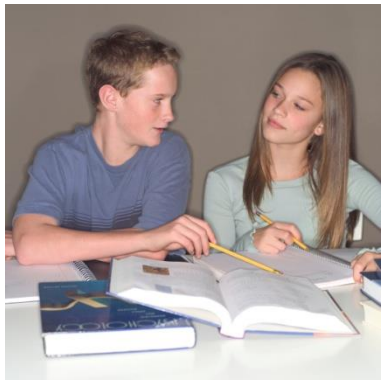
South West London and St George's NHS
Mental Health NHS Trust

Well I tried CBT and it didn't work, so what do I do now?????

Lynne M Drummond

Two main clinically proven effective approaches to treatment

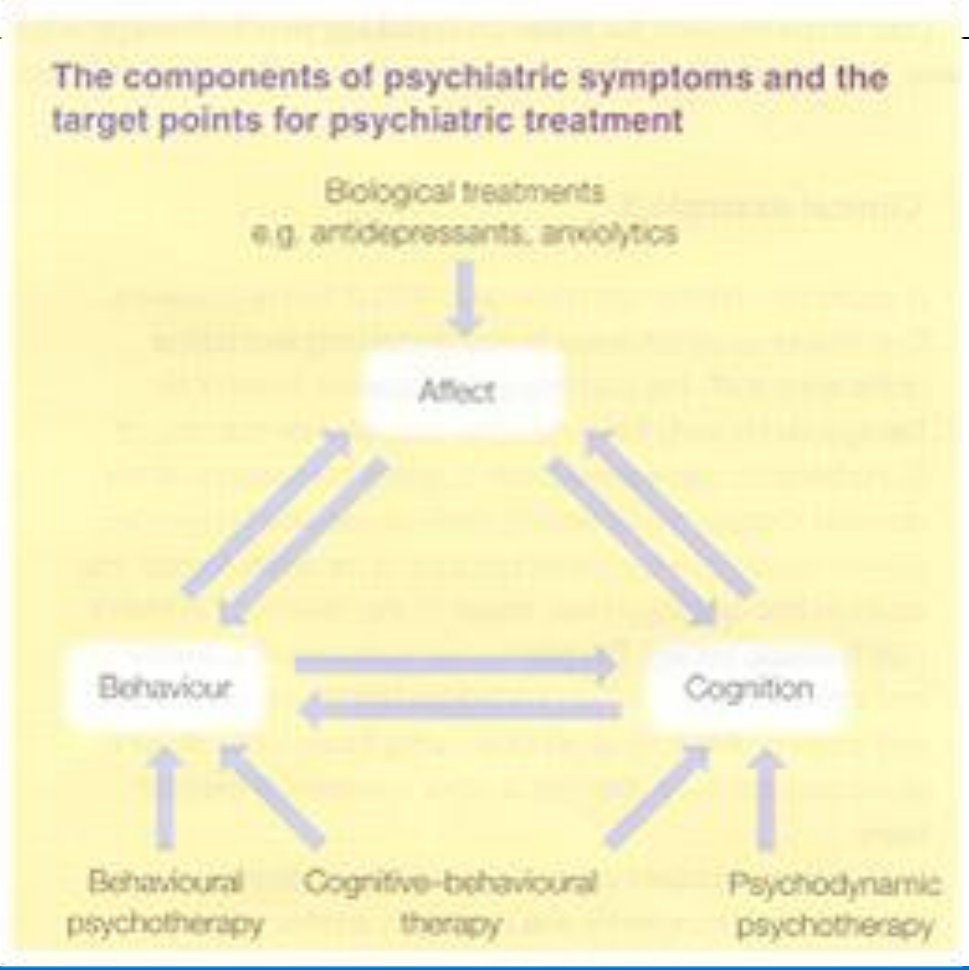
- Psychological Therapy



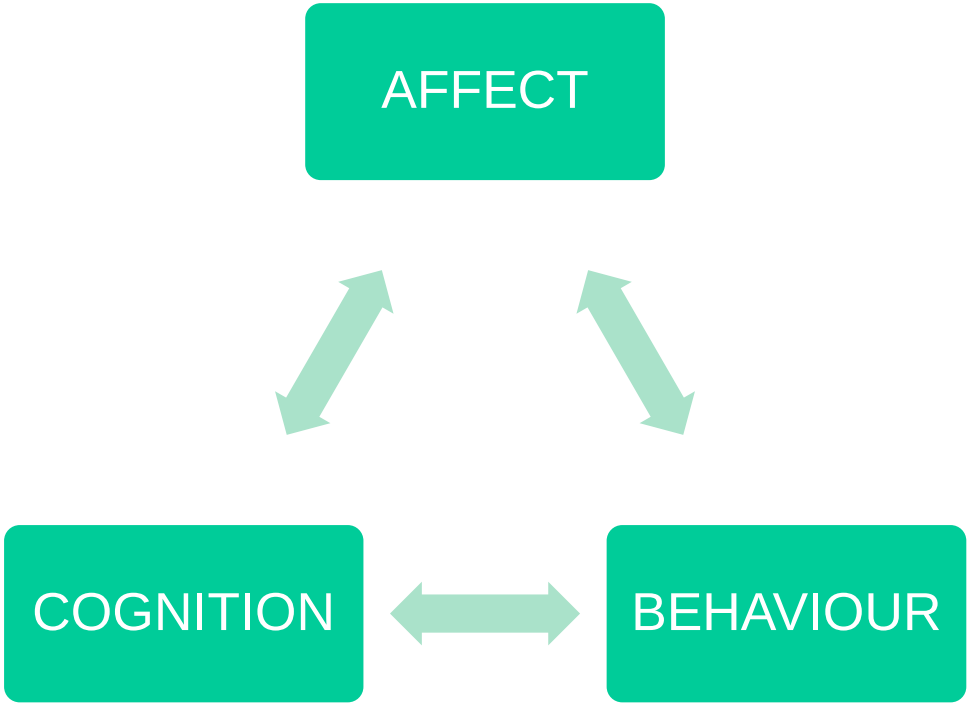
- Drug Therapy

What is CBT?

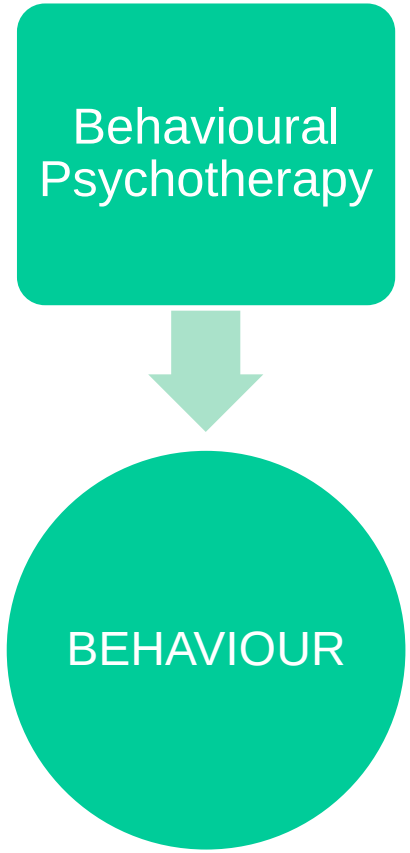
Psychological Symptoms



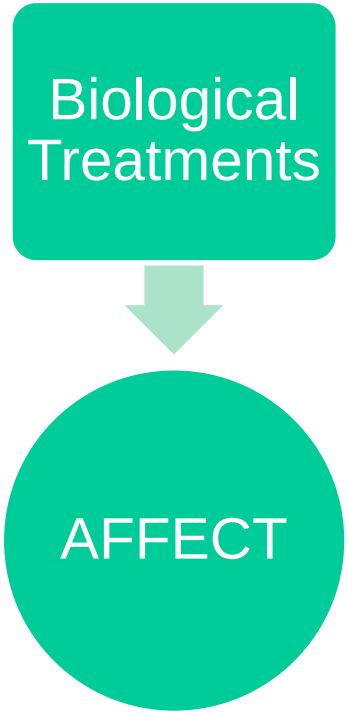
Behaviour Therapy



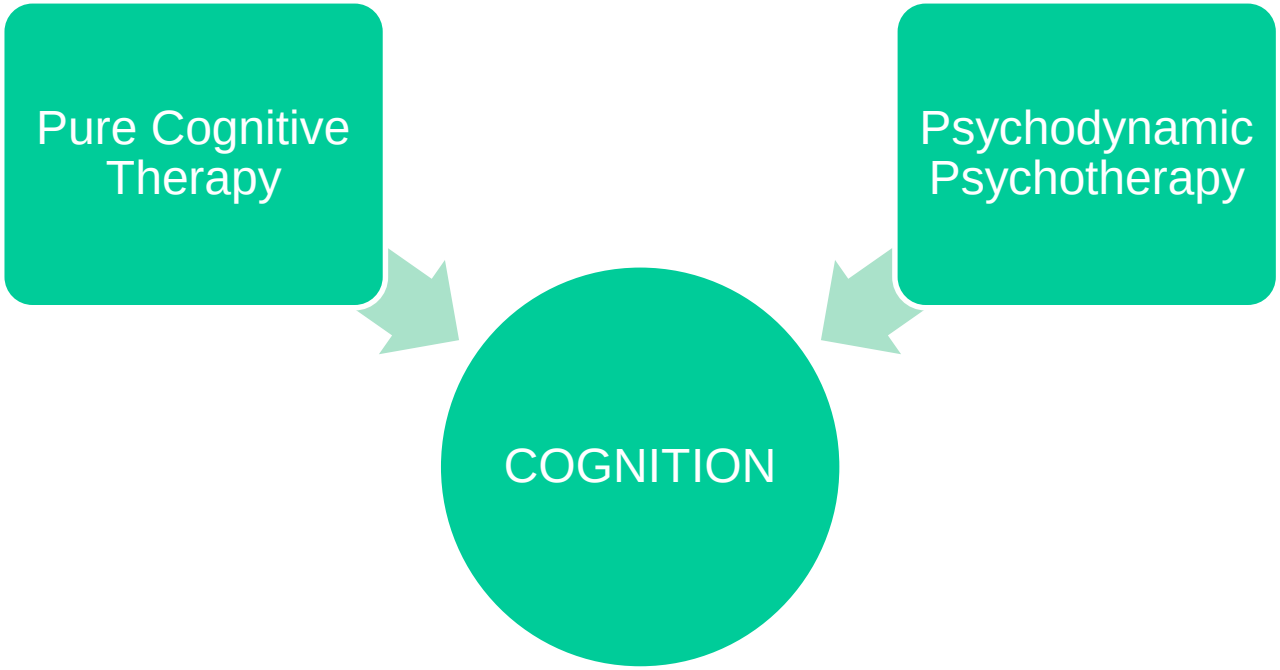
Behaviour Therapy



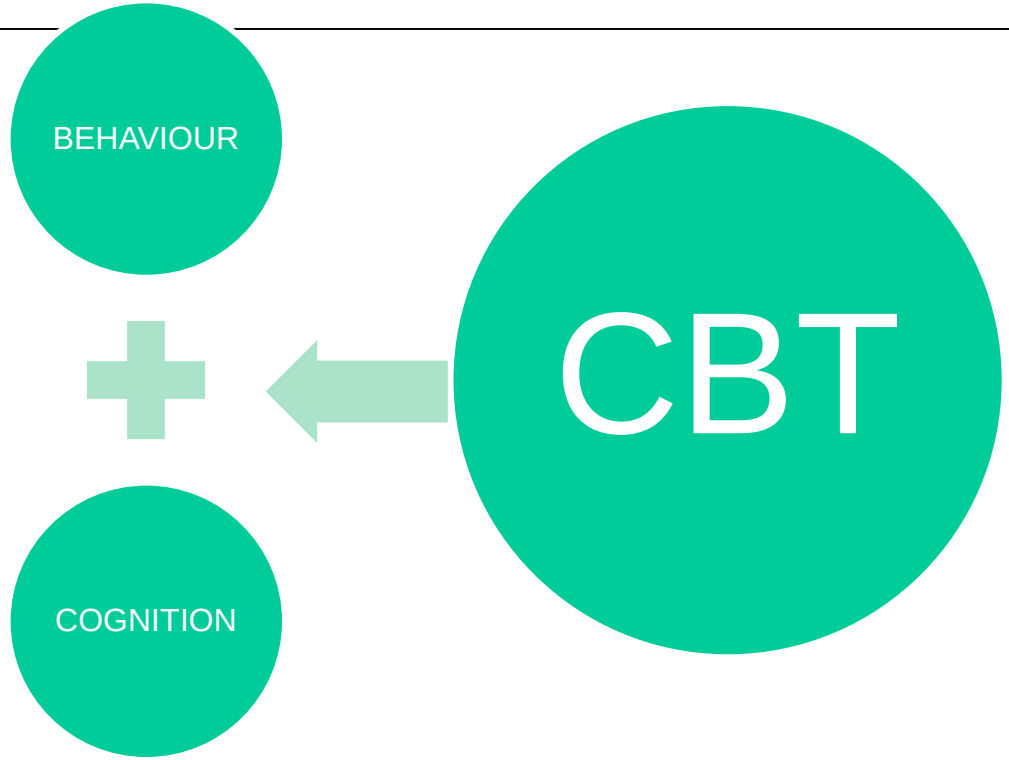
Behaviour Therapy



Behaviour Therapy



Behaviour Therapy

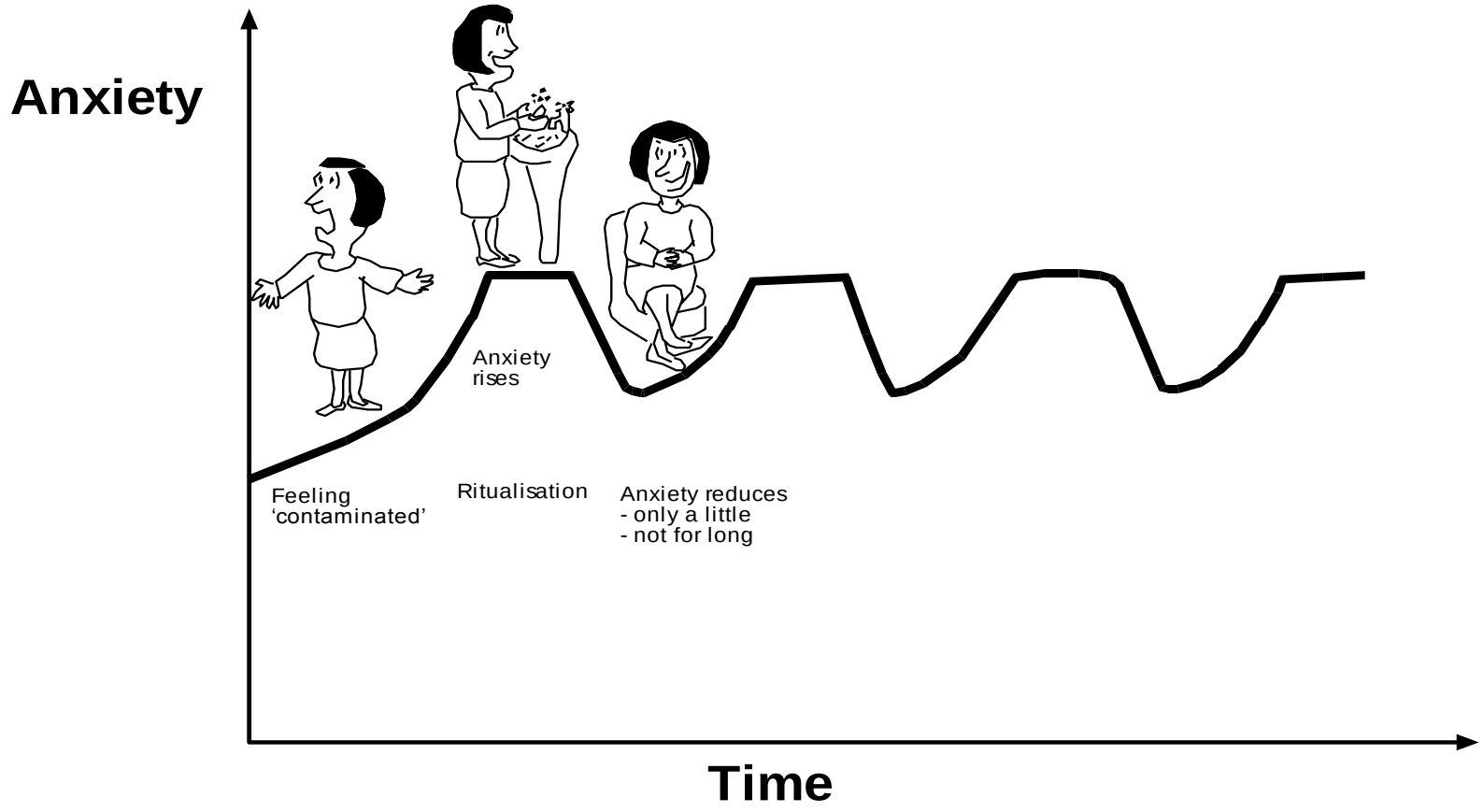


Psychological Treatment of OCD.

Gold Standard = **ERP**

- Prolonged graduated exposure in real life to the feared situation with self-imposed response prevention

Education about the role of Compulsions/ Reassurance/ Rituals (Adapted from Stern and Drummond, 1991)



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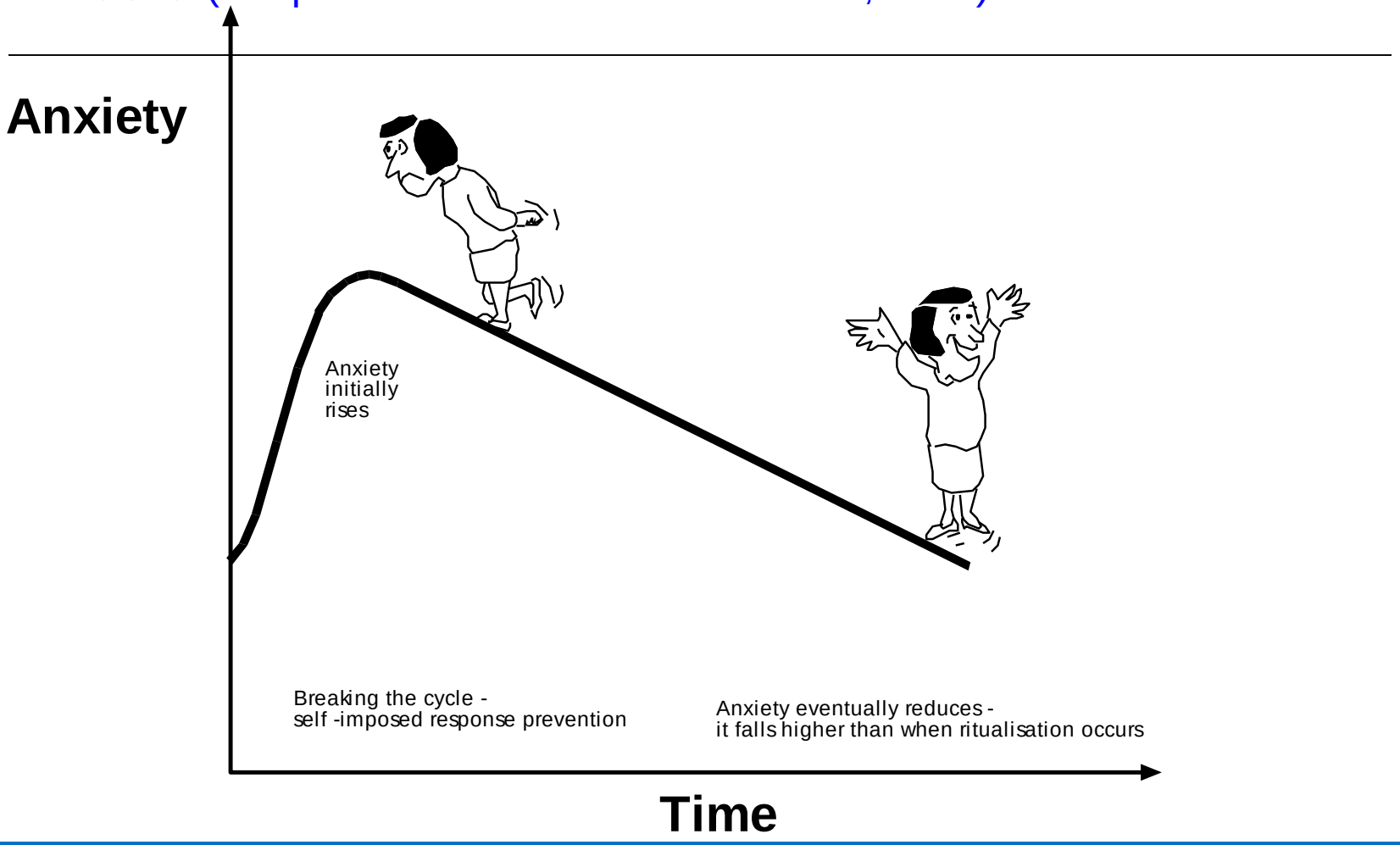


Outcome for Exposure Treatment of OCD

- 75% improved by at least 50%
  - Marks, Hodgson and Rachman, 1975

- 80% improved following I.P treatment
  - Foa and Goldstein, 1978

Cognitive Therapy

Outcome of Exposure Treatment

Researchers	Reference	Study	Outcome
Anholt et al.	Psychother Psychosom, 2008:77(1):38-42	ERP vs CT	EQUAL
Whittal, Thorarson and McLean	Behav Res Ther ,2005:43(12):1559-76	ERP vs CBT	EQUAL
Cottraux et al.	Psychother Psychosom, 2001:70 (6): 288-97	ERP vs CBT	Equal (CBT>ERP for depressive symptoms)
McLean et al.	J Consult Clin Psychol, 2001:69(2):205-14	CBT vs ERP (Group Treatment)	ERP >CBT

Outcome of Exposure Treatment

- Despite many theories and many studies over the years
- THERE IS NO EVIDENCE that cognitive therapy is any more effective than ERP

Maybe we should use Cognitive Therapy in a targeted way???

What should good ERP look like??

Steps to ERP

- EDUCATION
- Construction of hierarchy/treatment contract
- Exposure task
- Feedback
- Preparation for discharge

Education about anxiety

- Need to understand the:
  - Physical
  - Cognitive
  - Behavioural

  symptoms of anxiety.

Education about anxiety

Three “Golden Rules” of ERP:

- Anxiety is unpleasant but it does no harm.
- Anxiety does eventually reduce.
- Practice makes “good enough”

Educate about anxiety

You need to agree and accept the 'risks' of inducing and tolerating anxiety without neutralising or engaging in compulsive behaviours

Construction of hierarchy/treatment contract

- Establish the life-style that you would like to achieve
  - " If I had a magic wand and could get rid of your OCD, what would your life be like? Where would you be living? What would be your job? Et c.
- Identify what are the current obstacles to this
- Develop hierarchy based on this

Exposure Tasks

- Choose a task initially that causes anxiety BUT AT A LEVEL YOU CAN TOLERATE without performing compulsions
- Perform chosen task 3 x /day
- Duration is until anxiety is reliable 50% - usually 1-2 hours initially
- Task should be obviously beneficial to overall goals.

Feedback

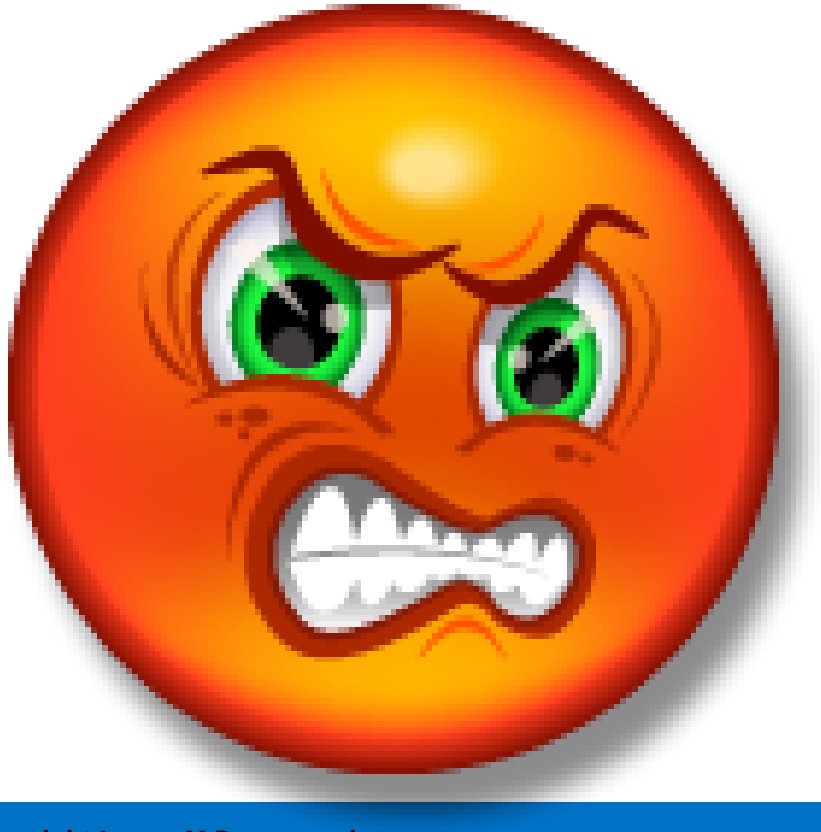
- Review progress
- PRAISE +++ Remember you have just faced your worst fears!!

- If progress is satisfactory, move up the hierarchy

Preparation for Discharge

- Increasingly the therapist will expect you to plan treatment programme yourself
- Less frequent sessions with professionals
- Start to ensure over-learning and plans for future maintenance

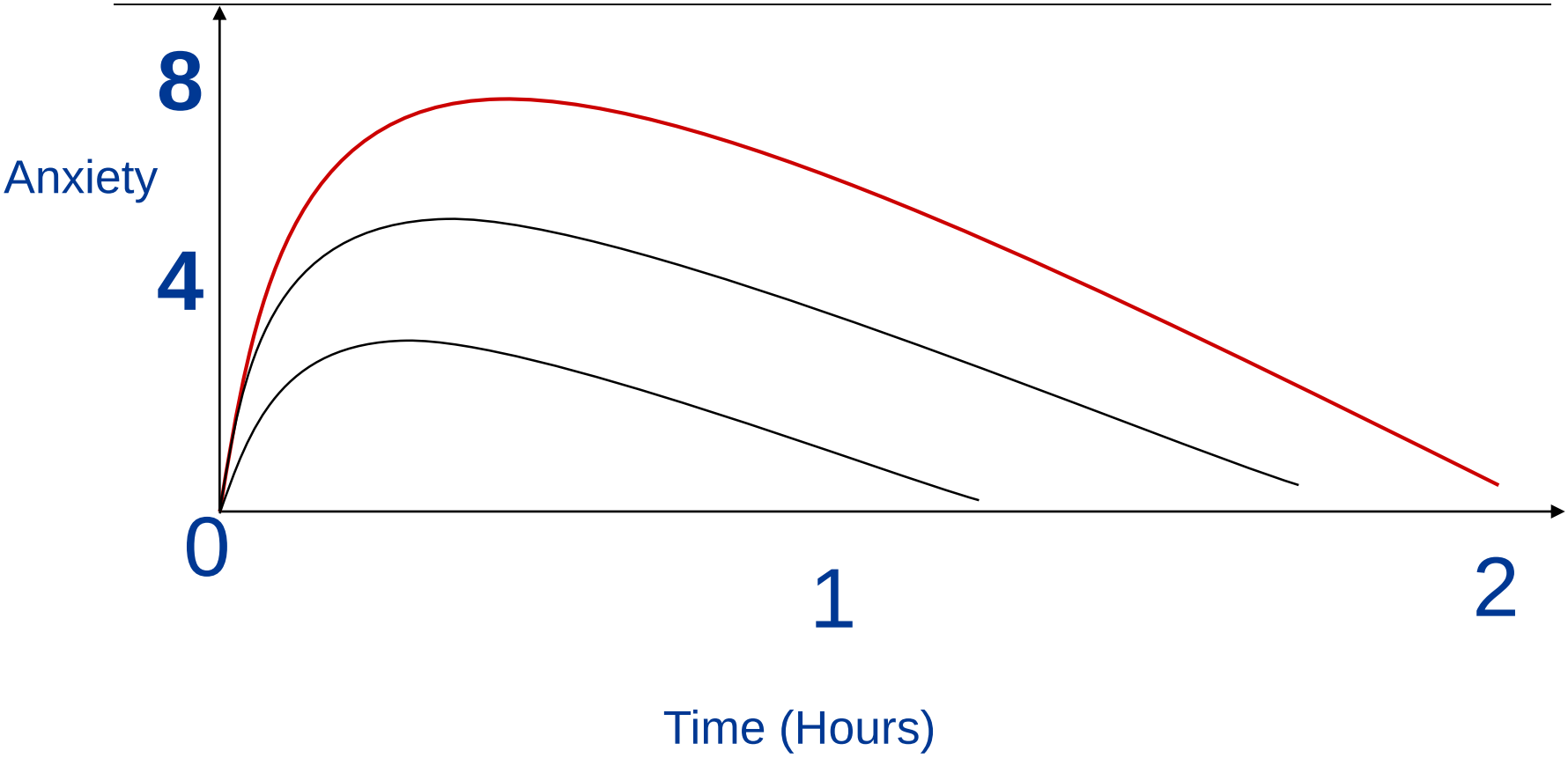
But I've had treatment using ERP and it didn't work for me??



Possible reasons for failure of ERP

- Was the exposure performed for sufficient length of time?? PROLONGED
- Was the exposure performed reliably on a daily basis?? PREDICTABLE
- Was the exposure performed without "putting it right" ?? PURE
- Was the exposure to your core fears?? PERTINENT
- Did the exposure go far enough to challenge these core fears?? PERSISTENT

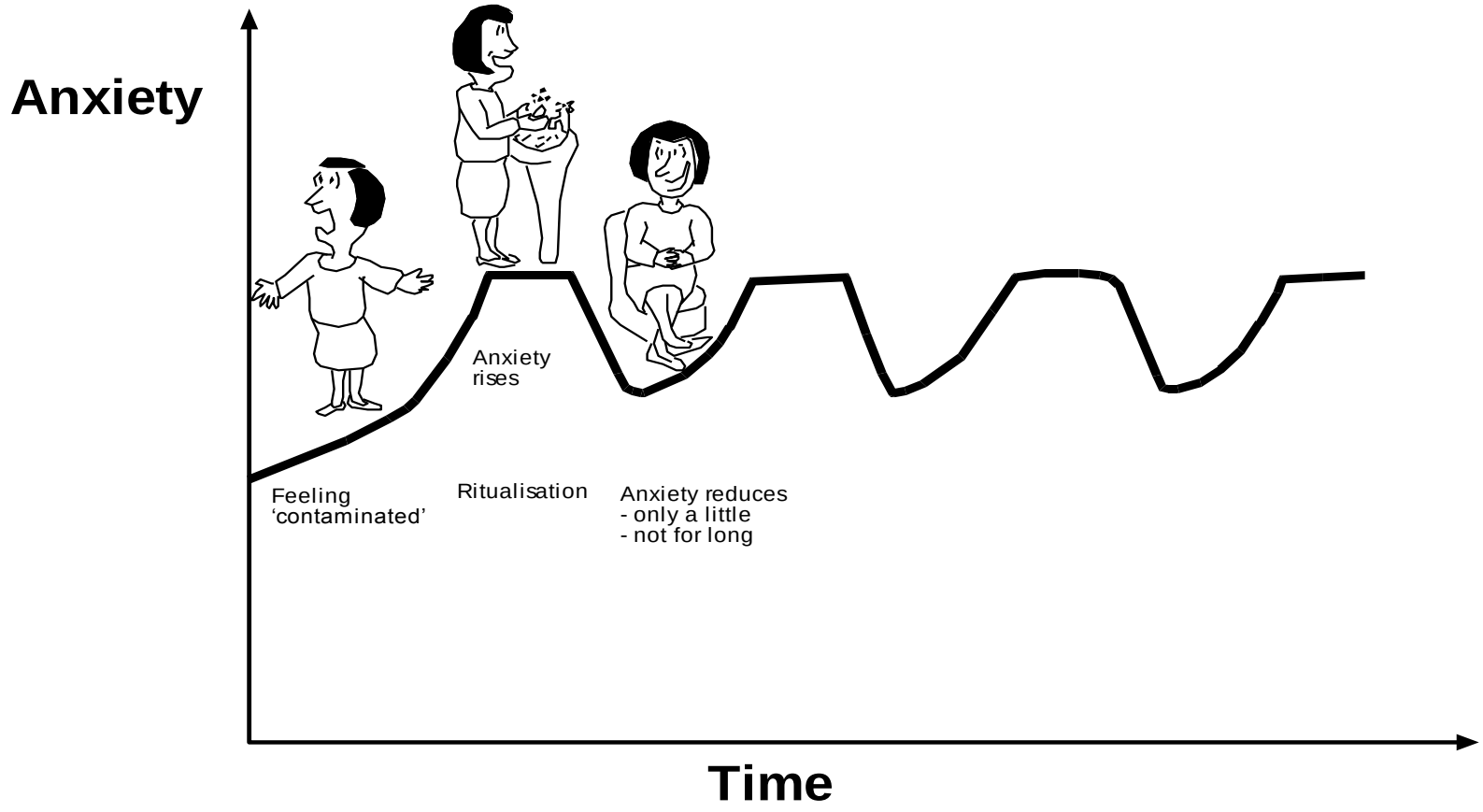
PROLONGED



PREDICTABLE

- THREE TIMES A DAY
- AFTER MEALS

PURE

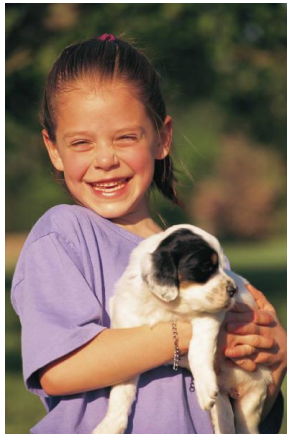


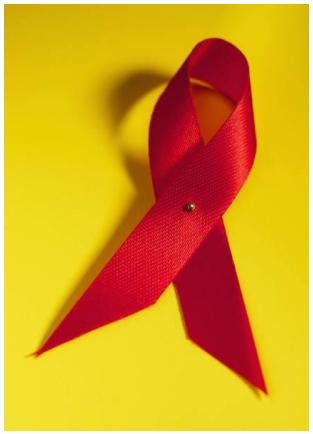
PERTINENT

- Are these really your worst fears?
- Or are you avoiding them as they are too scary??
- Is this a real fear but there are also other worse ones which you are scared to tackle

PERSISTENT

- At end of treatment you should have completely faced your worst fears……





But I tried but couldn't do this?????

Medication can help!!

Drug Treatment of OCD - CLOMIPRAMINE

Drug	Dose	Major side effects	Any special features
Clomipramine	Up to 225mg at night (increase slowly as tolerated)	Seizures in a small number of patients and less likely if <250mg Sexual Dysfunction in 80 % Dry mouth; blurred vision drowsiness; weight gain and orthostatic hypotension	The first SRI to demonstrate effectiveness in reducing OCD symptoms It is a tricyclic

Drug Treatment of OCD - SSRIs

Drug	Dose	Major side effects	Any special features
Fluvoxamine (Faverin)	50 mg in evening initially and increased gradually to 300mg (divided doses for >150mg)	Gastro-intestinal upsets; anorexia and weight loss. Insomnia Hypersenstitivity reactions Sexual dysfunction in 30%	The first SSRI to be widely used for OCD May have more side-effects than others?

Drug Treatment of OCD - SSRIs

Fluoxetine (Prozac)	20mg (usually morning) and then if inadequate response after 2 weeks then increase up to maximum of 60mg	As above	Long-half life
Paroxetine (Seroxat)	10mg initially in the morning increasing to 40mg if required	As above	Maximal dose of paroxetine is 50mg
Sertraline (Lustrial)	50mg (usually morning) increasing over several weeks to maximum of 200mg if required	As above	
Citalopram (Cipramil)	20mg increase over time to maximum of 60mg (morning or evening)	As above	Now cannot be recommended for new OCD sufferers
Escitalopram (Cipralex)	10mg increase over time to maximum of 20mg (morning or evening)	As above	Now cannot be recommended for new OCD sufferers

Outcome with SRIs

- Overall 40 – 60% of patients will respond to an SRI (McDougle et al, 1991; Piggott et al., 1999; Erzegovesi et al., 2005)

- Symptom reduction on standardised measures is 20-40% (Doughty et al., 2004)

Drug Treatment of OCD

- If the patient fails to respond to 2 different SRI drugs (clomipramine or SSRI) in maximal doses for a minimum of 3 months each and has also failed to respond to psychological treatment involving ERP then consider psychopharmacological treatment for refractory OCD

Psychopharmacological Treatment for Refractory OCD

- There are 2 main approaches to this and also some new ideas.
- **Dopamine Blockade**
  - **This is the most likely intervention outside of a specialist centre and is the most extensively researched**
  - **Doses of drug is normally considerably lower than that used for psychotic illness**
- **Supranormal doses of SSRI**
  - **Some patients are rapid metabolisers of SSRIs and thus higher doses are required**
  - **Blood levels should be checked and so this is best done at a specialist OCD clinic**

Psychopharmacological Treatment for Refractory OCD - Dopamine Blocking Agents

- There are many side-effects with Dopamine Blocking agents BUT most of these are unlikely to occur at the low low doses used in OCD

Psychopharmacological Treatment for Refractory OCD- Dopamine Blocking Agents

Drug	Dose	Major side effects	Any special features
Sulpiride	Can start as low as 100mg per day and titrate according to response	Parkinsonian and other movement disorders but rarely at lower doses	Has been used as adjunct to SRIs for OCD for >20 years Typical antipsychotic agent
Risperidone	Start at 500 micrograms and titrate according to response	Weight gain dizziness; postural hypotension and side effects for all atypical antipsychotics	

Psychopharmacological Treatment for Refractory OCD - Dopamine Blocking Agents

Olanzepine	Start at 2.5mg and titrate according to response g	As other atypical antipsychotics	Weight gain can be a major problem
Aripiprazole	Start at 2.5mg and titrate according to response	As other atypical antipsychotics plus insomnia, agitation and GI symptoms	
Quetiapine	Start at 25mg and titrate according to response	As other atypical antipsychotics plus insomnia, agitation and GI symptoms	

But surely if I'm on medication….I am a failure???

- We know people with OCD have different brain function to others without OCD
- Medication can help the ERP to work
- This may have to be continued for decades
- Cf DIABETIC

What else can go wrong in therapy????

Other problems that may occur...

- Depression (Foa 1979 found SEVERELY depressed individuals did not habituate within sessions)
- Overvalued Ideation (Foa 1979 found these individuals did not habituate between sessions)
- Obsessive Ruminations
- Obsessive-Compulsive Slowness
- Thought-Action Fusion

DEPRESSION

Depression

- Most patients with severe OCD are depressed but most improve as the OCD improves but if not habituating....

- Start Medication with SSRI
- +/- Cognitive Therapy for depression

OVERVALUED IDEATION

Overvalued Ideation

- Everyone with OCD will claim to believe in the obsession if there has been recent exposure but for some this goes further.....

- Add Dopamine blockade to SSRI
- Cognitive therapy - Psychoeducation

Psychoeducation and Normalisation

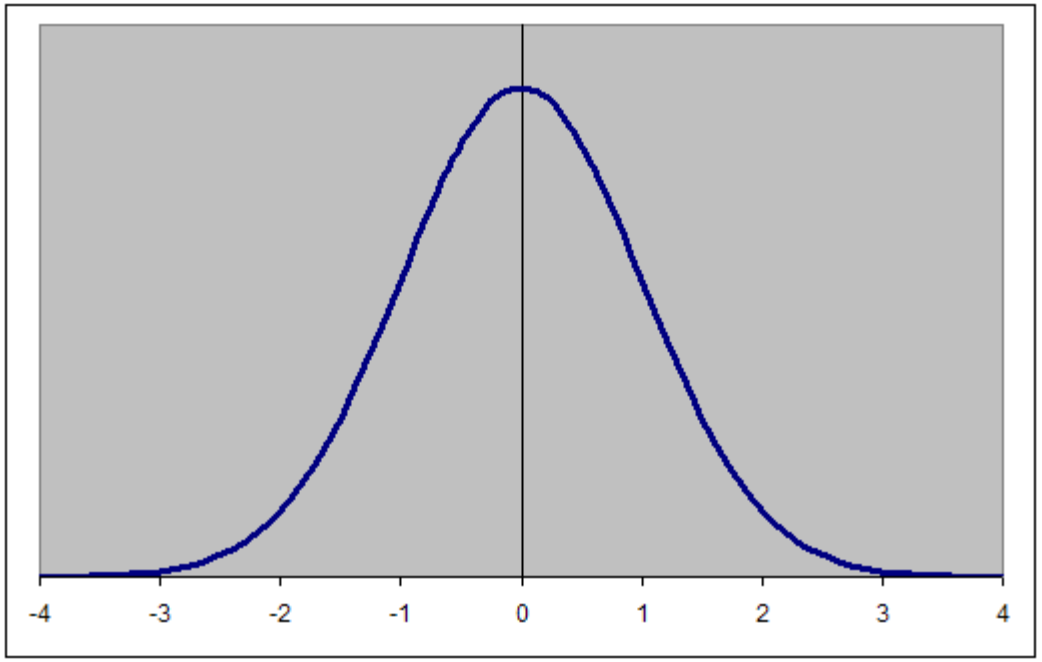
- Many OCD sufferers have been brought up with parents who also suffer from OCD and thus are unaware of “normal” behaviour

  OR

- Many OCD sufferers have had the problem so long they have forgotten “normal” behaviour

- Need to educate the patient about “normality” using “normalisation” or psychoeducation

Normalisation



Normalisation involves....

- Providing a sufferer correct information either yourself or by setting them a task to :
  - Check the internet
  - Ask friends

  - BUT...BE CAREFUL THIS DOESN'T BECOME REASSURANCE!!!!

Normalisation examples.....

- Man believes the fact that he finds some 14 year old girls mildly sexually attractive is a sign of paedophilia
- Woman very worried about catching HIV by touching areas in GP surgery and hospital

Psychoeducation

- E.G the DIRT programme for people with contamination fears developed at the University of Sydney.....

Danger Ideation Reduction Therapy = D.I.R.T Developed by Jones and Menzies 1998 in Sydney, Australia

D.I.R.T.

- **Corrective Information**
- **Microbiological Experiments**
- **Possibility of Catastrophe**
- **Filmed Interviews**
    - **Filmed interviews with workers in a range of relevant occupations**
- **Attentional Focussing**
- **Cognitive Restructuring**
    - **Identify unrealistic thoughts related to contamination/illness and teach to re-evaluate these. Rote learn reappraisals**

Corrective Information

The OCD Sufferer is asked to view a list of facts about their feared contaminant. For example, the number of health-care workers who have contracted H.I.V. through their work.

The patients are also given information about the deleterious effects of overzealous hand washing. This is a report which discusses how the hand washing can break the skin's natural barrier to infection.

Microbiological Experiments

Results of microbiological experiments which were undertaken at the University of Sydney are discussed

In these experiments subjects were asked to touch frequently feared contaminants such as money or toilet door handles with one hand while keeping the other hand “clean”. Fingerprints from both hands were then imprinted on blood agar plates. Normal commensal flora were found after culture and no pathogens found despite subjects having touched such contaminants as dogs’ hair and toilet doors.

Probability of Catastrophe

- OCD Sufferer asked to estimate the probability of catastrophe occurring in different situations.
- Then asked to break down this scenario into its component parts
- Estimate the likelihood of the feared consequence at each stage.
- Computed and compared with the original probability estimate.

Example of Probability of Catastrophe Estimation

- **Original estimate of risk of contracting salmonella infection from touching rubbish bins = 90%**
- **Split this up**
  - **How often rubbish contain salmonella?**
  - **Risk of salmonella getting on outside of bin from rubbish?**
  - **Travelling on bin to Fingers?**
  - **Getting past skin barrier?**
  - **Not being destroyed by body immune defences?**

Filmed Interviews

.

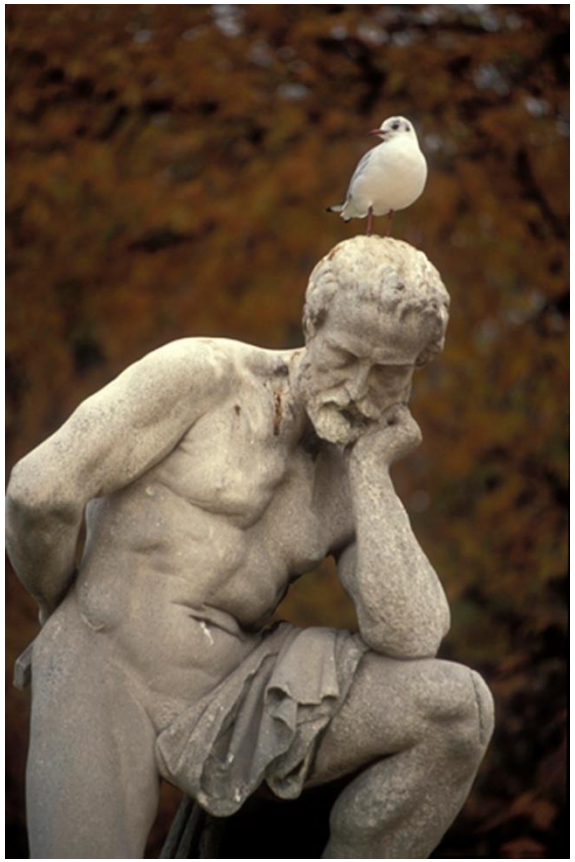
Filmed interviews with people who work in situations commonly feared by obsessive-compulsive patients.

For example, bank tellers who handle money, cleaners who handle cleaning fluids and clean other peoples' dirt.

Filmed Interviews

- The interviewee is asked to describe their contact with the feared "contaminant" and is then asked about their health and their and their colleagues sickness record.
- Only the appropriate film for the patient's feared contaminant is used.

OBSESSIVE RUMINATIONS



Obsessive Ruminations

- ANXIOGENIC obsessions
- ANXIOLYTIC compulsive thoughts
- EXPOSE to ANXIOGENIC
- PREVENT ANXIOLYTIC

Obsessive Ruminations –techniques to aid ERP

- Exposure using:
  - Deliberately provoking thoughts
  - Writing
  - Loop tape
  - Cue cards

OBSESSIVE COMPULSIVE SLOWNESS

Obsessive Compulsive slowness

- Usually is due to PERFECTIONISM
  - " If a thing's worth doing it is worth doing absolutely completely correctly at all times and despite whatever else"

Other Causes of Obsessional Slowness

- Doubting actions
  - Self-observation
  - Repeating
  - Breaking down complex tasks
  - Counting

- The “just right” feeling

Interventions

- PERFECTIONISM
  - deliberately do things incorrectly

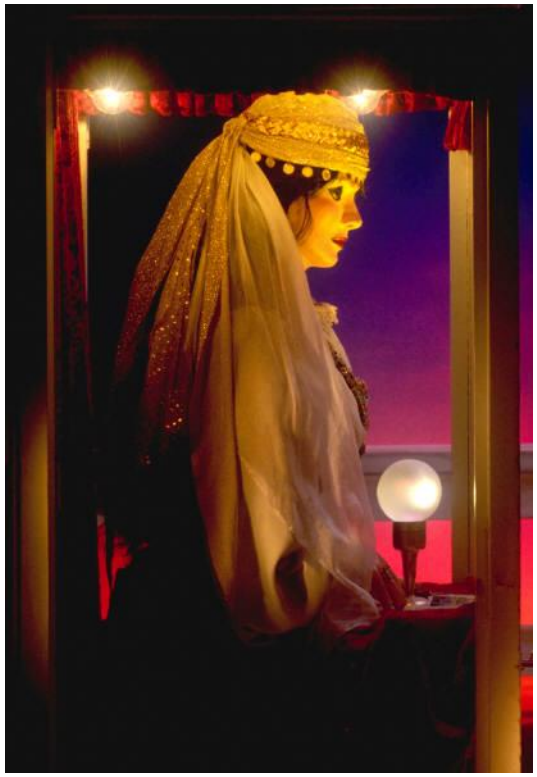
Interventions

- Prompting & pacing
  - I.e. talking the patient through speeding up their actions…usually with modelling to begin with…can then be recorded so that patient can use on their own until new routines are established

Interventions

- Taking the risk
  - Encourage the patient to take the risk that things may not be done perfectly

THOUGHT-ACTION FUSION

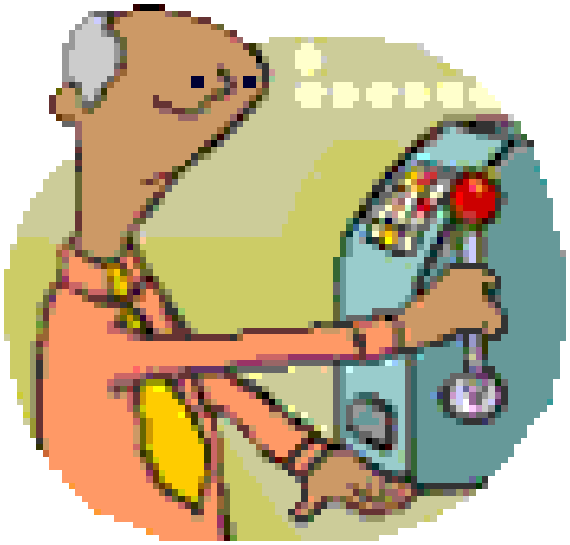


Thought-action fusion

- Thought is morally equivalent to deed
- Thinking about a negative outcome will cause a negative event to occur to self or others.
- Belief that the thought is evidence that this deed has or will be

Thought-action fusion

- Test out the belief
  - E.g lottery tickets to start with and then move on to wishing harm befalls therapist before moving onto family.



Dealing with Severe, Chronic Resistant Obsessive Compulsive Disorder

Treatment in an Inpatient Unit for Level 6 patients who also present a danger to self or others (needing 24 hour nursing care)

Basic criteria for treatment in National Service for OCD/BDD

- YBOCS>30 = Profoundly severe OCD

- 2 trials of different SRIs at BNF approved doses for >3 months
- Augmentation of above with dopamine antagonists or supra-normal SRI dosage or mood stabilisers
- 2 trials of CBT which should include Exposure and Self-Imposed Response Prevention – one of these trials should normally be carried out in a situation where symptoms are maximal e.g. intensive community and home-based treatments.

Criteria for admission to Inpatient Unit

- Danger to self either due to chronic suicidality (acute suicidal episodes should be managed by local services) or due to extreme self-neglect (e.g. failure to drink sufficiently with incipient renal failure without nursing input)
- Danger to others due to OCD (e.g. impulsive acts)
- Compulsions so severe that cannot manage without 24 hour care (e.g. regular incontinence due to OCD; Compulsions: taking >3 hours to get up in morning)

OCD Patients treated as inpatients

- **100 patients (55 men ; 45 women)**
- Average age = **35 years**

  (sd 12 range 18-66yrs)
- Mean Duration of diagnosed OCD = **17 years**

  (sd11;1-50years)
- 80% Long-term unemployed
- 85% were not in any cohabiting relationship

Physical attributes of OCD IP

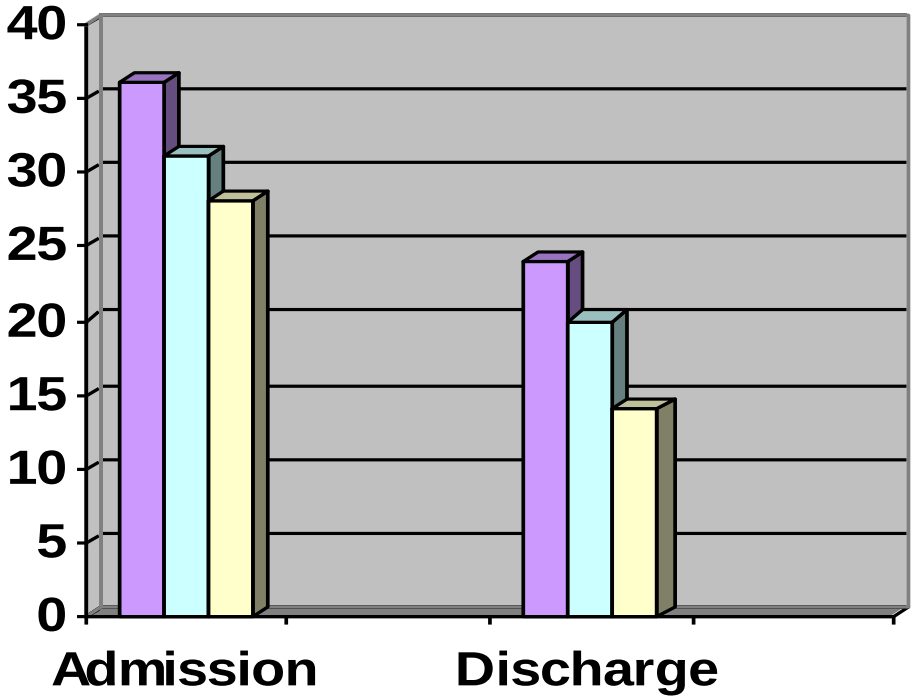
- 21% had raised urea and evidence of renal impairment
- 40% incontinent of urine+/- faeces on admission

Outcome of Treatment

Measure	Average Score at Admission (Number; sd)	Average Score at Discharge (n; sd)	Percent Change	Statistical sig
YBOCS [1,2]	36 (86; 3)	24 (86; 8)	33%	P<0.001
BDI[1,2]	31(76; 11)	20(76;12)	35%	P<0.001
Sheehan Disability Scale[1,2]	28(62;3)	14 (62; 7)	50%	P<0.001

[1] Paired T-test
[2] Intention to Treat Analyses

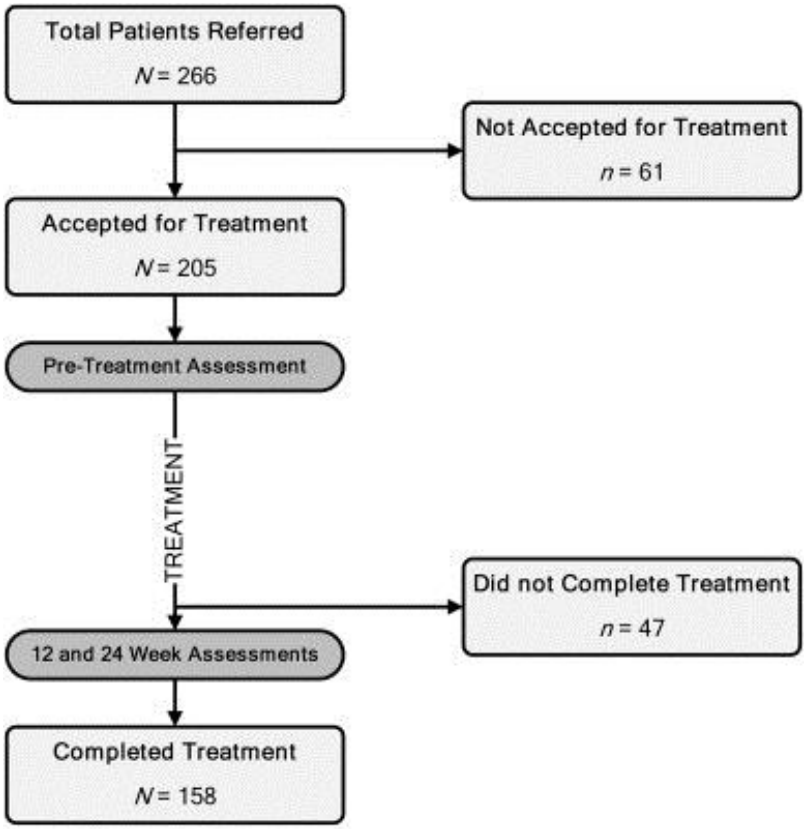
Outcome of Treatment



YBOCS = 33%
BDI = 35%
Sheehan =50%

Clinical Outcome for patients treated in the Community

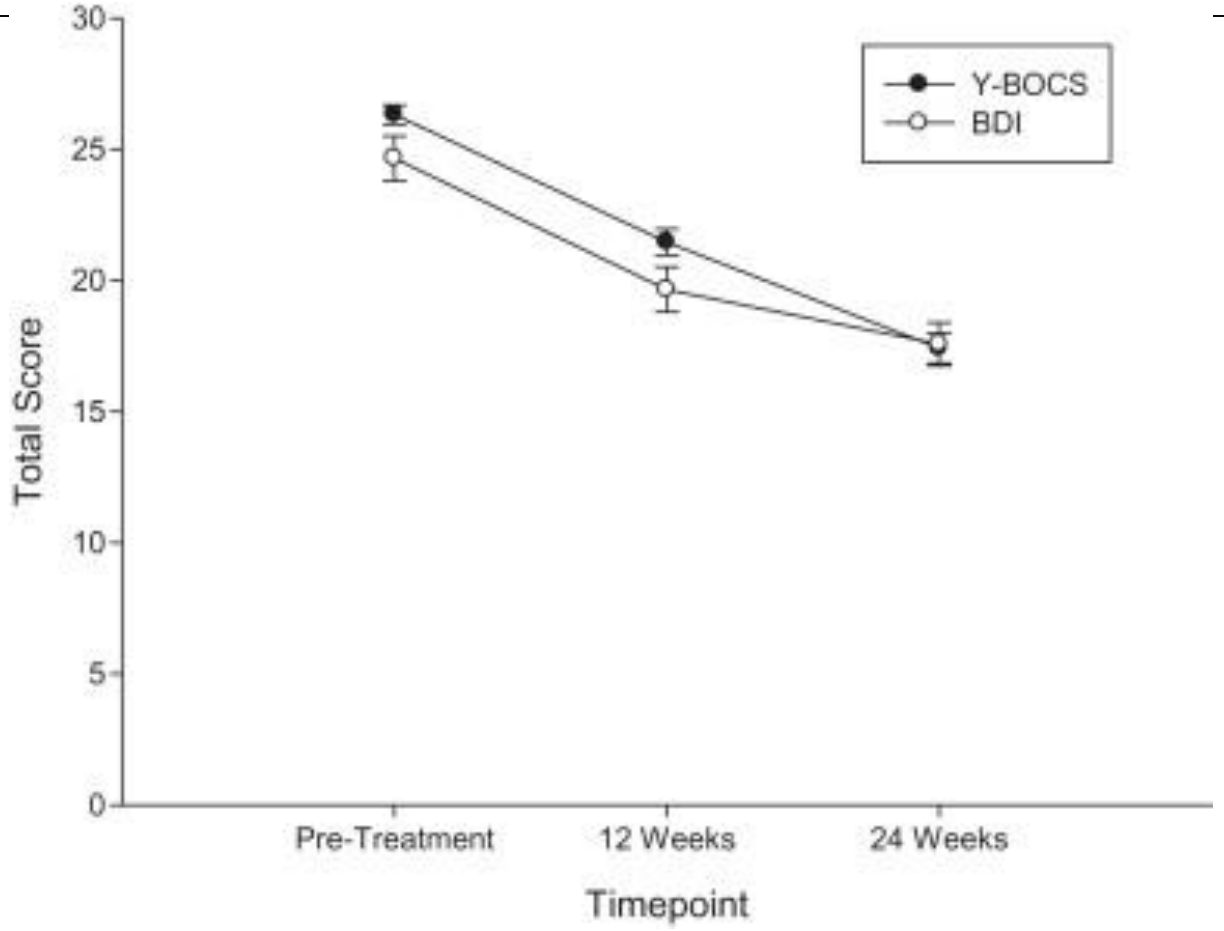
Boschen, MJ and Drummond, L.M. (2012) Community treatment of severe, refractory obsessive-compulsive disorder. Behaviour Research and Therapy 50, 203-209



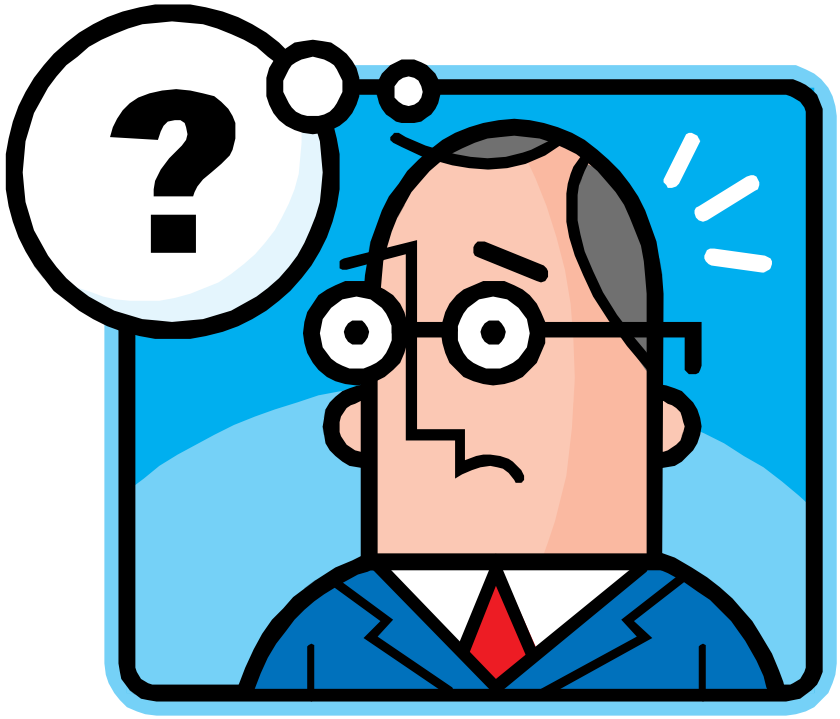
Boschen, MJ and Drummond, L.M. (2012) Community treatment of severe, refractory obsessive-compulsive disorder. Behaviour Research and Therapy 50, 203-209

Measures	Start of Treatment Mean (S.D)	After 24 weeks Mean (S.D)	Reduction	p-value
YBOCS (n=158)	28(6) (SEVERE)	18 (7) (MODERATE)	39%	<0.0005
BDI (n=158)	25 (12) (MODERATE)	18 (12) (BORDERLINE)	36%	<0.0005

Boschen, MJ and Drummond, L.M. (2012) Community treatment of severe, refractory obsessive-compulsive disorder. Behaviour Research and Therapy 50, 203-209



So is it worthwhile revisiting CBT????



YOU BET IT IS!!!!