Treatment of Obsessive Compulsive Disorder and Comorbid Social Phobia

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The purpose of this article is to help persons in the helping professions recognize the serious threats to self, family life, and work experienced by persons with obsessive compulsive disorder (OCD) and social phobia and help engage persons affected in focused, clinically responsible treatment. The article will present findings from epidemiological studies of the disorders presenting conjointly, illustrate comorbidity in clinical practice through case examples, and review clinically relevant information to be gleaned in the diagnostic assessment. Core triage decisions in initiating treatment will be reviewed. Medication approaches and patient concerns regarding medication will be overviewed. The article will summarize psycho-educational information regarding cognitive errors in OCD and social phobia that may be presented to the patient to help the patient limit anxiety evocative and depressive thought. The author will provide illustrations of cognitive behavioral treatment in individual and group psychotherapy, transfer of training, treatment resistance, and adjunctive treatments, resources for consumers and practitioners, and emerging challenges in the field. [Brief Treatment and Crisis Intervention 3:55–81 (2003)]

KEY WORDS: obsessive compulsive disorder, social phobia, major depression, cognitive behavioral treatment, Employee Assistance Program, psychotropic medication.

Obsessive compulsive disorder (OCD) is characterized by either obsessions or compulsions severe enough to last more than an hour a day or cause marked distress or significant impairment in a person’s normal routine, occupation, or academic functioning or social activities and relationships. In the course of the disorder the person has recognized the obsessions or compulsions as unreasonable or excessive. If another Axis I disorder is present, the obsessions or compulsions are not restricted to the Axis I disorder (e.g., subjective ruminations of worthlessness in the presence of an episode of major depression). The obsessions or compulsions are not due to the effects of a general medical condition or the physiological effects of substance use. A qualifier “with poor insight” is applied if in the course of the current episode the person,
for most of the episode, does not recognize that the compulsions or obsessions are unreasonable or excessive (American Psychiatric Association [APA], 2000). OCD oftentimes presents with a high degree of comorbidity (major depression, specific phobias, social phobia, panic disorder, generalized anxiety disorder, Tourette’s disorder, body dysmorphic disorder, trichotillomania, attention deficit and hyperactivity disorder, eating disorders, major depression, and obsessive-compulsive personality disorder [i.e., avoidant personality disorder, compulsive personality disorder, dependent personality disorder]; Yaryura-Tobias & Neziroglu, 1997).

Social phobia is characterized by a significant and persistent fear of social or performance situations in which the person anticipates that exposure to unfamiliar people or to scrutiny of others will result in behaviors or the emergence of anxiety symptoms, which will prove embarrassing or humiliating. Exposure to the feared situation typically results in the emergence of anxiety, which may reach panic proportion. The person recognizes the unreasonable or excessive nature of the fears and avoids or endures the feared situation with marked distress or anxiety. The person’s anticipatory anxiety, avoidance behavior, or subjective distress in the feared situation causes impairment in the person’s ordinary routines, occupational or academic functioning, social relationships, and activities or the person is highly distressed about having social anxiety. Duration is at least 6 months for persons under 18 years old. The anxiety and distress experienced by the person is not due to substance use or a medical problem and is not better accounted for by another psychiatric disorder (e.g., panic disorder, separation anxiety disorder, schizoid personality disorder). If another psychiatric disorder or medical condition is present, the fear is unrelated to the anxiety disorder (e.g., worries about nausea and vomiting in persons with severe migraine headache or anxiety laden thought of persons with anorexia or bulimia worrying that their eating behaviors may be observed by others). A qualifier “generalized” is specified if the fears encompass most social situations (APA, 2000).

**Prevalence**

The National Epidemiologic Catchment Area (ECA) Survey found that OCD occurs in approximately 2.5% of the adult population of the United States (Karno, Golding, Sorenson, & Burnam, 1988). As noted by Koran, subsequent epidemiological studies questioned the initially high prevalence of OCD (Koran, 2000). A recent study by Welkowitz, Struening, Pitman, Guardino, and Welkowitz (2000) found that 7.1% of participants in a National Anxiety Screening Sample met full screen criteria for OCD. In regard to social phobia, the ECA study found the prevalence of social anxiety disorder to be 2.4% (Schneier, Johnson, Hornig, Liebowitz, & Weissman, 1992). The more recent National Comorbidity Survey found a lifetime prevalence rate of 13.3% (Kessler et al., 1994). Despite disparities in prevalence rates, the epidemiological studies document OCD and social phobia, once both regarded as comparatively rare, as among the most common psychiatric disorders in the U.S. population.

A number of studies document the comorbidity of OCD and social phobia. Rasmussen and Eisen (1988) using a semistructured interview of 100 OCD sufferers found that 26% met criteria for social phobia. A study by Tukel, Polat, Ozdemir, Aksut, and Turksoy (2002) found that 15.6% of 147 persons diagnosed with OCD also met criteria for social phobia. DiNardo and Barlow (1990) found 13% of 15 persons diagnosed with OCD under DSM-III criteria had a comorbid diagnosis of social phobia. A study by Brown et al. (2001) in a sample of 1,127 outpatients found that the current and lifetime prevalence of additional Axis I disorders in primary
anxiety and mood disorders was 58% and 81% respectively. Such figures highlight the need for careful scrutiny of comorbidity in the initial clinical assessment.

Risks to Psychosocial Function

OCD and social phobia pose a significant threat to sense of self, social relationships, and occupational functioning. A study by Hollander et al. (1997) found that in a sample of 701 persons with OCD responding to questionnaires, 25% of persons had been hospitalized, average hospitalization costs were $12,500 and on the average, the person with OCD lost 3 full years of wages. Extrapolated to the population as a whole this would mean that the lifetime cost of OCD due to lost wages is $47 billion. Of significant concern was that the average person took a little over 17 years to become involved in appropriate treatment for OCD. The review of studies in clinical samples of persons with social phobia by Mendelowicz and Stein (2000) highlighted difficulties in the domains of education, employment, relationships with family members, romantic relationships and marriage, friendships, and social networks. Connor, Davidson, Sutherland, and Weisler (1999) note the risk of untreated social phobia potentially resulting in lifelong impairment in social development and occupational functioning and the risk of the development of other comorbid disorders such as dysthmic disorder, major depression, phobic disorders, and substance abuse.

A vignette from the hospital-based clinical practice of the author illustrates compromises in social-emotional and occupational functioning of persons with comorbidity of OCD and social phobia.

Ken is a 32-year-old never married newly hired appliance repair technician in training who lives with his 70-year-old mother. Ken had worked previously for a number of years developing film at night and was compelled to seek new employment when his former firm closed. While Ken had interest and skill in electronics and small engine repair as a personal avocation, he worried that others with presumptively higher intelligence and training would laugh at his “fumbling” attempts to perform repairs. He feared that his efforts in vain would result in a ceremony of humiliation. Ken also struggled with the fear that no matter how carefully he wired or soldered, an inadvertent error could result in a behind the wall electrical fire, with his being ultimately responsible for the deaths of others. On the first day of his new job, he survived the anxiety in meeting homeowners with a broken dryer and was able to change the timer in the dryer in less than two minutes. However, after he left the job, he returned to check the repair six times, prompting the homeowners to call his firm and call the police. After being advised of termination, Ken drank and was stopped by police and charged with a DUI. Because of his perseveration about fires and state of agitation, he was brought to the emergency room of the hospital and was seen by the Psychiatric Crisis Service who subsequently referred him for outpatient care. At point of evaluation Ken felt futile, citing his being unemployed, his having gravely disappointed his only support, his mother, and his now having a record of arrest, which would further complicate finding new work.

Considerations in the Diagnostic Evaluation

As noted by Koran (2000), the experienced clinician should assemble a case history. To be included in the assessment are chief complaint, history of present illness, concurrent diseases and disorders, prescribed medications, family history, educational and social history, history of substance use, history of physical or sexual
abuse, past psychiatric history and treatment, available social supports, and mental status exam.

Beyond obtaining these standard elements of the diagnostic evaluation, the clinician can make inquiry into several other domains of experience of the patient, which may prove of further use in diagnostics and treatment planning. The clinician may make careful and specific inquiry regarding comorbid disorders and the sequence in which the disorders presented. The clinician should inquire whether the patient has had a recent medical evaluation that might rule out other possible underlying medical causes of manifest anxiety symptoms and perceptions such as thyroid disorder, hypoglycemia, neurological disorders, etc. The clinician may elicit the patient's personal understanding and interpretation of the symptoms. Common responses by patients have included fears of being schizophrenic, psychotic, and attributions of inferiority or being “less than human.” These fears unchallenged may leave the patient misidentifying symptoms as core faults of the self that may further exacerbate anxiety and depressive symptoms. The clinician may discover circumstances related to potential crisis by asking why the patient is pursuing treatment at this time given the typically long latency of time between emergence of distressing symptoms and pursuit of professional treatment. Such inquiry may reveal extreme threat to a valued social or occupational role that merits crisis intervention and resolution before the patient can participate fully in outpatient care for OCD and social phobia. The clinician does well to ask how the patient has managed with self-directed attempts to control symptoms before pursuing help; answers may range from a healthier self-directed attempt at ritual prevention to deleterious attempts to manage anxiety through avoidance behavior or substance abuse. The clinician enhances his or her understanding of systemic variables through exploration of how family, significant others, and employers have responded to the patient in light of prevalent symptoms. Disclosures of the patient may help the clinician determine need for collateral interviews, reveal possible allies in the patient's treatment, forewarn potential crisis points, and profile possible sources of treatment resistance and indices of possible secondary gain.

Other lines of inquiry by the clinician may clarify the patient's motivation and preparedness to undertake treatment. Many patients with OCD have had years of psychiatric treatment with minimal or no gain with regard to specific obsessive thought and ritual behavior or OCD spectrum disorders such as body dysmorphic disorder (BDD) or trichotillomania. The clinician can explore the details of past involvement in psychiatric treatments. Many patients have been medicated on low dose tricyclic antidepressants or anxiolytics without benefit and many may never have had a specific course of focused cognitive behavioral therapy for OCD or social phobia. Many patients have been on the correct medication but at a subtherapeutic dose or stopped medication before medication was raised to a level that could successfully impact obsessive thought. Accordingly, the clinician can review with the patient understandable misgivings about the efficacy of treatment in light of such disclosures and provide corrective psycho-educational information under a notion of informed consent, consistent and within the bounds of training of the examining clinician. In the course of the psychosocial history, the clinician can examine the patient's “track record” for compliance-based behaviors, which may suggest ease or difficulty of the patient complying with the rigors and trajectory of cognitive behavioral treatment. In the psychosocial history, the clinician could ask the patient to describe positively valued personal and social pursuits that antedated emergence of incapacitating symptoms. The clinician may return to these disclosures of the patient to enhance motivation.
for treatment and the development of specific target goals for treatment. Patients with obsessional thought about causing harm are often initially more comfortable in revealing presumptively less socially embarrassing difficulties with hand washing or ordering rituals. The clinician may present in a nonthreatening and universalizing manner the more difficult symptoms of OCD or social phobia to enable the patient to feel less anxious about what would otherwise feel like “risky” disclosures.

**Value of Family Involvement in Treatment**

As the patient and the clinician discuss thoughts about needed areas of treatment and treatment methods, the clinician may ask about trusted others who may be willing to be involved in the patient’s treatment. Involvement of family and significant others in treatment may offer advantages in engagement of the patient, treatment planning, performance of exposure and response prevention, in vivo social exposures, and hedge against relapse prevention. With consent of the patient, family may offer perspectives on areas of ego strength not addressed by the depressed individual prone to discount or forget periods of adaptive functioning prior to the development of severe and prolonged anxiety symptoms. The mother of a past patient with OCD and social phobia commented about how her son prior to the development of the disorders had skipped grades and was in classes for the intellectually gifted. This information gave the author a better appraisal of the person’s native intellect, which was elicited in the design of exposure and response prevention practices and in the design of abbreviation of relaxation practices for use in modifying patterns of physiologic arousal in feared social situations. Concerned family and significant others may provide support for the depressed person remaining in treatment. As a wife of a former patient commented, “I can tell the difference between the way my husband has been for the past year and the way he was before all the anxiety, the worries, the retreat. But I know and have faith that he will be back. I told him from the word go that I was a partner and partners stay in for the long haul. When he feels like he is just an annoyance and an embarrassment to me, I tell him I don’t share that opinion and I want us to see this through.” Spouses or significant others may give valuable information related to cultural beliefs of their mate’s family system that may have become blind spots. For example, a female patient of the author, an unmarried 38-year-old executive with social phobia and minor compulsive behaviors, refused to drive to work, opting to walk five miles to work, even in the winter. The woman denied having panic or agoraphobia. She experienced panic of subclinical proportion after being informed that rather than work from a private office she would share a suite with other executives and would be required to work within a team format. In this instance, a close female friend invited to the session by the patient indicated that my patient came from a closed family system in which anyone outside the family could not be trusted and every action had a risk. By extension, driving could engender a potentially foolhardy risk, to be avoided if possible. Trusting in the follow through of others team members seemed to invite disappointment and failure. With this disclosure by her female friend, the patient acknowledged her wishes and fears related to transcending the rigid rules of her parents and grandparents. With encouragement of the friend, my patient was able to drive and work through fears of entrapment and belittlement by coworkers.

Family members have been instrumental in assisting persons with OCD and social phobia in exposure and response prevention therapy and in establishing hierarchies for in vivo social
exposures. Kate, a 24-year-old graduate student, permitted the author to meet with her parents. Kate and parents were advised of how well-intentioned reassurance by her parents regarding her blamelessness in the development of illness in family might unintentionally increase the strength of the fear. Kate and parents developed a hierarchy for exposures, ranging from the least anxiety evocative situation (sending relatives holiday cards, which prompted fears of chemicals leaching from the cards causing blood poisoning in elderly relatives) to the most extreme fear of exiting home for school without verifying the itinerary of parents and abstention from ritualized tapping of the door to a number count upon her leaving home. Her parents, both PhDs at the same university, encouraged their daughter in investigating lectures and other social events afforded by area colleges. Their knowledge of their daughter’s interests, learning, and personality style and culture of the colleges proved to be more effective in developing initial targets for in vivo exposure than those originally envisaged by the author. Her parents provided supportive and accurate critical feedback regarding social exposures that Kate found adaptive and sustaining.

Family members may also provide critically needed information regarding significant psychosocial stressors that could become effective determinants of potential relapse. Mary, the wife of Bill, a 77-year-old retired former machinist with OCD and social phobia advised that Bill was found to need an MRI with contrast ordered by his primary care physician to evaluate causes of late onset severe headache. Mary advised that her husband, after understanding how he would be observed by medical personnel in the test area, became acutely anxious rather than feeling relieved. She confided that her husband feared that he would stammer, sweat, and become an object of laughter by personnel observing the test. His original plan was to “drink a fifth of whiskey, so I could go through the test and not have to worry.” Mary advised that Bill had been sober for the past 25 years, after experiencing prior severe depressive episodes and becoming assaultive in the course of past drinking episodes. Mary was also quite helpful in providing the clinical treatment team of successes and lack of response to clinical interventions. She reported her husband’s initial anxiety complaints stimulated by trials on antidepressants (which also prompted thoughts of drinking). Several years after formal sessions ended, she contacted the author to report her husband having difficulties with memory, motivation, and a recurrence of patterns of social withdrawal. Based on her awareness of signs of relapse reviewed as part of previous treatment, she proved instrumental in referring her husband for reevaluation and attended AA meetings with him (given his fears of social contact). With a restart on antidepressant medication and with encouragement from Mary, Bill’s states of rumination lessened, his memory improved, and both attended an adult education course on use of the Internet (a social exposure scrupulously avoided because of fears of radiation emanating from computer monitors and envisaged derisive stares of other attendees).

The involvement of significant others in monitored home practice of exposure and response prevention has proven useful for patients with OCD, given the oftentimes greater prevalence of OCD symptoms within the patient’s home and limited carryover of exposure and response prevention strategies modeled and performed initially in office sessions. In the experience of the author, most families highly support therapeutic efforts for OCD and social phobia. However, in rare instances, patients with checking rituals may be questioned by family members who also have pronounced checking rituals and view with suspicion or alarm changes in household
routine. With the patient’s consent, outreach and explanation to relevant family is recommended.

The clinician may review with patients situations in which they faced ambiguity, took a risk, and succeeded despite their significant and oftentimes pervasive doubts. This review is useful in enabling the patient to face the anxiety of exposure and response prevention when the patient faces the uncertainties introduced by performing what appear to be high risk behaviors without a guarantee of foolproof results. The review is also useful in preparing the patient with social phobic symptoms to make opening conversational statements in ambiguous social situations otherwise avoided because of the intolerance of uncertainty or the forecast of failure. The clinician may involve the patient in animated discussion of valued social and occupational roles. The clinician may learn of the patient’s learning style and acquire metaphors, which may be invoked in treatment. As an example, if the patient is a trial attorney, the clinician may review how the patient convicts self a priori, using as evidence idiosyncratic thought without empirical evidence (a standard of practice the attorney would never accept in practice at trial). Disclosures about these valued roles can be used later in treatment to generate structured reflections as part of an imaginal exposure, a prelude to in vivo exposure, as part of a desensitization to anxiety evocative situations. Finally, the clinician may ask the patient about the percentage likelihood that his or her worst fears would come true. Disclosures in this area may allow the clinician to review with the patient embedded cognitive errors that may be corrected or reveal possibly delusional or magical elements in the patient’s thinking that might necessitate alternative branching in treatment planning (e.g., psychological testing, medication consultation, a more extensive first course of cognitive therapy).

**Triage Decisions at Point of Initial Evaluation**

Because of the significant number of other syndromes that can occur with OCD and social phobia, the clinician hopefully will have ruled out other possible comorbid Axis I diagnoses such as major depression, BDD, substance abuse, eating disorders, etc. Detection of a potentially hazardous medical state such as emaciation with anorexia nervosa, skin picking behavior resulting in infection, burns associated with use of caustic chemicals or superheated water used in cleaning rituals require prompt medical evaluation. If the patient has not had a recent comprehensive medical evaluation to rule out possible underlying medical causes of presenting complaints, the patient should be instructed to contact his or her primary care physician, with the treating clinician sending a note regarding clinical diagnosis with possible need for medical testing to rule out anxiety or depression due to a medical disorder (presuming the patient consents to contact). Many patients seen for evaluation report past unsuccessful trials on antidepressant medication. A detailed review of medications prescribed may reveal that the patient was on a low dose tricyclic antidepressant such as Elavil, which might help with sleep, but not impact primary obsessive thinking in OCD. If use of psychotropic medication is seen as essential or advisable by the patient and the clinician, medication evaluation should be performed by a medication provider well trained and versed in OCD, social phobia, and frequently presenting comorbid conditions.

If the individual presents in crisis or is at high risk of emergent crisis, clinical efforts should be directed to resolution of crisis before initiation of treatment for OCD and social phobia. Roberts’ *Crisis Intervention Handbook* (2000) explains methods of working with individuals experiencing crisis over a wide array of presenting cir-
cumstances such as rape, severe and life threatening illness, addictions, psychiatric emergencies, etc. A recent case of the author illustrates strategies of intervention for persons with OCD and social phobia experiencing crisis. Strategies utilized by the author to help the patient correspond to the seven-stage model of crisis assessment and intervention of Roberts (2000). Jennifer is a 36-year-old married mother of two who presented for evaluation for treatment of depression. In the initial evaluation, Jennifer indicated that she felt acutely saddened and anxious about being a “bad mother.” Jennifer had been unable to help her 6- and 7-year-old daughters make Christmas ornaments for the holiday and had been unable to attend PTA meetings, which she viewed as condemning evidence of her being a failure as a mother. In the evaluative session, the author learned that Jennifer feared that by letting her children play with clay and fingerpaints and play with toys with batteries, she was exposing her children to carcinogens. She feared that because she had not had this recognition earlier, she therefore was blameworthy for her children’s eventual cancer-related deaths. In regard to her not being able to attend PTA meetings, she feared that she would stutter, blush, and be “under the microscope” as she approached the refreshment table. Jennifer acknowledged having postpartum depression. Jennifer was given an explanation of how her depression and anxiety might be a consequence of untreated OCD and social phobia. The author explained use of cognitive-behavioral therapy (CBT) and medication for OCD and social phobia. The author attempted to help Jennifer understand the range of her adaptive ego strengths and begin to view her maladaptive cognitions as symptoms of OCD, social phobia, and depression as opposed to her thoughts factually establishing her lack of worth. Jennifer was given an explanation of how her depression and anxiety might be a consequence of untreated OCD and social phobia. The author explained use of cognitive-behavioral therapy (CBT) and medication for OCD and social phobia. The author attempted to help Jennifer understand the range of her adaptive ego strengths and begin to view her maladaptive cognitions as symptoms of OCD, social phobia, and depression as opposed to her thoughts factually establishing her lack of worth. Jennifer was given an explanation of how her depression and anxiety might be a consequence of untreated OCD and social phobia. The author explained use of cognitive-behavioral therapy (CBT) and medication for OCD and social phobia. The author attempted to help Jennifer understand the range of her adaptive ego strengths and begin to view her maladaptive cognitions as symptoms of OCD, social phobia, and depression as opposed to her thoughts factually establishing her lack of worth. Jennifer was given an explanation of how her depression and anxiety might be a consequence of untreated OCD and social phobia. The author explained use of cognitive-behavioral therapy (CBT) and medication for OCD and social phobia. The author attempted to help Jennifer understand the range of her adaptive ego strengths and begin to view her maladaptive cognitions as symptoms of OCD, social phobia, and depression as opposed to her thoughts factually establishing her lack of worth. 

Before the second scheduled session, Jennifer’s husband Mark called to voice concern about his wife’s level of depression after she tearfully told him he and the children would be better off if she were dead and the thoughts of suicide had become more intense. It was agreed that Mark come with his wife to a session scheduled on an emergency basis. In this session, Jennifer appeared subdued and showed a stream of tears. She acknowledged contemplating what it might be like if she were dead, contemplating ending her life, but resisted suicide given her beliefs as a practicing Catholic. In the session, Jennifer revealed that the precipitating event to her worsening symptoms was a call from the school nurse who expressed concerns about what appeared to be a seizure and subsequent fall by her older daughter, resulting in minor facial lacerations. With active listening by the author, Jennifer viewed the call as evidence confirming her negligence in not having ascertained the well-being of her daughter before daughter’s departure for school that day. She ruminated about her daughter’s seizures being caused by toxins or by a tumor. Jennifer viewed her negligence as sufficient reason for her husband and children regarding her as unworthy and unlovable. She viewed as an utter shaming experience her belief and fear that the pediatrician, in learning of her negligence, would contact the Department of Social Services and have her children placed in foster care.

Given Jennifer’s obvious level of depression and more recent difficulty in limiting depressive ruminations, the author suggested as a possibility that Jennifer participate in a partial hospitalization program. Jennifer declined, citing expense and her view that her daughters would see her as psychologically abnormal, causing them psychological harm. Jennifer denied having an active suicide plan/intent and agreed to a contract for safety.

The author worked out with Jennifer and her husband a focused plan of treatment. Mark
agreed to take some time away from work to spend with Jennifer. Jennifer was seen for an emergency medication appointment and was begun on an antidepressant medication that could impact depression, obsessive thought, and anxiety symptoms. Because of the length of time for build-up on the antidepressant, Jennifer was begun on a low-dose anxiolitic to help with panic of subclinical proportion. With twice weekly CBT sessions and supportive therapy, Jennifer’s mood gradually improved.

Jennifer was able to understand that with OCD persons often hold themselves as responsible for events beyond their functional control. She was able to see the exaggerations in her thinking in regard to the possibility of harm befalling her children as a result of her errors of omission or commission and her actual history of supportive and adaptive behavior in every aspect of their care. Jennifer and Mark agreed to exercise together for an hour a day, having understood that the exercise would help with anxiety and depression. Jennifer agreed to reengage in activities associated with her ego strengths, personal crafts, cooking, and writing. Mark was given an explanation of CBT for OCD and social phobia. He modeled use of the finger paint and glue in projects with the children with Jennifer following in suit. It was agreed that Jennifer and husband take their daughter to the pediatrician, with Jennifer asking the pediatrician to account for possible causes of her daughter’s symptoms (which Jennifer was able to do despite quite significant anticipatory anxiety). The pediatrician examined Jennifer’s daughter and made referral to a pediatric neurologist, which initially elevated Jennifer’s negative apprehensions. After evaluation by the pediatric neurologist, Jennifer and Mark were advised that their daughter had a fall on the stairs with disorientation after the fall, that there was no evidence of seizure or head trauma per se or likelihood of permanent scarring.

To help with Jennifer’s sense of isolation as the “only one” with emotionally painful thoughts of responsibility for causing harm and social isolation, the author discussed with her the potential of her meeting with another of the author’s patients who had difficulty with obsessional thought and social phobic symptoms. Despite her initial reluctance, Jennifer did agree to the meeting. Within the meeting, Jennifer felt that someone other than a therapist understood her angst and felt recovery was possible. After the meeting she reported feeling understood and relieved.

Jennifer’s active involvement in the OCD support group appeared to help increase her social comfort level with interpersonal contact and with making spontaneous statements in a group context. The OCD support group appeared singularly helpful in enabling Jennifer to return to PTA meetings. After several weeks, Jennifer no longer experienced suicidal thought. She was able to be involved in projects with her children and had joined a craft group at a local community center. Jennifer viewed the craft group as a useable “practice lab” for initiating conversation to help in work with her social phobic symptoms. Given the notable lessening of symptoms of anxiety and depression, along with her resumption of normalized personal and family related activities, Jennifer opted to continue with medication monitoring, participate in the OCD support group and to be seen for biweekly sessions focusing on the interplay between her fears of causing inadvertent harm and her expectation of social ridicule, which engendered further anxiety and avoidance of social situations.

About a year after the initial session, Jennifer, Mark, and the author met to review treatment planning. Jennifer voiced that the meeting with one of the author’s patients and other learning from the OCD support group constituted the most helpful interventions. New cognitive and social learning appeared to constitute the final part of cognitive mastery in recovery from crisis.
as noted by Roberts (2000). It was agreed that given sustained improvement in terms of lessening of depression and greater involvement in social groups, Jennifer could continue with medication monitoring sessions and involvement in the OCD support group. The patient and her husband were acquainted with changes in thinking, affect, and behavior whose occurrence would warrant reevaluation.

If the patient is experiencing felt risk of loss of employment based on difficulty in concentration, reduced productivity, or avoidance of job tasks (stemming from fears of contamination or social ridicule), the patient should be referred, if possible, to the Employee Assistance Program (EAP) of the company. The EAP professional can help the patient evaluate use of disclosure of OCD or social phobia, which might protect the patient under the Americans with Disabilities Act or help the patient obtain a leave under the Family Medical Leave Act. The EAP professional may contact human resources to describe the nature of difficulty experienced by the worker (with confidentiality preserved) and discuss the nature of functional accommodations, which could be implemented to enable the worker to perform the essential functions of the job. Persons with OCD often ruminate unendingly about ways to ward off the prospect of making any kind of mistake no matter how small. The worker with OCD who has spent hours struggling with thoughts about circumventing error to avoid negative attention in the workplace may be mortified by a supervisor giving the abrasive warning, "What have you been thinking about? I’m writing you up on this—you take too much time; we can’t have you here and doing essentially nothing." Such inappropriate feedback may escalate tension, exacerbate ruminations, and reinforce social fears, resulting in a more global decline in function of the patient. Appropriate guidance by professionals in the EAP or in human resources may help avoid such a destructive negative interdigitation between the person with OCD and social phobia and the work environment.

The first several sessions of treatment may be devoted to discussion of how social phobia or OCD singularly or in combination have affected the patient’s view of self and interpersonal and occupational functioning. Based on review of problems in these several domains of functioning, the patient and therapist will begin formulation of target goals. In clinical practice the author has found that patients may request strategies that offer immediate relief from acute symptoms of anxiety or straining involvement in ritual behavior. The goal of the cognitive-behavioral therapist is to engender interest and involvement of the patient in reeducation and retraining that will result eventually in anxiety reduction. The author has found in practice that asking the patient to select the initial targets of work, whether in the area of social phobia or OCD, appears to empower the patient. While groups for persons with social phobia offer distinct advantages in terms of desensitization and transfer of training (Barlow, 1998; Heimberg, 1990), many persons with social phobia may feel more comfortable in working in individual treatment with a therapist who will also be leader of the social phobia group to which the patient may be referred.

Strategies for Strengthening the Therapeutic Relationship

The patient with both OCD and social phobia typically presents with doubts about the self, along with worries about any course of action to be undertaken. As a former patient remarked, “What you’re saying may work for other people, but they probably have more to them than I do; at the end of this treatment you’ll be able to find me in the breakdown lane.” Asking the patient to commit to the strategies of exposure and response prevention in CBT for OCD and to the in
vivo exposures in social or performance situations for persons with social phobia may catalyze anxiety and result in rethinking of involvement in treatment. A former patient of the author worried that “If I do something good for myself, this may trigger something bad happening. Though I strongly doubt it, I worry that my successes may have been facilitated by an act of the devil. Although there might not be any immediately apparent bad result, it is possible that the bad result could show up at some unknown time in the future when I was too busy or distracted to notice.” When this patient initially responded to prompts from family to do something good for himself and accept social invitations, he experienced a marked increase in palpitations, blushing, and palmar sweating, a result of a partial fight/flight response triggered by the reactivation of this obsessive thought about doing good for self somehow causing negative results for others at some unknown time in the future. The author was able to involve the patient in an understanding of the implications of the obsessional thought, as they would impact practice of in vivo social exposures. The establishment of rapport and strengthening of the therapeutic relationship may allow the patient to proceed with exposure and response prevention or in vivo social exposures. As part of planned ending of sessions, the author reviews with patients their appraisal of the course of treatment from precontemplation of entering therapy to the decision to end and continue behavioral practices alone (the option to return at a later date is always extended). Patients most frequently comment that their experience of someone understanding, having positive expectations in regard to feasibility of improvements in their quality of life and viewing them as visible co-collaborators in treatment engendered the motivation to proceed in treatment despite doubt and depression prevalent at the start of sessions.

Beyond the therapist demonstrating positive regard of the patient and the therapist understanding cultural and ethnic issues that may affect the patient’s views of therapist and patient role, the therapist may utilize approaches that strengthen therapeutic relationship. The clinician can highlight discounted areas of positive ego function. As an example, a former patient in his sixties with social phobia postponed or did not show for many appointments with neurologists and cardiologists, prompting the medical offices to send a rather terse note advising the patient that no further appointments would be scheduled. When the author questioned the patient about the reasons for avoidance of medical visits despite incapacitating pain, the patient noted he feared he would “look stupid” in answering any question the doctor might ask. He lamented, much like the scarecrow in the Wizard of Oz, “If I only had a brain.” The patient somehow left school in the sixth grade because of illness in the family and his need to work. At the end of the session the patient mentioned that he could not come in for an appointment for a couple of weeks because he had to help his son build the son’s new house. When the author expressed confusion and concern about how the patient could help build the house given moderate to severe cardiac and neurological problems, the patient indicated that he would provide his son technical advice on materials and construction. The patient humbly indicated that because he was poor, he had to learn how to build a home and do it himself. The patient went on to talk about issues in digging the foundation, mechanics of retaining walls, plumbing, electrical wiring and fixtures, roofing, connecting to the sewer line, pouring asphalt for the driveway, etc. While still astounded, the author was able to convince the patient that such accomplishments simply could not be planned and executed without the person having good native intelligence. Further, the author was able to point out to the patient that despite medical difficulties and social pho-
bia, he was able to achieve valued goals. (By comparison, the author still struggles with proper use of the caulking gun.)

The clinician enhances the strength of the therapy relationship by highlighting skills that the patient brings to the work ahead. For the patient with compulsive personality features, the author explains that the therapy for OCD is highly detailed and the patient’s assiduous attention to detail can be a decided asset. The skilled clinician will carefully listen to the metaphors in the patient’s language. Metaphors from work and identified areas of positive ego functioning may be utilized by the therapist to explain treatment principles and practices. A former highly driven “workaholic” master painter and paper hanger expressed frustration bordering on agitation because his psychiatrist wanted to perform appropriate medical testing to evaluate liver function before beginning a medication trial. The painter wanted to build up to the highest dose as fast as possible so that the medication would “let me do whatever I need to do; I don’t have time to waste.” The author reviewed with the patient that as a master painter and paper hanger, he would never “just slap the paper on the wall” without first carefully examining the wall and performing careful surface preparation, which obviated expensive “re-do’s” and customer complaints. The patient was able to see how a comparably competent psychiatrist would want to do an analogous “surface prep.”

The therapist does well to use language of collaboration: “Let’s see what we can do together to change these patterns that are so distressing to you.” This language is typically at odds with the harsh superego of the patient with dysthymia. Utilizing forethought and discerning clinical judgement, the therapist may make brief personal disclosures that contribute to the patient’s movement in treatment. For the patient who believed that only he was anxious before speaking before a group, the author briefly reviewed the at least moderate levels of anticipatory anxiety he experienced when he was “formally volunteered” to give his first grand rounds for the department of psychiatry. The clinician may attend to and reinforce the social phobic patient’s first manifestations of lighter social behavior in session; for example, the author, at the first lighter comment made in session by one patient with social phobia, commented, “I like the way you looked so relaxed and joked about the comments of the van driver” (who reminded the patient of Jim Carrey in Ace Ventura, Pet Detective).

Provision of Psychoeducational Information

An essential task of the clinician in the initial sessions is to understand and modify the inaccurate and dysfunctional meanings patients have about their condition. Patients with OCD with violent and sexualized thoughts may view such thoughts as core evidence of depravity, lethal risk, or insanity. Patients with large-scale ritual behavior may view their inability to resist rituals as evidence of weakness, evidence of a decline into schizophrenia, and evidence of a global and irreversible decline. These negative views may lead to depressive states with further loss of function. The person with social phobia may view the symptoms of palpitations, sweating, and blushing, as one patient remarked, “like a neon sign from the highway pointing right at me, for everyone to see and laugh.” Leah, one of the author’s patients with OCD and social phobia who was in her fifties at the time of initial evaluation, indicated that she “did her best” to hide ritual behavior during cleaning (washing her hands between every dish she put in the dishwasher and washing again between every clothes item she put in the laundry machine), and convinced every teacher to let her write papers as opposed to giving class presentations. One day, in her early twenties,
she was witnessed sweeping the sidewalk in front of her apartment in a ritualized manner by a group of adolescents. The adolescents taunted her with “We saw it, don’t try to hide it, you’re weird as hell and we’re going to camp out here to watch you!” The patient spent the next 30 years in isolation, performing ritual behavior in the home all day and most of the night. When asked to view how she saw herself in relation to others, one of her comments was “I guess I belong below the rug.”

Given the pervasiveness and depth of patients’ beliefs related to self and the world as cued by the anxiety symptoms and concomitant depression, the therapist cannot simply argue away the patients’ deeply held beliefs. The clinician may establish rapport with the patient through empathy and the understandability of their beliefs given their inferences from their experience.

Since Leah had had positive experiences with educators, the author presented the patient a “course” on OCD and social phobia and assigned readings. Through this means, the patient came to accept neurobiological aspects and theories of OCD, which lessened the frequency of her view of symptoms as a primary fault or failure of the self. In regard to the devastating comments of the group of adolescents, the author reviewed in detail information which the patient deleted from her account. The patient was able to recall that these adolescents often embroiled in conflict with school administrators for truancy, drug involvement, and malicious damage to property. The patient recalled that the adolescents were truant on the day they taunted her. With recall of this deleted information the patient commented, “I have to remind myself to consider the source,” and with this insight, the patient’s anxiety diminished appreciably. The clinician may then segue to other information sets that might have been available and absorbed by the individual if the disorders had not been so incapacitating and isolating. The author often reviews the ways in which the mental health profession has made significant errors, diagnosing persons with OCD and social phobia as schizophrenic because of obsessive thought, social withdrawal, and impoverishment of interpersonal relationships. Given the negativistic experience persons with OCD or social phobia may have had prior to pursuing treatment or in ineffective past treatment, the author asks patients if it were feasible to maintain their healthy skepticism, while learning of newer learning related to the neurobiology of the disorders. The author will present relevant information, cued to the patient’s educational level, about PET scan studies, functional MRI studies, and documentation of physical change in glucose metabolic rates, restoration of appropriate levels of brain neuroenzymes with either CBT or certain antidepressant medications. The author will explain gains that may be attained with either CBT or medication or a combination of the two from an informed consent perspective. The author may direct patients to relevant readings such as The Anxiety and Phobia Workbook (Bourne, 1990), Anxiety and Its Disorders (Barlow, 1998), Getting Control and Imp of the Mind (Baer, 1992, 2001), Stop Obsessing! (Foa & Wilson, 1991), etc. The author refers patients to the Web sites of the Obsessive Compulsive Foundation (www.ocfoundation.org) and the Web site of the Madison Institute of Medicine (www.minic.org) for accurate, relevant, consumer-friendly information. The author may invite patients to attend a local OCD support group without feeling under any obligation to disclose personal information. The patient and author review the patient’s questions and concerns and most patients are ready to proceed with treatment. Many patients find the mind/body explanation and learning theory explanations of OCD and social phobia to be relieving and humanizing compared to their prior negative self-judgments.
Review of Cognitive Theories

For persons with both OCD and social phobia, clarification of the role of thought in generating and maintaining symptoms is crucial. In *Cognitive Approaches to Obsessions and Compulsions: Theory, Assessment and Treatment* (2002), Taylor summarizes the domains of belief in persons with OCD, a pivotal contribution to the field by the Obsessive Compulsive Cognitions Working Group. Core to obsessional thought are the overimportance of thoughts, importance attached to controlling one’s thoughts, perfectionism, excessive responsibility, overestimation of threat, and the intolerance of uncertainty. In his work on depression, Beck (1976) studied the role of thinking (negative views of self, negative views of the future, and idiosyncratic interpretation of events) in the creation and exacerbation of depression. Burns (1999) and other cognitive behaviorists examined cognitive errors in the genesis of anxiety: selective abstraction, personalization, overgeneralization, labeling, “fortune teller error,” “black or white” thinking, etc., in the genesis of anxiety states. Meichenbaum (1985) highlighted the importance of understanding the individual’s self-monologue or “narrative account” in shaping perception of events and behavioral strategies derived from this perspective. In practice, the author may review elements of these cognitive theories most related to the patient’s presenting complaints, personality, and learning style.

Perhaps the application of cognitive theory is best illustrated by case example: Todd, a 14-year-old high school student, when stressed by annoying “back to school” shopping, experienced a transient thought of killing his parents, with a subsequent intrusive image of his parents being taken from the home in coffins. With this intrusive image, Todd developed a panic attack and could no longer travel to the town in which he had shopped with his parents. He quickly developed the pattern of arranging books in his room, ensuring that all books were ordered according to height, and that each was perpendicular to the shelf and equidistant from the back wall. While he acknowledged that these behaviors were unrelated to the safety of his parents, he felt that somehow unless he ordered the books, he might be at greater risk of losing control and killing his parents, with whom he had an excellent relationship. Todd also experienced longstanding social anxiety: “I never know what to say. I see other people talking; I want to say something but I just don’t know what the right comment is. I begin to think everyone is noticing my delay in speaking and know that I don’t know the right thing to say. I start to sweat, get afraid that I will stammer or stutter. Then I start wondering what people were thinking of me because I didn’t say anything and then I just leave.” Todd declined social invitations citing his view of himself as “an awkward fifth wheel” and from a moral perspective; as he put it, “And if other people really knew they were inviting Jack the Ripper to the party, I don’t think they would do it.” Todd had minor difficulty with motor tics that also contributed to his social anxiety. As Todd spent less time with his parents fearing he would cause them harm and less time with peers because of social anxiety, he spent more time in his room worrying about causing harm and ordering his books. The experience of panic and his exceedingly difficult time leaving his bedroom prompted his parents to arrange for psychiatric evaluation. Todd was first seen by a private psychiatrist who started him on a selective serotonin reuptake inhibitor (SSRI) antidepressant and referred him for CBT for OCD and social phobia.

In engaging Todd in treatment, the author reviewed with him areas of interest and skill unaffected by OCD or social phobia. Todd was quite expert in making his own fishing equipment and lures. The author asked Todd how he knew how to design a particular lure for a particular fish. He very quickly gave the author
the history of the life cycle of certain insects, how these insects might be hit by a rain drop and fall into the water, and how the particular species of fish would perceive the insect given depth of water, branch cover, clarity or cloudiness of water, etc. Todd would then design lures that took advantage of the environmental conditions and perceptual habits of the particular species. By manipulation of the lure, he could essentially commit the fish to strike. The author was able to draw an analogy between the arrival of the first obsessional thought as a lure under the stressful condition of return to school, and how the permutations of his obsessional thoughts were driving his ritual behavior. With Todd’s identification with the analogy, the author was able to explain some of the biomechanics of OCD and social phobia (e.g., intrusive thoughts of harm as a brain event, exaggerated importance attached to thought, overestimation of harm, etc., the significance of projective thought regarding how he would be perceived by others, which generated anxiety in the classroom and subsequent avoidance of social events). Todd continued to work with his private psychiatrist who adjusted levels of antidepressant to control obsessional thought and Clonidine to control motor tics. He was able to complete the course of CBT described more fully later in this article.

Selection of Basic Treatment Modalities

Not uncommonly, the patient with comorbid OCD and social phobia faces simultaneous and interactive difficulties in biological, psychological, social, and occupational spheres. Ideally, selection of first target goals, whether in the domain of social phobia or OCD, should be the choice of the patient. As noted previously in the section on triage decisions, the clinician may need to intervene to help shape choices should the individual have severe depression, suicidal ideation with active plan and intent, psychotic thought, symptoms of bipolar disorder, substance use, or other presenting crisis. Patients are advised of the availability of consultation for a trial on psychotropic medication, which may be quite helpful in reducing pure obsessional thought, severe generalized anxiety, panic, and vegetative symptoms of depression. Some patients may be frightened either by medication or by the rigors of behavior therapy. Following the presentation of relevant psychoeducational information, the patient may elect CBT alone, medication alone, or combined cognitive behavioral and pharmacological approaches. The author will also review rationale for the combination of medication and CBT, which Jenike (1998) considers to be the optimal. Jenike notes also that provision of CBT with medication may enhance maintenance of treatment gains after medication is discontinued (Jenike, 1998). In instances in which there is clear evidence of the patient’s lack of social skills maintaining or amplifying the patient’s difficulty with social phobia, the author will attempt to help the patient understand that psychotropic medication cannot fill gaps in social learning. Often, the patient may choose to begin work on symptoms that interfere with a valued social or occupational role. The experience of the author is that most commonly patients with both moderate to severe OCD symptoms and equally severe symptoms of social phobia have often opted to work in individual therapy on control of ritual behavior before undertaking work on social anxiety. When the author questioned patients about their criteria of selection, patients most often commented that they felt at less risk of shame if they were unsuccessful in private exposure and response prevention strategies as opposed to their vision of humiliation in social situations if CBT-based strategies for social exposures failed. The author has found that patients with social phobia often have been
reluctant to accept referral to a social phobia group led by the author until they experienced some gains in symptom control in individual sessions.

**Concerns Regarding Medication**

A detailed exposition regarding medication benefits, side effects, augmentation strategies, and choices when the patient has numerous Axis I diagnoses, concurrent medical problems, and takes numerous medications for medical problems falls beyond the scope of this article and training expertise of the author. As noted, such significant decisions regarding medication assessment should be made by a well trained medication provider quite familiar with the psychopharmacology of concurrent Axis I diagnoses and the possible interactive effects of psychotropic medications and medications used to treat medical disorders. The use of psychotropic medication during pregnancy is best reviewed among the patient, her OB/GYN, the prescriber of her psychotropic medication, and her treating therapist. In *The Expert Consensus Guideline Series: Treatment of Obsessive-Compulsive Disorder* (2002), March, Frances, Carpenter, and Kahn as a first line intervention recommend for comorbid panic disorder and social phobia CBT and an SSRI or CBT alone, and as second line interventions CBT plus clomipramine, CBT plus an SSRI plus a benzodiazepine, or CBT plus an MAOI with or without a benzodiazepine. Jenike (1998) outlines a wide array of medication approaches that may be used in treatment-resistant cases.

As a prelude to referring the patient for a possible medication trial, the therapist should be aware of the patient’s beliefs about medication. Some patients view medication as the necessary and ultimate answer for their difficulties. A former patient who did not proceed with CBT commented, “I don’t really understand why I should have to meet with you when I could have a pill that does it all.” Of note is the fact that this patient withdrew from treatment when the psychiatrist advised that efficacy of the first antidepressant trial could only be evaluated after at least a 2-month trial and the patient might experience anxiety, weight gain, and sexual side effects on the medication. Other patients view medication as a potential toxin. Patients who fear medication may ask, “What will this medication do to me?” rather than asking how this medication might help. After a primary care physician prescribed Prozac and referred the patient for CBT, the patient immediately researched the medication in the *Physician’s Desk Reference* (PDR), saw himself as at risk for developing every side effect noted, and vented anger towards his doctor: “This man is supposed to be a doctor and he hands me a scrip for something which could kill me! I just can’t get over that! And wasn’t Jeffrey Dahmer on Prozac?” Some of the author’s patients with social phobia viewed referral for medication as incontrovertible evidence of weakness and inferiority. Some came to the waiting room for their medication appointment but left before the appointment, fearing that others in the waiting room would see them leaving the prescribers’ offices, which they viewed as a penultimate ritual of shame. As these examples suggest, clarification and review of the patient’s beliefs and emotional response to medication facilitates compliance with completion of medication evaluation and compliance on a medication trial.

**Case Illustration of a Patient in Individual Therapy**

In cognitive behavioral therapy for OCD, the patient and therapist review occurrences of obsessions and compulsions and related ritual behavior. The degree of distress and interference caused by obsessions and/or compulsions
is scored on the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS; Goodman et al., 1989). The patient is asked to score distress associated with the obsession or compulsion on a Subjective Unit of Discomfort Scale (SUDS; self-anchored rating of anxiety on a scale of 1–100). Beginning with items lower on the stress hierarchy, the patient and therapist devise strategies that enable the patient to have sufficient contact with the feared situation to permit habituation to occur. The patient agrees to abstain from ritual behavior for a several hour period after exposure. With repetition of the exposure work, the feared situation comes to be associated with lower levels of physiologic arousal, decreased occurrences of thoughts that gave rise to anxiety, and a subsequent diminution of ritual behavior. (For the purposes of this article, it is assumed that the reader has a basic familiarity with cognitive behavioral treatment of OCD. Texts that detail methods of CBT for consumers or for professionals are listed in the reference section of the article.)

For illustration of techniques in the individual treatment, the author will return to the case of Todd, who, as mentioned earlier, experienced frightening intrusive thoughts of harming his family, subsequent checking ordering behavior, and social anxiety. Todd was first seen by a private child psychiatrist, was begun on 60 mg of Prozac and was referred for CBT. At the time of the initial evaluation, Todd scored a 22 on the Y-BOCS, placing him in the upper moderate range of severity. The author met with the patient’s parents to obtain supplemental social and emotional history, their views of changes in mood and behavior of their son with the development of OCD, and limitations in social involvement due to social phobia. The family was given appropriate psycho-educational information related to CBT of OCD and social phobia. Todd and family agreed to work on ritual behavior that was threatening Todd’s ability to attend school. The parents were advised of the effect of their provision of reassurance regarding ordering of books and ideation related to his harming them as having the unintentional consequence of rewarding symptom behavior (anxiety reduction following reassurance rewarded antecedents of the relief, in this case, checking behavior and before that intrusive thoughts related to harm). Todd and the author assembled a hierarchy, rating anxiety on the SUDS scale. Todd rated his leaving for school without asking his parents about their health or their itinerary of the day as a 60. Todd rated leaving his room without ordering books a 75. Driving to the town in which he experienced intrusive images of harm rated a 100.

Todd and his parents agreed that he would leave for school with the phrase “I’ll see you tonight,” and suspended his inquiries regarding his parents’ health and schedules of the day. After 2 weeks, his SUDS score declined to less than 10. Todd then practiced scattering his books across the shelf without pausing to rearrange the books. After 3 weeks of practice on a daily basis, his SUDS score declined to a 10. Todd then agreed to drive to the town in which he experienced the original thoughts of causing harm to family with family as passengers. After 4 weeks of daily drives, Todd no longer experienced any intrusive images of harm and correspondingly rated his SUDS level a zero. Todd’s last measure on the Y-BOCS was 9. Given the emergence of other concerns in the family system unrelated to treatment and the family’s satisfaction with control of OCD symptoms, Todd and his parents opted to end treatment before beginning treatment for social phobia, indicating they would return to sessions at a later date. Todd’s response to exposure and response prevention for OCD symptoms is summarized in Table 1.

About a year after ending treatment, Todd became more dissatisfied with his anxiety and avoidance behavior related to social events at school and worries about dating, prompting him to reenter treatment. He reported some check-
ing of books in his locker and this difficulty was quickly addressed and corrected with techniques of exposure and response prevention. Todd indicated that with the significant lessening of obsessive thought and ritual behavior, he became more concerned about deprivations in social relationships and saw this as the next area of work. Todd recorded SUDS scores over a range of social situations. Entering an ongoing conversation in a small group received a score of 60, and asking for a date received a score of 78. The author reviewed with Todd common misconceptions of persons with social phobia such as the belief that all others know the “perfect” comment and the perfect moment to insert the comment, projective thought that others were tuning in to his “defects,” etc. To help with control of anxiety, Todd agreed to stretching and mild aerobic exercise 3 to 5 days a week. Todd agreed to go to public places to view the social behavior of others in small group conversation with no obligation whatsoever to say a word. It was agreed that Todd would enact these sociological fact-finding expeditions after exercise, which would allow him to feel calmer and to have a more neutral perspective. Todd agreed to observe from a distance conversation in the student union of a local college as well as conversations in the cafeteria and in the library. Todd was to note how conversations started and stopped, pauses in conversations, how switches in topics were made, how individuals entered and exited conversations, and how people were spoken of after their departure. Todd returned to report that in each setting and in each interpersonal grouping, there were a number of intermittent starts and stops in conversation, shifts in topics discussed, and moments of silence; no “brilliant” insights into the meaning of the universe were proffered; the most frequent exiting comment was “bye, gotta go;” and no negative comments about persons departing occurred. The field observations resulted in shifts in Todd’s perfectionist views of social performance and a greater ease in experimenting with small talk comments in groups. Todd practiced relaxation techniques before entering social groups and practiced making joining statements in groups, which had been reviewed in CBT sessions. After a month and a half of practice in making “small talk conversational openers,” Todd rated his anxiety in joining conversation in social groups an 8. Todd progressed to work on his fear of asking a woman for a date. The author reviewed with Todd that not all requests for dates are accepted. The author explained to Todd the dysfunctional nature of black and white thinking, and negative projective thought. Todd agreed to attend coeducational interest groups at his new college. After several weeks of attending the group, he announced his intent to ask the woman for a date, which was accepted. After several months of dating, Todd indicated that he and his girlfriend both decided on a mutual basis to date others. Todd went on to several other dating relationships, which he noted were “friendship and fun, you know, the good stuff of college life.”

### TABLE 1. Behavioral Practice Log for OCD Symptoms

<table>
<thead>
<tr>
<th>Feared situation</th>
<th>SUDS score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leaving home without questioning parents about health or schedule</td>
<td>60</td>
</tr>
<tr>
<td>Leaving home without ordering books</td>
<td>75</td>
</tr>
<tr>
<td>Intrusive images of causing harm to parents</td>
<td>100</td>
</tr>
</tbody>
</table>

Note: YBOCS at baseline: 22; YBOCS after ERP: 9.
Todd noted anxiety in asking women for dates, but anxiety levels had declined appreciably, with SUDS scores at last measure ranging from 10 to 15. Of note, Todd is now performing well in a graduate program and is involved in a monogamous relationship. Todd’s response to CBT for anxiety related to social phobia is summarized in Table 2.

**Case Illustration of a Patient in a Social Phobia Group**

Jim is a 39-year-old single insurance company executive living with his parents who was referred for treatment of OCD and social anxiety. Jim showed favorable response to Celexa (40 mg) and CBT for difficulties with excessive hand washing and counting rituals using exposure and response prevention. After success in reducing OCD symptoms, Jim agreed to work on social anxiety in a social phobia group led by the author. Jim was given a detailed explanation of the structure, process, and rationale for each session. Three other group members were referred by other clinicians treated within Outpatient Psychiatry and were seen for prescreening interviews to determine preparedness and suitability for the group, modified from the cognitive behavioral group treatment model for social phobia as developed by Heimberg et al. (1990). Session 1 consisted of introduction of group members, rationale for group format, and psycho-educational information about social phobia. Session 2 explained methods of CBT for social phobia. Session 3 consisted of instruction in relaxation methods (progressive muscle relaxation and meditation) followed by detailing of cognitive errors in perceptions in social phobia. The group leader then recited an internal monologue that contained cognitive errors involved in the course of anticipatory anxiety of members as they contemplated social encounters. Members pointed out cognitive errors and corrections for these errors. Members were asked to practice at home relaxation exercises paired with recitation of cognitive corrections for frequently occurring cognitive errors. Members role-played and received feedback on behaviors in dealing with authority figures and social and dating situations. In Session 4, members reviewed home practice of relaxation techniques and established goals for making entry and exiting statements in interpersonal situations in social and work environments. In Session 5, members reviewed their experience in or resistance to environmental practice. The author explained the need for transfer of training, explaining that while it was good that members had felt more comfortable with others in the group despite their initial fears, they needed to carry over learning from the group to outside situations. Therapist and group members explored concerns that led to avoidance behavior and encouraged enactment of behavioral practice. In Sessions 6 and 7, the group leader faded his orchestration of group process, resulting in group members becoming more spontaneously verbal and emotive in group, with group members addressing wishes and fears related to social involvement and providing support and constructive feedback to each other regarding

<table>
<thead>
<tr>
<th>Feared situation</th>
<th>SUDS score</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Entering ongoing situation in a small group</td>
<td>60</td>
<td>8</td>
</tr>
<tr>
<td>Asking for a date</td>
<td>78</td>
<td>10–15</td>
</tr>
</tbody>
</table>

**TABLE 2. Behavioral Practice Log for Anxiety Related to Social Phobia**

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practice in the field. In Session 8, group members reviewed their experience in-group, transfer of training to the outside environment, and the regimen of CBT based practices to maintain therapeutic gains. As a function of group involvement, Jim was able to engage in small talk at the water cooler, was able to engage in “think tank” meetings with upper echelon executives at work without sweating or palpitations, began to date, and at the end of treatment was thinking of purchasing his own home. Of note is that Jim also reported that with the lessened anxiety in social situations, ritual washing performed upon returning home after stress at work diminished further.

**Working With Treatment Resistance**

Persons with OCD and social phobia may delay or ruminate unproductively about treatment issues and methods. The author has found several approaches helpful in working with frequently presenting resistance. Given the patient’s obsessive doubt, the patient often responds with “I’ll have to think about it.” Patients may be encouraged to review texts such as *Getting Control, Brain Lock, or Stop Obsessing!* and attend a support group meeting to expand their information base, with subsequent review of the patient’s learning in the next session. Patients may be involved in furtive avoidance behavior and thought suppression. In regard to a planned clinical focus on anxiety evocative thought, the patient may maintain that discussion of thought will only make the thought worsen in content and frequency. To illustrate the consequence of avoidance and suppression, the author asks patients to rid the mind of any and all thoughts of a giraffe and focus on this task for several minutes. Patients note the surprising increase of thoughts related to the giraffe and intuit the unproductive nature of avoidance of work on their thoughts. Patients may maintain that symptoms have become blended into the lifestyle. The author clarifies concretely the cost of their managing; for example, spending $18,000 a year on household cleaners or losing $2,000 a week in “billables” due to checking behavior is not economic and notes risk of increased symptoms under higher stress conditions. As previously noted in the article, patients with medication phobia may fear the negative consequences of medication use. Rather than attempting to ignore or dissuade, the clinician could clarify the patient’s concerns, obtain records of past medication trials, and establish a consultation session in which the patient’s concerns could be clarified in sufficient detail with a qualified medication provider. Patients with a severe level of depression who might fail to habituate with exposure and response prevention might be referred initially for a possible trial on antidepressant medication with initial efforts in psychotherapy directed towards stabilizing depression. Patients with comorbid compulsive personality disorder may cite the changes in treatment paradigms over time and demand a method that is perfect and immutable. In such instances the clinician may acknowledge the imperfections in the field, review with the patient the possible costs of the perfectionist style. The author reminds the patient of the role of the therapist as a consultant and the patient being the investor, noting that the wise investor validates information and measures and documents gains or losses and makes the final investment decisions. Threats of withdrawal from treatment after the initial evaluative session and prior to the initial CBT session may arise when significant others with whom the patient lives are disdainful to the treatment or are themselves untreated sufferers. The clinician may, with patient’s permission, invite the significant others to review treatment goals and methods. The participation in a multifamily behavioral treatment group (Van Noppen, 2002) could prove effective.
Use of Adjunctive Treatment Strategies

In instances where patients had distressing intrusive obsessional thought that had not responded to medication and medication augmentation, exposure and response prevention, imaginal exposure, response scheduling, etc., the author explained to patients the potential use of biofeedback to assist in exposure and response prevention (Seigel, 1997). Biofeedback is a technique for learning body self-control in which a person receives timely measures of change in physical stress levels while monitored with equipment which measures subtle changes in underlying physical function and “feeds back” to the person a timely display of change in the physical process being monitored. The relevance, utility, and appropriateness of biofeedback-based practice needs to be based on a collaborative discussion among the person with OCD or social phobia, his or her treating therapist, and his or her primary care physician prior to the initiation of treatment to rule out any possible contraindications to use of biofeedback and to allow for monitoring of medications taken by the person for other physical problems as training proceeds. Patients with obsessional thought may engage in furtive neutralization rituals such as saying phrases under the breath to ward off harm. When a former patient heard words related to health, he would utter “cancellation” phrases under his breath at a high enough frequency to produce jaw pain. The patient learned to use electromyographic (EMG) biofeedback, which gives a person a display of changing measures of tension in surface skeletal muscles. The patient learned to reduce muscle tension in his jaw to extremely low levels. At this point a threshold was set on the EMG unit so that with any movement of muscles of the mouth associated with use of cancellation phrases, the unit sounded a beep and triggered a light display. The patient practiced viewing words related to health on cue cards ordered on a hierarchy and was able to resist subvocalizations. The patient practiced with cue cards resisting subvocalizations in home practice, with the attendant result of diminished health-related obsessions.

When a person airs an anxiety-laden thought, sweat levels in the fingertips change. With galvanic skin response (GSR) biofeedback, about 12 to 20 seconds after an anxiety-laden thought or image, the unit gives a person a measure of elevation in level of sweat in the fingertips associated with the thought or image. By practicing with the GSR unit, the individual can see what kinds of thoughts elevate or decrease anxiety. The author has used the GSR unit to help patients explain basic mind/body connections and establish a hierarchy for behavioral practice. For patients with social phobia who experience difficulties with profuse sweating, GSR biofeedback may be beneficial.

With anxiety, as part of a partial fight/flight response, there is a decrease in peripheral blood flow. With temperature biofeedback, the person learns to restore and maintain warm finger temperature with the attendant result of diminished bodily tension. The author has given patients portable and hardly visible temperature units to enable the patient to observe temperature changes in climate-controlled environments, where the observed temperature change may be related to subjective changes in stress level. Patients are asked to record setting, temperature (or color change associated with temperature change with other units), and thoughts that pass through stream of consciousness at numerous intervals during the day. Review of temperature change, setting, and thought can enable the patient to see patterns in stress response that may be contingent upon thought. This review allows for work on cognitive restructuring and the development of problem-solving methods for noted stress-evocative situations. While the author has had success with use of biofeedback
with individual patients, the reader is advised that biofeedback as a recognized treatment for OCD comorbid with social phobia awaits formalized empirical research.

The author has explained to patients the value of volunteer work in modulating patterns of depressive and projective thinking that may worsen if the patient is unemployed, socially isolated, and without structure. Patients have agreed to perform volunteer work on a committed basis to create structure and provide a forum for learning relative to OCD and social phobia. With signed consent from patients, the author has communicated with the directors of volunteers from local area hospitals and organizations. For patients with OCD, the patient may be involved in duties that entail exposure to feared situations that would otherwise trigger ritual or avoidance behavior and proceed along a gradient of difficulty with exposure and response prevention. The decisions regarding exposure are discussed among the patient, therapist, and director of volunteers. Persons with social phobia may opt for initial volunteer work in “parallel play” situations in which persons in the workroom may be performing the same task, where there is no mandate for interpersonal conversation. As a prelude to the start in volunteer work, the patient may learn relaxation techniques in the therapy session, transfer practice of relaxation to home practice, with the planned utilization of abbreviated and socially invisible forms of the relaxation technique (such as slow, controlled breathing) in social exposures in the course of the volunteer work. As the patient feels less anxious in the milieu, therapist and patient can review brief opening and exiting statements that the patient may initiate. Patients, as volunteers, may then progress to involvement in assignments where interpersonal conversation occurs more frequently as part of the work-related role. Patients of the author have been receptive to honest feedback from the directors of volunteers regarding their performance in the volunteer work, both in terms of task and interpersonal response. This feedback has been highly instrumental in modulating patients’ negativistic, projective thoughts. Of note is that many patients with significant social phobic symptoms have been able to attend banquets honoring volunteers, an event which might otherwise have been pre-envisaged as an anathema, scrupulously avoided.

Collaborative assessment of the strengths and difficulties experienced by the person in the course of volunteer work may provide the patient with usable information in making choices about job preparedness and accommodations that the person might need under the Americans with Disabilities Act. For persons who have been separated from employment in which the employer has an EAP, the author encourages the employee to contact the EAP for a confidential consultation to discuss issues of disclosure to human resources or to the supervisor so that possible accommodations under the Americans with Disabilities Act could be reviewed. The author may also encourage patients to review the Web sites of the Job Accommodation Network (www.jan.wvu.edu), a service of the Office of Disability Employment Policy of the U.S. Department of Labor and the Center for Psychiatric Rehabilitation, Boston University (www.bu.edu/sarpsych), for ideas regarding work-site accommodations for persons with psychiatric disabilities. In instances where the patient and clinician believe that the return to work is not feasible given gaps in education or training, job availability, or disturbances in cognition and affect that still interfere significantly with job performance, the patient may be referred to state departments of vocational rehabilitation. Upon provision of formal psychiatric diagnosis, the departments of vocational rehabilitation may formally assess impediments to full-time gainful employment and provide reeducation, training, and/or placement. Kevin, a 40-year-old former patient of the author with an undergraduate de-
gree in business, had not been able to work for twenty years because of deleterious combined effects of OCD and social phobia. Before the start of treatment, upon being given any work-related responsibility, the patient typically ruminated for 4 hours regarding the consequences of making a wrong decision. Kevin felt too anxious to join in conversation in any work group. He was initially ignored and subsequently ridiculed by other workers prior to his termination from employment (a process that negatively reinforced his social phobia). Fortunately, Kevin showed a positive response to medication and CBT for OCD and social phobia. Through the Massachusetts Department of Vocational Rehabilitation, he was placed in a low-stress office setting where all responsibilities for the day were clearly documented. After a year at the job, Kevin found a higher paying, more intellectually challenging job on his own.

Relapse Prevention

In order to help reduce the likelihood of patient relapse, the author, as part of the psycho-educational information about OCD and social phobia, discusses openly what clinicians have come to understand as frequent causes of relapse: patient self-initiated stoppage of medication, non-compliance with exposure and response prevention, self-selected social isolation, and substance abuse. The author reviews with patients the known waxing and waning course of OCD and unavoidable frustrations and reversals in interpersonal encounters which might otherwise result in patients stopping treatment because of feelings of failure or betrayal by the therapist who presumably had promised a cure. The author queries patients regarding anticipated psychosocial stressors that might engender relapse so that appropriate functional coping strategies can be developed and deployed. The author attempts to acquaint the patient and the patient’s family with indices of relapse whose occurrence would warrant review in session or a return for reevaluation and treatment if the patient had stopped treatment. For maintenance of ritual prevention, the author and patient develop behavioral practice schedules that the patient will continue to enact beyond the last outpatient session. When possible and where clinically appropriate for the patient, the author asks patients who have made considerable gains in their treatment to meet in conjoint session with another patient who is experiencing doubt and difficulty early on in treatment. In treatment review at termination, patients have reported that this altruistic act of outreach constituted a corrective emotional experience that modified the view of self as “weak” or “less than.” The author recommends that patients attend a support group in which the member can continue to be valued and goals for cognitive behavioral practice will be maintained. Lastly, the author encourages patients to bring to the attention of the therapist, the medication provider, or the primary care physician new information in the media about OCD or social phobia that might engender doubt or confusion about treatment and enhance likelihood of relapse through stoppage of medication or maintenance behavioral practices. As an example, a former patient of the author who was making excellent recovery from major depression, OCD with ego dystonic thoughts of causing harm, panic, and agoraphobia called to the clinic to advise that she was going to stop all her medication “at once” because a friend told her that some of the better known serial killers were on the same SSRI. This disclosure by the friend caused the patient who was suggestible to fear that she might lose control and that the therapist and the psychiatrist had not been honest with her regarding their true diagnosis. In this case the psychiatrist carefully reviewed with the patient the nature of her concerns, addressed openly the best-known prevalence of persons on psychotropic medica-
tion showing adverse response to medication, and explained to patient that she had not shown any of the adverse responses to medication in the course of nearly a year in treatment. The psychiatrist voiced his continued availability to the patient if other questions arose. The patient continued productive involvement in treatment. Given her remaining being virtually asymptomatic with original presenting complaints after this contact, the patient agreed to have her medications monitored by her primary care physician (PCP) with the option to return for consultation session with the psychiatrist at a later date if needed.

Emerging Challenges in the Field

The clinician treating OCD and social phobia in comorbid presentation, apart from being well grounded in CBT and familiar with medication approaches, needs personal flexibility in shifting conceptual models and related treatment strategies. A former patient, a married mother of three, had generalized social phobia since early teenage years. Several years after her marriage, the patient was raped by a man who offered to help her start her car. The patient began compulsive washing immediately after the rape and began to think in “black or white” terms. Within a year after the rape, cleaning, checking, and ordering behaviors became incapacitating, threatening the ability of the patient to work and care for her children. While the patient’s husband was compassionate regarding his wife’s emotional reaction to the rape, the marriage became strained by the wife’s incessant checking on the safety of family members, her experience of flashbacks of the rape at times of sexual intimacy (not disclosed to husband), which prompted her to withdraw from the bedroom to shower, pray, and order (behavior that made the husband believe his wife was becoming psychotic). The patient was referred for treatment by a psychiatric crisis service several years after the rape, prompted by husband’s fears that his wife was physically harming herself by washing in scalding water. In treatment, the author needed to shift between trauma theory and practice, CBT, and family system theory and practice. Fortunately the patient showed favorable response to treatment, no longer required medication or CBT, and was accepting of a return to treatment if difficulties in functioning reappeared.

Recent professional concern has arisen regarding computer addiction (Orzack, 1999) and the interplay between comorbid psychiatric disorders and pathological computer overuse leading to marked declines in functioning (Orzack & Orzack, 1999). Several of the single male patients of the author with comorbid OCD and social phobia began involvement in chat rooms, which they contended allowed them to “feel close and get to know” someone whom they might later meet and date. However, since the patients were often self-denigrating, they created alternate personas and identities to ingratiate themselves with women whom they met online. It appeared that the ability to control time of contact and shift at will by a keystroke offered an appealing sense of control. The men confessed to high levels of sexual arousal during the contacts and reversal of sleep schedule because of hours of computer use through the night, often resulting in cancellation or postponement of commitments at work. While the men acknowledged impairments in living secondary to their computer use, they could not stop dysfunctional patterns of computer usage that came to threaten their participation in psychiatric treatment. The author referred several patients with apparent computer-related difficulty to the Computer Addiction Services at McLean Hospital, Belmont, Massachusetts, for specialized treatment in this area.
With the advent of managed care, clinicians face concerns regarding treatment design and advocacy of longer-term maintenance treatment. A number of managed care companies offer “guidelines” in regard to the number of therapy appointments needed to treat a specific Axis I disorder. However, the guidelines do not recognize the epidemiology and clinical significance of comorbidity. In reference to a patient with comorbid OCD, social phobia, panic disorder with agoraphobia, dysthymic disorder, and skin picking behavior who had used eight therapy sessions in the prior 2 months, the author received a reply from a reviewer, “For the remainder of the calendar year, you will be granted four sessions, dating from 7/01/01 through 12/31/01. Perhaps when the patient’s benefits renew at the start of the next calendar year, you could then work on the social anxiety.” The reviewer was not grounded in the need and value of behavioral work to remediate social learning deficits and the interactive effects of comorbid Axis I disorders, which also negatively interdigitated with extant environmental stressors. Another emergent trend that introduces discontinuity in treatment is the frequency in which business firms offering employees health insurance frequently shift contracts with managed care companies. The shift may necessitate the employee beginning a relationship with a new mental health provider. The patient with prominent symptoms of social phobia who has just begun treatment may resist the transfer of care rather than once again face significant stress associated with reevaluation and establishing relationship with a new provider.

Conclusion

Patients with OCD and generalized social phobia face significant threats to biopsychosocial and occupational functioning. More recent epidemiological studies have shown a more accurate substantially higher prevalence of these disorders occurring individually and in comorbid presentation. While advances have been made in the design of CBT for OCD and social phobia and in the pharmacotherapy of the disorders, it is recognized that many years transpire before the person with OCD and social phobia receives appropriate care. Developing and strengthening the relationship with the patient, provision of psycho-educational information related to the disorders and their interactivity and treatment, and establishment of jointly created and attainable goals remain core to appropriate treatment. Group treatment formats for OCD and social phobia show promising results and medication augmentation strategies have been developed. However larger controlled studies are needed to refine the nature of interactivity between OCD and social phobia, which may allow for more refined cognitive-behavioral and pharmacological treatments.

References


Center for Psychiatric Rehabilitation, Boston University. Available: www.bu.edu/sarpsych/


