Treatments for Obsessive-Compulsive Disorder: Deciding What Method for Whom

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The aim of the present paper was to address variables that should be considered in deciding the optimal treatment modality for individual patients with obsessive-compulsive disorder (OCD). We begin by briefly discussing strengths and limitations of the various empirically supported treatments for this disorder. Next we discuss general factors, such as demographics and familial support, that may contribute to the treatment decision-making process. Following this, we describe factors related to the presentation of OCD (e.g., insight, comorbidity) that may impact such decisions. It is important to rely on both empirical findings and informed clinical judgment when deciding which treatment(s) to recommend for patients. For this reason, familiarity with the research literature as a backdrop to thoroughly assessing the relevant variables is imperative for clinicians working with OCD patients. [Brief Treatment and Crisis Intervention 3:261–273 (2003)]

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Effective treatments for obsessive-compulsive disorder (OCD) can be divided into two broad categories: biological and cognitive-behavioral. Biological treatments include pharmacotherapy with serotonin reuptake inhibitors (SRIs) and neurosurgery. Cognitive-behavioral treatment (CBT) includes exposure, response prevention, and cognitive therapy. These CBT procedures can be delivered on an individual, group, or inpatient basis. Moreover, the frequency of therapy sessions may vary from weekly to daily. The overall aim of this article is to assist clinicians with deciding on the most appropriate treatment program for an OCD patient. Therefore, relying on empirical findings and our extensive clinical experience, we address factors to be considered in making this decision. We begin by familiarizing the reader with the above treatment approaches as well as their principal strengths and limitations.

Serotonin Reuptake Inhibitors

Pharmacotherapy using SRIs is the most widely available treatment for OCD (see Pato and Phillips, this issue). On average, SRIs produce a 20%
to 40% reduction in symptoms (Rauch & Jenike, 1998). The major strengths of a pharmacological approach to treating OCD include convenience and the requirement of little effort on the patient’s part. Limitations include the relatively modest improvement and likelihood of residual symptoms, high rate of nonresponse (40–60% of patients do not show any favorable response), and the prospect of unpleasant side effects (which can often be stabilized by adjusting the dose). Moreover, once SRIs are terminated, OCD symptoms typically return rapidly (Pato, Hill, & Murphy, 1990).

**Individual Outpatient CBT**

Traditional behavioral treatment for OCD primarily involves exposure and response prevention (ERP) procedures. *Exposure* entails repeated and prolonged confrontation with obsessional stimuli; *response prevention* means refraining from compulsive rituals. It has now become conventional to describe ERP therapy as “cognitive-behavioral” since it is thought to produce reductions in obsessional fear via changes in cognition. Cognitive therapy, a newer approach to OCD, emphasizes cognitive change through education and rational discourse, although behavioral experiments involving exposure procedures are almost always performed to test and reinforce accurate beliefs and assumptions about probability and risk (e.g., McLean et al., 2001). Because of their procedural and conceptual overlaps (i.e., ERP and cognitive methods both aim to modify dysfunctional cognitions), we will collectively refer to these procedures as CBT in the present article and differentiate between ERP and cognitive techniques only when discussing their implementation in specific circumstances. Articles by Whittal and O’Neill and Maltby and Tolin in this issue provide some detail about these methods.

Research consistently shows that ERP is a highly effective therapy for OCD. An average of 60–70% reduction in obsessions and compulsions has been found in treatment outcome studies (Franklin, Abramowitz, Kozak, Levitt, & Foa, 2000). Although initial studies show that cognitive therapy is also beneficial, research currently underway will determine whether or not it is as effective as ERP. Strengths of CBT in general include its brevity (most programs involve 16 sessions), short-term effectiveness, and long-term maintenance of treatment gains. A drawback of this approach is that patients must confront their fear-evoking stimuli and resist urges to ritualize to obtain symptom reduction. Because CBT requires compliance with these demanding procedures, a number of patients refuse this form of therapy or terminate prematurely. Moreover, CBT is highly focused and typically does not directly address comorbid problems, such as personality disorders, which often accompany OCD. Finally, only a small percentage of mental health treatment providers are trained in the provision of CBT for OCD.

A few OCD/anxiety-disorder specialty clinics offer CBT on an intensive basis, meaning 15 daily outpatient treatment sessions over a period of approximately 3 weeks. A recently completed study (Abramowitz, Foa, & Franklin, 2003) found that 15 sessions of intensive ERP were more effective than 15 sessions of twice-weekly ERP (delivered over 8 weeks) immediately after treatment. However, at 3-month follow-up, these differences were no longer apparent. A practical advantage of the intensive approach over less intensive schedules is that massed sessions allow for regular therapist supervision and therefore rapid correction of subtle avoidance, rituals, or suboptimal exposure practice that might otherwise compromise outcome. The primary disadvantage includes the inherent scheduling demands for both the clinician and the patient.
**Group CBT**

Group CBT programs that emphasize ERP and cognitive techniques have been found to be effective in reducing OCD symptoms (McLean et al., 2001). Strengths include the support and cohesion that are nonspecific effects of group therapy. Potential weaknesses of a group approach include the relative lack of attention to each individual’s symptoms, particularly given the heterogeneity of OCD symptoms (see Himle, Van Etten, & Fisher’s article in this issue).

**Inpatient CBT**

Although most inpatient psychiatric hospitals are equipped to provide standard care for patients with OCD, programming in such facilities is often limited by the short duration of stay. Therefore, the initial focus is often on stabilizing patients via medication and nonspecific psychotherapy (e.g., supportive counseling, stress management training). Only a few such hospitals have specialized inpatient treatment programs for severe OCD, requiring that patients travel to receive this form of care. These residential OCD programs typically include individual and group CBT and medication management, as well as supportive therapy for comorbid psychiatric conditions. Length of stay may vary from a few weeks to a month or more.

One strength of specialized inpatient OCD programs is that they provide constant supervision for patients requiring help with implementing treatment (i.e., conducting self-directed ERP). Moreover, such programs are ideal for individuals who lack family or friends to assist with treatment or have severe impairment in functioning, are at suicidal risk, or have comorbid medical complications. A shortcoming of inpatient treatment for OCD is that it is often costly. In addition, patients with obsessions and compulsions regarding specific places or stimuli (e.g., bathrooms at home) may have difficulty reproducing these feared situations within the hospital setting for the purposes of exposure. Thus, generalization of treatment effects must be considered. The only study to directly compare inpatient with outpatient CBT for OCD found that there were no differences in outcome between 20 sessions of outpatient and 5.4 months of inpatient treatment (van den Hout, Emmelkamp, Kraaykamp, & Griez, 1988).

**Neurosurgical Treatment**

Currently there are four different types of neurosurgical interventions for OCD: subcaudate tractotomy, limbic leucotomy, cingulotomy, and capsulotomy. These procedures involve severing interconnections between areas of the brain’s frontal lobes and the limbic system. Recommended only in cases in which severe OCD and depressive symptoms persist despite trying all other available treatments, the risks of neurosurgery include alterations in cognitive functioning and personality, as well as the usual risks that accompany surgery. (Surgical procedures are reviewed by Pato and Phillips in this issue.) Although clinical improvement has been observed in some cases, it remains unknown why these procedures are successful for only a subset of OCD patients (Jenike, 2000). There is also an increased risk of suicide following failure with this approach.

We now examine various factors that might be considered when making decisions regarding treatment. First we review nonspecific factors related to undergoing psychiatric care in general, then we discuss factors specific to OCD that may influence treatment choices.
**Nonspecific Factors to Consider When Deciding on Treatment**

**Age**
Age is an important variable to consider. For different reasons, children, adolescents, and the elderly may have more difficulties with adherence to medication regimens compared with young and middle-aged adults. Missed doses or overdoses may result in reduced benefit or dangerous side effects with pharmacotherapy. It should be noted that SRIs are generally considered safe, with overdoses unlikely to produce harmful long-term effects, unlike tricyclic antidepressants (e.g., clomipramine), which are potentially more dangerous. Additional considerations are that older adults may be subject to more adverse side effects from SRIs because of reduced metabolic rates and contraindications with medications prescribed for other medical conditions.

Thus, CBT may be the best initial treatment option for younger children and older adults. Evidence that CBT is highly effective for children with OCD is accumulating (Abramowitz, Whiteside, & Deacon, 2002), and initial studies conducted in elderly patients suggest success with this population as well (Calamari & Cassidy, 1999; Calamari, Faber, Hitsman, & Poppe, 1994). Nevertheless, family conflict occasionally interferes with the effects of CBT in children with OCD. It has also been our experience that many older individuals feel more comfortable with medication rather than attending outpatient psychotherapy. This issue should be discussed openly with such patients.

**Gender**
Research has not identified gender as a variable to consider when making treatment decisions for OCD. Nevertheless, some patients may feel more comfortable with therapists of their same sex, especially if they have obsessions or compulsions regarding uncomfortable sexual or contamination concerns (e.g., public restrooms). For example, a same-sex therapist would be necessary to accompany the patient during exposure to public restrooms.

**Race**
The majority of research on treatment outcome in OCD has been conducted with white adults. Only a handful of studies have specifically examined outcome of CBT with African American individuals, and research on other minority groups is seriously lacking. Nevertheless, an epidemiological catchment area study found that the incidence of OCD in African Americans is similar to or greater than the incidence in the general population (Robins et al., 1984). One explanation to account for the dearth of minority participants in OCD treatment studies is that African Americans are unlikely to seek treatment in psychiatric settings, preferring instead to consult a minister or a physician or, if in crisis, visit the emergency room (Williams, Chambless, & Steketee, 1998).

Some members of minority groups may perceive an increased stigma in presenting for treatment of their OCD. They may fear being viewed as “crazy” by members of their community and thus may be more likely to opt for pharmacotherapy over psychotherapy, as there is typically less stigma associated with medication treatment (Williams et al., 1998). Case reports have found that this sense of stigma and shame can interfere with CBT treatment for OCD. For example, Williams et al. (1998) observed that self-consciousness prevented a patient with OCD from performing exposure exercises in public settings.

This sense of shame has also been reported to interfere with the patient’s initial report of his or her symptoms. African Americans tend to underreport OCD symptoms and terminate treat-
ment without having addressed all of their symptoms, increasing chances for lapse or relapse (Hatch & Friedman, 1996; Williams et al., 1998). Shame and isolation may also be salient in group settings, where a minority patient may feel uncomfortable as the only nonwhite participant. This may adversely affect group attendance or participation (Williams et al., 1998).

As we discuss further below, the inclusion of family members to facilitate compliance with CBT procedures is often advocated among experts (Van Noppen & Skeketee, this issue; Neziroglu & Yaryura-Tobias, 1991; Steketee & White, 1990). However, minority individuals may be reluctant to involve friends or relatives in their treatment (Hatch & Friedman, 1996), thus leaving themselves without benefit of outside support. Hatch and Friedman reported that one African American patient they were treating with CBT refused a home visit because of concerns about what the patient’s family would think.

Despite the above issues related to psychotherapy with minority groups, Williams et al. (1998) did report clinically significant changes for African American patients with OCD who received CBT. However, they do note that the above complications likely prevented these patients from making even greater improvement. Given the stigma that minority patients may experience during outpatient CBT, the suggestion of inpatient treatment may induce even more shame; thus this issue should be addressed with sensitivity. In some cases, the cultural issues described above may make pharmacotherapy a better initial treatment option for some minority individuals with OCD.

**Education and Cognitive Level**

Research on the association between cognitive and educational levels and OCD treatment outcome is lacking. However, successful CBT requires that the patient comprehend a theoretical conceptual model of OCD and a rationale for using specific treatment procedures. Moreover, patients must be able to consolidate information learned during cognitive and behavioral treatment procedures (e.g., exposure) and implement these procedures on their own. This may be difficult for individuals who are very concrete in their thinking, and we have anecdotally observed reduced benefit from CBT in such cases. Because group CBT may proceed at a pace that is too rapid for individuals with cognitive impairment, individual therapy is recommended. For those OCD patients too cognitively impaired to comprehend or profit from CBT, it may be more fruitful to explore pharmacotherapy options.

**Availability of Treatment**

Geographic location and finances may limit the availability of treatment for OCD. Although the number of professionals well trained to provide CBT for OCD has increased in recent years, access to a qualified therapist is still quite limited, especially in rural areas. Thus, many patients need to travel for specialized treatment. This imposes added financial expenses and, if travel is not feasible, may dictate the need for an initial trial of pharmacotherapy, since it is more widely accessible. Insurance coverage may also dictate treatment, since some insurance providers do not completely cover mental health visits. In such instances, pharmacotherapy would be preferable. Unfortunately, this problem may also prevent many patients from obtaining the necessary inpatient CBT treatment for OCD.

The aforementioned obstacles to obtaining CBT from a qualified therapist have led to the development and systematic evaluation of two self-help programs for OCD: bibliotherapy and computer-aided self-treatment. Fritzler, Hecker, and Losee’s (1997) 12-week bibliotherapy program involved readings from Steketee and White’s (1990) self-help book, *When Once Is Not Enough*, and five sessions with a therapist to
reinforce information presented in the readings, including help with developing exposure hierarchies. Therapists did not assist with actual exposure practice. Overall, improvement among the 9 patients in this study was modest; yet 3 obtained clinically significant improvement. Unfortunately, long-term results were not reported. These findings suggest that some patients with OCD may benefit from bibliotherapy and minimal therapist contact.

Baer and Greist (1997) described a voice-activated interactive (over the telephone) computerized self-assessment and self-help behavior therapy program for OCD (BT Steps) that would allow patients without access to a behavioral therapist to obtain guidance in designing and implementing ERP. The intervention incorporated education about OCD, assessment, treatment planning, ERP instructions, and relapse prevention. In a randomized comparison of BT Steps with both clinician-administered ERP and relaxation, Greist et al. (2002) found that patients receiving the computerized self-help program improved about 25% in their OCD symptoms. This improvement was significantly greater than with relaxation (7%), yet less than improvement with therapist-assisted ERP (>30%). These findings suggest that some degree of benefit may be obtained from self-help programs absent a therapist. However, results of a comprehensive meta-analytic review of the ERP literature suggest that the lack of therapist assistance may jeopardize the integrity of exposure, and therefore compromise the effects of ERP (Abramowitz, 1996).

Patient Preference

It is important to weigh the patient’s treatment preferences when considering therapeutic recommendations. We typically describe and review the pros and cons of both CBT and pharmacotherapy when helping patients decide which treatment(s) they will receive. Indeed, greater adherence can be expected if the patient is agreeable with the particular treatment plan. For example, some patients may not be willing to experience increased levels of anxiety, as would occur during ERP. In such a case, it would be important to collect information about why they may be unwilling and to thoughtfully address any concerns at intake.

Availability of Support System

Family Support Spouses or other relatives and close friends of OCD sufferers sometimes play a role in the maintenance of patients’ ritualistic or avoidance behavior. In some cases family members are aware that their own behaviors are counterproductive and serve to promote OCD symptoms. In other cases, relatives believe that their involvement in rituals serves to help the patient, or that the patient must engage in symptoms to avoid conflict. As discussed above, it is generally useful for CBT to involve at least one support person to help with the completion of therapy exercises outside of the session. However, a certain kind of support is helpful in CBT, and unhelpful family involvement in treatment may negatively impact outcome, as we discuss below.

Family Involvement in Therapy Individual family characteristics are critical to consider when determining the extent to which family members should be involved in treatment. Mehta (1990) compared a family-based CBT approach to one that was patient based and observed significant improvement in the former as compared with the latter. He concluded that emotional support given by family members during home-based exposure therapy was of great benefit and that nonanxious, firm family members were more successful than anxious and inconsistent ones. There were, however, some cases where family members indulged in argument and ridicule, and these patients
showed little improvement. Steketee (1993) also observed that significant others’ empathy and positive interactions were associated with the maintenance of behavioral treatment gains. She also found that relapse was more likely for patients whose family interactions were characterized by criticism and anger, and in cases where family members believed that the patient should be able to control his or her symptoms.

Recently, Chambless and Steketee (1999) found a relationship between family’s expressed emotion and outcome of CBT for OCD. Specifically, relatives’ emotional overinvolvement, criticism, and hostility predicted higher rates of treatment dropout; and perceived criticism and hostility predicted poorer long-term outcome. Thus, it is important to evaluate individual family members’ interactions with the patient before assuming that their assistance with CBT will be beneficial. If family members are not deemed to be supportive and empathetic, involving them in treatment may in fact be counterproductive and should be discouraged. For patients who are in need of additional support, group CBT may be a good option. Similarly, depending upon the severity of the individual’s OCD symptoms, inpatient CBT may also provide a supportive and structured environment.

Results have been conflicted as to whether the level of marital satisfaction impacts the efficacy of CBT for OCD. Hafner (1982) suggested that marital distress might account for poor outcome; however, two other studies (Emmelkamp, de Haan, & Hoogduin, 1990; Riggs, Hiss, & Foa, 1992) found that the level of marital distress was unrelated to treatment outcome. This further suggests that the family’s role in a patient’s OCD symptoms must be carefully assessed. We recommend educating family members about their role in OCD symptoms and that CBT requires the patient’s abstinence from performing rituals or avoidance. In some instances, the patient and family are able to align themselves in addressing the patient’s symptoms; and we deem this a necessary prerequisite for initiation of CBT. In cases where the family dynamics would likely undermine the benefits of CBT, we recommend family education and/or pharmacotherapy as a first-line treatment. Further information regarding family aspects of treatment for OCD are included in Van Noppen and Steketee’s article in this issue.

**OCD-Related Variables to Consider When Deciding on Treatment**

**Symptom Presentation**

**Primacy and Severity of OCD Symptoms** A principal characteristic of CBT is that treatment methods are fairly specific in terms of their targets. Thus, we recommend CBT for OCD only when obsessions and compulsions are of clinical severity and are among the patient’s primary complaints. Because intensive ERP requires a particularly generous commitment to treatment, we typically do not initiate this treatment if patients are concurrently undergoing simultaneous therapies likely to compete for their time and energy (e.g., intensive therapy for substance abuse or eating disorders). Commitment issues are less relevant to the use of pharmacotherapy. Thus, patients seeking OCD treatment who have additional therapeutic undertakings would be advised to delay therapy, or begin with SRIs, until their schedule can accommodate CBT.

For the majority of patients with OCD, clinical severity itself should not factor into the decision of whether to pursue medication or CBT. If at all possible, we tend to recommend CBT as the first-line treatment, before SRIs. However, more severe symptoms may require a more intense treatment regimen of whichever treatment is offered: a higher dose of medicine or more frequent CBT sessions. In cases where patients are practically incapacitated by their symptoms
(e.g., cannot leave their home) or present a danger to themselves or to others, inpatient treatment is recommended. Where possible, however, we recommend that CBT be conducted on an outpatient basis to maximize the generalizability of treatment gains to different environments, most importantly the patient’s own personal surroundings.

**Symptom Theme** Because OCD is a heterogeneous condition, clinicians and researchers have been interested in whether patients with different symptom presentations (e.g., washing, checking, hoarding) respond preferentially to certain forms of treatment. With respect to ERP, a series of older studies found inconsistent results regarding differences between “washers” and “checkers” (e.g., Basoglu, Lax, Kasvikis, & Marks, 1988). However, a problem with older studies in this area was that they tended to overrepresent more common symptoms such as washing and checking and underrepresent symptoms such as mental, hoarding, and ordering/arranging (symmetry) rituals. In more recent investigations, hoarding symptoms have been identified as associated with poorer response to both ERP (Abramowitz et al., 2002; Saxena et al., 2002) and SRIs (Mataix-Cols et al., 1999). Despite accumulating evidence that the two established OCD treatments are of reduced benefit for hoarding symptoms, novel CBT interventions specifically for these symptoms have been developed and tested in preliminary studies (e.g., Hartl & Frost, 1999). Thus, although still experimental, these newer procedures are recommended by us when patients present with primarily hoarding symptoms (see Frost, Steketee, & Greene, in part two of this special issue).

Some have suggested that patients with primarily cognitive OCD symptoms (i.e., mental rituals or “pure obsessions” [obsessions without overt compulsive rituals]) fare less well in treatment compared with those displaying overt compulsive rituals (Baer, 1994). However, recent developments in the conceptualization of obsessions have led to a highly effective form of CBT for patients with no overt compulsive rituals. Developed and tested by Freeston and colleagues (1997), CBT for severe obsessional thoughts involves a more cognitive approach, in which patients are taught to appraise unwanted intrusive thoughts as nontreating and part of normal human thought processes. Exposure to the obsessional thought itself, and abstinence from neutralizing or mental rituals, is introduced to test assumptions that such thoughts do not portend disastrous consequences. Freeston et al. found that over 70% of patients evidenced a clinically significant reduction in obsessional symptoms with this regimen, suggesting that this form of CBT is an effective treatment for such OCD patients.

**Feared Consequences and Degree of Insight** Whereas some OCD patients articulate fears of disastrous consequences (e.g., “If I touch the bathroom floor I will become very ill”), others do not verbalize such specific outcomes (e.g., “I just wouldn’t feel right unless I ritualized”). Recently, Foa, Abramowitz, Franklin, and Kozak (1999) found that compared with patients who described specific feared consequences, those who could not articulate such fears benefited less from ERP. Since exposure-based therapy is thought to reduce anxiety by providing corrective information that disconfirms anticipated harm (Foa & Kozak, 1986), perhaps a patient’s inability to articulate feared consequences decreases the therapist’s ability to devise exposure exercises that provide corrective information, thereby reducing the effectiveness of therapy.

We believe that most OCD patients do have feared consequences of not performing compulsive rituals, yet may vary in how well they can...
articulate such fears. For example, some patients report that their anxiety will persist indefinitely, or that things will not seem “just right” unless they ritualize. In arranging an ERP treatment plan, it is important to clarify any anticipated outcomes of exposure in the absence of performing rituals. In one example, a patient with contamination obsessions was unconcerned about getting ill, but instead feared that without washing his hands his anxiety would mount to the point that others would notice and think he was “strange.” In cases where feared consequences are not well articulated, a more cognitive approach may be incorporated, in which the obsessional thoughts are considered as senseless and insignificant, and therefore not worthy of responses such as avoidance, neutralization efforts, or behavioral compulsions.

For OCD patients who do articulate specific feared consequences, there is a range of insight into the senselessness of the obsession and use of compulsive rituals to prevent the feared outcome (Foa et al., 1995). Clinical observations and research findings suggest that patients who are strongly certain that their feared consequences will occur if they do not perform rituals (poor insight) improve less with ERP than those who are less certain (Foa, 1979; Foa, Abramowitz, Franklin, & Kozak, 1999). Perhaps it is difficult for patients who are strongly convinced that their fears are realistic to consolidate disconfirming evidence gleaned from exposure exercises. Alternatively, those with such poor insight may be more reluctant to confront obsessional situations during therapy because of their fears (Foa et al., 1999). These findings highlight the importance of assessing insight when considering ERP. While we recommend a trial of ERP even for patients with poor insight, the therapist should consider augmentation with additional options, as we discuss below.

Cognitive approaches might be helpful for patients with poor insight who are having difficulty with ERP. For example, Salkovskis and Warwick (1985) described the case of a woman who refused to participate in exposure because she was highly convinced she would get cancer from contaminants. These authors employed several sessions of cognitive restructuring during which the patient was taught to consider evidence for and against her beliefs about the probability of getting cancer (e.g., from UV light or cosmetics). Following this intervention the patient was able to engage in exposure. A second augmentative approach for OCD patients with poor insight is pharmacotherapy using SRIs. Some psychiatrists will even prescribe antipsychotic medication for such patients, yet no studies on the effects of these medicines for OCD have been completed.

Comorbidity Certain comorbid Axis I conditions have been found to impede the effects of behavioral treatment for OCD, yet few pharmacological studies have addressed this question. Major depressive disorder (Abramowitz & Foa, 2000; Abramowitz, Franklin, Kozak, Street, & Foa, 2000; Steketee, Chambless, & Tran, 2001) and generalized anxiety disorder (Steketee et al., 2001) are particularly associated with poorer response to ERP. Perhaps seriously depressed patients become demoralized and experience difficulties in complying with the demands of this form of treatment. Strong negative affect may also exacerbate OCD symptoms and limit treatment gains. For generalized anxiety patients, pervasive worry concerning other life issues likely detracts from the time and emotional resources available for learning skills from ERP treatment (Steketee et al., 2001). However, whereas highly anxious patients, once engaged, often can benefit from ERP, severe depression might be cause for postponing behavioral treatment for OCD until the depression can be brought under control (e.g., with antidepressant medication). Given that SRIs have efficacy with generalized anxiety disorder, depression, and OCD, they represent another possible
recommendation in this case. Our research group is presently developing a CBT program to address OCD and depressive symptoms simultaneously. For a detailed review of assessment and treatment considerations with OCD and comorbid major depression or substance abuse, see Roberts, Yeager, and Siegel’s article in this issue.

Other Axis I conditions likely to interfere with ERP are those involving psychotic and manic symptoms. OCD treatment studies have traditionally excluded patients with active psychotic and bipolar disorders, since these symptoms often interfere with normal perception, cognition, and judgment. Active substance abuse or dependence is also grounds for exclusion from CBT. These problems presumably would impede patients’ ability to follow treatment instructions on their own or attend to the cognitive changes that ERP or cognitive therapy aims to facilitate. Our recommendation is that patients receive treatment to bring symptoms of these other conditions under control before attempting ERP for OCD.

The results of several studies and our clinical observations converge to suggest that both CBT and medication may also be negatively impacted by severe Axis II psychopathology (e.g., schizotypal personality disorder; de Haan et al., 1997; Steketee et al., 2001). It is our experience that different personality disorder (PD) clusters differentially influence the process and outcome of CBT. For example, anxious (e.g., obsessive-compulsive PD) and dramatic (e.g., histrionic PD) traits seem to interfere with developing rapport and implementation of CBT (especially ERP); however, if a therapeutic relationship can be developed, success is possible. It is important to also consider that some patients with dramatic traits may gain reinforcement for their OCD symptoms. In such circumstances, CBT is unlikely to succeed because patients do not perceive themselves as gaining rewards for their efforts in therapy. In contrast, patients with personality traits in the odd cluster (e.g., schizotypal PD) present a challenge to CBT because of their reduced ability to consolidate corrective information during exposure or cognitive interventions. On the basis of these observations, we recommend considering CBT for OCD patients with comorbid anxious or dramatic personality traits while remaining aware that the problems discussed above may suggest the need for pharmacotherapy. However, for OCD that is comorbid with odd personality traits, we recommend intensive inpatient CBT along with medication.

**Treatment History**

It is important to carefully assess patients’ previous experiences with treatment for OCD, since these will likely impact current recommendations. For the most part patients who have received an adequate length and dosage of one SRI (see March et al., 1997, for recommended doses) are unlikely to respond to others, or to combinations of SRIs. Thus, for medicated patients who have not tried psychotherapy, ERP is the optimal next choice. If, however, patients report that they have undergone ERP, the adequacy of this therapy course should be assessed before making additional recommendations.3 If the previous ERP included infrequent sessions, lack of adequate exposures, and little emphasis on refraining from rituals, or if patients were not given a clear rationale for ERP, another course of manually driven (and perhaps more intensive) ERP and/or cognitive therapy should be considered.

There may be different reasons that patients previously receiving adequate ERP trials seek additional treatment. The most common reason is that they require booster sessions to help with maintenance of earlier gains. In such cases, patients approach therapy having already been so-

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2. We have developed a tool for estimating the adequacy of previous CBT trials for OCD patients (Schwartz & Abramowitz, 2002, Mayo Clinic, OCD/Anxiety Program, Rochester, MN), which is available upon request.
cialized to its techniques and often fare quite well. However, some individuals seek additional ERP due to a lack of response from an earlier trial. In such cases it is important to determine the reason for nonresponse and discuss additional options. Noncompliance with prior ERP due to extreme fear may necessitate the use of alternative forms of CBT, such as cognitive therapy, before initiating exposure. However, a history of noncompliance due to motivational factors may suggest the need for either inpatient treatment or alternative methods altogether (e.g., medication, individual therapy for other difficulties). Finally, for patients who have failed adequate trials of both pharmacotherapy and intensive CBT, we recommend supportive therapy, OCD support groups, or (if symptoms are unremitting and insufferable) psychosurgery.

How to Discuss Treatment Decisions with Patients

Our aim in the present article was to elucidate some important considerations in the decision-making process for treatment-seeking patients with OCD. As the reader will note, there are numerous variables to think about when recommending a specific treatment or combination of treatments, and no formal blueprint for arriving at a recommendation. For this reason, the information-gathering process at intake must be comprehensive and may require multiple assessment visits before it is complete. Following the intake, we initiate the process of discussing treatment options by reviewing the strengths and limitations of the various OCD therapies (as reviewed above) along with the theoretical bases for each treatment. We invite patients to involve loved ones in the decision-making process and encourage questions or concerns regarding each approach to therapy. Next, we provide a compelling rationale (based on our experience and/or clinical data) for our specific recommenda-

tion. We find that patients and their families often feel comforted by our knowledge and expertise regarding the various treatment options and appreciate being included in the decision process. We also let the patient know that although our decision is guided by expertise, we remain flexible regarding the course of treatment depending on how therapy progresses.

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