Specialized Cognitive Behavior Therapy for Obsessive Compulsive Disorder

An Expert Clinician Guidebook

Debbie Sookman

Practical Clinical Guidebooks

Specialized Cognitive Behavior Therapy for Obsessive Compulsive Disorder

An Expert Clinician Guidebook

Debbie Sookman

Routledge
Taylor & Francis Group
NEW YORK AND LONDON

First published 2016
by Routledge
711 Third Avenue, New York, NY 10017

and by Routledge
2 Park Square, Milton Park, Abingdon, Oxon, OX14 4RN

Routledge is an imprint of the Taylor & Francis Group, an informa business

Library of Congress Cataloging-in-Publication Data
Sookman, Debbie, author.
Specialized cognitive behavior therapy for obsessive compulsive disorder : an expert clinician guidebook / by Debbie Sookman.
p. ; cm. – (Practical clinical guidebooks series)
Includes bibliographical references and index.
I. Title. II. Series: Practical clinical guidebooks series.
[DNLM: 1. Obsessive-Compulsive Disorder–diagnosis–Case Reports. 2. Cognitive Therapy–methods–Case Reports. 3. Comorbidity–Case Reports. 4. Obsessive-Compulsive Disorder–therapy–Case Reports. 5. Treatment Refusal–Case Reports. WM 176]
RC489.C63
616.89'1425–dc23
2015007996

ISBN: 978-0-415-89954-3 (hbk)
ISBN: 978-0-415-89953-6 (pbk)
ISBN: 978-1-315-68065-1 (ebk)

Typeset in ITC Legacy Serif
by Apex CoVantage, LLC

"I strongly recommend this expert clinical guide to the psychological treatment of obsessive compulsive disorders. The depth of Dr. Sookman's clinical experience and her command of the literature are evident in the thorough coverage of assessment procedures, how to optimize the effects of therapy and deal with problems. The numerous case illustrations are well-chosen and clearly described."

—**S. Rachman**, Emeritus Professor, Institute of Psychiatry, London University, and University of British Columbia.

"*Specialized Cognitive Behavior Therapy for Obsessive Compulsive Disorder: An Expert Clinician Guidebook* by Dr. Debbie Sookman is an outstanding contribution to the science and clinical practice related to the full range of Obsessive Compulsive Disorder. This is an excellent book in every way imaginable. Clearly written and organized, Sookman provides a critical and scholarly review of the state of the art on OCD. Every researcher and clinician can benefit from this superb book. The reader benefits from the considerable clinical experience and scholarship that Dr Sookman possesses, while learning specific and powerful tools in helping those who suffer from OCD. Case examples illustrate the importance of conceptualization and the value of empirically supported treatments. I am particularly impressed that Sookman was able to balance such sophistication in her critical and scientific understanding of OCD, while still writing a clear and concise book on the topic. This is a book I will recommend to both beginning clinicians in training and to seasoned researchers and practitioners."

—**Robert L. Leahy**, *Ph.D.*, Director, American Institute for Cognitive Therapy

"Dr. Sookman's book is a remarkable compilation of the current literature on Obsessive-Compulsive Disorder (OCD). Dr. Sookman emphasizes the need for evidence based treatments and elaborates what these are, how specialty cognitive behavior therapy interventions are best applied, their efficacy rates and the reasons for failure. Case illustrations make this guidebook especially compelling. I strongly recommend this expert guidebook to everyone who is interested in OCD."

—**Fugen Neziroglu,** *Ph.D., ABBP, ABPP*, Director of the Bio-Behavioral Institute, Great Neck, NY and author of numerous books including, *Overcoming Body Dysmorphic Disorder* and *Overcoming Compulsive Hoarding*, both OCD Spectrum Disorders.

Specialized Cognitive Behavior Therapy for Obsessive Compulsive Disorder

Specialized Cognitive Behavior Therapy for Obsessive Compulsive Disorder is an expert clinician guide for administration of evidence-based specialized cognitive behavior therapy (CBT) for obsessive compulsive disorder and its subtypes. This book focuses on strategies to identify and resolve complex and varied reasons for resistance to CBT and to optimize symptom remission, generalize improvement, and forestall relapse during treatment for OCD. The interventions discussed build upon and elaborate the clinical and research work of other OCD experts, clinicians, and researchers in the field of cognitive therapy, and are based on the author's own research and clinical experience as an internationally known expert treating thousands of OCD patients. Criteria are outlined for symptom recovery and for treatment resistance in the context of optimal evidence-based specialized CBT delivery. Featuring treatment models and illustrative case studies, this book is a necessary addition to the library of mental health professionals who work with patients suffering from OCD.

Debbie Sookman, PhD, is Director of the Obsessive Compulsive Disorder (OCD) Clinic, Department of Psychology, McGill University Health Centre, Associate Professor, Department of Psychiatry, McGill University, Montreal, Canada, and President of The Canadian Institute for Obsessive Compulsive Disorders (CIOCD, www.ciocd.ca). Dr. Sookman is an internationally known expert in specialty assessment and treatment for OCD and Related Disorders and is a Fellow and Certified Trainer/Consultant of the Academy of Cognitive Therapy, USA.

Practical Clinical Guidebooks Series

Rosqvist
Exposure Treatments for Anxiety Disorders: A Practitioner's Guide to Concepts, Methods, and Evidence-Based Practice

Marshall, Marshall, Serran, and Fernandez
Treating Sexual Offenders: An Integrated Approach

Emmelkamp and Vedel
Evidence-Based Treatments for Alcohol and Drug Abuse: A Practitioner's Guide to Theory, Methods, and Practice

Dugas and Robichaud
Cognitive-Behavioral Treatment for Generalized Anxiety Disorder: From Science to Practice

Perkins, Conklin, and Levine
Cognitive Behavior Therapy for Smoking Cessation: A Practical Guidebook to the Most Effective Treatments

Ramsay and Rostain
Cognitive Behavioral Therapy for Adult ADHD: An Integrative Psychosocial and Medical Approach

Hofmann and Otto
Cognitive Behavioral Therapy for Social Anxiety Disorder: Evidence-Based and Disorder-Specific Treatment Techniques

Muller and Mitchell
Compulsive Buying: Clinical Foundations and Treatment

Gardner and Moore
Contextual Anger Regulation Therapy: A Mindfulness and Acceptance-Based Approach

Sookman
Specialized Cognitive Behavior Therapy for Obsessive Compulsive Disorder: An Expert Clinician Guidebook

In loving memory of my parents Bella and Larry Sookman,
to my partner Arthur Landa with deep appreciation
for your love and inspiration,
to the many helpful and supportive colleagues from
whom I have learned,
and to the thousands of persons suffering from
this disabling
disorder who sought my help

Contents

Chapter 1

Introduction

> No issue facing the field, however, is as daunting and important as the dissemination crisis, since failure to improve access to care is a threat to the relevance of all of the psychological treatments of established efficacy for OCD.
>
> (Franklin & Foa, 2011, p. 238)

The aim of this book is to describe and illustrate specialized evidence-based cognitive behavior therapy for obsessive-compulsive disorder (OCD). This chapter describes an overview of the phenomenology, symptoms, and specialized treatment that are elaborated in subsequent chapters. Select issues relevant to treatment decisions facing clinicians treating this disabling disorder will be addressed. Symptoms of obsessive-compulsive related disorders will be briefly mentioned but are not the focus. Importantly, no guidebook is a substitute for systematized training that comprises didactics and supervised clinical practice. Training and supervision with an OCD expert are recommended of sufficient duration and scope to achieve specialty-level knowledge and clinical competency with varied OCD presentations.

About OCD

The World Health Organization (2008) ranks OCD as a leading cause of disability worldwide. Affecting approximately 3% of the population through the life span, the risk of occurrence and long-term persistence is substantial (de Bruijn, Beun, de Graaf, Have, & Denys, 2010; Peris et al.,

2010). OCD affects all cultural groups and substantially impacts youth. In approximately two-thirds of cases, onset is by age 22 (Fineberg et al., 2013a). OCD is recognized as a major mental illness in which sufferers experience impaired functioning across domains on par with major physical illnesses (Koran, Thienemann, and Davenport, 1996). The disabling effect on psychosocial functioning compares with that of schizophrenia, considered to be the most severe of mental disorders that affect youth (Bystritsky et al., 2001). Depression, anxiety, and hopelessness secondary to OCD symptoms are common and further increase the impact of symptoms. However, OCD is poorly recognized, and there are insufficient clinicians experienced with evaluation and treatment of the disorder, which leads to substantial treatment delay, progression to serious illness, and high rates of treatment resistance due to intervention inadequacies (Dell'Osso, Buoli, Hollander, & Altamura, 2010). Severity and chronicity of illness are associated with high health-care costs and hospitalizations (Drummond et al., 2008). Approximately 25% of these cases attempt suicide (Kamath, Reddy, Kandavel, 2007). Comorbid major depressive disorder (to be distinguished from secondary depression) augments the risk.

In the new fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, known as DSM-5 (American Psychiatric Association, 2013), OCD and Related Disorders are a separate classification, no longer classified with Anxiety Disorders. This development represents major progress in diagnosis, reflecting convergent research that indicates OCD is distinctive in terms of psychopathology and treatment requirements. Treatment for enduring or complex OCD constitutes a specialized field. There is considerable heterogeneity of symptom subtypes that each require specific interventions (Sookman, Abramowitz, Calamari, Wilhelm, & McKay, 2005). These will be summarized and illustrated in subsequent chapters.

OCD is associated with seriously reduced quality of life as well as high levels of psychosocial impairment (Hollander et al., 1996). Impairment occurs across many different domains of life (such as basic self-care and parenting, intra-familial and social functioning, capacity for school or work) and severely restricts functioning. Eisen et al. (2006) found that one-third of their treatment-seeking sample was unable to work due to

their OCD symptoms. Degree of impairment increases dramatically for people whose symptoms are in the moderate or higher level of severity: i.e., Yale-Brown Obsessive Compulsive Scale (Y-BOCS) score of 20+, (Goodman et al., 1989). For example, obsessions about harm can make relationships with family and friends feel dangerous, with resultant social withdrawal and isolation. Intrusions about the need to be perfect interfere with completion of school or work projects, resulting in school failure or job loss. Individuals with contamination fears may avoid doctors' offices and hospitals because they fear exposure to germs, or they may develop dermatological problems such as bleeding and skin lesions due to bathing with bleach in order to feel "clean enough." Children and adolescents avoid socializing with peers and may be unable to attend school, with multiple long-term impacts (Hollander, Stein, Fineberg, & Legault, 2010). Young adults struggle or fail when they try to leave home to live independently. Many individuals impose ritualistic rules and prohibitions on family members (such as repeatedly cleaning every object that enters the home, with no visitors allowed for fear of contamination), which are associated with high levels of family dysfunction. Parents and significant others report feeling burdened by accommodation to a severe mental disorder and also frequently report high levels of distress. Impoverished quality of life for many sufferers as well as their families is devastating and constitutes a significant burden for society.

There is robust evidence that early detection and prompt evidence-based treatment of OCD can improve recovery rates (e.g., Hollander et al., 2010). Among the best predictors of long-term outcome is degree of improvement at posttreatment (O'Sullivan, Noshirvani, Marks, Monteiro, & Lelliot, 1991; Leonard et al., 1993; Foa et al., 2013). Symptom alleviation is associated with an improvement in quality of life (Bystritsky et al., 1999, 2001; Cordioloi et al., 2003; Tenney, Denys, van Megen, Glas, & Westenberg, 2003; Diefenbach, Abramowitz, Norberg, & Tolin, 2007). Early establishment of *accurate diagnosis* before the illness becomes entrenched and *effective intervention* would represent a major health-care advance. The aim of evidence-based treatment for OCD, as for other disorders, is sustained symptom recovery. Suboptimally treated OCD is associated with severe functional impairment across a broad range of functional and health-related quality of life domains, and

impaired professional and socioeconomic status (Hollander et al., 2010). Without timely specialized treatment, remission rates among adults are low (approximately 20%, Skoog & Skoog, 1999; Bloch et al., 2009).

Education and training of primary health-care professionals and mental-health practitioners is crucial to increase early detection and accurate diagnosis of OCD throughout the life span, and to promote early intervention and appropriate referral. However, an urgent difficulty in this field is that although evidence-based treatments have been developed, these are not accessible to many sufferers because there are insufficient clinicians and clinical sites experienced with assessment and treatment of this disorder. In many regions there are long waiting lists to access care that may not be evidence based (e.g., Illing, Davies, & Shlik, 2011; Szymanski, 2012). Lengthy delays in accurate diagnosis, misdiagnosis, and unavailability of specialty treatment is most dire in remote regions but is also widespread in urban centers with long waiting periods due to insufficient staff and resources. In a survey of use of specialist services for OCD and Body Dysmorphic Disorder (BDD) in the UK, patients wait approximately 20 years from first diagnosis to receiving highly specialized treatment, with devastating consequences in terms of progression of illness to disability (Drummond, Fineberg, Heyman, Veale, & Jessop, 2013). In a national US survey of office-based practice, only 39% of visits included psychotherapy (Patel et al., 2014).

The first-line evidence-based psychotherapeutic treatment of choice for OCD is specialized cognitive behavior therapy (CBT), including exposure and response prevention (ERP). Analyses of more than 24 randomized, controlled trials have shown that approximately 60–85% of patients report a substantial reduction in symptoms following ERP, with improvement maintained at 5-year follow-up for the majority of treatment responders (Ponniah, Magiati, & Hollon, 2013). Most experts recommend that cognitive therapy and behavioral experiments be combined with ERP in CBT evidence-based approaches for OCD (e.g., Grant, 2014). However, research indicates that the "majority" of individuals with OCD do not receive optimal specialty CBT treatment for their symptoms (Shafran et al., 2009). This clinical reality has been cogently elaborated by several authors (e.g., Franklin & Foa, 2011). Research indicates that clinicians report using CBT for OCD, and patients report receiving it, but

the content of sessions often does not resemble evidence-based protocols (Stobie, Taylor, Quigley, Ewing, & Salkovskis, 2007). This may be because training in general psychiatry, psychology, and/or CBT are not necessarily sufficient to acquire the specialized clinical skills required for evidence-based best practice for treating complex OCD. Academic training programs that offer longer-term rotations in the treatment of OCD as an elective are desirable, to ensure that the next generation of clinicians is adequately equipped and that sufficient qualified supervisors are available to teach this greatly needed expertise. Improvement of existing models of continuing education and training to disseminate *advanced* specialty clinical skills is required to optimize illness recovery, and to ensure that clinicians are not practicing with inadequate clinical skills (Sookman & Fineberg, 2015).

Pharmacotherapy with selective serotonin reuptake inhibitors (SSRIs) is the first-line evidence-based pharmacological treatment of choice (Koran & Simpson, 2013). Treatment should be optimally delivered at maximal tolerated dose levels with assessment of adherence. Sustained treatment may protect against relapse (Fineberg, Brown, Reghunandanan, & Pampaloni, 2012, Fineberg et al., 2013b; Fineberg et al., in press). Duration of suboptimally treated illness impacts adversely on response to pharmacotherapy, also underlining the need for effective and timely intervention. The evidence on efficacy of combined treatment with CBT and medication is reviewed in this chapter. Adjunctive treatment with medication acting differently from SSRIs, such as low-dose antipsychotics, or newer pharmacological compounds, may be helpful in treatment-resistant cases.

It has been emphasized by experts that the OCD patient have access to care at a level appropriate to his/her treatment needs. The application of optimal treatment, in terms of intensity and specificity, is recommended to avert unnecessary deterioration to chronicity, disability, intransigence of symptoms, ineffective health-care utilization, and erroneous labeling as "treatment resistant." Patients who show an incomplete treatment response, that is those who remain ritualistic following treatment, remain susceptible to relapse. Training of primary health-care professionals and general mental-health practitioners is crucial to increase early detection, accurate diagnosis, and appropriate referral

for treatment of OCD throughout the life span. Early referral to a specialist center may represent the cost-effective option for OCD patients regardless of illness severity (i.e., for less severely ill patients as well), as specialized treatment would be expected to increase the rate of response and recovery. In response to limited resources, "stepped care" models have been proposed that would involve many patients being offered low-intensity treatment as a first step in the pathway of care. However, these pathways have not so far been sufficiently empirically validated for OCD and Related Disorders and run the serious risk of undertreating the disorder (Sookman & Fineberg, 2015).

Clinical Symptoms of OCD

Obsessions are repetitive intrusive thoughts (e.g., of contamination), images (e.g., of violent or horrific scenes), or abhorrent urges (e.g., to stab someone) experienced as involuntary and highly distressing. Sensations reported include feeling "not just right" and a sense of incompleteness (Summerfeldt, 2007) as well as sensorial experiences (Simpson & Reddy, 2014). Patients may report repeated involuntary intrusive thoughts, images, or memories about past events about which they have strong feelings (e.g., guilt or anger) that include "every detail." Rituals are repetitive behaviors (e.g., washing, checking) or mental acts (e.g., repeating or replacing words or images) carried out in response to an obsession in order to reduce distress or to prevent a feared event (e.g., becoming ill). Rituals are not connected realistically to feared events (e.g., arranging items perfectly to prevent harm to a loved one) or are clearly excessive (e.g., showering for five hours daily with seven repetitions on every body part). In most cases insight is retained: the individual recognizes his/her beliefs and fears are unrealistic. Mild to moderate illness involves 1–3 hours per day obsessing or doing compulsions, however, many individuals experience virtually constant distressing intrusive thoughts and rituals that are incapacitating. Up to 30% of individuals with OCD have a lifetime tic disorder, most commonly in males with childhood onset of OCD (please see DSM-5, APA, 2013).

Content of intrusive thoughts differs with the developmental stage of the individual. For example, there are higher rates of sexual

and religious obsessions reported by adolescents than children. Higher rates of intrusive thoughts of harm and catastrophic events, such as death or illness to self or loved ones, are reported by children and adolescents compared with adults. These themes occur across different cultures and may be associated with different neural substrates (Clark et al., 2014). Many individuals report multiple symptom subtypes. Reported distress associated with symptoms is often intense: anxiety or panic; feelings of disgust (e.g., that one's own or others' bodily fluids such as urine, menstrual blood, feces are dirty or disgusting and must be avoided); a sense of "incompleteness" or uneasiness until things feel "just right" (Summerfeldt, 2007). Feared situations that provoke intrusive thoughts and urges to ritualize are commonly avoided such as restaurants, public transportation, and restrooms in the case of washers or social situations related to fears about causing harm. The content of obsessions tend to be those that are against the moral values of the individual (Rachman, 2003).

OCD Related Disorders

Body Dysmorphic Disorder (BDD)

Approximately 8–37% (Phillips, 2000) of patients suffering from OCD also report BDD. Individuals suffering from BDD report highly distressing unrealistic beliefs and preoccupations that one or multiple aspects of their appearance are "ugly," "deformed," or "hideous." BDD is associated with checking rituals and multiple psychosocial impairments, including refusal to attend school. Prevalence of suicidal ideation and attempts attributed to appearance beliefs is high. The mean age of onset is 16–17 years, but the most common age of onset is 12–13 years. BDD has been reported to be associated with childhood neglect or abuse in some cases. Prevalence is elevated in first-degree relatives of individuals with OCD. One's view of appearance generally ranges from exaggerated in a negative direction to a wholly unrealistic view. As an example of the latter, a beautiful 21-year-old woman saw 10 physicians—including dermatologists and plastic surgeons—because she believed that small lines around her eyes meant she was "prematurely aging and ugly." Some of