Exposure and ritual prevention reduces symptoms more than stress management training in OCD treated with SSRIs

QUESTION

Question: Is exposure and ritual prevention more effective than stress management for controlling symptoms in people with obsessive–compulsive disorder (OCD) already taking adequate doses of serotonin reuptake inhibitors (SSRIs)?

Patients: 108 people with moderate to severe DSM-IV OCD (aged 18–70 years, 57% male) despite a therapeutic SSRI dose for at least 12 weeks. Exclusions: OCD not the primary diagnosis; psychosis, mania, suicidal, substance abuse or dependence in previous 6 months; subclinical OCD (Yale–Brown Obsessive Compulsive Scale score <16); taking SSRI but receiving no benefit; unstable medical condition; or prior cognitive behavioural therapy (CBT) or stress management training while taking SSRI.

Setting: Outpatient setting, Philadelphia, USA; recruitment November 2000–November 2005.

Intervention: Exposure and ritual prevention or stress management training CBT. Exposure and ritual prevention involved two treatment planning sessions and then 15 in vivo and imaginal exposure sessions in which participants faced their fears without ritualisation. Participants were asked to stop ritualising after the first exposure session. Stress management involved two treatment planning sessions and 15 sessions in which participants were taught stress management techniques, including deep breathing, progressive muscle relaxation, assertive training, positive imagery and problem solving. Both intervention and control involved 17 twice weekly sessions (90–120 min each), homework and between session phone calls (2 per week, <20 min each). Outcomes were assessed at 4 and 8 weeks.

Outcomes: Primary outcome: OCD symptom severity (Yale–Brown Obsessive Compulsive Scale). Secondary outcomes: responder status (≥25% reduction in OCD symptom severity) and minimal symptoms achievement (Yale–Brown Obsessive Compulsive Scale score ≤12).

Patient follow-up: 87% at 8 weeks.

METHODS

Design: Randomised controlled trial.
Allocation: Unconcealed.
Blinding: Assessors blinded to CBT assignment.
Follow-up period: 8 weeks.

MAIN RESULTS

At 8 weeks, exposure and ritual prevention CBT reduced OCD symptom severity more than stress management CBT in people taking adequate doses of SSRIs (Cohen's d 1.31, 95% CI 0.86 to 1.75). People receiving exposure and ritual prevention were more likely to respond to treatment and achieve minimal symptoms of OCD than people receiving stress management (responder status achievement: 74% with exposure and ritual prevention vs 22% with stress management, p<0.001; minimal symptoms achievement: 33% with exposure and ritual prevention vs 4% with stress management, p<0.001).

CONCLUSIONS

Exposure and ritual prevention is more effective than stress management training for reducing symptoms in people with moderate to severe OCD who are managing their condition with an adequate dose of SSRIs.

ABSTRACTED FROM

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Correspondence to: Helen Blair Simpson, Anxiety Disorders Clinic, New York State Psychiatric Institute, Unit 69, 1051 Riverside Drive, New York, NY 10032, USA; simpson@nyspi.cpmc.columbia.edu

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► A reference list is published online only at http://ebmh.bmj.com/content/vol12/issue1

COMMENTARY

Providers who treat individuals with obsessive–compulsive disorder (OCD) frequently face questions regarding the efficacy of cognitive behavioural therapy (CBT) following pharmacotherapy. Simpson and colleagues have provided empirical support for the clinical hunch that CBT enhances medication treatment. While this is encouraging, the findings also point to the chronic and serious nature of OCD. At the end of the trial, whereby clients received 17 sessions twice weekly, 90 min per session, the average level of obsessive–compulsive symptoms remained substantial.

The investigators point to an important potential limitation in the findings related to initial symptom severity. The sample in this trial had severe symptoms at baseline. An additional point worth highlighting, however, is the heterogeneity of OCD. Recent literature has shown that OCD is comprised of symptom subtypes[1 2] and other complicating features.[3] Furthermore, it has been shown that presenting symptoms predict treatment outcome,[4 5] with some problems associated with OCD particularly difficult to treat with the existing empirically supported approaches. These variations in symptom presentations lead to considerable differences in the conduct of CBT, including the emphasis on in vivo or imaginal exposure.[6]

An additional important feature in research examining severe and chronic cases of OCD is the presence of overvalued ideas.[7] The presence of this complicating factor is often associated with more severe symptoms and poorer outcome with CBT[8] and pharmacotherapy.[9] As this trial was rigorously controlled, and adherence to the protocol was carefully monitored, we can assume that the presence of overvalued ideas were identified and would be reflected potentially in the degree of behavioural homework compliance. However, this is a serious issue facing practicing clinicians, with other interventions necessary before initiating exposure.[10]

Collectively, this trial has much to offer practitioners in documenting the efficacy of CBT after patients are on a stable trial of pharmacotherapy. Another application is in the ability for clinicians to offer realistic expectations for treatment outcome. Too often clinicians are tempted to offer goals for treatment that exceed the likely benefit that will be achieved. The next step involves putting a sharper point on the anticipated outcome by highlighting the differential outcome based on presenting symptoms and complicating factors that commonly occur in OCD.

Dean McKay, PhD, ABPP
Associate Professor, Department of Psychology, Fordham University, New York, USA

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Notes