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Cognitive therapy for obsessive–compulsive disorder

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Abstract

A multiple baseline across subjects design was used to test the efficacy of cognitive therapy for obsessive–compulsive disorder (OCD). Six people with OCD received 10–18 sessions of weekly, outpatient cognitive therapy. Assessment included both structured interviews and diary data. For three to four of the six patients, stable baseline periods were followed by reductions of symptoms during intervention. Two clients met stringent criteria for Jacobson and Truax's (J. Consulting Clin. Psychol. 59 (1991) 12) recovered status at posttest according to the Yale–Brown Obsessive–Compulsive Scale (Arch. Gen. Psychiatry 46 (1989) 1006). For the group, large pretest–posttest effect sizes were found.

Introduction

Although medication and exposure with response prevention (ERP) are efficacious treatments for obsessive–compulsive disorder (OCD; e.g., Abramowitz, 1998), side-effects, nonresponse, and treatment refusal suggest alternatives are needed. Cognitive therapy (CT) may be a viable alternative or adjunct. Although different versions of CT have outperformed wait list, results are mixed in comparison to ERP (Cottraux et al., 2001; Jones & Menzies, 1998; McLean et al., 2001; van Oppen et al., 1995). However, the versions of CT investigated in these studies differ somewhat

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from conventional forms of CT. Whereas conventional forms address a wide variety of distortions (Beck, 1976, 1995), most of the CTs examined in the OCD literature were designed to target one or two themes stipulated by the protocol. The treatment manual (Wilhelm & Steketee, 2001) in the current study includes modules to address a wider array of specific themes and permits greater flexibility to tailor specific interventions to individual clients.

Further, none of these studies have used treatments that incorporate strategies to target core beliefs. To enhance the depth with which meaningful cognitive change can occur and to align the treatment with more current CT approaches (e.g., Beck, 1995), the manual followed here includes focus on schemas in addition to automatic thoughts. Finally, behavioral experiments were minimized to facilitate a purer test of cognitive restructuring. Prior studies have included these experiments as important elements, which leaves open debate on the utility of a purely cognitive intervention.

Method

A multiple-baseline across subjects design was used to test CT's efficacy in reducing symptoms. To show efficacy, symptoms should be stable during baseline and then drop once treatment is introduced. Baseline was staggered across subjects (never <4 time points) to test whether any symptom decline was attributable to CT rather than time, testing, and contact with the clinic (Kazdin, 1992). The design was quasi- and not fully experimental because baseline length was not determined randomly, but by the time it took for their symptoms to stabilize.

Participants

Inclusion criteria were: (a) primary diagnosis of at least moderate OCD according to the Structured Clinical Interview for DSM (SCID; First, Spitzer, Gibbon, & Williams, 1995) and a score >16 on the Yale–Brown Obsessive–Compulsive Scale (YBOCS; Goodman et al., 1989); (b) age 18–65; (c) OCD $\geqslant 1$ year; and (d) rituals $\geqslant 1$ h/day. Exclusion criteria were (a) failure of previous ERP ($n = 1$); (b) substance dependence ($n = 2$); (c) suicidality ($n = 1$); (d) thought disorder ($n = 3$); (e) schizotypal or borderline personality disorder ($n = 1$ each); (f) concurrent psychotherapy for OCD ($n = 11$); (g) OCD medication initiation or changes within 3 months prior ($n = 4$); (h) living too far to attend weekly treatment ($n = 9$). Thus, we deliberately selected participants who would be included in ERP studies. Criteria were assessed through standardized phone screens or initial evaluations with the first author. Six clients met criteria and initiated treatment. All completed at least 10 sessions of treatment, and no one terminated treatment early.

Sample characteristics

Ms. A was a 50-year old, divorced woman on disability. Her intrusive thoughts involved fear of mistakes and fear of stickiness. Feared consequences included delinquency in bill payment and financial catastrophe. She also feared she would never rid her hands of substances, and she would ultimately be ruined. Ms. A had childhood OCD that reappeared 18 years ago. She tried numerous drugs (e.g., clomipramine, fluvoxamine) without success, and took none throughout the

study. Ms. A met criteria for past major depression. She had serious financial difficulties, social isolation and relationship distress.

Ms. B was a 20-year old student who feared her family might be harmed if she did not engage in extensive rituals. She undressed in a particular order, turned the lights off with her right hand, drank 1/2 a glass of water, set the glass on her nightstand with her left hand, etc. In addition, she ritualized in the shower by spitting water from her mouth and thinking positive thoughts. The duration of Ms. B's OCD was 4 years. She had never taken OCD medication and had no history of other disorders.

Mr. C was a 22-year old school teacher who feared he stepped in something unclean, soiled his hands, made a mistake, or left his door unlocked. He engaged in mental reviews, checking, and washing. Mr. C had never taken any OCD medication. He endorsed considerable general anxiety and stress-related nausea, and met criteria for major depression.

Mr. D was a 46-year old, part-time toolmaker whose intrusions consisted of images of penises. In response, he conjured up images of nude women. He also had obsessions about stabbing people, to which he responded by repeating idiosyncratic phrases. The onset of Mr. D's OCD was 12 years ago. Mr. D had been stabilized on 20 mg fluvoxamine prior to the study. He met criteria for past major depression, past alcohol dependence, and present paranoid personality disorder.

Ms. E was a 29-year old attorney who had intrusive thoughts about harming others through carelessness or inadequacy. She responded by washing, confessing, checking, placing bandages on nicks, and avoiding discolorations. Her symptoms began 4 years ago. She also had PTSD precipitated by childhood sexual and physical abuse. Although her mood was very depressed, she did not meet criteria for major depression at intake.

Mr. F was a 32-year-old health care worker who feared he had contracted hepatitis or HIV and passed it on to his daughter. He engaged in excessive, ritualistic washing. He frequently retraced his steps to ensure that he had not made contact with contaminants. He was on a steady dose of fluvoxamine. His OCD began 11 years ago. He also met criteria for past major depression and present PTSD from childhood sexual abuse.

Main outcome measures[2]

The *Yale–Brown Obsessive–Compulsive Scale* (YBOCS; Goodman et al., 1989) is the standard semi-structured OCD interview with strong psychometric properties. In this study, interrater reliability was assessed and deemed high on all interviews, $r_s = 0.84$.

Target Symptom Ratings were developed for this study. At intake, participants identified individual compulsions to track. Each night, they rated the frequency of their compulsions on a 7-point scale that ranged from 0 (absent) to 6 (extreme) and called these into the clinic.

Two widely used and well-validated measures of mood were administered: the Beck Anxiety Inventory (BAI; Beck & Steer, 1990) and the Beck Depression Inventory (BDI; Beck & Steer, 1987).

[2]Prior to beginning the study, the outcome variables addressed in this paper were defined as primary. Secondary measures, other diary measures and the Padua Inventory, were also administered but are not discussed here due to space limitations. E-mail the first author for the full text.

Procedure

Assessment

After phone screening in response to broad advertising, potential participants came to the clinic for the SCID (First et al., 1995; First, Spitzer, Gibbon, Williams, & Benjamin, 1994), and YBOCS (Goodman et al., 1989) interviews. These evaluations occurred across two weekly sessions to facilitate collection of baseline data.

Baseline was established with four points of self-report data at Assessment Sessions 1 and 2 and Treatment Sessions 1 (information gathering) and 2 (presentation of treatment rationale), as well as at least 21 days of diary data. If a patient's compulsion ratings demonstrated any downward slope during this time (e.g., Mr. F), we deliberately extended the baseline period to await stabilization. This resulted in nonrandom waiting periods, but was necessary to facilitate data interpretation (Kazdin, 1992). Patients were asked to e-mail or phone their diary ratings to the project nightly. At pretest and posttest, patients also completed the BDI and BAI. The posttest assessment included the YBOCS with an interviewer not otherwise invested in the study.

Treatment

Treatment was 10–18 weekly 1-h sessions. To enhance external validity, treatment length was flexible, allowing for earlier termination if progress was established by that time. Treatment followed the CT manual by Wilhelm and Steketee (2001),[3] and focused on identifying and modifying maladaptive cognitions that were deemed important for individual cases (e.g., overimportance of thoughts, perfectionism, responsibility). Relevant core beliefs (e.g., "I'm unlovable," "I deserve to be punished because I'm inherently bad") were targeted similarly once patients learned how to apply cognitive strategies to more malleable interpretations of intrusions. Although core beliefs can vary widely, we found within our sample prominent themes of being worthless or dangerous.

Treatment did not include ERP, as shown by perfect adherence on this item according to independent raters. Behavioral experiments, made explicitly cognitive, were used only once with each of two patients and not at all with the other four. Ms. B believed that her thoughts put her family at risk. One week she conducted a daily experiment in which she imagined a particular celebrity breaking her leg to test that harm would come to this person. The patient did not engage in this experiment in relation to her family (her chief concern). Mr. D believed that, if knives were in view, his anxiety would never decrease and he might stab his wife. He and his wife agreed to leave a knife out once to test whether his anxiety lasted forever and whether he would try to stab her. He was not encouraged to engage in this exercise more than this once. These exercises were framed as scientific attempts to test and generate alternate hypotheses, goals that are distinct from habituation. Their brevity was inconsistent with exposure paradigms for OCD, and ritual prevention was never addressed.

Training

All three therapists had at least 1 year of experience with cognitive–behavior treatment (CBT) of anxiety. They also participated in a specific 6-month training using the study manual. Training

[3]To request information about the treatment manual, contact Sabine Wilhelm at MGH-East, Building 149, 2nd floor OCD clinic, 13th St, Charlestown, MA 02129.

was led by the second author who trained at the Beck Institute and has delivered cognitive treatments for 25 years. It consisted of manual review, role-plays, pilot cases, and weekly supervision that continued throughout the study.

Treatment integrity

Patients rated the treatment credible and their expectancy high on the Treatment Expectancy Scale (mean = 8.25; Borkovec & Nau, 1972). All sessions were taped and reviewed by both authors. Trained raters not otherwise invested in the study tested adherence on 36% ($n = 35$) of all sessions with checklists that followed Waltz, Addis, Koerner, and Jacobson (1993). Violations were defined a priori. Adherence was deemed acceptable for every rated session. The supervisor determined that student therapists were administering the therapy competently.

Results

Efficacy of CT was examined by visual inspection of change in compulsions across six individuals with staggered baselines and by analysis of clinically significant change indices and effect sizes. See Table 1.

Diary data were plotted for visual inspection of the change in target ratings over time. The efficacy of CT is supported if, after a stable baseline, symptoms decline when the intervention is introduced but not before, while subjects still in baseline remain stable or worsen. See Fig. 1.

On compulsions, no baselines exhibit a downward trend just before intervention. We initiated active treatment only after 3 weeks of stable or worsening symptoms, as recommended by Kazdin (1992). Mr. D had an initial adjustment period as he acclimated to completing the ratings, but he then reported 3 weeks of worsening symptoms prior to treatment. After intervention, compulsions reported by Participants B, D, and F appear to have declined, whereas those reported by Participants A, C, and E appear to remain stable or worsen. Mr. F's graph demonstrates a delay in response to treatment. At the end of treatment, Participants B and D endorsed scores below 1, which indicates very mild symptoms (<30 min). Mr. F originally ritualized from 2 to 8 h, but then limited his compulsions to about an hour a day at the close of treatment. Ms. A's scores show no change for the duration of the treatment, and she remains stable at the level of about 3 h of compulsions per day. Participant E's compulsions also stayed at the same level throughout treatment and lasted about an hour a day.

To augment findings from visual inspection, Table 2 shows reliable change indices (Jacobson & Truax, 1991) for the YBOCS. Two of the six patients recovered. For the group, effects were large for OCD and medium for depression and anxiety.

Discussion

Overall, CT may be an acceptable choice for some OCD patients. Treatment was well tolerated, with no one dropping out. For two to three of the six, change was observed during but not before treatment, suggesting that change was likely due to treatment. Effect sizes for OCD were large, whereas effect sizes for both depression and anxiety were moderate.

Table 1
Summary of pre- and post-treatment assessment measures

	Pre	Post	Reliable change index	Status at post
Participant A				
YBOCS	27	27	0	Not reliably changed
BDI	17	25		
BAI	9	13		
Participant B				
YBOCS	22	2	5.23	Recovered
BDI	4	0		
BAI	20	10		
Participant C				
YBOCS	17	12	1.31	Not reliably changed
BDI	16	9		
BAI	20	11		
Participant D				
YBOCS	17	11	1.57	Not reliably changed
BDI	35	21		
BAI	26	27		
Participant E				
YBOCS	20	20	0	Not reliably changed
BDI	20	21		
BAI	12	8		
Participant F				
YBOCS	26	12	3.66	Recovered
BDI	34	3		
BAI	20	2		

Notes: Participants were rated recovered if they met criteria for reliable change and statistically significant change. Cutoff points for clinically significant change were deemed 14 for the YBOCS (norms from Steketee, Frost, & Bogart, 1996). YBOCS = Yale–Brown Obsessive–Compulsive Scale; BDI = Beck Depression Inventory; BAI = Beck Anxiety Inventory.

Results here are generally consistent with other trials that emerged while the current study was in progress (Krochmalik, Jones, & Menzies, 2001; McLean et al., 2001). However, the treatment delivered in this study differs from previous treatment trials (Cottraux et al., 2001; Emmelkamp & Beens, 1991; Emmelkamp, Visser, & Hockstra, 1988; Jones & Menzies, 1998; van Oppen et al., 1995). Our CT was delivered on an individual and individualized basis, and drew from a wide spectrum of appraisals that typify this group (OCCWG, 2001). This type of treatment should best match the theory upon which CT is drawn because it targets the full spectrum of distortions that presumably drive OC pathology. In addition, this CT targeted core schemas as well as automatic thoughts. These components may not make the current CT superior. In fact, results from Krochmalik et al.'s (2001) research suggest that targeting threat may be all that is warranted, at least for washers. More research is needed to identify CT's critical elements.

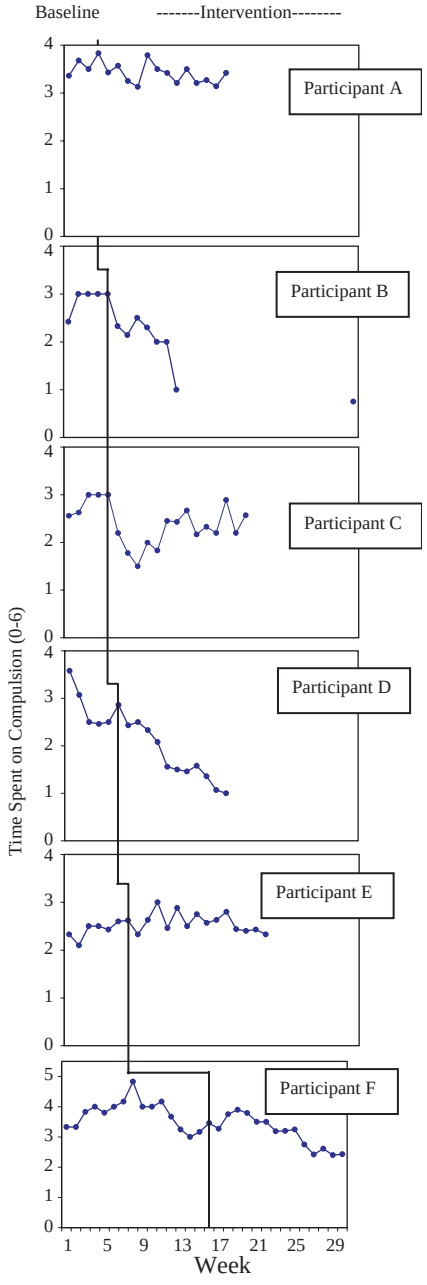

Fig. 1. Time spent on compulsions.

The treatment offered here was almost purely cognitive. This was not the case in other CT studies for which data are perhaps more promising (e.g., Krochmalik et al., 2001; van Oppen et al., 1995). It may be that behavioral experiments, used freely in those treatments, are critical components. Experiments do provide potent tests of beliefs, which may help patients digest new

Table 2
Means and effect sizes on outcome variables

Measure	Pre-treatment mean (SD)	Post-treatment mean (SD)	Cohen's *d*
Yale–Brown Obsessive–Compulsive Scale			
	21.50 (4.32)	14.00 (8.56)	0.96
Beck depression inventory	21.00 (11.80)	13.17 (10.55)	0.63
Beck anxiety inventory	17.83 (6.21)	11.83 (8.33)	0.65

Note: On all measures, higher scores reflect more pathology.

information at a gut level beyond the scope of reasoning. Dismantling studies can help explore this question further.

Several explanations are worth considering for those patients who did not benefit here. First, Ms. A struggled with three poor prognostic factors for OCD treatment generally: poverty (e.g., Steketee, 1993), poor insight (Tolin, Abramowitz, Kozak, & Foa, 2001), and extreme avoidance (5.25/6; Cottraux, Messy, Marks, & Mollard, 1993). Another potential hindrance for some was comorbid PTSD, diagnosed in two participants. One, Ms. E, never improved, and the other (Mr. F) improved after a long delay. Gershuny, Baer, Jenike, Minichiello, and Wilhelm (2001) illustrated poor response to CBT for OCD when an unidentified PTSD was left untreated. In addition, Ms. E's BDI scores consistently fell within the mid-30s, in the range of extreme depression. Both the cognitive model and data from experimental studies show that negative thoughts are more difficult to dismiss during negative mood states (Wenzlaff, Wegner, & Klein, 1991). Furthermore, depression has been shown to hinder effects of ERP (e.g., Steketee, Chambless, & Tran, 2001).

Another poor prognostic factor appeared to be an obsessive manner that extends well beyond the Axis I criteria and into a more characterological style. Here we refer to a way of thinking in which a person considers each and every perspective and gets stuck on minutiae to the exclusion of flexibility. This trait makes cognitive therapy challenging, and characterized Mr. C, who spent excessive time describing the details of his thinking. This fine point analysis often detracted from effective in-session restructuring.

Limitations

This study used a quasi-experimental multiple baseline across subjects design. Although this does not allow for definitive conclusions about cause, the stable and staggered baselines prior to intervention rule out the effects of repeated testing, maturation, and regression to the mean. In addition, the literature has clearly demonstrated that OCD is particularly resistant to placebo effects, and several treatments have been shown to be ineffective (e.g., paradoxical intention, aversion therapy, thought stopping, and relaxation; Foa, Franklin, & Kozak, 1998; Lindsay, Crino, & Andrews, 1997). Thus, confidence that changes were likely due to the intervention is reasonable.

Another limitation of the current study is the small number of participants, a component that limits the generalizability of findings. Although small *N* studies facilitate more in-depth case analysis, larger studies are also needed for corroboration.

Finally, follow-up data would be beneficial. Only Ms. B provided 6-month follow-up data (gains were maintained, YBOCS = 3). To provide proper clinical care, the other participants were given referrals for OCD (if symptoms had not improved sufficiently) or for other problems (e.g., PTSD, GAD). Therefore, evaluation at follow-up would have been inappropriate, and was thus not conducted.

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