Obsessive-Compulsive Disorder:
enhancing the behavioural approach

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This short report is based upon a workshop which included presentations by leaders in the field of cognitive-behavioural and behavioural treatment approaches for this very difficult-to-treat, and often apparently treatment-resistant, distressing problem (Salkovskis & Kirk, 1997). The following is a review of the clinical condition and the main treatment approaches, outlined within the workshop and as experienced within clinical practice.

Obsessions & Compulsions

Obsessions are perhaps best described as anxiogenic, persistent ideas, thoughts, impulses and images experienced as intrusive and senseless. Typically, the person will attempt to ignore or suppress such thoughts or impulses, or neutralise them with some other thought or by carrying out some other action.

Compulsions are distinct from obsessions in being anxiolytic, repetitive, purposeful and intentional behaviours which are performed in response to an obsession, in accordance with certain rules or in a stereotyped fashion. They are carried out to 'undo' the obsession.

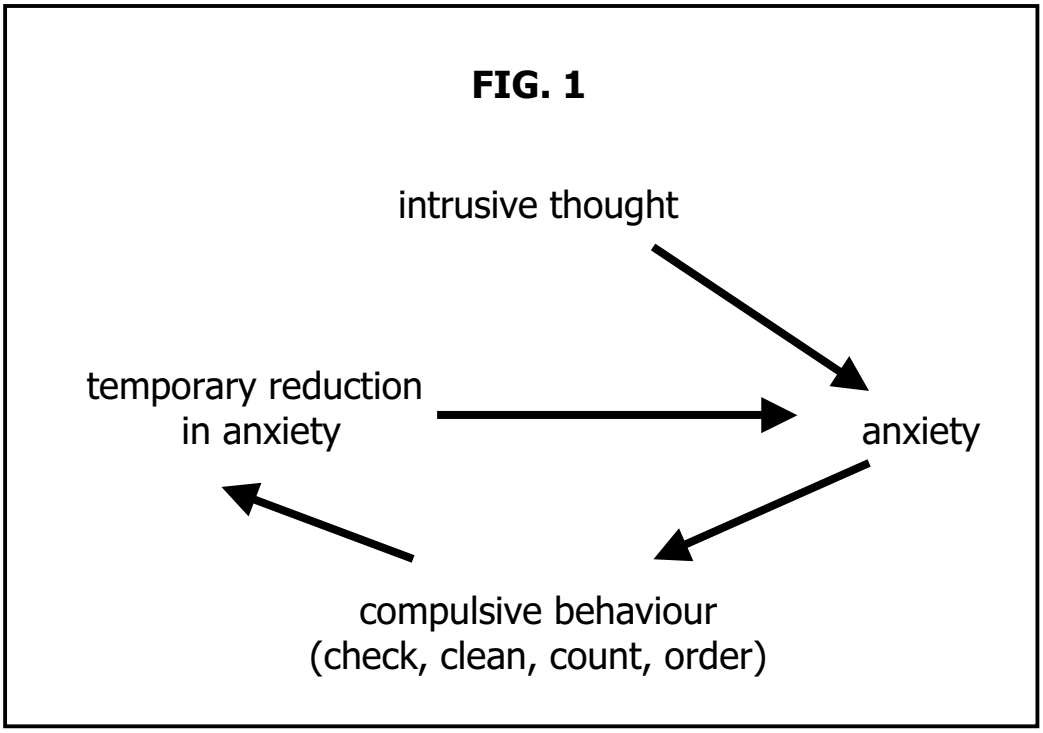
The relationship between obsessions and compulsions is perhaps best illustrated by the 'vicious circle', as shown in Fig.1, in which the temporary reduction in anxiety levels serves to reinforce the repetition of the compulsive behaviour or ritual.

Some clients present primarily with obsessional thoughts whilst others present predominantly with compulsive acts, rather than fulfilling the criteria for 'Obsessive-Compulsive Disorder' (WHO, 1992).

Behavioural Approach: an outline

Briefly, the key treatment components of the behavioural approach to OCD involve:

- exposure to the anxiety-provoking intrusions and situations, which if to be effective, needs to be prolonged, live (in vivo), graded (but as rapid as the client can tolerate), and incorporate self-exposure within homework assignments between treatment sessions
- response prevention, which involves the client resisting all urges to carry out the compulsive behaviour
- other techniques e.g. modelling, shaping, reinforcement



The key principles for planning and implementing such a behavioural programme are that:

- exposure needs to be self-imposed by the client, deliberate and directed to all avoided situations
- the prevention of rituals and neutralising behaviour
- exposure needs to be carried out gradually in a hierarchy of difficulty which commences with the least difficult step, with an emphasis upon repeating exposure to particular situations
- direct exposure to a particular anxiogenic intrusion or situation needs to continue until the client experiences a reduction in his/her anxiety levels of at least 50%
- the patient should retain responsibility for planning and carrying out their treatment goals as quickly as possible, therefore becoming his/her own therapist and minimising the possibility of perceiving the therapist as having responsibility for the client's actions
- it is often necessary to carry out exposure at a level beyond that which constitutes everyday 'normal' behaviour
- all exposure goals should be discussed in advance, so that the client is fully aware of the rationale for being asked to carry out goals which s/he may perceive as unpleasant and ensuring that there are no surprises for the client

Throughout the implementation of the programme, it is useful to remind the client that whilst anxiety is unpleasant, it does not harm and will eventually reduce, and also that continued practice will make for a 'good effect'.

It is good practice to evaluate aspects of the programme using both self-monitoring tools which incorporate ratings of the individual's level of anxiety or unease, and outcome rating instruments such as the Beck Depression Inventory (Beck et al, 1961) and MOCI (Hodgson & Rachman, 1977).

Treatment Difficulties

Success in the behavioural treatment of OCD tends to mean that clients are much improved or improved. However, accounting for treatment refusers (25%) and early drop-outs (12%), the success rate in obtaining reported improvement is only about 50% of those suitable for inclusion and seeking treatment in clinical trials (Salkovskis & Kirk, 1997). One of the factors associated with poor response to treatment is the presence of depressed mood or very distorted beliefs (Foa et al, 1983). To date, there are no established effective ways of treating these 'treatment failures'. It is this limitation of behavioural treatment that has led to the development of an alternative approach to the conceptualisation and therapy of OCD.

Cognitive-Behavioural Approach: an outline

As an alternative to the traditional model of behavioural treatment (Fig. 1), Salkovskis (1985) has proposed a re-framed cognitive-behavioural model of OCD, which is summarised in Fig. 2, below. The cognitive hypothesis suggests that OCD patients show characteristic thinking, and typically that any influence over outcome equates to responsibility for outcome (Salkovskis & Kirk, 1997). It is thus proposed that OCD patients make a series of assumptions:

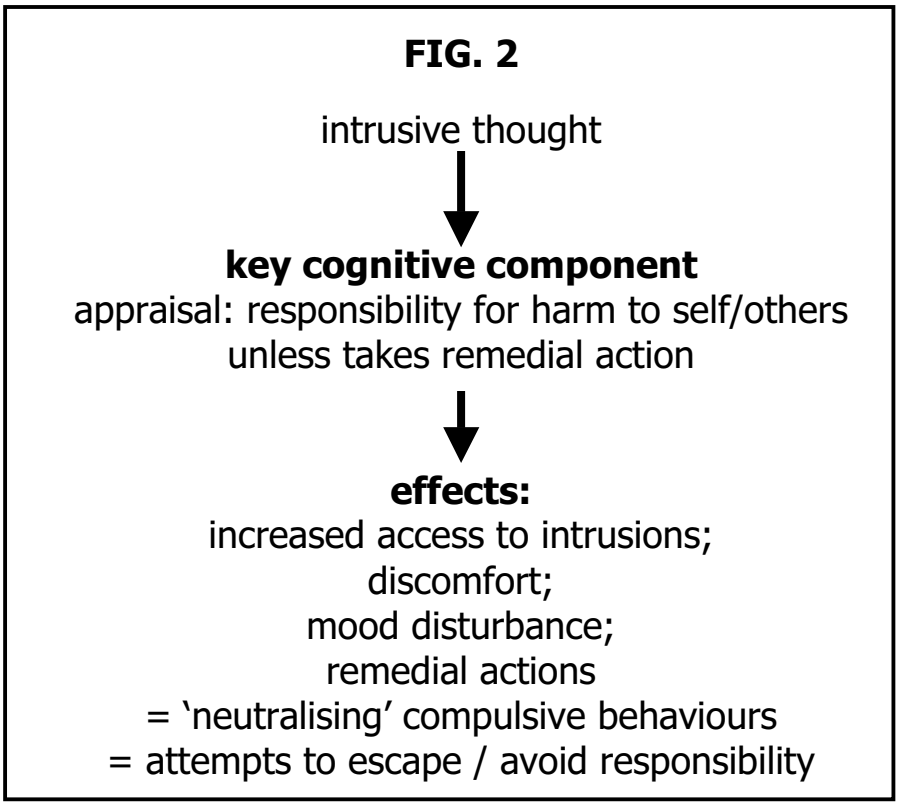
- having a thought about an action is like performing it
- failing to try to prevent harm is the same as having caused it in the first place
- responsibility is not reduced by other factors like a low chance of occurrence
- not neutralising an intrusion equates with seeking or wanting the harm associated with the intrusion to happen
- you should and can always exercise control over your own thoughts

Cognitive-Behaviour Therapy:

Therapy therefore aims to help the patient to conclude that intrusions, however distressing, are irrelevant to further action, and more specifically: that intrusions are normal; that intrusions can be got rid of, such being most likely to be achieved by experiencing them rather than attempting to over-control or act upon them; that the exercise of control is unnecessary; that it is more useful to construct and test a new less threatening model or explanation of their experience, using behavioural tests to focus the patient upon the view that their problem is worry about being responsible for harm rather than being actually responsible. The cognitive - behavioural approach thus emphasises the pivotal role of appraisals and the therapeutic tasks involved in the patient's re-

consideration of the problem. Alternative 'normalising' explanations, exposure, response-prevention, behavioural experiments and the use of loop tapes to assist belief modification are all strategies which are employed as part of the cognitive-behavioural approach for OCD (Salkovskis & Kirk, 1997).

FIG. 2



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