Treatment and management of obsessive-compulsive disorder

Lesson 3.5.3 | Clinical psychology

Core ideas

CBT for OCD helps people examine intrusive thoughts, responsibility beliefs and the feared consequences of not doing rituals.

Exposure and response prevention asks the person to face obsession-related triggers while resisting the usual compulsion.

Response prevention is important because it helps break the short-term relief cycle that keeps compulsions going.

SSRIs may be used to reduce OCD symptoms by affecting serotonin activity, but medication does not directly teach new coping behaviours.

Treatment can be difficult because exposure may feel distressing and medication may involve side effects or delayed improvement.

Management should include relapse prevention, support, review of progress and adaptation for the person's symptoms and daily life.

Key terms

CBT: A therapy that works on thoughts, beliefs and behaviour.

Exposure: Planned contact with a feared thought, object or situation.

Response prevention: Resisting the usual compulsion after anxiety is triggered.

ERP: Exposure and response prevention for OCD.

SSRI: Medication that increases serotonin availability at synapses.

Adherence: How far a person follows a treatment plan.

Relapse: A return of symptoms after improvement.

Relapse prevention: Planning to reduce the chance of symptoms returning.

Non-inferiority trial: A trial testing whether a treatment is not unacceptably worse than a comparison, using a margin set in advance.

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Further detail and evidence

Biological treatment: SSRIs alter serotonin reuptake and may reduce obsessive-compulsive symptoms; evaluate symptom reduction alongside adverse effects, adherence and relapse. Biological treatment does not itself teach how to resist rituals.

Required exposure and response prevention (ERP) involves planned contact with obsession-related triggers while resisting compulsions. Lehmkuhl et al. (2008), an illustrative case involving a 12-year-old with autism and OCD, shows how ERP can be adapted; distinguish case-specific usefulness from broad generalisation.

Key study - Lovell et al. (2006): to improve access, this randomised non-inferiority trial compared telephone-delivered and face-to-face CBT/ERP in 72 OCD patients recruited from two Greater Manchester outpatient units. Participants were allocated 36 to each arm; eligibility included age 16-65 and clinically significant OCD.

Lovell method: face-to-face treatment comprised ten one-hour sessions. The telephone arm had an initial face-to-face session, eight calls of up to 30 minutes and a final face-to-face session; both used graded ERP and homework. Blind assessors monitored outcomes, including Y-BOCS, depression and satisfaction, through six months.

Lovell findings: both groups improved and satisfaction was high. The six-month Y-BOCS difference was -0.55, with a 95% interval from -4.26 to 3.15, within the prespecified non-inferiority margin. The result supports the telephone-assisted format, not the claim that no face-to-face contact was needed.

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Continued

SSRIs reduce serotonin reuptake, increasing its availability at synapses. Improvement may take time; adverse effects, discontinuation and relapse are relevant to usefulness. Symptom change does not establish a unique biological cause.

ERP combines exposure to a trigger with prevention of the usual ritual or neutralising act. A hierarchy and repeated practice allow the person to learn that anxiety can change and feared predictions need not be fulfilled. Lehmkuhl's child case illustrates adapting explanations and support for autism alongside OCD.

Applying the ideas

Lovell tests delivery format, not whether CBT is better than no therapy. Both groups received active ERP. A non-inferiority design asks whether the new format is no worse than a clinically acceptable margin; failure to find an ordinary significant difference alone would not prove equivalence.

Evaluation and connections

Lovell evaluation: randomisation and blind assessment strengthen comparison; manuals/supervision support consistency. Participants and therapists could not be blinded. Clinic recruitment, exclusions and limited follow-up restrict generalisation; a deterioration-triggered switch to face-to-face care illustrates participant protection.

Telephone-assisted treatment can reduce travel and therapist contact time, supporting access. Its initial/final face-to-face meetings and safety procedures remain part of the tested package. Blind outcome assessment reduces one source of bias, but cannot blind participants to receiving calls. Consider motivation, privacy at home and ability to complete homework when generalising.