Introduction to the Two-Part Special Issue (Issues 2 and 3): Innovations in the Treatment of Obsessive-Compulsive and Spectrum Disorders

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Obsessive-compulsive disorder (OCD) and obsessive-compulsive (OC) spectrum disorders are among the most prevalent psychiatric conditions. They are often chronic, and they impair functioning. Cognitive-behavioral therapy (CBT)—with or without medication—is the treatment of choice, yet many questions about assessment protocols and the delivery of treatment remain. For instance, what are the most effective assessment tools and methods for measuring the types and intensity OCD spectrum disorders and their various forms? How do cognitive and behavioral methods differ? Is cognitive therapy alone effective? With comorbid OCD, substance abuse, and depression, which disorder should be treated first? Do some patients benefit more from a group modality? Should family members be included in treatment? How does CBT for kids differ from the treatment for adults? How is CBT for the OC spectrum disorders implemented? What is the role of medication in CBT?

This special two-part issue of Brief Treatment and Crisis Intervention is devoted to innovative evidence-based treatments of OCD and OC spectrum disorders. Experts in the field have contributed articles covering a broad range of topics targeted specifically for clinical practitioners. Most articles include clinical case examples to illustrate therapy methods and some of the complexities of applying these treatments. It is an exciting time to be providing treatment to people with OCD and OC spectrum disorders because of the wealth of clinical research that has resulted in the development of efficacious treatments that are replicable.

To open this special issue, the paper by Maltby and Tolin provides an overview of treatments for OCD and spectrum conditions. These clinical researchers outline current concerns about the concept of OC spectrum conditions and models for treatment. They review literature regarding the accepted behavioral treatment of choice, exposure, and response prevention, and they note some common obstacles that face clinicians in delivering this therapy. A stepped care model is presented as an important concept in addressing OCD symptoms.

Next, Steketee and Neziroglu summarize a variety of assessment tools for use with OCD and OC spectrum conditions that are particularly useful in helping clinicians determine what problems to address in treatment and whether therapy is having the desired effect. Included are clinician interviews, self-report questionnaires, clinician-rated forms, and behavioral observations and self-monitoring by the patient.

Roberts, Seigel, and Yeager examine the nature and prevalence estimates, symptom clusters, treatment plans, and research on comorbid OCD with substance abuse, and/or major depression and suicide ideation. Case examples
unravel the most complex patient cases presented with psychiatric comorbidity and/or neurological brain lesions. In addition, this article provides the latest information on differential diagnosis of OCD, major depression, different types of first-time psychotic episodes, and untreated temporal lobe epilepsy, which can precipitate suicide ideation and suicide attempts.

Whittal and O’Neill explain that as a technique, exposure and response prevention (ERP) can be powerful, but cognitive theory additionally accounts for positive changes following a successful treatment. Their paper introduces cognitive-behavioral theory, assessment of common thought domains in OCD, and treatment strategies via a detailed case illustration.

Wilhelm’s article provides a detailed follow-up to Whittal and O’Neill’s paper for patients with predominant obsessions without overt compulsions. She briefly describes the nature and prevalence of obsessions without overt compulsions, and she also reviews a cognitive model and various cognitive domains relevant for OCD. A case example highlights the application of cognitive strategies for this special case of OCD.

In the next paper, Himle, Van Etten, and Fischer discuss the advantages of delivering exposure and response prevention in a group format that includes cost savings and time efficiency. This review summarizes the 12 adult trials and 4 adolescent trials of group behavioral therapy for OCD conducted to date, and it describes a typical group-therapy protocol in detail.

The paper by Van Noppen and Steketee suggests that some family responses to OCD, such as family accommodation and expressed emotion (EE), may have relevance to behavioral treatment. A model of multifamily behavioral treatment (MFBT)—in which relatives and patients are trained in exposure and in the blocking of rituals, as well as in behavioral contracting to improve communication—is presented and illustrated in case examples.

Following this, Pato and Phillips present a paper on somatic treatments that covers a broader array of biologic interventions and pharmacotherapy. They review the pathophysiology of OCD, the medications commonly used in the treatment of OCD, and the augmentation strategies. In addition, this paper presents experimental biological treatments for the truly treatment refractory—such as neurosurgery, deep brain stimulation, and vagal nerve stimulation—that are being developed and may ultimately offer new hope to the sickest of patients.

Abramowitz and Schwartz then provide a review of the outcome literature for the treatments described in earlier articles to help clinicians determine the optimal method(s) to provide for their OCD patients. They point out the strengths and limitations of the various empirically supported treatments, and they note factors that influence decision making about treatment, thereby urging clinicians to rely on empirical findings and on informed clinical judgment when deciding which treatment(s) to recommend.

Most children with OCD do not receive CBT, at least in part due to the shortage of clinicians. Wagner’s paper reviews developmental factors that complicate the diagnosis and treatment of OCD in youngsters, and it also discusses appropriate adaptations of CBT protocols for children. She includes a developmentally sensitive protocol (RIDE Up and Down the Worry Hill) that is flexible and feasible to replicate.

Neziroglu and Khemlani-Patel review the cognitive and behavioral strategies in the treatment of body dysmorphic disorder (BDD). They describe the current literature and provide a summary table of all the research conducted until today. Specific treatment suggestions are noted in light of the present evidence. Special attention is given to prognostic variables and how to overcome treatment obstacles. They note the importance of engaging the patient in treatment.

Frost, Steketee, and Greene review findings regarding the complex problem of compulsive hoarding, and they present a model for understanding this multifaceted problem. They focus
on information-processing problems as well as on excessive attachment and strong beliefs about saving possessions that lead to excessive acquisition and difficulty in discarding possessions. Their case example illustrates methods of assessment as well as cognitive and behavioral treatments for hoarding.

Stemberger, Stein, and Mansueto begin their paper with a case illustration of an individual who has trichotillomania (TTM). They go on to describe the current literature on TTM with a discussion of why TTM may or may not fall within the spectrum of disorders. A review of the pharmacological and behavioral treatments is provided, intertwining with the case presentation.

Salkovskis, Warwick, and Deale define hypochondriasis (HC) from its inception till today with a discussion of the controversial issues. They outline assessment procedures and emphasize how to engage the patient in treatment. Cognitive and behavioral formulations are contrasted with other modalities of treatment, and specific methods for questioning patients’ beliefs are noted.

The article by Deckersbach, Keuthen, and Wilhelm reviews the clinical characteristics of self-injurious skin picking, methods for assessing this problem, and modalities of treatment. A clinical vignette describes the implementation and outcome of cognitive-behavior therapy for a patient with self-injurious skin picking and comorbid body dysmorphic disorder (BDD).

In the hope of developing alternative treatment approaches for OCD, Kundalini Yoga (KY) meditation holds some promise. Shannahoff-Khalsa describes in detail an effective, specific meditation protocol that has been tested in both uncontrolled and controlled study designs. This paper includes additional techniques that are claimed by yogis to be effective for depression, anxiety, and a range of nervous disorders.

Despite the exciting efficacy in symptom reduction produced by current methods of delivering outpatient CBT, the last article in the issue addresses the problem encountered by some OCD patients who remain profoundly symptomatic following treatment yet want more improvement. Osgood-Hynes, Riemann, and Björgvinsson describe three specialized, short-term OCD residential treatment programs currently available in the United States. They compare similarities and differences across these programs, and they discuss residential treatment, intensive day treatment, and outpatient treatment options.


In addition, we have included a list of self-help books, therapist manuals, and organizations, which is not intended to be a comprehensive list, but rather a subset of books and organizations that may be useful to readers of this special issue.

We believe that this special issue will be particularly helpful to clinicians in its breadth of coverage of OCD symptoms and spectrum conditions as well as in the variety of treatment strategies described and depicted in case examples. We sincerely hope it proves useful to clinicians and their patients.