

# HOW I TREAT OCD

By: Bradley C. Riemann, Ph.D.

Overall, the psychosocial treatment protocol for obsessive-compulsive disorder (OCD) has been well established and empirically supported. Exposure and ritual prevention (ERP) has been found to produce successful management of symptoms in roughly 85% of OCD cases. This strategy was first described by Meyer in 1966 and has since been studied and refined by many outstanding researchers and clinicians (e.g., Edna Foa). However, over time most behavioral therapists have added their own “personalized spin” to ERP and in some cases added other types of therapy to the mix. In this article I will discuss the ways that I have “tweaked” the basic approach to treating OCD. As you will see, there are far more similarities to the basic protocol than differences but there are some divergences that are worth noting.

First, I have added a cognitive therapy (CT) component to treating OCD, making my philosophy a cognitive-behavioral therapy (CBT) approach. The premise behind adding cognitive therapy to ERP is the belief that there are “errors” in thinking that generate the anxiety in the first place. It is believed that everyone makes these errors in thought from time to time, but that someone with OCD tends to make them more often and have a harder time self-correcting them. An example of a type of thinking error that an OCD sufferer would make is an overestimation error. Here an individual is overestimating the likelihood of a bad event occurring (e.g., believing that you will contract HIV from touching a doorknob and not washing your hands). Cognitive therapy helps one identify and better self-correct these errors in thought. I believe that cognitive therapy or what others and I call “thought challenging” is a good addition for most of my OCD patients. I have developed worksheets that provide individuals the structure and framework for learning how to better identify and ultimately better self-correct the errors in thought that they make. Clearly, I believe the main emphasis should still be on ERP, but the CT plays an important role. I would say that my protocol is 80-85% ERP and 15-20% CT.

Second, in talking with colleagues from other OCD treatment facilities, it appears that my exposure hierarchies tend to have more specific exercises on them. An exposure hierarchy is a master list of all the exposure exercises that an individual will perform to reduce their OCD symptoms. These exercises are then ordered in some fashion from least to most difficult to do (i.e., in a hierarchical fashion). I have patients rate potential exercises on a zero (i.e., “no anxiety whatsoever”) to seven-point scale (i.e., “the most anxiety you could possibly imagine experiencing”) in terms of how anxious they think the exercise would make them feel if I actually had them perform the exercise. My average hierarchy probably has 100 exercises on it. Many other clinicians I have talked to have far fewer exercises (e.g., 20-25) on their hierarchies. The reasons for these differences are varied and not entirely clear. Some clinicians feel they can successfully “bunch” or combine exercises (i.e., combining two or more exercises into one entry on the hierarchy) in an attempt to make exposure therapy more time efficient. Others have stated that they believe the

process of generalization (i.e., anxiety will habituate or go down in certain OCD areas without directly exposing one’s self to those areas) will occur (e.g., by touching light switches an individual’s fear of touching doorknobs will also substantially reduce).

I have not had much luck with combining exercises or a generalization effect. I have found it difficult to combine exercises due to what I will call a “stock piling” of anxiety that I have seen occur when I have attempted to do this. Meaning that sometimes two plus two equals five (i.e., combining an exercise that was rated a two on their hierarchy with another two yields a higher anxiety rating, say a five, than what you had wanted, which was a two). This stock piling effect I have found makes exposure less efficient due to it taking many more repetitions to see the necessary anxiety reductions within and between exposure trials. Therefore, I have individuals conduct one exercise at a time.

Although some generalization does take place in exposure therapy, in my experience it is rarely enough to completely eliminate the need to work on an entire OCD area (e.g., light switches completely generalizing to doorknobs and thus eliminating the need to address). Thankfully, generalization is present to an extent but I see it usually within an OCD area (i.e., there is no need to touch every light switch to overcome a fear of them) not as much between them. I have individuals demonstrate their mastery over every OCD area. Despite the observed generalization effect in my patients, I also tend to develop separate exposure exercises within each area (e.g., light switches) to address the differences most patients perceive between certain circumstances (e.g., differences between light switches in bedrooms and ones in bathrooms). In summary, I believe these are the reasons my hierarchies are larger in terms of number of items than most behavioral therapists. I believe that the more specific the exposure exercises are the more functional (i.e., anxiety reducing) they will be in the long run. Obviously, this is a bit of a balancing act and too big of a hierarchy can really slow someone’s progress. It also does not help an individual’s confidence to give them a hierarchy the size of a phone book!

The third main way I have tweaked the treatment for OCD is emphasizing the graduated nature of exposure more than some clinicians. I believe the three keys to successful exposure therapy are making sure the exposure is prolonged, repetitive, and done in a graduated or hierarchical fashion. As mentioned before, I use a zero to seven-point scale when developing an exposure hierarchy. Generally, I suggest individuals start doing their exercises in their two’s and three’s. I consider anything less than four on this scale to be in the manageable range of anxiety. Fours and fives cause pretty significant anxiety, and sixes and sevens is unmanageable anxiety. I believe starting people off in their two’s and three’s allows them to learn how to do exposure work, and increases compliance with doing their exposure exercises and with the ritual prevention portion of the treatment. The latter issue is an important one. Overall, refusal and dropout rates for

ERP are very high (i.e., 25%). There certainly are many reasons for this, but the major one appears to be their lack of willingness or ability to do ERP. By making it more “user friendly” my refusal / dropout rates are considerably lower (i.e., anecdotal estimate of roughly 8-10%).

Some have questioned the speed and efficiency of this approach, believing that it will take individuals much longer to complete their hierarchies if they start “so low” in them. On the contrary, it appears to be a “tortoise and the hare” kind of phenomenon. Despite starting lower in the hierarchy, I believe individuals complete treatment in roughly the same amount of time that others do in treatment facilities that don’t emphasize the need for graduated exposure as much. What I lack in terms of starting place in the hierarchy I make up in needing fewer repetitions to achieve anxiety habituation with a particular exercise and thus being able to move on to new exercises faster. It should also be noted that the individual whom I am working with has a strong say in where we start in their hierarchy. Some opt to start higher, but most see the “method” behind what some of my colleagues teasingly call the “madness” behind this approach and start in that manageable anxiety range. In summary, I believe emphasizing the graduated nature of exposure ultimately allows more individuals to seek and complete treatment in roughly the same amount of time.

As stated before, there are far more similarities than differences in the way I treat OCD and the ways others choose to. The bottom line is that ERP works. Most of the “spins” that others and I have made are really only slight modifications. These modifications come from personal philosophies and professional experience in attempt to make an already powerful treatment approach a little bit better.

*Dr. Riemann is the clinical director of The Obsessive-Compulsive Disorder Center and Cognitive-Behavioral Therapy Services at Rogers Memorial Hospital.*



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