

# Treatments for OCD: Cognitive-Behavioural Therapy

## Obsessive-Compulsive Disorder: An Information Guide

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Modern treatments for OCD have radically changed how the disorder is viewed. While in the past OCD was regarded as chronic and untreatable, a diagnosis of OCD may now be regarded with hope. Cognitive and behaviour therapy and antidepressant medications are currently used to treat the disorder. Neither provide a "cure" for OCD, but they control the symptoms and enable people with OCD to restore normal function in their lives.

Treatment for OCD ideally involves a combination of cognitive-behavioural therapy and drug therapy. It is important that people with OCD receive treatment that is specific to OCD, from a fully qualified therapist. Some forms of traditional psychotherapy are not effective at relieving symptoms of OCD.

Many people with OCD benefit from supportive counselling in addition to treatments aimed at reducing the symptoms of OCD. Individuals may see a therapist one-on-one, or they may involve the partner, spouse or family in counselling. Group therapy (with people who have similar concerns) can also help. For more information on supportive counselling, see [Chapter 5](#).

### **Cognitive-Behavioural Therapy**

Cognitive-behavioural therapy refers to two distinct treatments: exposure and response prevention and cognitive therapy. Although these treatments are increasingly offered in combination, we will discuss them separately.

### **Exposure and Response Prevention (ERP)**

The mostly widely practised behaviour therapy for OCD is called exposure and response prevention (ERP).

The "exposure" part of this treatment involves direct or imagined controlled exposure to objects or situations that trigger obsessions that arouse anxiety. Over time, exposure to obsessional cues leads to less and less anxiety. Eventually, exposure to the obsessional cue arouses little anxiety at all. This process of getting "used to" obsessional cues is called "habituation."

The "response" in "response prevention" refers to the ritual behaviours that people with OCD engage in to reduce anxiety. In ERP treatment, patients learn to resist the compulsion to perform rituals and are eventually able to stop engaging in these behaviours.

### **How does ERP work?**

Before starting ERP treatment, patients make a list, or what is termed a "hierarchy" of situations that provoke obsessional fears. For example, a person with fears of contamination might create a list of obsessional cues that looks like this:

1. touching garbage
2. using the toilet
3. shaking hands.

Treatment starts with exposure to situations that cause mild to moderate anxiety, and as the patient habituates to these situations, he or she gradually works up to situations that cause greater anxiety. The time it takes to progress in treatment depends on the patient's ability to tolerate anxiety and to resist compulsive behaviours.

Exposure tasks are usually first performed with the therapist assisting. These sessions generally take between 45 minutes and three hours. Patients are also asked to practice exposure tasks between sessions for two to three hours per day.

In some cases, direct, or "in vivo," exposure to the obsessional fears is not possible in the therapist's office. If, for example, a patient were being treated for an obsession about causing an accident while driving, the therapist would have to practice what is called "imaginal" exposure. Imaginal exposure involves exposing the person to situations that trigger obsessions by imagining different scenes.

The main goal during both in vivo and imaginal exposure is for the person to stay in contact with the obsessional trigger without engaging in ritual behaviours. For example, if the person who fears contamination responds to the anxiety by engaging in hand-washing or cleaning rituals, he or she would be required to increasingly resist such activities - first for hours, and then days following an exposure task. The therapy continues in this manner until the patient is able to abstain from ritual activities altogether.

To mark progress during exposure tasks with the therapist and in homework, patients are trained to be experts in rating their own anxiety levels. Once they have made progress in treatment, participants are encouraged to continue using the ERP techniques they have

learned, and to apply them to new situations as they arise. A typical course of ERP treatment is between 14 and 16 weeks.

### **Self-Directed ERP**

For people with mild OCD, self-directed ERP may be equally as effective as seeing a therapist. Three excellent self-directed ERP manuals with step-by-step strategies include:

- Baer, L. (1991). *Getting Control*. Lexington, MA: Little, Brown & Company
- Foa, E.B. & Wilson, R. (1991). *Stop Obsessing!* New York: Bantam
- Steketee, G. & White, K. (1990). *When Once Is Not Enough*. Oakland, CA: New Harbinger Press.

### **How effective is ERP?**

Even patients with longstanding and severe symptoms of OCD can benefit from ERP treatment. Success depends on a number of factors and requires that the patient be motivated to get well.

Studies documenting the benefits of ERP treatment have found that upwards of 75 per cent of patients experience improvement in their OCD symptoms during treatment. The majority show long-term improvement two and three years after treatment.

Patients who benefit less from ERP include those who do not exhibit overt compulsions and those with moderate-to-severe depression.

### **Cognitive Therapy**

As mentioned earlier, people with OCD often become anxious about their thoughts (or obsessions) when they interpret such thoughts as dangerous and likely to occur. Thoughts of leaving the house with the stove on, for example, can result in a debilitating anxiety that sends the person running back to check again and again.

### **How does cognitive therapy work?**

In the treatment of OCD, cognitive therapy (CT) is most often done in combination with exposure and response prevention (ERP). Patients create a hierarchy of situations that cause distress and when they participate in exposure tasks, they are asked to pay particular attention to thoughts and feelings related to these situations.

In CT, the focus is on how participants interpret their obsessions: what they believe or assume to be true about them, what their attitude is toward them and why they think they have these obsessions. For example, the person who fears shaking hands may believe it will pass on germs that may cause him or her to become ill. This interpretation of this fear can be challenged and re-interpreted so that shaking hands is no longer viewed as a high-risk activity. Achieving these results takes time, but can provide effective relief.

CT also helps participants identify and re-evaluate beliefs about the potential consequences of engaging or not engaging in compulsive behaviour, and to work toward

eliminating this behaviour. For example, a person who compulsively washes his or her hands for 30 minutes at a time may believe that he or she is doing so to guard against infection. When this belief is challenged and confronted as false, it can help control the behaviour.

One tool used in CT to help people identify, challenge and correct negative interpretations of intrusive thoughts is the **thought record**. In the thought record, participants record their obsessions and their interpretations associated with the obsessions. The first step is for the person to begin to record each and every time they experience an intrusive thought, image or idea. The important details to record include:

1. Where was I when the obsession began?
2. What intrusive thought/image/idea did I have?
3. What meaning did I apply to having the intrusive thought/image/idea?
4. What did I do?

### **An Example of a Thought Record**

Situation: Sitting at home watching television.

Intrusive Thought: "God doesn't care."

Appraisal of Intrusive Thought:

1. I am a bad person for thinking blasphemous thoughts.
2. God will punish my family and me.
3. I must be losing my mind if I can't stop these thoughts from happening.

Ritual: Engage in prayer. Engage in behaviours of atonement.

After people learn to identify their intrusive thoughts and the meanings they apply to them, the next steps are:

- Examine the evidence that supports and does not support the obsession.
- Identify cognitive distortions in the appraisals of the obsession.
- Begin to develop a less threatening and alternative response to the intrusive thought/image/idea.

These patterns are identified in session together with the therapist; again during actual exposure exercises; and then the person continues to record information on the thought record between sessions.

### **How effective is cognitive therapy?**

Only a small number of studies have tested the effectiveness of CT for OCD. The studies that have been done, however, have found CT to be effective.

Although behavioural and cognitive therapy can be separate, many therapists combine the two strategies. Patients can benefit both from exposure exercises and cognitive restructuring exercises. Behavioural and cognitive therapy are increasingly delivered in a

group setting because there are benefits in meeting and working with people who have the same difficulties

"My experience in group therapy has been extremely beneficial, as I have gained much greater insight into my disorder and have been given many useful tools by my therapists to help me to learn to live with OCD. Although the weekly homework was particularly difficult for me, being a list maker and a checker, it afforded me plenty of practice learning to alleviate the anxiety that it caused. Meeting other people who suffer from OCD has allowed me to experience a shared empathy, which has helped me shift my focus outside of myself. Their understanding and support has made my struggle far less lonely and hopeless.

"Thanks to the strategies learned in the group I now know I can have control over my OCD. Although at first it was very difficult to confront my fears, doing this has paid great dividends in the reduction of my symptoms. Working through my OCD challenges with others in the group has made me feel that I am by no means alone or unusual in this struggle. Listening to the challenges and triumphs of the other group members has motivated me to challenge myself more and continue to loosen the grip OCD has had on my life."