

What is good quality CBT for OCD?

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Cognitive Behaviour Therapy



"I have nothing to offer but blood, toil, tears and sweat."

CBT is not like Prozac



Prozac depends on taking it regularly
dose, duration, tolerance of any side
effects - actual drug is standardized
CBT is not always delivered optimally
Aim today is to guide you on how to
make informed judgment on overall
impression of CBT

CBT (includes E & RP) for OCD

- CBT is “Cognitive Behaviour Therapy”
- “Cognitive” is the meaning you attach to your intrusions (thoughts, images, urges and fears)
- “Behaviour” is what you do (e.g escape, avoid, undo something, wash, check)
- So CBT is about about changing the meaning of your intrusions and the way you respond (called exposure and response prevention)
- Behaviour Therapy (E & RP) focuses on just how you respond
- *“What type of therapy will I be offered?”*

Non Specialist Services Tier 3

- GP
 - Is easy to access
 - Can make diagnosis
 - Can start medication if prefer
 - Can signpost & refer to either local Increasing Access to Psychological Therapies (IAPT) (www.iapt.nhs.uk) or community mental health team (depending on complexity & severity)

Non Specialist Services Tier 4

- NHS Increasing Access to Psychological Therapies in most of England www.iapt.nhs.uk (Wales & Scotland more variable)
 - Some services allow self referral
 - May be offered low intensity CBT with Psychological Well-Being Practitioner (PWP) and guided self help or group if less severe
 - Usually individual CBT 12-15 sessions
 - Therapist should be reasonably well trained and receive supervision
 - May be a trainee under supervision

Structure for CBT

- Out-patient CBT is usually at least 45 minutes long usually once a week
- Sessions may be extended for 2-3 hours when doing prolonged exposure or on home visit
- Sessions may be shorter but more frequent on a residential unit or inpatient unit over 12 weeks

Setting for CBT

- Few specialist centres in OCD (compared to say eating disorders)
- No agreement on what an OCD specialist centre is
- NHS or private? - good and bad CBT
- Accredited by BABCP? (cbtregisteruk.com) - helpful in private sector. Therapist has had minimum standards of training and supervision in CBT but not specific to OCD - but also good psychologists in NHS not accredited
- Have you been to specific workshops on treating OCD?
- Do you keep up to date & attend conferences?
- How often do you treat OCD? How many case have you treated?
- Do you have supervision? How it is supervised?
- Someone you can trust? Someone who respects you?

Number of sessions/ hours

- Average 3-4 hours low intensity support over telephone/ cCBT
- Average 12-15 hours for out-patient CBT
 - Same number of hours for an *intensive* - but delivered over a week
- May be 20 hours or more in treatment refractory cases
- May be an about 36 individual sessions in a residential unit or inpatient unit over 12 weeks (plus groups or additional support with an assistant therapist)

Who else can attend?

- Need to consent on who else attends individual session
- Often helpful for therapist to get information from family member and to assess their degree of involvement - therapist needs consent to give information to family member
- Family member or friend (Family CBT may be offered and this is often important)
- Student or trainee with your consent
- If group CBT is only on offer, what do you do if you want individual therapy ?
- If group CBT it should be only OCD who have mild to moderate functional impairment (unless extra as in-patient)

Usually unhelpful in OCD

1. Spent most of the sessions talking about your childhood.
2. Spent most of the sessions with your therapist silent.
3. Been encouraged to challenge or rationalise your thoughts or keep thought records especially when you have intrusive doubts.
4. Repeatedly discussing your worries and been provided with reassurance by your therapist (focus on immediate content rather than the meaning and how you respond)

Usually unhelpful 2

5. Been encouraged to try and control, stop or block your intrusive thoughts, images or urge - if not sure, ask what is the intended aim?
6. Been given a mantra or phrase to repeat to yourself or reassure yourself when anxious.
7. Felt that you are being given tasks that you don't understand the rationale for.

Usually unhelpful 3

- Not endless discussions “trying to find an underlying cause” of the OCD
- The cause of OCD is unknown - good therapy will acknowledge biological, psychological and social factors and their influence on the present
- **If** intrusive images and thoughts seem to have an emotional link to past aversive memories during childhood or as a young person then a specific procedure may be used for 1-2 sessions.

Timing

- Usually unhelpful if you are told you are “not motivated” (motivation may be strong but fear driven)
- May need sessions to focus on advantages & disadvantages of change
- Be sceptical if wait until “feels right” or “comfortable”
- You maybe “not ready to change” or need to wait for social circumstances to change (but beware of others changing them)

Agree on problems & goals

- Problems defined and agreed
- Short term goals e.g. “ By the next session, I will...”
- Medium term goals e.g “By the end of therapy I would like to....”
- Long term goals e.g. “By 6 months I’ d like to look for another job, start new course, try to make some new friends, move out of my current accommodation...”
- Goals often based on what you are avoiding or are anti-OCD but can also be value driven i.e what is important to you
- Goals should be regularly monitored
- Will we set goals together? (Rather than setting them for you)

Agree an agenda

- Agree how much time is available
- Check on outcome measures
- Review homework/ overall improvement
- Problems to be discussed today
- Negotiate new homework
- Any other feedback and agree on next appointment
- Make written notes after the session and listen to the tape
- Make a plan when you will do homework and experiments and how record results

Understanding of OCD

- Agreed understanding of how your OCD works (“what keeps it going”)
- Diagram of how your solutions are the problem
- Cognitive understanding is the meaning you attach to your intrusions (thoughts, images, urges and fears) (e.g. “Because I feel dirty, I must be dirty and the feeling will go on for ever and I’ ll lose control”)
- Behavioural understanding is what you do (e.g escape, avoid, undo something, wash, check)
- - Will you help me have a shared understanding of how my OCD works?

Tasks 1

- “Exposure” is a task that is planned and causes distress for which one should wait until the discomfort goes down. (i.e. exposure is not just being triggered in the environment)
- Exposure needs to be repeated and done after a compulsion (e.g. touching something “dirty” after compulsive hand washing) (just cutting down on compulsion ineffective)
- Encourage an anti-OCD stance (exposure to activities that might be considered “abnormal” in the short term)
- “Behavioural experiment” is a task done to test out a particular theory Does this best fit with theory A or theory B)

Tasks 2

- Therapist aided exposure or experiments within a session and consistently
- Encouraged to do tasks between sessions
- You should understand why you are being asked to do something and what you will learn
- It should be collaborative and negotiated
- Therapist may visit location where OCD is strongest (e.g home)

Homework

- Therapist should negotiate homework tasks between sessions
- Your responsibility to do the homework
168 hours a week - 49 hours sleep a week
= 119 hours a week (17 hours a day if incorporate in to daily routine)
The more you practice the more you improve
- Must be relevant home work and consistent with achieving your goals (or monitor frequency of compulsions)

Back up

- Asked to listen to recordings of the sessions or keep written summaries of the sessions and records of your homework
- Recordings can be helpful for therapist in supervision
- Be recommended or given appropriate reading material to help you further understand what keeps your OCD going

Bonus points



- Socratic style - not just told what to do or not do
- Imagery & metaphors - not rationalism
- Summaries - asked by your therapist to summarise what you have learned

Relationship

- “Good enough” relationship with your therapist who you can trust and can support you - like a teacher
- You should feel your views are sought and you are involved in the process.
- The therapist should be challenging and have high expectations about your ability to change
- The therapist is encouraging and positive about your ability to make improvements (especially in the moment), seeing problems as a way of learning better ways of dealing with the OCD

Outcome monitoring

- Keep a record of outcome session by session
- For example by a questionnaire or rating scale that is specific for OCD
- For individual progress and audit of a service

Focus of therapy

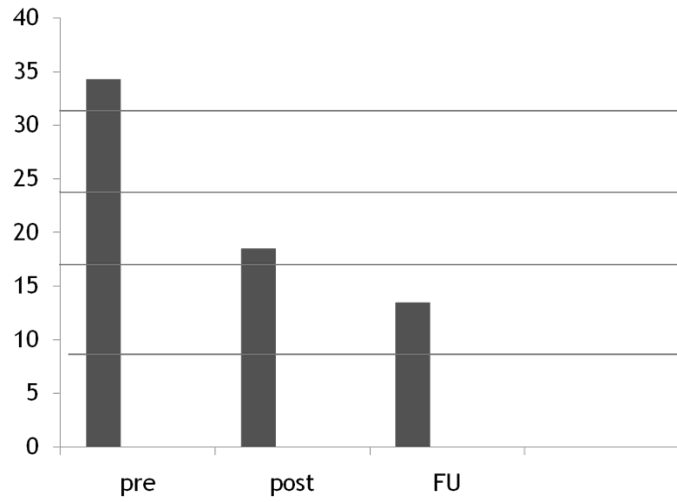
If it is agreed that the OCD is the main problem

- Focus should be on your OCD most of the time
- May need to focus on depression or another problem especially if it is interfering in therapy e.g. behavioural activation for depression
- Other problems or rebuilding your life may be dealt with later on in therapy
- Fear of change and a different relationship with partner or family member may interfere in therapy.

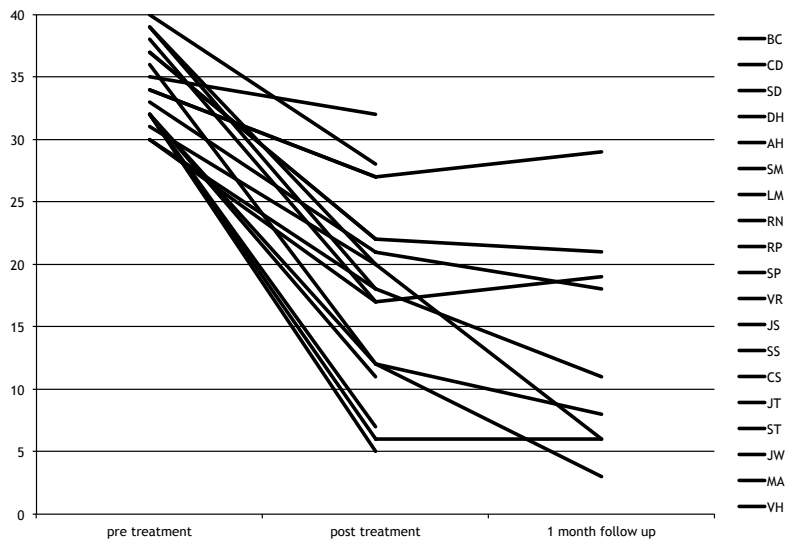
Audit & Research

- Session by session measures of OCD
- Does your service audit it's outcome data?
- Can I see the results?
- Are you happy with the results achieved?
- Do any of your staff or your unit conduct research into OCD?

NSCT OUTCOME ADRU MEAN YBOCS



NSCT Outcome Ybocs



If it goes wrong....

Talk with existing therapist/ psychiatrist

Get a 2nd opinion for care to be stepped up

- Is this a technical failure of the therapy or where it was not delivered optimally?
- Is it because my view of the problem is still fundamentally from the rest of the world?
- Is this breakdown in the relationship with the therapist?
- Are the social circumstances not right?
- Am I not ready to change yet?
- Should medication be reviewed?