Cognitive Therapy for OCD – Beyond ERP

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Delivering cognitive-behavioural therapy (CBT) for obsessive-compulsive disorder (OCD) requires a detailed understanding of the phenomenology and the mechanism by which specific cognitive processes and behaviours maintain the symptoms of the disorder. A cognitive-behavioural model of OCD begins with the observation that intrusive thoughts, doubts or images are almost universal in the general population and their content is indistinguishable from that of clinical obsessions(1). The difference between a normal intrusive thought and an obsessional thought lies both in the meaning that individuals with OCD attach to the occurrence or content of the intrusions and in their response to the thought or image.

THOUGHT-ACTION FUSION

An important cognitive process in OCD is the way thoughts or images become fused with reality. This process is called 'thought-action fusion' (2). Thus, if a person thinks of harming someone, they think that they will act on the thought or might have acted on it in the past. A related process is 'moral thought-action fusion', which is the belief that thinking about a bad action is morally equivalent to doing it. There is 'thought-object fusion', which is a belief that objects can become contaminated by 'catching' memories or other people's experiences (3). 'Thought-event fusion is the belief that an intrusive thought can cause a particular event to occur or the belief that an intrusive thought means that an event must have already occurred (4).

RESPONSIBILITY

One of the core features of OCD is an inflated sense of responsibility for harm or its prevention. The belief that one has power to bring about or prevent subjectively crucial negative outcomes. These outcomes may be actual, and/or at a moral level' (5).

Individuals with OCD believe they can and should prevent harm from occurring, which leads to compulsions and avoidance behaviours.

NON-SPECIFIC COGNITIVE BIASES

Another important feature is less attention is focused on real events. An excessively narrow focusing on monitoring occurs for potential threats, even when no immediate threat is present. This reduces the individual's confidence in his memory, which in turn leads to further checking behaviours. Intrusive thoughts, images or urges are often accompanied by an excessive attentional bias on monitoring them. This leads to a heightened cognitive self-consciousness and an increase in the detection of unwanted intrusive thoughts and worries about not performing a compulsion or safety behaviour.

EMOTION

The dominant emotion in an obsession may be difficult for some patients to articulate but it is commonly anxiety. Some also experience disgust, especially when they think that they could have been in contact with a contaminant. Feeling of shame, condemnation and guilt is also very common. Depression is present due to various secondary problems caused by the handicap; however, comorbidity with a mood disorder is relatively common. At times, anger, frustration and irritability are prominent. Because of the range of emotions, patients find it difficult to articulate their dominant emotion.

COMPULSIONS AND SAFETY - SEEKING BEHAVIOURS

A compulsion can either be overt or a covert mental act. Covert compulsions are generally more difficult

to resist or monitor, as they are easier to perform. The term 'rumination' covers both the obsession and any accompanying mental compulsions and acts. Compulsions may function as a means of avoiding discomfort, as in obsessional slowness (6).

AVOIDANCE

Although avoidance is not part of the definition of OCD, it is an integral part of the disorder. It is most commonly seen in fears of contamination. Avoidance can also occur mentally (like, trying not to think or feel something upsetting). Not all situations can be avoided and safety-seeking behaviours are often used within a feared situation.

The treatment protocol of OCD specifies a number of stages of treatment. Those are as follows :

- Working with patients to develop a comprehensive cognitive-behavioural model of the maintenance of their obsessional problems.
- Detailed identification and self monitoring of obsessional thoughts, and individuals' appraisal of them.
- Modifying their beliefs about responsibility.
- Discussion techniques and behavioural experiments intended to challenge negative appraisals and the basic assumptions with the aim of modification of the patient's negative beliefs and their own personal responsibility.
- Behavioural experiments to directly test appraisals, assumptions and processes hypothesized to be involved in the patient's obsessional problems.
- Helping patients to identify and modify underlying general assumptions which give rise to their misinterpretation of their own mental activity.
- Exposure and response prevention strategies are used to help the patient discover the way in which neutralizing.

COGNITIVE INTERVENTION

Exposure and response prevention (ERP) has been found to be very effective for treating obsessive-compulsive disorder (OCD) over the last 35 years. However, there were other cognitive techniques also used successfully to treat OCD.

CHALLENGING ASSUMPTIONS

The use of techniques such as the downward arrow and verbal challenging is used to address the specific appraisals the person makes. This can be of the occurrence or the content of the intrusion, or both. Therapy aims 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. These techniques are also used to address the irrational estimation of danger. Pie charts can also be used to understand and address the inflated sense of responsibility.

HABITUATION TRAINING

This is based on the idea that the practical to elicit thoughts over the period required for anxiety reduction. At the same time it prevents any covert avoidance and neutralizing behaviour. The rationale for habituation training with response prevention is introduced by drawing attention to the way in which avoidance prevents the patient from confronting anxiety and getting used to with it. This includes neutralizing thoughts as well. In order to present the thoughts repeatedly in a predictable way, a number of strategies are possible :

- Deliberate thought evocation
- Writing the thought down repeatedly
- Listening to a 'loop tape' of the thought in patient's own voice
- A combination of these strategies can be particularly powerful.

THOUGHT STOPPING

This aims to provide a strategy for dismissing thoughts and thereby reducing their duration. This may also have the effect of increasing the patient's sense of control and hence reduce discomfort. As the cognitive behavioural model predicts that obsessional thoughts are maintained by neutralizing and avoidance, effective thought stopping is accompanied by a programme to eliminate neutralizing (including reassurance) and avoidance.

The rationale begins with a discussion of similarities between normal and abnormal intrusive thoughts. This leads to an agreement to try to reduce the duration of the obsessional thoughts without neutralizing, thus making them more 'normal' and increasing the patient's sense of control.

METACOGNITIVE THERAPY

Metacognition is particularly relevant to OCD and advance the understanding of the disorder. It refers to knowledge or beliefs about thinking and strategies used to regulate and control thinking processes (7). It is based on the principle that it is not merely what a person thinks, but how he or she thinks that determines emotions and the control over that emotion. Metacognitive therapy starts with the explanation of treatment rationale. It develops through effective engagement (this includes normalizing and destigmatizing), detached mindfulness, exposure and response commission, and exposure and ritual prevention.

MINDFULNESS BASED COGNITIVE THERAPY (MBCT)

It is a manualized intervention programme consisting of eight sessions. It uses CBT methods in collaboration with Eastern psychological strategies such as mindfulness and mindfulness meditation and has originally been designed to prevent relapse in depression.

Mindfulness and mindfulness meditation focus on becoming aware of all incoming thoughts and feelings and accepting them. But it is not attaching or reacting to them(8). This process is known as "Decentering" and aids in disengaging from self-criticism, rumination, and dysphoric mood that can arise when reacting to negative thinking patterns(9).

CONCLUSION

The effectiveness of ERP in OCD is well established. However, there are other cognitive strategies found efficacious as well. Cognitive therapy primarily focuses on identifying the dysfunctional assumptions, negative automatic thoughts as well as cognitive errors. A basic premise of traditional cognitive behavior therapy is that disturbances and biases in thinking cause psychological disorder. However, other therapeutic techniques are in agreement with this view as a general principle. Cognitive therapies assume that problem remains in erroneous and distorted views of the self and the world. It deals with changing this thought content and the person's belief in the validity of that content. It also deals with the way people think and assumes the problem remains in inflexible and recurrent styles of thinking in response to the negative thoughts, feelings and beliefs. Remedy focuses on the removing the unhelpful processing styles.

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