CHAPTER 1

Introduction to Obsessive–Compulsive Disorder

Obsessive–compulsive disorder (OCD) is a psychological disorder that is diagnosed based on the presence of either obsessions or compulsions (although, in most cases, both typically occur). Obsessions can take the form of thoughts (e.g., "That stain on the floor is dried blood!"), images (e.g., mutilated bodies), urges (e.g., to blurt out an obscenity in a formal setting), or impulses (e.g., to push an unsuspecting person in front a train). Note the repugnant, distasteful, and inappropriate nature of obsessions. They are typically much more bizarre and upsetting than everyday worries, and the individual usually knows that they don't make sense. Nevertheless, they occur over and over again and feel impossible to control and therefore become extremely anxiety-provoking and distressing. In an attempt to cope with these obsessions, the individual often tries to suppress or neutralize them in some way to make them go away—such as through use of repetitive behaviors or mental acts (i.e., compulsions or rituals) or through avoidance of situations that trigger the obsessions. Both obsessions and compulsions are time consuming and significantly interfere with the individual's ability to function in life.

OCD (by various names) has been noted in the literature for centuries. For example, persons with obsessive blasphemous or sexual thoughts were once considered to be *possessed*, as was consistent with the more religious worldview of the time and, as such, *exorcism* was considered the treatment of choice. Over the years, the explanation of obsessions and compulsions moved from a religious view to a medical view, which was formalized in 1838, when Jean-Étienne Dominique Esquirol (1772–1840) first described OCD in the psychiatric literature.

By the end of the 19th century, OCD was generally regarded as a manifestation of melancholy or depression, and by the beginning of the 20th century, theories of obsessive–compulsive neurosis shifted toward psychological explanations. In the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-I; American Pyschiatric Association, 1952), OCD was called "obsessive compulsive reaction." In DSM-II (American Pyschiatric Association, 1968), OCD was called "obsessive compulsive neurosis." With the publication of the DSM-III (American Pyschiatric Association, 1980), however, OCD as we now understand it was named and described. The definition only changed slightly in DSM-III-R (American Pyschiatric Association, 1987) and in DSM-IV (American Pyschiatric Association, 1994), and was not changed at all in the DSM-IV-TR (American Pyschiatric Association, 2000).

In DSM-5 (American Pyschiatric Association, 2013), however, OCD was removed from the anxiety disorders section and placed into a new, separate section called "obsessive–compulsive and related disorders." This section consolidated OCD with body dysmorphic disorder and trichotillomania, as well as newly added diagnoses of hoarding disorder and excoriation (skin-picking) disorder, and new diagnostic categories of substance/medication-induced OCD and OCD due to another medical condition. Also added was the following specifier, where indicated: With good or fair insight, with poor insight, or with absent insight/delusional beliefs. The decision to create a separate section for these disorders was based on the latest scientific evidence, which supported the interrelatedness of these disorders in terms of several diagnostic validators (e.g., symptoms, neurobiological substrates, familiality, course of illness, and treatment response) as well as the clinical utility of grouping these disorders in the same chapter.

Despite OCD being recognized in the medical literature over 175 years ago, historically, it has taken, on average, 14 to 17 years for people suffering with it to be accurately diagnosed and treated. This delay appears to be related to several factors, including (1) the tendency of many people to hide their symptoms, often in fear of embarrassment or stigma, and thus failure to seek seek help until many years after the onset of symptoms; and (2) the scant public awareness of OCD until recently, so that many people suffering from OCD were unaware that their symptoms were actually part of a disorder that could be treated.

More recently, however, OCD seems to have caught the interest of the mainstream media, and, as a result, it has now been portrayed in characters in films (e.g., *The Aviator*, *As Good as It Gets*) and television shows (e.g., *Monk*, *Glee*); featured on documentaries and reality series (e.g., MTV's *True Life*, A&E's *Obsessed*, VH1's *The OCD Project*, A&E's *Hoarders*, and TLC's *Hoarding: Buried Alive*); and linked to a growing list of celebrities who have admitted having the diagnosis (e.g., Megan Fox, Alec Baldwin, Jennifer Love Hewitt, Howie Mandel, Howard Stern, Leonardo DiCaprio, Charlize Theron, Cameron Diaz, Billy Bob Thorton, and Jessica Alba). Although it is hoped that all of the media attention will ultimately be to the benefit of sufferers via an increase in awareness and destigmatization, it should be noted that some forms of OCD that are less "classic" or common may not be so easily recognized by the public, the patient, the patient's family members, friends, or coworkers—or even seasoned therapists.

Complicating matters further is the research suggesting that the average person has approximately 4,000 distinct thoughts in a typical waking day (16 hours), with approximately 500 of these thoughts being spontaneous, out of character, and experienced as intrusive (Klinger, 1978, 1996). In addition, this appears to be a global phenomenon: a recent study found that as many as 94% of people in 13 countries, across six continents, experience unwanted intrusive thoughts (Radomsky et al., 2014). There are also many people in community samples who report engaging in behaviors that could easily be classified as rituals, such as commuters who perform a check of their seat as they get up to leave a train or bus to "make sure" they did not leave something behind and people who use a public bathroom and place some form of barrier on the toilet seat or flush the toilet using one of their feet instead of one of their hands. Yet, not all of these people would be diagnosed with OCD.

Finally, in society today, we are constantly bombarded with stories in the press that contain warnings about the threats and dangers that are all around us, waiting to happen—all of which can encourage, if not create, compulsive-like behaviors. For example, we hear all the time about contamination hazards from bodily fluids and cleaning agents, dangers of radiation from cell phones, X-ray equipment, and computers, and the personal devastation caused by home invasions

and robberies and, more recently, digital pickpocketing and identity theft. Constantly hearing this type of negative, sensationalized news can generate feelings of anxious apprehension, which in turn switches on our natural instinct to take action to make things safe. Yet, engaging in these types of behaviors would also not necessarily warrant a diagnosis of OCD.

So what is OCD? The above examples demonstrate an important fact of OCD (and most other mental health disorders): rather than being categorical in nature (i.e., either you have it or you don't), it is more dimensional (i.e., many of the defining symptoms are commonly found in most people, but it only crosses over into becoming a disorder at certain levels of severity). As such, it becomes important to understand the criteria used to determine when the symptoms of OCD move from being normal to being pathological.

DIAGNOSTIC CRITERIA FOR OCD

To be diagnosed with OCD, an individual must experience *obsessions* or *compulsions* that are *severe enough* to cause a great deal of distress, interfere with the individual's life in some way (work, academic, social, etc.), and/or take up a lot of time (e.g., more than 1 hour a day). In addition, the *content* of the obsessions or compulsions cannot be better accounted for by another disorder (e.g., excessive checking to make sure the doors and windows are locked at night in a patient diagnosed with posttraumatic (PTSD) after being physically assaulted). Finally, the symptoms of OCD cannot be due to the direct effect of substance abuse, a medication, or a general medical condition. Please refer to the most recent version of the DSM for more detail on the diagnostic criteria.

MOVING FROM NORMAL TO PATHOLOGICAL

As it is fairly common for people in societies around the world to experience unwanted intrusive thoughts and to engage in occasional rituals, establishing the presence of obsessions and/or compulsions is necessary but not sufficient to establish a diagnosis of OCD. The key step is to determine how much distress, disruption, or disability the experiencing of these symptoms is causing. To determine this effect, you can ask if the person is ever late in getting to work or school or in completing projects, papers, assignments, or tasks owing to obsessions or compulsions. In addition, you can also ask if the person's social life/relationships have been negatively impacted by the symptoms. Alternatively, you can ask the person to think of an average day and give an estimate of the total time he spends preoccupied with obsessive thoughts or engaged in compulsive behaviors. Finally, given that the person is presenting to you for help, you can typically assume he is experiencing a great deal of distress (unless his family, friends, or employer has pressured the patient into attending treatment).

RULING OUT OTHER DIAGNOSES

Along with establishing the severity (i.e., distress, disruption, or disability) of the symptoms, it's important to remember that a diagnosis of OCD should not be given if the content of the obses-

sions or compulsions is better accounted for by another psychological disorder. For example, symptoms resembling OCD that would not warrant a diagnosis of OCD include repetitive hair pulling in a patient diagnosed with trichotillomania; obsessive thoughts about having a disease or illness along with excessive medical check-ups in a patient diagnosed with either somatic symptom disorder or illness anxiety disorder; or obsessive thoughts about food in a patient diagnosed with an eating disorder. In addition, the symptoms of OCD must not be due to the direct effect of substance abuse (e.g., cocaine), a medication (e.g., thyroid medications), or a general medical condition (e.g., Parkinson's disease, brain injury).

In some cases, however, symptoms that mimic OCD that are better explained by another disorder may appear *in addition to* other symptoms of OCD that are *not* better explained by this disorder. As a result, it is important to be knowledgeable of common comorbid conditions and thorough and detailed in your assessment in order to make a precise differential diagnosis. This issue will be discussed in more detail in Chapters 2 and 4.

SPECIFIERS

Individuals with OCD differ in their level of understanding about the accuracy of the thoughts, images, impulses, or urges central to their disorder. The DSM refers to these different levels of understanding as different levels of *insight*, which can range from good to absent. In brief, the poorer the insight (i.e., the less a patient recognizes his or her obsessions as unreasonable), the greater the chance that treatment of the patient will be challenging. Please refer to the most recent version of the DSM for more detail on the different specifiers that can be used to account for differing levels of insight.

Also, insight can vary *within a patient* over the course of the illness (again, with poorer insight generally being linked to worse treatment outcome). Thus, at certain times an individual patient may acknowledge that his symptoms are unreasonable and/or excessive, whereas at other times that same patient may be totally convinced that his beliefs are true! Thus, throughout the treatment it is important to check in from time to time on the patient's level of understanding about the accuracy of his obsessions.

Finally, when the individual has a history of a *tic disorder*, you should use the specifier "tic-related" (the DSM notes that up to 30% of individuals with OCD have a lifetime tic disorder and that this condition is most common in males with onset of OCD in childhood).

RATIONALE FOR COGNITIVE–BEHAVIORAL TREATMENT

As will be discussed in more detail in Chapter 2, the exact cause of OCD remains unknown. Perhaps that is why many competing theories have emerged over the years, often espousing very different approaches to treatment. This competition likely helped fuel the significant advances that have been made in the treatment of OCD. In just the past 30–40 years, for example, our notion of OCD has moved from that of a disorder that came with a poor prognosis to one in which many patients can expect to see a significant response to treatment and, occasionally, a total remission of the disorder). At the same time, it has also made it confusing for patients (and clinicians) to know which approach to begin with when starting treatment of OCD.

Fortunately, various expert consensus guidelines have been written over the years to aid in the treatment selection for patients diagnosed with OCD (e.g., March et al., 1997; National Institute for Health and Clinical Excellence, 2005; Nathan & Gorman, 2015; *www.psychologicaltreatments.org*). Of the many different psychological treatments offered for OCD, cognitive-behavioral therapy (CBT) in general, and exposure and ritual prevention (Ex/RP) in particular, have the strongest evidence base. As such, a consistent recommendation found in the expert consensus guidelines is to start treatment with CBT alone or in combination with a medication, with the likelihood that a medication will be included in the recommendation varying as a function of both the severity of the OCD and the age of the patient. For example, for milder forms of OCD, starting treatment with CBT alone appears to be the expert consensus. As the severity of the OCD increases, however, expert consensus guidelines are more likely to suggest adding a medication to CBT as the initial treatment—or even starting with medication alone. Similarly, for younger patients, as the patient's age decreases, expert consensus guidelines are more likely to suggest using CBT alone.

CBT, with its focus on cognitions (e.g., obsessions, mental rituals) and actions (e.g., behavioral rituals) and their connection to emotions (e.g., anxiety), lines up nicely with the DSM criteria for OCD. In addition, CBT's emphasis on the present, providing patients with education about their disorder, and being more actively involved as a therapist can be utilized to "meet patients where they are," normalize their symptoms, and encourage patients to become active collaborators in their treatment. Together, these elements serve to instill hope and increase motivation for change—even in patients who have suffered with the disorder for years.

CBT is, however, a challenging treatment for some patients to embrace. In fact, critics of CBT point out that some studies using Ex/RP for OCD have very high patient dropout rates. As such, it is very important for clinicians who are new to this treatment to understand how it works, so that they may first present it to their patients in a way that demonstrates an understanding of, and confidence in, both the CBT model and treatment components and then be able to anticipate any potential problems, concerns, or issues that their patients may experience. If the treatment is presented properly, patients hearing it will likely feel anxious about the short-term challenges that lie ahead, but confident in the therapist's ability to help them get through it, as well as their long-term prognosis.

USING THIS TREATMENT PLANNER

This book is intended to be a comprehensive guide for clinicians who wish to take an evidence-based approach to the treatment of OCD. Experienced clinicians, new professionals, and graduate students should all find useful information within this planner to guide their treatment of OCD. Although no prior training in CBT is required for use of this treatment planner, a basic knowledge of the key concepts of CBT will be useful for any practitioner. Interested readers should refer to Appendix A (Resources) for suggested readings.

Included in this treatment planner are the diagnostic criteria for OCD; background information on the conceptualization and treatment of OCD; assessment tools; patient handouts and worksheets; a session-by-session treatment manual for clinicians wanting to know the "nuts and bolts" of conducting Ex/RP; a chapter containing supplementary techniques from cognitive therapy, acceptance and commitment therapy, and metacognitive therapy; and an extensive case

example to illustrate the treatment plan in action. Used together, these materials will equip you to assess, diagnose, conceptualize, and treat a patient with OCD, using Ex/RP as a backbone and supplementing with additional techniques when necessary.

Before providing this treatment, you should be familiar with the entire treatment protocol. In addition, consistent with ethical guidelines for clinical conduct, you should seek clinical supervision prior to treating an individual when the presenting problems are outside the bounds of your expertise.

Despite the rise of alternative psychological treatments, it is important to note that Ex/RP remains the "treatment of choice" for OCD. As such, it is strongly recommended that you use the cognitive-behavioral treatment plan described in detail in this planner first, in conjunction with a detailed assessment and case formulation (see Chapter 4), for the appropriate target population (adults and adolescents with a primary diagnosis of OCD, in an outpatient treatment setting).

Of course, it is expected that you will adapt the treatment to fit each patient's unique symptoms and needs, and will augment the treatment with additional evidence-based treatment components as roadblocks are encountered. To support your individualizing each client's care, I make suggestions for incorporating components from other evidence-based treatments into the treatment. Thus, the included treatment planning materials represent a synthesis of Ex/RP, the gold-standard treatment for OCD, along with more recent innovations that have burgeoning empirical bases.

In this introductory chapter, I have discussed the history of OCD, explored the diagnostic criteria of OCD, defined obsessions and compulsions, and provided basic information about CBT and its application to OCD. In Chapter 2, I expand on the essential features and give examples of subtypes of OCD, discuss comorbid conditions and differential diagnosis, provide a review of the epidemiology of OCD, and summarize several different theories that have been offered to explain the etiology and maintenance of OCD.

Chapter 3 reviews the various evidence-based treatments for OCD, including biological treatments (e.g., pharmacotherapy, stereotactic neurological procedures, subconvulsive stimulation treatments) and psychological treatments (cognitive therapy, behavioral therapy, with and without various medications) in different formats of delivery and treatment settings.

Chapters 4 and 5 present a detailed discussion of how to use diagnostic and clinical evaluations to aid in the assessment, diagnosis, and case formulation and, in so doing, maximize the potential for a positive treatment outcome.

Chapter 6 provides a detailed overview of the treatment plan, with Chapters 7–13 presenting session-by-session suggestions for implementing Ex/RP for OCD, including thorough descriptions of interventions, in-session worksheets, patient handouts, and suggestions for between-session homework. Although this 16-session treatment manual has been written for adult and adolescent patients seeking outpatient treatment for OCD, it can also readily be adapted for younger or older patients.

Chapter 14 includes a summary of additional techniques taken from three other evidence-based treatments (cognitive therapy, acceptance and commitment therapy, and metacognitive therapy) that can be used to supplement the core treatment.

Chapter 15 offers a case example that parallels the session-by-session treatment planner.

Chapter 16 offers a summary, some reminders and concluding remarks, and of course, a few final take-home messages!

Finally, in the two appendices you will find resources (readings, websites, sources for expert consensus guidelines, and lists of empirically based self-report measures) and reproducibles (forms and handouts) that will help you in the delivery of the treatment.

TAKE-HOME MESSAGE

If we start to view OCD "symptoms" as global and universal phenomena, we can learn a few valuable lessons about the assessment, diagnosis, and treatment of patients with OCD. First, we must keep in mind that intrusive thoughts and compulsions are *common*—almost all people experience occasional symptoms that are, in content, no different from those of patients diagnosed with OCD. As a result, OCD is a disorder that is best viewed in a *dimensional* rather than *categorical* manner. Second, in order to move from normal to abnormal, the symptoms of OCD must take up a significant amount of time, cause significant distress, or significantly impact on the person's work functioning, social life, or home responsibilities. Third, many other psychological, medical, and substance-related disorders can generate symptoms that resemble those found in OCD. As such, a careful screening should be conducted to allow for a meaningful differential diagnosis and consideration of comorbid disorders. Lastly, patients' insight into the nature of their OCD is often dynamic. As a result, it may be useful to view the patient's level of insight about her symptoms as fluctuating on a spectrum, ranging from seeing them as normal intrusive thoughts to believing 100% that they are true (i.e., delusional thinking). It may also prove useful to inquire about whether a patient's insight has shifted over the course of the disorder. Of the many different psychological treatments offered for OCD, CBT, in general, and Ex/RP, in particular, have the strongest evidence base and, as such, treatment should begin with Ex/RP—either alone or in combination with a medication.