Ineffective and Potentially Harmful Psychological Interventions for Obsessive-Compulsive Disorder

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*James**[1]** sought treatment with one of us for his severe obsessive-compulsive disorder (OCD). His symptoms were primarily intrusive images of harming others, as well as concerns with contamination that led to lengthy hand-washing rituals. James is very successful professionally, he is well-educated, and he arrived for treatment armed with extensive knowledge of what treatment he needed based on his understanding of the research into psychological interventions for OCD. During his initial evaluation, he asked repeatedly if he would receive exposure with response prevention (ERP). The dialog went approximately like this:*

James (J): I've done research on your work, and see that you have published on ERP. Do you promise, now that you've assessed me and know I have OCD, that you will provide this treatment?

***Clinician (C):** Yes, of course.*

J: Now, I hate to seem pushy about this, but really, can you re-assure me that you will, without question, provide ERP?

***C:** Yes, without a doubt, you are an ideal candidate for ERP.*

J: Look, I've been told this by three prior therapists, that they would deliver ERP, but when it came time to do so, they didn't. So, I'm not sure how easily you can convince me, but I cannot go through this disappointment again. Will you swear you will deliver ERP?

***C:** I can 100% guarantee you will receive ERP.*

This encounter was perhaps the most extreme in someone demonstrably requesting ERP, but for this clinician, it is not an isolated incident. A client with true OCD comes seeking therapy after seeking consultation with other providers claiming they will deliver CBT, and specifically ERP, only to receive some other intervention. The client then terminates treatment either with no symptom relief, or possibly with symptoms worse than when they began; as well as reduced hope that they can get better and a loss of faith in the mental health profession.

With OCD affecting around one to two percent of the population, and an increase in the recognition of this problem, many clinicians have begun to hold themselves out to the treatment-seeking public as healthcare providers for this disorder, even if their knowledge of OCD and appropriate interventions are not consistent with the current science. The aim of this article is to highlight how inappropriate, non-evidence-based treatment may be ineffective at best, and even harmful in some instances.

In medicine, it is routine to hear about side effects, including those that may cause a worsening of symptoms or cause other negative outcomes that could be so severe that the medication is unwarranted. Side effects and possible negative outcomes are rarely discussed in psychotherapy (McKay et al., 2018), and even less frequently studied systematically (Lilienfeld, 2007). However, there are some treatments that are known to be harmful for OCD, or at the least not likely to benefit individuals seeking treatment.

Potentially Harmful Treatments for OCD

Here we discuss treatments that have documented harmful effects. We have grouped these together into those identified as cognitive-behavioral, and non-cognitive-behavioral.

Interventions often labeled as "cognitive-behavioral therapy"

Exposure and response prevention (ERP) is a form of cognitive-behavioral therapy (CBT) that is well-studied and known to be particularly effective for reducing OCD symptoms. In fact, it is the most effective overall treatment for OCD (OCRDs; see Abramowitz, McKay, & Storch, 2017). However, it is important to understand that ERP is only one type of cognitive-behavioral intervention.

CBT is an approach to understanding and treating psychological disorders, and it encompasses a large universe of techniques and interventions. Thus, the label "CBT" can mean many things. Indeed, there are some CBT interventions that, while effective for some problems, are either of limited value or may worsen the symptoms of OCD. **What follows next is a description of CBT-based interventions that do not have support in treating OCD.**

Thought-stopping

It sounds simple enough — start by applying a mild unpleasant stimulus every time an unwanted thought enters consciousness, usually a rubber-band snap on the wrist. Move to less unpleasant experiences, such as saying "STOP!" out loud and then moving to simply saying "STOP" to oneself. The approach was derived from basic behavioral principles of aversive conditioning, and while the theoretical underpinnings are fairly sound, the evidence suggests this approach will lead to worsening of symptoms. This has been fairly well known for a long time now (see Christensen, et al., 1987), and so bona fide experts in OCD are unlikely to offer this procedure.

The reason for the ineffectiveness of thought-stopping comes from the now well-understood problems associated with thought suppression (Magee, Harden, & Teachman, 2012). Specifically, when a person tries to suppress a thought, the accessibility of that very thought paradoxically increases. Consequently, there is a "rebound effect" whereby the previously unwanted thoughts are present more frequently, and at a higher intensity (Purdon, 2004). Research actually shows that many people with OCD compulsively suppress their thoughts — that is, thought-stopping can actually be a ritual. Thus, this "treatment" essentially amounts to helping people with OCD do rituals, which is the opposite of what we know works as a treatment for OCD.

Thought-stopping, therefore, is based on a misunderstanding of the psychological mechanisms of OCD. In fact, effective treatments for OCD, such as ERP, are beneficial precisely because they ask clients to do the *opposite* of thought-stopping. When someone with obsessions purposely provokes these thoughts and "leans into them," they have the opportunity to learn that these experiences do not need to be stopped or suppressed because they are not dangerous.

Cognitive Therapy

Cognitive therapy is an approach to psychological treatment based on the idea that overly rigid and exaggerated thoughts and beliefs, rather than *situations*, are what largely cause negative emotions. For example, if I fail an exam, I become depressed not because of my grade per se, but rather because of what I might tell myself about the grade (e.g., "*I am a failure*"). The aim of cognitive therapy is to help the person gather evidence for or against such faulty thinking patterns (e.g., "I might have failed the exam, but I succeed in many other things; I can learn from this failure") to develop more helpful ways of thinking that lead to more appropriate and helpful emotional responses (e.g., "Failing the test is disappointing; it means I need to work harder if I want to pass next time").

This type of evidence-gathering is called the Socratic method and there is plenty of research showing that cognitive therapy is extremely useful in the treatment of problems such as depression, anger, and anxiety. There are also empirically supported cognitive therapy protocols for OCD (i.e., Wilhelm & Steketee, 2006), derived from basic research into the specific cognitions that are associated with OCD, such as the tendency to overestimate threat and responsibility, as well as the importance of intrusive thoughts.

Unfortunately, however, many therapists are unfamiliar with the OCD-specific version of cognitive therapy and end up getting drawn in to "helping" their patients with OCD gather evidence for or against their obsessional fears (e.g., "Let's figure out the likelihood that you will actually get sick from touching the floor") — which is not how the OCD-specific version of cognitive therapy is used. The problem here is that this type of "gathering evidence" is very similar to what people with OCD are already doing: trying to find a guarantee or trying to get reassurance. At a minimum, this approach is frustrating since the vast majority of people with OCD recognize that the thoughts surrounding their symptoms are unreasonable or exaggerated. But at worst, the cognitive therapist is again merely contributing to helping the person perform a reassurance-seeking ritual.

In fact, we have had some patients tell us how they've (unknowingly) hijacked cognitive therapy and turned it into a ritual (e.g., "My therapist told me that less than 1% of people get sick from touching toilets, so as long as I say that to myself over and over, I can use the bathroom without having to shower afterwards"). This is merely substituting one ritual for another, and not a useful long-term treatment for OCD! It is, however, important to remember that some aspects of cognitive therapy may help, for example externalizing intrusive thoughts, or focusing on the learning from ERP. But, the typical

Socratic methods used in the treatment of other psychological problems have in fact proven to be of limited use in the treatment of OCD.

Non-Cognitive Behavioral Interventions

As anyone who has sought psychotherapy will tell you, there are a lot of different 'brands' of therapy on the open market. The majority of these also have limited evidence to support their use in the treatment of OCD. **The following are a few that may be harmful rather than helpful or even benign.**

Psychodynamic/Psychoanalytic Therapy

Sometimes also referred to as 'general psychotherapy,' the goal of this treatment is to achieve insight into the underlying nature of the presenting problem. The clinician does not offer any definitive answers, and clients are left to speculate about possible connections between their symptoms and some other prior events or personal history.

While this may be fine for some conditions (see Thoma et al., where quality of study was more indicative of outcome than theoretical approach in the treatment of depression), in the case of OCD it can be harmful. There is a compelling reason — this form of treatment fosters doubt, which is a root problem in OCD. Remember James from earlier? Well, he also recounted a typical dialog with a prior therapist, before he learned that he needed ERP:

J: Over the past week, my thoughts have been really intense. I had to avoid my son for fear I would get the urge to harm him, especially when we were in the kitchen near the stove.

C: *I see. Tell me, have you been feeling hostility toward your son of late? You mentioned last week that you had to punish him.*

J: Um, I get frustrated with him like any parent does with their six-year-old, but I don't want to burn him by grabbing his hand and pressing it to the stove!

C: *Yes, yes. But, you have to sometimes think of how much easier life was when you did not have children.*

Dialog such as this fuels a sense of doubt about one's intentions. Research has demonstrated that there are several key cognitive areas that are relevant to OCD. Two in particular – intolerance of uncertainty and over-importance of thoughts – are emphasized when psychodynamically-oriented approaches are adopted. This stands in contrast to the aforementioned cognitive model (Wilhelm & Steketee, 2006). Quantitative evidence also shows that psychodynamic approaches worsen symptoms of OCD (Christensen et al., 1987).

Interpersonal Psychotherapies

The interpersonal psychotherapies (IPT) have shown significant benefits in the treatment of depression and other conditions (Lipsitz & Markowitz, 2013), but the connection between interpersonal difficulties and OCD is not well developed. Further, it has not been shown to be a mechanism of symptom presentation or improvement. IPT may be useful to alleviate depressed mood that frequently accompanies OCD, but as a stand-alone treatment it is likely to contribute to a worsening of symptoms for the same reasons as noted above for psychodynamic therapies.

Ineffective Treatments for Obsessive Compulsive and Related Disorders

The focus thus far on treatments that lead to worsening symptoms is not the only negative outcome that can occur when individuals with OCD seek therapy. Seeking treatments that can be expected to provide limited or no benefit has been previously described as harmful due to resource loss, frustration/demoralization, and potential worsening of symptoms due to the natural course of an untreated condition (Dmidjian & Hollon, 2010).

Relaxation Therapy

Progressive muscle relaxation (PMR) is a classic behavioral intervention that was developed for anxiety problems. It was commonly administered as part of systematic desensitization (Wolpe, 1990). However, as exposure methods became more refined, PMR specifically and systematic desensitization in general became less commonly practiced, since symptom relief is achieved more slowly and with less durability (McGlynn, Mealiea, & Landau, 1981).

Currently, PMR is typically used as a control treatment condition in research trials, and while some limited relief may be attained, OCD symptoms remain

quite significant after treatment (i.e., as shown in Greist et al., 2002). The reason PMR fails to reduce symptoms is because rather than address the specific problem that leads to anxiety (intrusive thoughts), it only alleviates the anxiety that results from it. While relaxation is pleasant, unlike ERP it does not address the primary causal symptom that leads to anxiety and distress.

Energy Therapies

The basic premise that underlies the energy therapies is that people are imbued with a basic energy system around the physical space, and that psychopathology emerges from disruption in this system. The clinician works to adjust the energy field through tapping specific points on the body (so-called "meridian points") or engage in other minor physical contact in order to "adjust" the field, typically while the treatment-seeking individual visualizes some aspect of their problem.

At present, there is no compelling evidence that these hypothesized energy fields exist, that there is any connection to psychopathology (not just OCD), or that the physical tapping has any benefit (McCaslin, 2009). At best, the visualization component could be construed as a mild form of exposure therapy, but it is typically not of sufficient duration or intensity to lead to any beneficial outcome. Despite the lack of scientific evidence to support their use, energy therapies enjoy a surprising measure of popularity among clinicians (Sharp, Herbert, & Redding, 2008).

Equine (and other animal-assisted) Therapy

In places where there is ready access to horses, equine therapy may be a more common intervention. In a survey of mental health professionals who offered anxiety disorder services in Wyoming, Hipol and Deacon (2013) found that a large proportion of providers offered equine therapy. While engaging with horses is often quite pleasant and even relaxing, the evidence that a successful program of therapy can be built around this is, at present, non-existent (Anestis et al., 2014).

Life Coaching

There is no single unifying theory or approach for life coaching. The training involved is highly variable, but more importantly, there is no connection between this and alleviation of symptoms of OCD. It is important to list this

area of practice here because there are many individuals offering life coaching as part of a plan of treatment for OCD. A search of the research literature showed no research for life coaching to alleviate anxiety disorders or OCD (search conducted January 6, 2019).

Recommendations for Consumers

There are many clinicians offering their services, and many of these clinicians state that they treat OCD. While it may be all too easy to say "caveat emptor"/buyer beware, there are some things that can help the treatment-seeking individual make an informed choice when selecting a psychotherapist.

Investigate the Treatments

Once you've been diagnosed, check to see what treatments are recommended for your condition. Check the IOCDF website for information regarding available interventions. See if treatment guidelines have been developed, and if so, what the first, second, and possibly third-line treatments may be for the disorder.

Ask "Hard" Questions

Each of the authors here welcome questions about how the client's presenting symptoms will be treated, what outcomes can be expected, how our approach to implementing CBT will be specific to the broad presenting problem, and what kind of outcome might be reasonably expected. If a particular method other than ERP is being recommended, a clear justification is offered that ties specifically to the individual's presenting problem based on knowledge of the whole person. This is the least anyone should expect of their clinician.

When seeking a provider who says they offer CBT, ask them how they will address OCD, and specifically how they will administer ERP. Be persistent on this issue, too. If the clinician seems unwilling to describe how they approach treatment, or if they are apparently unfamiliar with the current best practices for your condition, it may be best to seek a different provider. While it may be frustrating, the frustration is greater when treatment is begun that is ineffective.

Our illustrative *James* from earlier started treatment with five providers over a five-and-a-half-year period before finding someone who was familiar with

the proper treatment for his condition. In between each failed therapy, he waited four to six months before trying again due to the demoralization from failing to benefit from therapy.

Continue to Ask Questions

Once you are confident you have found a provider and begin treatment, continue to ask questions during the course of treatment. Inquiring about progress, the speed/pace of treatment, how outcome is being assessed, and whether there are adjustments in the time course expected for treatment to complete, are all worth asking. Similarly, asking about the role of loved ones — especially for children and adolescents — is very important to build a team to battle against OCD, similar to how one would fight against cancer or other chronic physical illnesses.

Conclusions

As noted at the outset, there is limited research on side effects and negative outcomes in therapy for OCD, or for most psychological conditions. Complicating matters, there are many treatments, and the practitioners offering these interventions claim effectiveness, even when there is little research to support these claims. Although these clinicians are generally well meaning, and genuinely wish to alleviate the symptoms of those suffering, the methods employed may fall short, or may cause harm. The list of treatments discussed here are ones that OCRD sufferers should consider avoiding in light of the risk of worsening, or at best remaining unchanged.

It is our hope that more systematic research will accumulate to document potential harms in treatment. At the moment, the best that can be offered are some guidelines to identify practices and practitioners who are familiar with the proper evidence-based interventions for OCD.

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[1] The name, symptoms, and background information of this individual have been altered to protect his identity.