OBSESSIVE-COMPULSIVE DISORDER (OCD)

BEHAVIORAL DEFINITIONS

1. Intrusive, recurrent, and unwanted thoughts, images, or impulses that distress and/or interfere with the client's daily routine, job performance, or social relationships.
2. Failed attempts to ignore or control these thoughts, images, or impulses or neutralize them with other thoughts and actions.
3. Recognition that obsessive thoughts are a product of his/her own mind.
4. Repetitive and/or excessive mental or behavioral actions are done to neutralize or prevent discomfort or some dreaded outcome.
5. Recognition of repetitive thoughts and/or behaviors as being excessive and unreasonable, not realistic worries about life's problems.

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LONG-TERM GOALS

1. Reduce the frequency, intensity, and duration of obsessions and/or compulsions.
2. Reduce time involved with or interference from obsessions and compulsions.
3. Function daily at a consistent level with minimal interference from obsessions and compulsions.

4. Resolve key life conflicts and the emotional stress that fuels obsessive-compulsive behavior patterns.
5. Let go of key thoughts, beliefs, and past life events in order to maximize time free from obsessions and compulsions.
6. Accept the presence of obsessive thoughts without acting on them and commit to a value-driven life.

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SHORT-TERM OBJECTIVES

1. Describe the history and nature of obsessions and compulsions. (1, 2)

2. Obtain a complete medical evaluation to rule out medical and substance-related causes for anxiety symptoms. (3, 4)

3. Complete psychological tests designed to assess and track the nature and severity of obsessions and compulsions. (5)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a therapeutic alliance.
2. Assess the frequency, intensity, duration, and history of the client's obsessions and compulsions (consider using a structured interview such as *The Anxiety Disorders Interview Schedule-Adult Version*).
3. Refer the client to a general physician for a complete medical examination to rule out medical or substance-related etiology for the anxiety.
4. Assist the client in following up on the recommendations from a physical evaluation, including medications, lab work, or specialty assessments.
5. Administer an objective measure of OCD to further assess its depth and breadth (e.g., *The Yale-Brown Obsessive-Compulsive Scale*;

Obsessive-Compulsive Inventory-Revised); readminister as indicated to assess treatment progress.

4. Disclose any history of substance use that may contribute to and complicate the treatment of OCD. (6)

5. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (7, 8, 9, 10)

6. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).

7. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

8. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

9. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.

10. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the

	behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
6. Cooperate with an evaluation by a physician for psychotropic medication. (11, 12)	11. Arrange for an evaluation for a prescription of psychotropic medications (e.g., serotonergic medications).
	12. Monitor the client for prescription compliance, side effects, and overall effectiveness of the medication; consult with the prescribing physician at regular intervals.
7. Keep a daily journal of obsessions, compulsions, and triggers; record thoughts, feelings, and actions taken. (13)	13. Ask the client to self-monitor obsessions, compulsions, and triggers; record thoughts, feelings, and actions taken; routinely process the data to facilitate the accomplishment of therapeutic objectives (or assign "Analyze the Probability of a Feared Event" in the *Adult Psychotherapy Homework Planner* by Jongsma).
8. Verbalize an accurate understanding of OCD, how it develops, and how it is maintained. (14)	14. Convey a biopsychosocial model for the development and maintenance of OCD highlighting the role of unwarranted fear and avoidance in its maintenance (see *Mastery of Obsessive-Compulsive Disorder* by Kozak and Foa).
9. Verbalize an understanding of the treatment rationale for OCD. (15, 16)	15. Provide a rationale for treatment to the client, discussing how treatment serves as an arena to desensitize learned fear, reality-test obsessional fears and underlying

beliefs, and build confidence in managing fears without compulsions (see *Mastery of Obsessive-Compulsive Disorder* by Kozak and Foa).

16. Assign the client to read psychoeducational chapters of books or treatment manuals or consult other recommended sources for information on the rationale for exposure and ritual prevention therapy and/or cognitive restructuring for OCD (e.g., *Mastery of Obsessive-Compulsive Disorder* by Kozak and Foa; *Getting Over OCD* by Abramowitz; *The OCD Workbook: Your Guide to Breaking Free from Obsessive-Compulsive Disorder* by Hyman and Pedrick).

10. Identify and replace biased, fearful self-talk and beliefs. (17, 18)

17. Explore the client's biased schema and self-talk that mediate his/her obsessional fears and compulsions; assist him/her in generating thoughts that correct for the biases; use rational disputation and behavioral experiments to test fearful versus alternative predictions (see "Obsessive-Compulsive Disorder" by Salkovskis and Kirk).

18. Assign the client a homework exercise in which he/she identifies fearful self-talk, identifies biases in the self-talk, generates alternatives, and tests though behavioral experiments (or assign "Journal and Replace Self-Defeating Thoughts" or "Reducing the Strength of Compulsive Behaviors" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success, providing corrective feedback toward improvement.

11. Participate in imaginal or in vivo exposure to feared internal and/or external cues. (19, 20, 21, 22)

19. Assess the nature of any internal cues (thoughts, images, and impulses) and external cues (e.g., persons, objects, and situations) that precipitate the client's obsessions and compulsions.

20. Assist the client in the construction of hierarchies of feared internal and external fear cues.

21. Conduct exposure (imaginal and/or in vivo) to the internal and/or external OCD cues; begin with exposures that have a high likelihood of being a successful experience for the client; include response prevention and do cognitive restructuring within and after the exposure (see *Mastery of Obsessive-Compulsive Disorder* by Kozak and Foa; or *Understanding and Treating Obsessive-Compulsive Disorder* by Abramowitz).

22. Assign the client homework exercises in which he/she repeats the exposure to the internal and/or external OCD cues, using response prevention and restructured cognitions, and records responses (or assign "Making Use of the Thought-Stopping Technique" in the *Adult Psychotherapy Homework Planner* by Jongsma); review during subsequent sessions, reinforcing success, problem-solving obstacles, and providing corrective feedback toward improvement (see *Mastery of Obsessive-Compulsive Disorder* by Kozak and Foa).

12. Verbalize an understanding of relapse prevention. (23, 24)

23. Provide a rationale for relapse prevention that discusses the risk and introduces strategies for preventing it.

24. Discuss with the client the distinction between a lapse and relapse, associating a lapse with a temporary setback and relapse with a return to a sustained pattern of thinking, feeling and behaving that is characteristic of OCD.

13. Identify situations at risk for a lapse and strategies for managing these risk situations. (25, 26, 27, 28)

25. Identify high-risk situations and rehearse the management of future situations or circumstances in which lapses could occur.

26. Instruct the client to routinely use strategies learned in therapy (e.g., continued everyday exposure, cognitive restructuring, problem-solving), building them into his/her life as much as possible.

27. Develop a "coping card" or other reminder on which coping strategies and other helpful information can be kept and consulted by the client as needed (e.g., steps in problem-solving, positive coping statements, other strategies that were helpful to the client during therapy).

28. Schedule periodic maintenance or "booster" sessions to help the client maintain therapeutic gains and problem-solve challenges.

14. Participate in Acceptance and Commitment Therapy (ACT) for OCD. (29, 30, 31, 32)

29. Use an ACT approach to OCD to help the client accept and openly experience obsessive thoughts, images, and impulses without being overly impacted by them, and committing his/her time and efforts to activities that are consistent with identified, personally meaningful values (see *Acceptance and Commitment Therapy for Anxiety Disorders* by Eifert, Forsyth, and Hayes).

30. Teach mindfulness meditation to help the client recognize the negative thought processes associated with OCD and change his/her relationship with these thoughts by accepting thoughts, images, and impulses that are reality-based while noticing, but not reacting to, non-reality-based mental phenomena (see *Guided Mindfulness Meditation* [Audio CD] by Zabat-Zinn).
31. Assign the client homework in which he/she practices lessons from mindfulness meditation and ACT in order to consolidate the approach into in everyday life.
32. Assign the client reading consistent with the mindfulness and ACT approach to supplement work done in session (see *The Mindfulness and Acceptance Workbook for Anxiety* by Forsyth and Eifert).

15. Identify and discuss unresolved life conflicts. (33, 34)

33. Explore the client's life circumstances to help identify key unresolved conflicts that may underlie OCD.
34. Read with the client the fable "The Friendly Forest" or "Round in Circles" from *Friedman's Fables* by Friedman, and then process using discussion questions.

16. Verbalize and clarify feelings connected to key life conflicts. (35, 36)

35. Encourage, support, and assist the client in identifying and expressing feelings related to key unresolved life issues.
36. Assess for secondary gains the client may be receiving by remaining disordered with OCD (e.g., attention, care-receiving, avoidance of activity); directly address gains, if evident.

17. Accept or work to resolve identified life conflicts. (37)

37. Explore the resolution of identified interpersonal or other identified life conflicts; assist the client with acceptance of those that cannot be changed or use a conflict-resolution approach to address those that can.

18. Gain insight into how childhood experiences might influence current struggles with OCD and take appropriate actions. (38)

38. Use an insight-oriented approach to explore how current obsessive themes (e.g., cleanliness, symmetry, aggressive impulses) may be related to unresolved developmental conflicts (e.g., psychosexual, interpersonal); process toward the goal of insight and change.

19. Implement the Ericksonian task designed to interfere with OCD. (39)

39. Develop and assign an Ericksonian task (see *Ericksonian Approaches* by Battino and South) that is consistent with the theme of the client's obsession or compulsion (i.e., "symptom as task"); process the results with the client. (e.g., if obsessed with a loss, give the client the task to visit, send a card, or bring flowers to someone who has lost someone).

20. Engage in a strategic ordeal to overcome OCD impulses. (40)

40. Create and sell a strategic ordeal that offers a guaranteed cure to the client for the obsession or compulsion. (Note at the beginning of the therapy that Haley emphasizes that the "cure" offers an intervention to achieve a goal and is not a promise to cure the client; see *Ordeal Therapy* by Haley).

21. Develop and implement a daily ritual that interrupts the current pattern of compulsions. (41)

41. Help the client create and implement a ritual (e.g., find a job that the client finds necessary but very unpleasant, and have him/her do this job each time he/she finds thoughts becoming obsessive); follow up with the client on the outcome of its implementation and make necessary adjustments.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	300.3	Obsessive-Compulsive Disorder
	300.00	Anxiety Disorder NOS
	296.xx	Major Depressive Disorder
	_____	_____
	_____	_____
Axis II:	301.4	Obsessive-Compulsive Personality Disorder
	_____	_____
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
300.3	F42	Obsessive-Compulsive Disorder
300.09	F41.8	Other Specified Anxiety Disorder
300.00	F41.9	Unspecified Anxiety Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
301.4	F60.5	Obsessive-Compulsive Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.