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Mindfulness-based Behavioral Therapy (MBBT) for OCD

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Abstract

OCD is a widespread disorder affecting about 1.21% or 3.3 million people in the US alone. Despite the relative benefits of pharmacological interventions and cognitive-behavior therapy, the full recovery rate is low, and dropout and relapse rates are high. Apart from the standard outpatient Exposure and Response Prevention (ERP) method, other options for severe, refractory OCD include general psychiatric inpatient admission, intensive residential treatment, and partial-hospitalization. None of these options is completely or universally effective, and there is a need for continued innovation in OCD treatment. Over the last two decades, interest has grown in integrating aspects of mindfulness training into the treatment of psychiatric disorders and the prevention of relapse. Meta-analyses suggest that such integration decreases distress in mood and anxiety disorders. The lead directives of mindfulness practice are to stay in the present moment and not to appraise internal and external events as they unfold. This is in direct contrast to OCD behavior that tends to ruminate on the past, to dread the future, and to over-value negative ideation at the expense of recognizing the current reality of a situation. However, in this pilot study of Mindfulness-Based Behavioral Therapy (MBBT), mindfulness training appears to help patients acquire behavioral strategies to manage OCD symptoms. Of the 140 subjects involved in this retrospective chart review, which integrated MBBT with Exposure and Response Prevention (ERP) methods, the average OCD YBOCS score was reduced by 60%. Thus, MBBT integrated with ERP appears to offer hope to those suffering from OCD who have been non-responsive to traditional treatments.

Traditional Treatments for OCD

CBT

Cognitive-behavioral therapy (CBT) is widely regarded as the gold standard for treating obsessive-compulsive disorder (OCD) [1]. It employs several key techniques to address the condition effectively. One part of CBT is exposure therapy, which involves two main approaches. In in-vivo exposure, individuals confront real-life anxiety-provoking situations, such as touching objects they perceive as contaminated. This direct engagement helps them gradually reduce their fear response. Imaginal exposure is a method that involves vividly imagining feared scenarios, such as hitting a pedestrian. By mentally confronting these fears, individuals can reduce their anxiety over time. Response prevention is a technique that involves resisting the urge to perform compulsive behaviors. For example, a person might refrain from checking the stove multiple times before leaving the kitchen. Over time, this helps reduce the compulsive urge and allows anxiety to reduce naturally. Cognitive intervention is a strategy that aims to correct faulty thinking patterns. Individuals learn to understand that anxiety will decrease without the need for rituals, helping to reframe irrational beliefs and reduce the intensity of their fears.

When CBT is effective, it enables individuals to break the cycle of avoidance, face their fears directly, experience a reduction in anxiety without resorting to compulsions, and recognize that the feared outcomes are unlikely to occur.

Pharmacotherapy

Another first-line treatment of OCD includes FDA-approved pharmacotherapy. This includes selective serotonin reuptake inhibitors (SSRIs) such as clomipramine which is taken 25-250 mg/day, fluoxetine taken 5-80 mg/day, fluvoxamine taken 25-300 mg/day, paroxetine taken 10-60 mg/day, sertraline taken 50-200 mg/day, and citalopram taken 20-80 mg/day [2].

Despite some effectiveness, pharmacotherapy has several limitations, including its numerous side effects.

Limitations of First-Line Treatments

Despite the relative effectiveness of CBT and pharmacotherapy, approximately 33% of individuals with OCD do not respond adequately to these treatments [2].

Pharmacotherapy can take up to three months to produce optimal effects, and 80-90% of individuals are shown to relapse once medications are discontinued. Additionally, the side effects of medications can be significant. This includes the amount of time required to achieve a response, the potential for relapse upon discontinuation, and various side effects including weight gain, sedation, sexual dysfunction, and hyperactivity in children. These limitations further highlight the need for alternative or adjunctive treatments for OCD.

Other short-term treatment options for OCD apart from the aforementioned also include general psychiatric inpatient admission, intensive residential treatment, and partial hospitalization.

Mindfulness in OCD Treatment

Defining Mindfulness

Mindfulness is the act of focusing attention on the present moment in a

particular way, non-judgmentally according to [3]. Mindfulness encourages staying in the present moment and refraining from appraising internal and external events as they unfold [3]. The idea of non-judgemental practice is extremely integral to mindfulness. Loving-kindness (metta) is an example of this, promoting a compassionate and loving attitude towards oneself and others [4]. Incorporating metta into OCD treatment includes not judging oneself when symptoms emerge, accepting the intrusive obsessions as is, and not reacting to fears with compulsions. This also involves only accepting reality-based thoughts and acknowledging and not reacting to non-reality-based beliefs.

Formal and Informal Mindfulness Practices

Formal practice is a method of prolonged practice during dedicated and protected time periods. These practices are often taught by a seasoned practitioner with their own individualized, formal meditation practice. They are established daily, in addition to informal practices.

Informal practice is a method that occurs in response to everyday events. It is a learned response that becomes automatic after having continued and extended mindfulness. This practice involves having an awareness of self-perceptions without reacting negatively to everyday stresses, emotions arising from social interactions, recurring negative thoughts, and the extraneous hassles of OCD symptoms. Examples of informal practice include noticing and pausing before engaging in a compulsion, focusing on breath sensations, and embracing fear sensations.

Benefits of Mindfulness for OCD

Meta-analyses suggest that integrating formal mindfulness training decreases distress across multiple mood and anxiety disorders and reduces relapse in Major Depressive Disorder, which often co-occurs with OCD in 75% of OCD patients [4]. Mindfulness is important as it can significantly reduce symptoms of OCD by helping individuals focus on the present moment, observe internal and external events without attachment, and relate to themselves and others in compassionate, reality-grounded ways.

Mindfulness-Based Behavioral Therapy (MBBT)

MBBT integrates intensive exposure and response prevention (ERP) with a modified Four Step Method (FSM) designed by Dr. Jeffrey Schwartz [5]. This includes utilizing extensive writing exercises, in vivo exposures, and imaginary exposures in ERP, as well as a modified FSM model. This would be followed by behavioral activation, time management, pharmacotherapy, and potential partial hospitalization for under a week if necessary. This approach aims to enhance the tolerability and efficacy of ERP by incorporating informal mindfulness training.

The Four Step Method (FSM)

The FSM is another method of response prevention, encouraging individuals to *relabel, reattribute, refocus, and revalue* [5]. The *relabel* step labels fear-producing cognitive activity as obsessions. It also urges one to engage in behaviors to reduce fear as compulsions without engaging in compulsive behaviors. The *reattribute* step focuses on attributing obsessions and compulsions to the neurobiological condition of OCD, rather than the self. The *refocus* step encourages individuals to practice shifting attention away from compulsions and towards observing the impermanence of OCD symptoms. The *revalue* step asks individuals to recognize the reality of the situation and use CBT and mindfulness tools to manage OCD symptoms. In the modified FSM model, the components of *refocusing* and *revaluing* is used only during the Relapse Prevention Phase.

MMBT Research Protocol

To assess the efficacy of MBBT on OCD, participants in this study followed an intensive CBT-integrated, MBBT protocol that was structured as follows. Treatment involved 2 planning sessions, followed by 15 daily ERP sessions over a period of 3 weeks, with a minimum of 90 minutes for each session. Each individual had daily homework which took a minimum of 3 hours, as well as ongoing assessment, psychoeducation, and relapse prevention.

Methodology

A retrospective chart review was conducted at the Westwood Institute for Anxiety Disorders outpatient center between 1995 and 2005. Out of 246 adults screened, 33% were excluded from the study. Participants had severe or extreme OCD symptoms and had undergone multiple unsuccessful treatments before starting MBBT [6,7].

Exclusionary Criteria

Participants with a diagnosis of psychosis, substance use disorders, or neurodevelopmental disorders acquired during childhood were excluded from the study.

Additionally, individuals who exhibited insufficient motivation or whose primary diagnosis was not obsessive-compulsive disorder (OCD) were not deemed eligible. Furthermore, those who required more than 30 sessions of Mindfulness-Based Behavioral Therapy (MBBT) were also excluded from the study.

Subjects

There were 139 adult subjects included in the study, with an average age of 32 years. 96% of participants had undergone multiple unsuccessful treatments before starting MBBT. A majority also had severe or extreme OCD symptoms, as measured by having a Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) score of 24 or more. Most participants of the study also had other comorbid disorders and received psychopharmacotherapy at the outset of MBBT. 60 of 139 participants also required partial hospitalization within a week. All OCD symptom types were represented in the study, except hoarding.

Results

The average OCD score on the Y-BOCS was reduced by 60%, from 31 to 12 points, indicating a shift from extremely severe to mild symptoms. Additionally, 115 participants were classified as responders, with 44 achieving complete remission. Reductions in comorbid anxiety and depression symptoms were also observed, along with increases in insight and general functioning in life, from an average Global Assessment of Functioning (GAF) of 49 to 65.

Limitations

A limitation of this study was that an inconclusive degree of mindfulness was shown to directly improve the treatment outcome. The study was retrospective in nature and lacked a control comparison group. It also lacked randomization to the treatment conditions. Additionally, there were potential confounding effects of changes in medication that could have affected the results. MBBT is an integrative treatment with many facets, and the current study design does not allow us to know with certainty which components of MBBT were associated with the promising changes seen on each outcome measure.

Conclusion

Despite the study's limitations, including its retrospective design and lack of a control group, the findings suggest that Mindfulness-Based Behavioral Therapy (MBBT) shows significant promise for improving outcomes in patients with refractory OCD. The immense reduction in the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) score, from 31 to 12 points, indicates a notable shift from extremely severe to mild symptoms. Additionally, the high response rate, with 115 participants classified as responders and 44 achieving complete remission, supports the potential effectiveness of MBBT when combined with traditional Exposure and Response Prevention (ERP) methods.

Improvements in comorbid anxiety and depression, as well as enhanced insight and general functioning, further demonstrate the broader benefits of MBBT. The increase in the Global Assessment of Functioning (GAF) score from 49 to 65 suggests meaningful enhancements in daily functioning and overall mental health.

These results highlight the value of integrating mindfulness practices with ERP to provide a more comprehensive approach to treating OCD. Overall, MBBT appears to offer a promising treatment option for individuals with severe, refractory OCD, potentially improving both symptom management and quality of life. Those who completed MBBT showed symptom reductions on measures of many emotional disorder symptoms in addition to OCD, increases in insight and reality testing, and improvement in general functioning.

Future Direction

MBBT offers hope to individuals with OCD who do not respond to interventions such as traditional CBT and/or pharmacotherapy, providing a comprehensive and integrative approach that addresses the complexities of this condition. Future research with randomized controlled trials can be studied to further validate the efficacy of MBBT on individuals with OCD and other limiting mood disorders. Additionally, a long-term study of participants could further support the findings of this study.

Mindfulness can be feasibly integrated into traditional interventions for OCD in future studies, leading to potential improvements in therapy outcomes for individuals previously considered refractory to treatment.

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