psychopathol Behav Assess* 1997; **15**: 1–21.
- 6 Rachman S. Obsessions, responsibility and guilt. *Behav Res Ther* 1993; **31**: 149–54.
- 7 Rachman S. A cognitive theory of obsessions. *Behav Res Ther* 1997; **35**: 793–802.
- 8 Rachman S. A cognitive theory of obsessions: elaborations. *Behav Res Ther* 1998; **36**: 385–401.
- 9 Salkovskis PM, Kirk J. Obsessional disorders. In: Hawton K, Salkovskis PM, Kirk J, Clark DM, eds. *Cognitive behaviour therapy for psychiatric problems: a practical guide*. Oxford: Oxford University Press, 1989.
- 10 Salkovskis PM, Richards HC, Forrester E. The relationship between obsessional problems and intrusive thoughts. *Behav Cogn Psychother* 1995; **23**: 281–99.
- 11 Salkovskis PM, Westbrook D. Obsessive-compulsive disorder: clinical strategies for improving behavioural treatments. In: Dent HR, ed.

- Clinical psychology: research and developments. London: Croom Helm, 1987.
- 12** Salkovskis PM, Wroe A, Gledhill A, et al. Responsibility attitudes and interpretations are characteristic of obsessive-compulsive disorder. *Behav Res Ther* 2000; **38**: 347–72.
- 13** Abel JL. Exposure with response prevention and serotonergic antidepressants in the treatment of obsessive compulsive disorder: a review and implications for interdisciplinary treatment. *Behav Res Ther* 1993; **31**: 463–78.
- 14** Van Oppen P, de Haan E, van Balkom AJLM, et al. Cognitive therapy and exposure *in vivo* in the treatment of obsessive compulsive disorder. *Behav Res Ther* 1994; **32**: 379–90.
- 15** Van Balkom AJLM, van Oppen P, Vermeulen AWA, et al. A meta-analysis on the treatment of obsessive–compulsive disorder: a comparison of antidepressants, behavior, and cognitive therapy. *Clin Psychol Rev* 1994; **14**: 359–81.
- 16** Stobie B, Taylor T, Quigley A, Ewing S, Salkovskis PM. ‘Contents may vary’: a pilot study of treatment histories of OCD patients. *Behav Cogn Psychother* 2007; **35**: 273–82.
- 17** Freeston MH, Ladouceur R, Gagnon F, et al. Cognitive-behavioral treatment of obsessive thoughts: a controlled study. *J Consult Clin Psychol* 1997; **65**: 405–13.
- 18** Lovell K, Cox D, Haddock G, Jones C, et al. Telephone administered cognitive behaviour therapy for treatment of obsessive compulsive disorder: randomised controlled non-inferiority trial. *Br Med J* 2006; **333**: 883.

Practice points

- Effective psychological treatment of OCD requires attention to both cognitive and behavioural aspects
- For some OCD patients, normalization and advice to cease neutralizing may be sufficient, but most require skilled treatment
- ‘Normalizing’ intrusions is important in reducing anxiety, as patients fear that their intrusions mean that they are bad or mad
- Relapse rate after treatment stops is very much lower in psychological treatment compared with pharmacological treatment