

Review Article

Cognitive Behaviour Therapy for Obsessive Compulsive Disorder**Savvas Milona, BNUR, MNUP**Mental Health Services Athalassa Hospital-Psychiatric Clinic Nicosia, Cyprus
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University of Athens, Greece**Correspondence:** Milona Savvas, Mental Health Services Athalassa Hospital-Psychiatric Clinic Athalassa Hospital, Nicosia, Cyprus E-mail: director.mhs@cytanet.com.cy**Abstract**

Introduction: Obsessive Compulsive Disorder (OCD) is a chronic psychiatric illness that includes obsessions and compulsions. It is a heterogeneous and intricate ailment described as the main cause for disability. Recycling of thoughts is one of the symptoms of this condition. Common obsessive behaviour patterns entail repeated check-ups, whose purpose is to “neutralize” the compulsions that relieve the individual. A person is usually aware of one’s excessive attitude. Psychological treatment routines are effective and Cognitive Behaviour Therapy (CBT) is often administered. Therapeutic Intervention is based on the concept that information processing is distorted when dealing with problematic situations.

Aim: The purpose of this dissertation is to find and present contemporary models of implementing CBT for OCD instances and their reporting, as well as the comparison of their effectiveness, in relation to other therapeutical interventions.

Methodology: The elaboration process of this study project is based on contemporary scientific articles and research essays. They have been sought in scientific journals, in recognised database sources, using keywords both in Greek and English. The scientific articles were selected from literature published during the last decade.

Results: Following detailed review of research projects studied during the preparation of this dissertation, quite a few surveys concerning the techniques applied by CBT in OCD were spotted and analyzed.

Conclusions: OCD comprises a serious, often chronic, psychiatric ailment, posing an imminent risk to people of any age group including boys, adolescent, adult men and women. This disorder is not curable. Instead, its degree can be limited, by administering medication, combined with various treatment techniques. There is a margin for further research, targeted at enhancing life quality standards for those individuals.

Key-words: Cognitive Behaviour Therapy, Obsessive Compulsive Disorder, compulsions, obsession, Cognitive Therapy, Behaviour Therapy.

Obsessive Compulsive Disorder

OCD is defined as repeated obsessions (de Alvarenga, Mastroiosa and do Rosario, 2012), causing evident anxiety or significant harm to an individual’s everyday functions (Karla and Swedo, 2009). It is a neuropsychiatric state,

namely a psychiatric exhausting illness or disorder.

It is characterised by persistent, disturbing, paranoid and unwanted thoughts, ideas, impulses, fears or images and urges (obsessions) and repeated and on-purpose painful behaviour

patterns or mental actions (compulsions), aiming at diminishing hardship (Krebs and Heyman, 2014; Seibell and Hollander, 2014; Goit and Ghimire, 2014).

Cognitive Behaviour Therapy

Verified medical and behavioural treatment courses are available to reduce the magnitude and the frequency of those obsessions and compulsions (Fenske & Schwenk, 2009).

The CBT is a realistic, therapeutic approach, orientated to action. It has become a widely-used means of treating several psychic disorders. (Wright, 2006). Abramowitz (2006) notes that CBT is the most effective form of therapy for OCD. The theoretical structure and basic method of applying CBT are outlined by Aaron Back in a series of articles published in 1960 (Wright, 2006).

The CBT Model

CBT is offered on the basis of combining two theoretical directions, included in the cognitive and classic behavioural theory. (Pallanti, 2008; Doron, 2009). It has been established as the single comprehensive therapeutic approach (Doron, 2009).

It is suggested that obsessions and compulsions arise from certain types of dysfunctional beliefs. The base is comprised of the findings of unwanted cognitive invasions experienced by most people among the general population (Doron, 2009) CBT in OCD requires that the customer tolerates anxiety to some extent.

This stage usually consists of the provision of general information in connection with OCD. The cognitive model being formed in psychological disorders is presented as the “triangle” of relations among thoughts, behaviour patterns, and the feelings involved (Doron, 2009).

Relationship between knowledge and behaviour

A bi-directional relationship between cognition and behaviour is observed. Cognitive procedures may affect behaviour and a change in behaviour may affect knowledge (Wright, 2006).

Cognitive techniques such as the examination of evidence details are used and on the basis of records, the examining process traces and alters non-adaptable knowledge. The therapist also, selects behavioural methods, so that long-

winded, elusive behaviour patterns are reversed, including exposure techniques (Wright, 2006).

The therapeutic intervention is based on the concept that in problematic situations, processing of information is distorted. Problematic behaviour is considered to be the result of erroneous learning, which is perpetuated by means of intensification. It is believed that psychopathological symptoms are the results of learning rates. (Seibell, and Hollander, 2014).

The Cognitive Basis

Cognitive Therapy (CT) puts emphasis on modifying dysfunctional beliefs and encourages new attitudes pertaining to external stimuli and situations (Mokmel, Neshat-Doost, Asgari, Abedi, 2013).

CT guides individuals to deal with obsessions with logical reasoning. Emphasis is put on the statistical possibility of the results of fear which is really happening (Brauer, Lewin and Storch, 2011). Cognitive interventions are used to “soften” distorted knowledge, that comprise the base of obsessive fears, thus creating the conditions for the patients to comply with the exposure procedures (Abramowitz, 2006).

The behavioural basis

It is especially necessary for patients whose condition is more serious, usually patients who are passive to external stimuli, socially withdrawn and are unable to concentrate for extended time periods (Boncher, 2009).

If the patient suffers from these symptoms, cognitive techniques on their own are not sufficient to bring about relief. Behavioural techniques are essential in such cases. It is possible that for sub-clinical cases cognitive methods are adequate, whereas, for more serious circumstances behaviour-pattern techniques are required in order to bring about relief (Boncher, 2009).

The CBT Objective

Initially, thoughts and thought mechanisms that are not realistic or they are problematic for a person, are defined and the ways in which they affect the person are determined. They assist the person to comprehend the way in which a given set of thoughts causes a problem and the examination of these thoughts follows.

The substitution of problematic thoughts by neutral or positive thoughts materializes over

time following the process of re-education (Abramowitz, Taylor, McKay, 2009).

Motivational Interviewing (MI)

MI is a method of reducing patients' ambivalence and supports their self-efficiency in their endeavours to change behaviour patterns (Merlo, Storch, Lehmkuhl, Jacob, Murphy, Goodman and Geffken, 2010; Meyer, Fernanda, Heldt, Knapp and Cordioli, 2010).

MI is used as a supplement to CBT, according to the above mentioned authors. In contrast to the abovementioned viewpoint, Simpson, Zuckoff, Maher, Page, Franklin, Foa, Schmidt and Want (2010), report that MI is a supplement to the exposure therapy in OCD.

Characteristics

MI is a brief intervention utilized for the reduction of resistance and alteration in the behaviour in promoting health standards (Simpson, Zuckoff, Page, Franklin and Foa, 2008). In MI, the therapist boosts motivational urge through the challenge posed and reinforcement provided in the interests of patients, their "uttering of desire", their capability, the reasons, their need, and finally their commitment to change.

MI provides a clear, theoretical and practical model describing how and when these techniques may be used (Simpson et al., 2010).

Where MI is conducted

MI has been used in various manners towards promoting participation in the treatment of patients suffering from OCD. Preliminary data indicate that MI may be integrated into the exposure and response prevention (ERP) standard and be used during introductory presentations of the ERP, as well as during the session reports (Simpson et al., 2010). MI may be of assistance in urging individuals to change their behaviour patterns associated with fear or anxiety (Simpson and Zuckoff, 2011).

Stages at which experience is gained

Miller and Moyers (2006) refer to eight stages regarding experience gained and know-how related to the construction of an educational MI programme.

- **Stage 1:** The MI spirit:

It is a collaborative and suggestive approach, bearing respect for the customer's autonomous

status. It acknowledges the fact that people possess significant amounts of personal experience and wisdom for themselves and they tend to develop a positive direction course.

- **Stage 2:** The Counselling and Customer-focused Method:

It includes the acquisition of adequacy in utilising classic customer-focussed, counselling skills.

- **Stage 3:** Acknowledgement and reinforcement of the change through speech:

The basic process is to assist customers in solving their ambivalence, by recalling on their own internal incentives for change. The significance, attached to the change of the customer's speech, is big and it is associated with alteration in behavioural patterns.

- **Stage 4:** Elicitation – Strengthening and change in speech mode:

As soon as the therapist is in a position to recognize the change in speech, he is also in a position to learn how to elicit and reinforce it.

- **Stage 5:** Resistance:

It is the starting point of MI from the forms of cognitive therapy that are based on the verbal rebuttal of the "irrational" beliefs of the customers.

- **Stage 6:** Development of a "change" plan:

The usual procedure commences with a transitional summary account of the speech on change and reference is made to what will follow. If no resistance is brought about, the customer proceeds and the manner in which the change will occur is discussed. If transition has been attempted prematurely, further reinforcement of the incentives for change is attempted.

- **Stage 7:** Establishment of the customer's commitment:

Change in behavioural pattern is unlikely to occur, unless and until the customer expresses one's commitment to it. Endeavour is required so that commitment by oral agreement is secured.

- **Stage 8:** Alternation between MI and other methods-counselling method:

This stage contains the knowledge of how MI may flexibly be combined with other methods, or

even put completely aside in order for another course of approach to be used.

Exposure and Response Prevention (ERP)

ERP is a psychological treatment that includes the development of a hierarchy of fear instances, confronted by the patient, gradually until one gets addicted to it (Jones, Wootton and Vaccaro, 2012).

CBT, accompanied by the essential ERP procedures, is considered today to be the golden rule of OCD treatment (Abramowitz, 2006-Mokmel, Neshat-Doost, Asgari and Abedi, 2013).

ERP is a skill bringing about good results in breaking the cycle of dysfunctional response (Doron, 2009).

Purpose

Mokmel et al. (2013) report that the purpose of ERP is to allow OCD patients to experience repeated situation conditions, in which they find themselves facing stimuli full of fear, that set a match to obsessions and anxiety (exposure). At the same time, they should refrain from participating in ceremonies or behaviours, normally being used to diminish this discomfort (prevention response).

Terms and manners of ERP implementation

The exposure section of the ERP treatment could be set up in one of the following ways:

- a) The patient may be encouraged to confront the fearful stimuli in situations of low hazard expectancy (exposure in vivo).
- b) The patient should be urged to visualize averting and fearful instances (imaginary exposure) (Mokmel et al., 2013).

Implementation

Provision of psycho-educational aspects concerning the ailment and the ERP procedure (Seibell and Hollander, 2014).

An assessment of the obsessive thoughts, ideas and stimuli that trigger obsessions related to rituals and evasive behaviour, is carried out (Abramowitz, 2006).

Patients are motivated to live through an obsession to the end, as well as experiencing a compulsion as long as it lasts. Twenty four hours later, using the assessment scale of obsessive and compulsive scores (Y-BOCs), the symptoms are

recorded. These data are then used to rank the symptoms caused in hierarchical order (Seibell and Hollander, 2014). The scores are based on a scale from 0 to 100.

Treatment usually commences with elements ranking moderately low on the above scale (Jones et al., 2012). Elements of a more difficult nature then follow. Exposure to situations causing a lot of anxiety is left to be dealt with at the end of the treatment. Thus, the possibility that the patients learn, how to control their own agony and complete the application of full exposure, is increased.

Furthermore, success accompanied by initial exposure potential, increases confidence in the treatment and it serves as an incentive for patients to persist their efforts at a later stage when they will have to deal with more difficult exercises. (Abramowitz, 2006).

At the end of each treatment session, the therapist guides the patient to continue exposure for quite a few hours and in different environmental conditions, such as at home (Abramowitz, 2006).

It is important to discuss with the patient the circumstances under which professional assistance would be useful to be sought (Doron, 2009).

Attention Training Technique (ATT)

Wells (2007) invented a technique, called “the attention training technique” (ATT), aiming at the attention deficit in sentimental disorders (Moritz, Wess, Treszl, Jelinek, 2011). According to Wells (1997), excessive self-focusing of attention is a common characteristic of anxiety disorders and depression.

According to Watson and Purdon (2008), ATT is a technique that focuses on attention so that anxiety and mood disorders are reduced. It is a cognitive therapy method whose purpose is to improve intrusive thoughts in anxiety disorders (Moritz et al., 2011).

Objective

ATT strives to reduce attention to dysfunctional preconceptions and it is not intended to be just a simple distraction of attention from annoying trains of thought (Wells, 2007). This serves towards weakening intrusive thoughts, which is a symptom, for example, of OCD.

A basic symptom in individuals suffering from OCD is a perceivable inadequacy in their ability to reject irritating thoughts (Watson and Purdon, 2008).

ATT is a method of self-assistance (Moritz et al., 2011). Self-assistance approaches can represent a significant supplement in increasing the effectiveness of the usual treatment.

ATT Steps

Each step lasts for approximately 3 to 5 minutes. The entire duration of a session is 10 to 15 minutes.

ATT contains a series of exercises pertaining to attention, which focus on sounds/noises. Conceptually it is classified as “selective attention”, “rapid conveyance attention” and “distraction of attention”.

1. In the “selective attention” phase, the participants are instructed to direct their concentration on comprehensive noises identified in their external environment.
2. In the “conversion of attention” phase, participants are directed to shift quickly the focus of their attention among defined sounds.
3. In the final phase of “distraction of attention”, the participants are instructed to simultaneously monitor as many of the identified sounds as possible (Watson and Purdon, 2008).

Association Splitting (AS)

It is a new cognitive technique. It aims at diminishing obsessions (Moritz, Jelinek, Klinge and Naber, 2007). It is a self-help technique. As a cognitive technique, it appears to be promising towards decreasing obsessions (Rodriguez-Martin, Mortiz, Molerio-Perez and Gil-Perez, 2013). It is available in German, English and in the language of Montenegro free of charge, through the web-site www.uke.de/assoziationsspaltung (Moritz et al., 2007). It aims at dealing with annoying thoughts.

AS is based on the principle of the semantic start. It was first described by Anderson (1974). The increase in the number of association instances for a particular cognitive function automatically reduces the strength of the other associations. This is called the “fan phenomenon” (Moritz et al., 2007).

Application

According to Moritz and Jelinek (2011) patients are taught how to create, or reinforce neutral or positive association cases, concerning the fear deriving from OCD. New association patterns should not bear an immediate connection with OCD.

This technique does not represent a ritual that covers avoidance or distraction of attention. For example, a patient who is preoccupied with “blood”, despite the good image of one’s illness, one can substitute this image by words like the word “blood”.

AS communicates to patients, through a cognitive model that there is nothing bad and whatever they think, simply does not apply. Their fears are based on simple learning principles that may easily change.

Metacognitive Therapy (MT)

Metacognition is the constant knowledge, or beliefs about the cognitive system of the individual, and his knowledge relevant to factors affecting the system functions.

It is the regulation and the awareness of the current state of knowledge and the evaluation of the importance of thought and recollections (Shareh, Gharraee, Atef-Vahid and Eftekhari, 2010).

The metacognitive model

The metacognitive model points out that OCD patients have positive, metacognitive beliefs pertaining to the necessity of conducting rituals, which maintain and exacerbate tyrannically persistent symptoms. (Önen, Uğurlu and Çayköylü, 2013).

The MT objective

The MT objective is to change dysfunctional metacognitive considerations and strategies (Simons, Schneider and eHerptz-Dahlmann, 2006). The main messages that MT conveys is that thoughts by themselves are not hazardous. They may be ignored and there is no need to be investigated (Jacobi, Calamari and Woodard, 2006).

The MT Steps

Fisher and Wells give us a rough guideline of the MT steps with regards to OCD:

The first step is to increase patients’ awareness in relation to the role that metacognition plays in

the continuation of their symptoms. Thus, patients will be in a position, to evaluate objectively their obsessions as ordinary mental events that do not require further processing.

Then convictions, thought fusion beliefs, are targeted using verbal reallocation and experiments are conducted within a session in which patients had been trained to meet their obsessions with complete “mind distraction”.

In response to their obsessions, patients are simply asked to observe their fixations and opt for leaving the train of thought to disintegrate naturally. This strategy aims at increasing awareness in sustaining the role of the metacognitive convictions in OCD.

At the same time, the metacognitive beliefs about obsessions, including both positive and negative beliefs about rituals, are amended (Myers, Fisher and Wells, 2009; Pazvantoglu, Algul, Ates, Sarisoy, Servet, Basoglu and Cetin, 2013).

The next step is the modification of the maladaptive internal criteria that patients use (Fisher and Wells, 2008). Attention strategic tactics are often used. Such a strategy is the over-awareness both to internal and to external stimuli for threat.

Patients often exhibit an increased amount of cognitive self-consciousness and they participate in the attendance for psychic manifestations regarding the absence, or the presence, of persistent thoughts. They are required to prohibit the attention maladaptive strategies. The two final therapy sessions are focused on relapse prevention and on the integration of draft therapy training, including a written as well as a diagrammatic configuration of the OCD of patients.

Acceptance and Commitment Therapy (ACT)

ACT is a CBT putting emphasis on acceptance when dealing with problems by reasoning them out (mindfulness) on values and on the enactment of skills (Smout, Hayes, Atkins, Klausen, 2012).

There are two objectives to the ACT: (a) the acceptance of active undesirable and perhaps uncontrollable thoughts and sentiments and (b) the commitment and the actions towards the goals being aligned with the values that have been selected by the patient. Thus ACT stands for acceptance and change at the same time (Sharp, 2012).

ACT endeavours to assist patients in adopting a more versatile psychological relationship with their cognitive and sentimental functions. Its aim is to enhance life quality by focusing on the patients' values or on the most important things in their lives (Fabricant, Jonathan, Dehlin, Michael, Twohig and Abramowitz, 2013).

Application

ACT consists of six basic therapeutic procedures that are not targeted in a linear fashion. The six therapeutic procedures are the following (Rees and Anderson, 2013, Twohig, 2008).

1. Acceptance: Acceptance allows experience to be as it is without resistance (Sharp, 2012, Rees and Anderson, 2013) and the participants to engage in worthwhile activities (Ruiz, 2010).

2. Cognitive maturity: It includes strategies designed to reduce the reality of thoughts, sensations and emotions (Sharp, 2012). Thought maturity assists in altering the way so that thoughts, that have less impact on behaviour, are less important, and are taken less into account (Ruiz, 2010).

3. The self as Framework: In “self as framework” a specific sense of a “self as observer” is developed that is constant and independent of the changing experiences each time (Sharp, 2012). The “self as framework” simply refers to the process that will help the customer to distinguish between one's internal experiences from one's self (Rees and Anderson, 2013). Without the “self as framework”, the patient will experience two problematic procedures: (1) One will respond to one's obsessions as if defined by them and therefore will attempt to control them, and (2) One will respond in ways to support one's self (Sharp, 2012).

4. Communicating at the current moment: All people participating in ACT are open to suggestions, they are interested and receptive to the “right-and-now”. (Sharp, 2012; Rees and Anderson, 2013).

5. Values: In this section reference is made to define what is most important in the life of an individual (Sharp, 2012). The concept of “selection” is addressed to these values intentionally, because it bypasses cognitive fusion. In ACT, there is a distinction between “options” and “decisions”. The usefulness of the

focus on the values of ACT has been demonstrated clinically and it becomes increasingly the main process for the treatment of anxiety disorders. According to our experience, the therapist may refer to the values quite a few times during the session period without elaborating on details at length (Rees and Anderson, 2013).

6. Assuming Action: The action assumption principle is focused on changing the behaviour pattern. It includes the provision of measures determined by the values that have been selected by the patient (Sharp 2102). ACT is a behavioural therapy but it focuses more on cognitive aspects compared to the traditional behavioural therapy. It seeks through acceptance and maturity to reduce greatly these processes and the effects of internal experiences on one's actions. It also encourages those who base their actions on values. In most cases, this will lead to a reduction in the compulsive behaviour, but only because the compulsive behaviour, usually interferes with the exercise of values (Rees and Anderson, 2013).

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