Obsessive Compulsive Disorder: Cognitive Behavioural Interventions and the role of the nurse

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Obsessive Compulsive Disorder (OCD) is a debilitating mental health problem. Derek Reilly examines current cognitive behavioural treatments and illustrates how they can be used to treat clients with obsessive compulsive problems

KEYWORDS

- mental health nursing
- psychological disorders
- community psychiatric nursing

What is OCD ?

OCD is an anxiety-based problem characterised by two main features: obsessions and compulsions (American Psychiatric Association 1994). Obsessions are recurrent and persistent thoughts and images that a person experiences and finds distressing. If we are honest most of us experience thoughts that we find repugnant, such as thoughts about harm occurring to others. But usually we are able to dismiss these. However, a person with an obsessional problem finds these thoughts very distressing and, generally, has the urge to neutralise the distress by carrying out a ritual or behaviour.

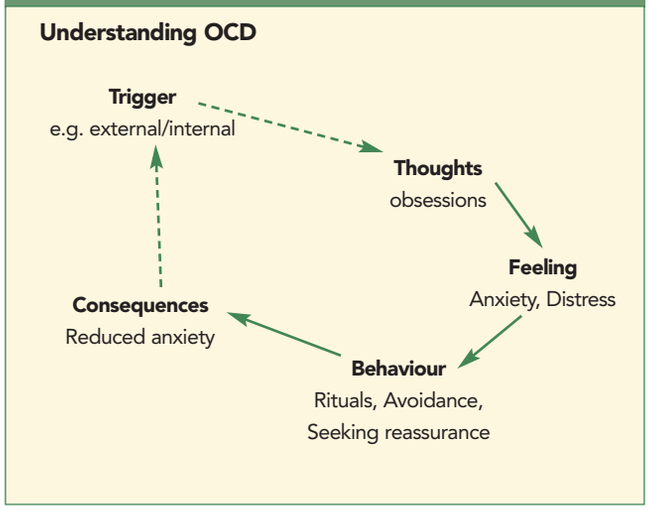
Compulsions are repetitive behaviours used to neutralise distress and include handwashing, ordering and checking or mental acts, such as praying, counting, repeating words silently. These reduce the distress in the short term but in the long term this pattern is repeated and endless hours of the day can be taken up in elaborate routines. In addition, people often avoid situations as they learn that this prevents obsessional thoughts and anxiety and the need to carry out compulsions.

Famous people such as Charles Darwin and John Bunyan are believed to have suffered with the problem, and Ash and Marks (1995) state that 11 per cent of people have obsessive compulsive symptoms. Karno *et al* (1988) suggest that the general population has a 2.5 per cent lifetime risk of developing an OCD.

Cognitive behavioural models suggest a cyclic problem that is usually triggered by an event (see Figure 1). This could be an external trigger (e.g. a place) or an internal trigger (e.g. thinking about a person). This triggers an obsessional thought, (such as a fear of becoming contaminated), leading to heightened anxiety or distress. Sufferers respond by carrying out a behaviour to reduce the distress and the short-term consequence is that they feel less anxious.

These neutralising behaviours are important in maintaining the problem in a number of ways. Firstly, by counteracting the thought, they act as a form of negative reinforcement and therefore reinforce the belief that the thought has some 'real' significance or threat. In addition, the behaviour removes the person's ability to discover that nothing bad happens if the thought is not acted upon. However, this is a vicious cycle and although the person experiences short-term relief, the trigger soon re-emerges and the whole cycle is repeated. Cognitive behavioural therapy

Fig. 1. A cognitive behavioural model of OCD



(CBT) approaches attempt to break this vicious cycle through behavioural and cognitive change.

Cognitive Behavioural Treatments

Exposure and Response Prevention

It is generally agreed that exposure and response prevention is the treatment of choice (Hawton *et al* 1996; Marks 1987; Newell and Gournay 1994; Steketee 1993) all report the successful use of such techniques by nurses. Treatment aims to assist clients to overcome the problem through exposing them to the triggers and then assisting them in resisting the urge to carry out their neutralising behaviours (response prevention). This continues whenever they experience an intrusive thought or trigger and confront feared stimuli and avoided situations (exposure). This encourages an initial increase of anxiety; however, over time this automatically reduces (habituation). By doing this, clients experience anxiety and can learn that it reduces naturally.

Exposure is a technique in which clients gradually face their feared objects and learn that anxiety reduces by itself. Staying in the situation is imperative. Rachman *et al* (1971) showed that if people can stay long enough in their feared situation, their anxiety gradually subsides.

An extension of this treatment is habituation training, which is used to expose clients to intrusive thoughts. This involves clients writing thoughts down on paper, speaking them out loud, or recording them on audiotape. Salkovski and Westbrook (1989) note that using an audio loop tape is most effective when clients listen to their voice articulating intrusive thoughts, leaving a gap of 30 seconds between each one.

Cognitive Therapy

Wells (1997) found an increasing number of cognitive models of OCD have been developed, including Salkovski's (1985). These incorporate exposure and response prevention but primarily focus on client's appraisal of intrusive thoughts. These models propose that problems are maintained by the client's sense of responsibility and irrational beliefs about thought and action. The client's sense of responsibility is seen as crucial, as Rachman (1993) postulated that clients do not make the distinction between a thought and an action; they believe that having a thought is evidence that it will happen. Therapy uses a range of experiments to challenge these underlying beliefs.

Case Study: John Miles

Assessment

A cognitive behavioural assessment is designed to elicit the role of thoughts, feeling and behaviours in the development of a formulation of the problem. Mr Miles' formulation was developed by examining a recent incident of the problem (see Figure 2) and carrying out a behavioural analysis as outlined in Hawton *et al* (1996). This involved asking many open questions. For example, 'What was the first thing you noticed?', 'When you felt distressed, what went through your mind?'.

Using this formulation Mr Miles neutralised the anxiety about harm happening to his sister by squinting his eye by moving his eyebrow. This also reduced his belief that harm could happen to his sister because by doing this he believed he transferred the responsibility to himself and could cope better.

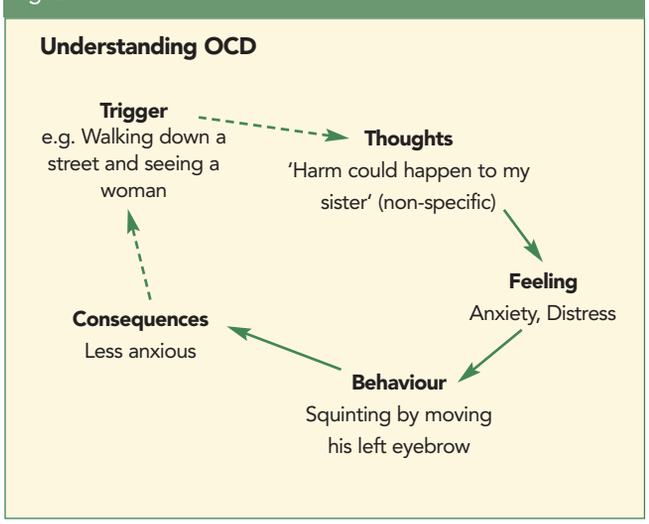
Mr Miles' main presenting symptoms were intrusive thoughts about harm occurring to people he cared about and a variety of compulsive behaviours, including squinting by moving his left and right eyebrows, saying words silently and re-reading words. He also avoided watching television and reading newspapers, which featured violence, fearing that this would trigger off thoughts of harm occurring to people he cared about. He was assessed as suitable for treatment as he had clear obsessional and compulsive symptoms, which met DSM IV criteria, and was highly motivated to engage in therapy. The rationale for exposure and response prevention was explained to Mr Miles, who accepted it.

Problem Definition and Targets

An important part of assessment is working collaboratively with the client to develop a problem definition (Marks 1986). This is a succinct summary of the problem which includes antecedents, coping behaviours, feared consequence and impact on living. Also, the extent to which the problem upsets and interferes with normal activities are rated using a 0-8 rating scale (Marks 1986) (where 0 represents 'no problem at all' and the greater the score, the greater the handicap). Mr Miles' problem definition was intrusive thoughts about harm happening to people he cared about, leading to anxiety and to being compelled to carry out neutralising behaviours, e.g. squinting his eye by moving his left eyebrow, leading to reduced socialisation and functioning. Mr Miles rated both problem upset and interference as 7 pre treatment.

Treatment targets are also developed with the client (Marks 1986). These are specific behavioural goals which the client currently is unable to achieve but wishes to do so by completion of therapy. These are rated on a 0-8 scale of discomfort and success at achieving the behaviour (where 0

Fig. 2. John Miles: case formulation



represents 100 per cent completion of the target. Again, greater scores represent greater handicap. Mr Miles developed three targets (see Figures 4-6 for ratings):

Target 1: 'To read an article from a research paper for 30 minutes without neutralising.'

Target 2: 'To walk down a busy street and look at a woman without squinting or neutralising.'

Target 3: 'To be able to type my English essay without re-reading or neutralising.'

Fig. 3. Problem severity over time

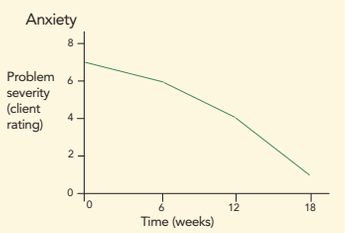
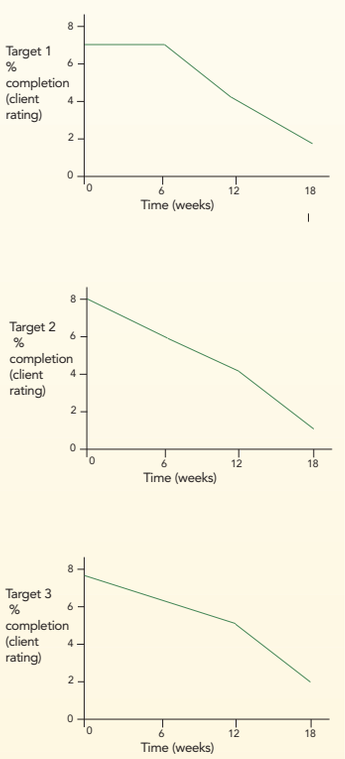


Fig. 4-6. Targets 1 to 3 over time



Cognitive Behavioural Treatment

Mr Miles' exposure programme

A programme of exposure and response prevention and habituation training was developed to tackle anxiety-provoking situations and avoidance behaviours. The programme was:

- **Graded** – A hierarchy of goals was created which gradually introduced Mr Miles to feared situations such as watching TV or verbalising intrusive thoughts. This allowed Mr Miles to make improvements and gradually gain confidence. Tackling a task and failing might reduce confidence and make the client end therapy prematurely. Getting clients to think of goals is crucial as client participation promotes responsibility and self help.
- **Prolonged** – Enough time must be allowed for habituation to occur. Generally, Mr Miles took between two and 15 minutes to habituate, but this can take up to 90 minutes with some clients.
- **Repeated** – Tasks are repeated until the client can complete them without any compulsive behaviour. This reinforces learning from sessions.
- **Focused** – Goals were focused on the problem, time specific and realistic. Goals included: 'to watch television for 10 minutes and resist the urge to neutralise'. Cognitive focusing on avoided thoughts was also encouraged.

Content of sessions

Mr Miles was seen for 18 one-hour sessions. These sessions were structured and involved in-session exposure and response prevention, reviewing and planning homework tasks and discussing difficulties that arose. Homework tasks form an integral part of therapy and promote independence by teaching clients self-help skills. Tasks included practising exposure and response prevention and reading relevant self-help books such as *Living with Fear* (Marks 1978).

Clinical outcome

The programme of exposure and response prevention helped Mr Miles to reduce his problem considerably. By the end of therapy his problem rating (see Figure 3) had fallen from 7 to 1 and he had made significant progress towards completion of his three targets (see Figures 4-6). At completion of therapy he felt confident enough to think about resuming his academic course and undertaking part-time work.

Overcoming Difficulties in Therapy

According to Bruch and Bond (2000), one of the most crucial parts of assessment and treatment is the collaborative development of the case formulation, as a client must understand this if engagement in therapy is to be achieved. Formulation can also help to overcome some of the difficulties encountered in therapy. For example in this case study, Mr Miles found some of the early tasks very difficult and didn't make much progress. At times he was able to manage not doing an overt ritual but compensated by saying words silently. This is a common problem and can be hard to detect because of the covert nature of the neutralising. To help overcome this we discussed Mr Miles' case formulation, explaining how covert behaviours also help maintain his problem.

Another problem was that Mr Miles initially found the habituation training difficult, especially when doing it as a homework task alone. Again, this can be a problem as the sufferer finds saying intrusive thoughts very distressing. A normalising rationale with the formulation was used, explaining how people with obsessive compulsive problems can find it difficult to verbalise thoughts (such as a new mother who has thoughts about harming her baby). This helped Mr Miles, who said that he was relieved that he was not foolish. Additionally, role modelling of verbalising thoughts was used. Mr Miles said he found this particularly helpful, as watching another person do it made the process easier.

Relapse Prevention

Salkovski and Kirk (1996) note that relapse rates in OCD can be as high as 40 per cent. Relapse prevention involved asking Mr Miles to identify what he had learned during therapy and how he

overcame difficulties, (such as the re-appearance of thoughts and behaviours, using a problem-solving approach). A preventive plan was developed, emphasising the continued use of self exposure and response prevention, using a self-help manual for obsessive compulsive problems (Ash and Marks 1995). By this time, Mr Miles was able to draw up his own goals for future exposure and practise these alone.

Discussion

This case study demonstrates the effectiveness of nurses treating OCD using exposure and response prevention. As Marks *et al* (1975) stated, suitably trained nurses are as effective as psychiatrists and psychologists at treating clients. The treatment of OCD has been carried out by nurse therapists for 28 years. Nurse therapists have undertaken specialised training in CBT, usually in the form of the ENB650 in Adult Behavioural Psychotherapy. At present, as Gournay (1998) points out, there is a relatively small number of both nurse therapists (200) in the UK and clinical psychologists (500) who have the necessary expertise to treat OCD clients. Consequently, nurse therapists generally treat the most severe clients and other OCD sufferers receive different interventions, including a range of self-help approaches.

However, there is a large number of people who do not meet these criteria and require more input than a purely self-help approach. Gournay (1998) states that this client group could be treated by experienced nurses, such as community mental health nurses who receive supervision from a nurse therapist or who have received suitable CBT training. Such clinicians could use the interventions outlined in this paper under supervision to treat OCD sufferers.

Nevertheless, there are currently a number of factors that could militate against this. Firstly, the National Service Framework (NSF) (Department of Health 1999) advocates the use of CBT for a range of anxiety disorders (including OCD) and it is likely that as more mental health services attempt to reach these standards there will be an increased demand for supervision by nurses. However, as Gournay (1998) points out, with the small number of trained nurse therapists unlikely to increase significantly in the next few years, there will not be enough nurse therapists to meet the burgeoning demand for supervision.

This poses a major problem not only for nurse therapists and nurses but also mental health services. If there is a lack of supervision available it is inevitable that some OCD sufferers will not receive the appropriate level of skilled help. This has implications for client care and the achievement of the NSF targets, as without appropriate supervision nurses cannot deliver skilled interventions. Perhaps a way to overcome this is if nurse therapists could offer group supervision to nurses. This could increase the number of people receiving supervision but could also compromise individuality and quality of care and raise issues such client confidentiality.

In the long term, more training courses in CBT need to be made available for non-specialised practitioners and it is possible the increased demand for supervision together with the need to meet NSF targets will create pressure on mental health services to provide appropriate training and supervision. However, in the short term there is likely to be an over demand for supervision from nurses.

Conclusion

Obsessive compulsive disorder is a relatively common disorder that can cause severe disruption and distress which can be treated effectively by trained nurse therapists using exposure and response prevention. Less severe cases can be treated using a wide range of interventions, including those outlined in this article by non-specialised nurses under supervision. Increases in demand for supervision by nurses are likely to result from the implementation of NSF and the small number of practising nurse therapists are unlikely to be able to cope with this demand. This has implications for the quality of treatment given to OCD sufferers. In the long term, increased pressure for supervision and achievement of NSF targets may put pressure on mental health services to provide more training courses on CBT for non-specialised practitioners and also to recruit more nurse therapists

The client's name has been changed.

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