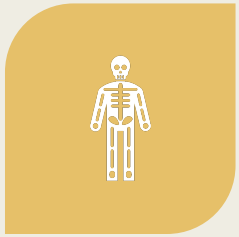
Los trastornos obsesivos y compulsivos: perspectivas actuales

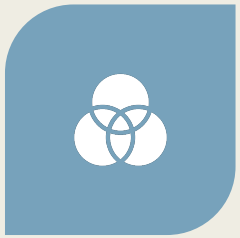
Amparo Belloch



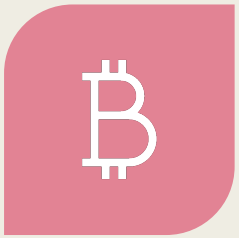
QUÉ ES EL TOC, EN QUÉ CONSISTE

¿CUÁNTAS PERSONAS LO SUFREN?

¿QUÉ IMPACTO TIENE EN LA VIDA DIARIA?



¿SON TODOS LOS CASOS IGUALES?



¿POR QUÉ SE PRODUCE?

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Fenomenología funcional del TOC

OBSESIONES:

Intrusiones mentales (pensamientos, impulsos, sensaciones, imágenes) egodistónicas, involuntarias, no deseadas, recurrentes, que generan malestar (ansiedad, disforia, culpa...). Contenidos diversos.

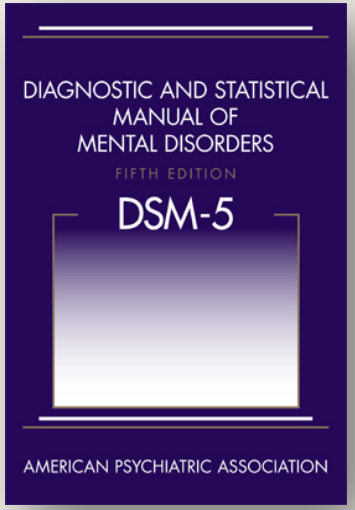
COMPULSIONES:

Urgencia/necesidad de "hacer algo", o de no hacerlo (evitar), para reducir el malestar, miedo, tristeza, etc., que provocan las obsesiones

- Gran variedad de contenidos
- Gran variedad de formatos
  - *Pensamientos*
  - *Sensaciones*
    - Asco
    - Incompletud
  - *Impulsos*
  - *Imágenes*
  - *Recuerdos*
- No siempre accesibles (“consciencia”) al contenido específico

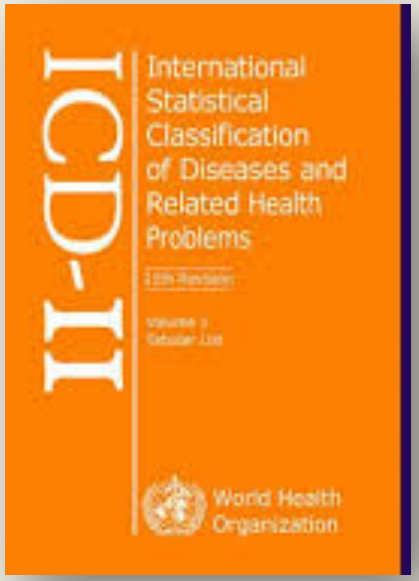
- Gran variedad de formas
- No siempre conectadas “lógicamente” con los contenidos obsesivos
- Manifiestas u observables
- Encubiertas
  - *Dificultades para comunicarlas*
  - *Predictor de mal pronóstico*
- Muchas veces tienen un componente automático (no consciente)
- No siempre son repetitivas (“compulsivas”)
  - *Estrategias de neutralización*
  - *Incluye evitación activa y pasiva*

TOC Y TRASTORNOS RELACIONADOS



1. TOC
2. TRASTORNO DISMÓRFICO CORPORAL
3. TRASTORNO DE ACUMULACIÓN
4. TRICOTILOMANÍA (HAIR PULLING)
5. SKIN-PICKING (EXCORIACIÓN)
6. TOC O TRASTORNOS RELACIONADOS INDUCIDOS POR SUSTANCIAS
7. TOC O TR. RELACIONADOS ASOCIADOS CON ENFERMEDAD MÉDICA CONOCIDA
8. OTROS ESPECIFICADOS
9. OTROS NO ESPECIFICADOS

CIE-11: ESPECTRO O-C



- TRASTORNO OBSESIVO-COMPULSIVO
- TRASTORNO DISMÓRFICO CORPORAL
- ACUMULACIÓN
- COMPORTAMIENTOS REPETITIVOS FOCALIZADOS EN EL CUERPO
  - *(tricotilomanía, excoriación, morderse los labios, como ejemplos)*
- **HIPOCONDRÍA** (o ansiedad por la enfermedad)
- **SÍNDROME DE REFERENCIA OLFATORIO**
  - *Emitir olores desagradables (sudor, halitosis).*

El TOC ES MÁS GRAVE QUE LOS TRASTORNOS DE ANSIEDAD

- *No remite sin tratamiento*
- *Incluso con tratamiento adecuado, recaídas frecuentes (30-40%)*
- *Más dificultad en inhibir intrusiones y conductas*
- *La remisión COMPLETA de síntomas no es lo habitual*
- *Mayor comorbilidad y complicaciones asociadas que con T. De Ansiedad*
- *Mayor cronicidad*

1. ESTÁ JUSTIFICADO UN ESPECTRO TOC

2. EL TOC ES EL TRASTORNO ORGANIZADOR DEL ESPECTRO

QUÉ ES EL TOC, E QUÉ CONSISTE

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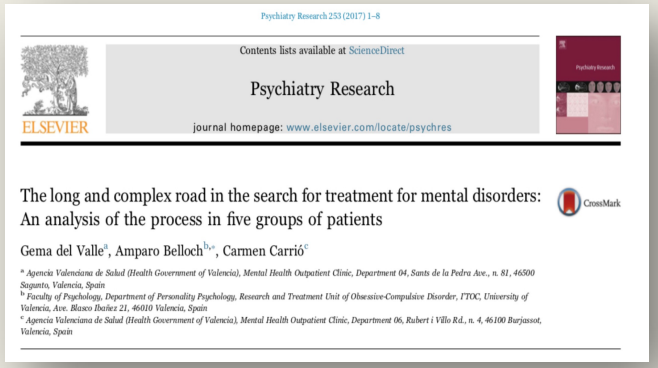
Las 10 principales causas de malestar

1. Depresión
2. Anemia
3. Caídas
4. Alcoholismo
5. EPOC
6. Trastorno Bipolar
7. Anomalías congénitas
8. Osteoartritis
9. Esquizofrenia
10. TOC

- Hasta los 80', se considera un trastorno raro, poco frecuente.
- Datos actuales prevalencia (vital):
  - **2%-3%**
- Inicio temprano frecuente (infancia, pubertad, adulto joven)
- Nula peligrosidad del paciente (para los demás)
- Distribución similar sexos
  - *Inicio infantil más frecuente en niños*
- Curso crónico con fluctuaciones
  - *No remite sin tratamiento*

- Tiende a ocultarse:
  - *Miedo al estigma, vergüenza, miedo,…*
  - *Consecuencia: cronicidad, resistencia a tratamientos, aumento comorbilidad*
- Demora en pedir ayuda:
  - *Tiempo medio desde el inicio de los síntomas:* ***5 - 7 años***
  - *Por qué se consulta: interferencia, tristeza, incapacidad para controlar*
  - *Por qué NO se consulta: miedo al estigma (burlas, rechazo, "loco", cabezota) vergüenza, culpa, "yo podré",..*


Psychiatry Research 253 (2017) 1–8

Contents lists available at ScienceDirect

Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

The long and complex road in the search for treatment for mental disorders: An analysis of the process in five groups of patients

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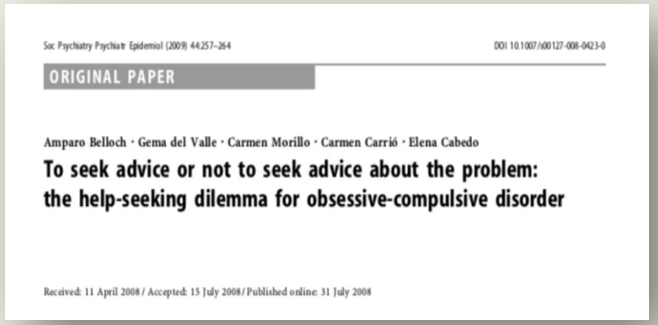
[a] Agencia Valenciana de Salud (Health Government of Valencia), Mental Health Outpatient Clinic, Department 04, Sants de la Pedra Ave., n. 81, 46500 Sagunto, Valencia, Spain
[b] Faculty of Psychology, Department of Personality Psychology, Research and Treatment Unit of Obsessive-Compulsive Disorder, ITOC, University of Valencia, Ave. Blasco Ibañez 21, 46010 Valencia, Spain
[c] Agencia Valenciana de Salud (Health Government of Valencia), Mental Health Outpatient Clinic, Department 06, Rubert i Vilo Rd., n. 4, 46100 Burjassot, Valencia, Spain


Soc Psychiatry Psychiatr Epidemiol (2009) 44:257–264

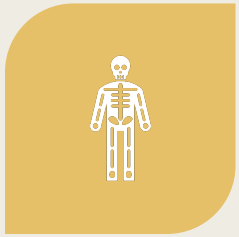
DOI 10.1007/s00127-008-0423-0

ORIGINAL PAPER

Amparo Belloch · Gema del Valle · Carmen Morillo · Carmen Carrió · Elena Cabedo

To seek advice or not to seek advice about the problem: the help-seeking dilemma for obsessive-compulsive disorder

Received: 11 April 2008 / Accepted: 15 July 2008 / Published online: 31 July 2008



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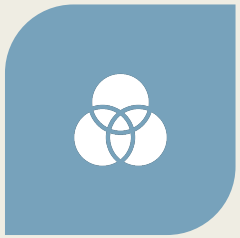

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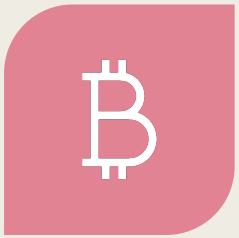

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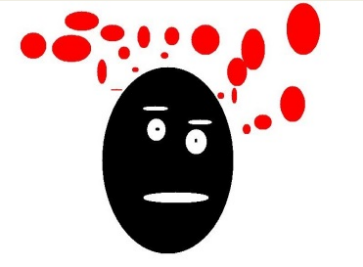


Interfieren en la vida cotidiana

Consumen mucho tiempo

Generan malestar

Dificultad para resistirse a las compulsiones (no hacer algo para “suprimir” las obsesiones)

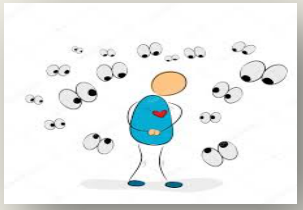
TR. BIPOLAR

DEPRESIÓN MAYOR (60%)

TR. PÁNICO

ESPECTRO PSICÓTICO

COMORBILIDAD: 50% DE LOS CASOS



FOBIA SOCIAL

GILLES DE LA TOURETTE

TR. ALIMENTARIOS

HIPOCONDRÍA

ALCOHOL, FÁRMACOS

TR. PERSONALIDAD

QUÉ ES EL TOC, EN QUÉ CONSISTE

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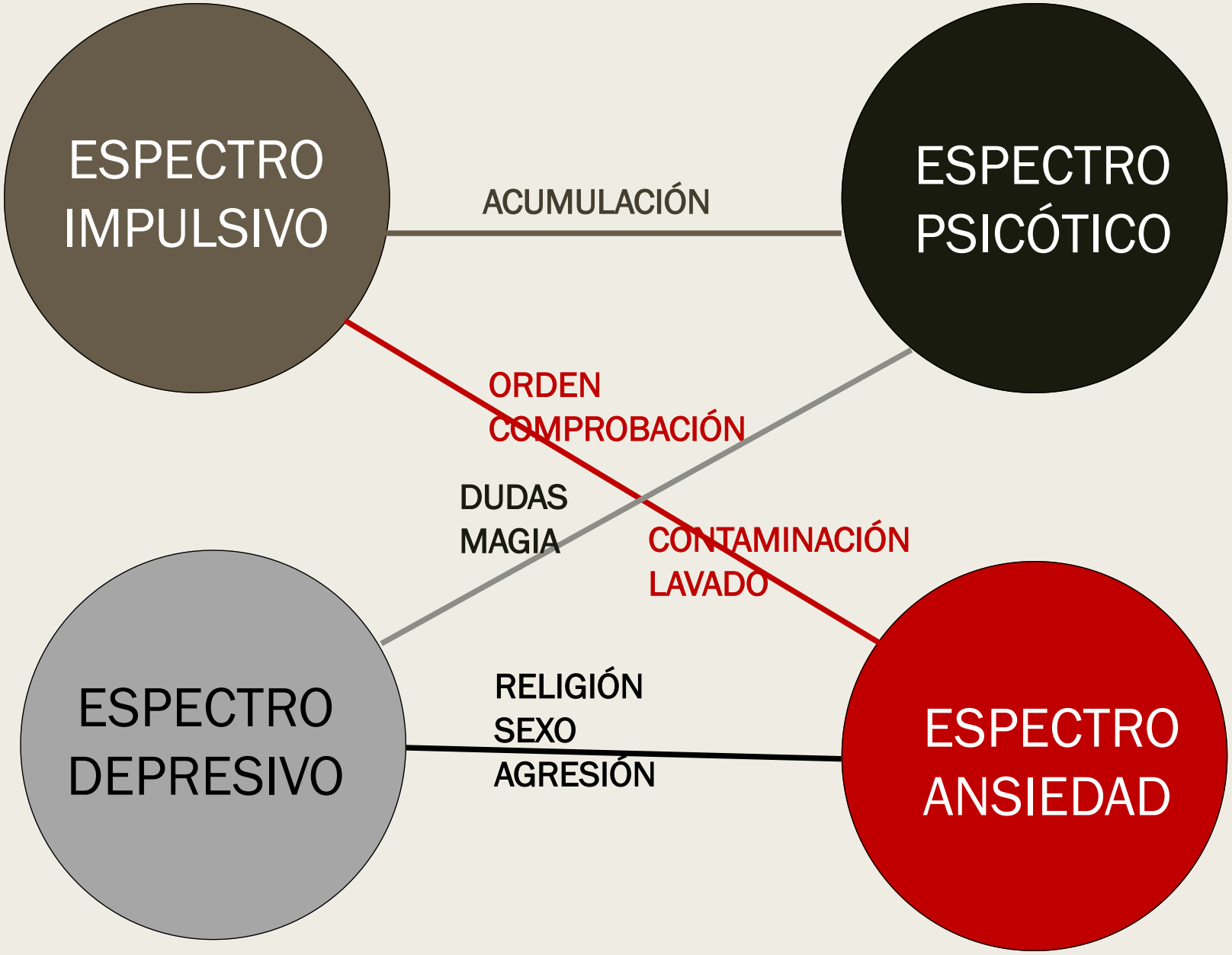
EL TOC, NO ES UN TRASTORNO UNITARIO

- *Ciertos subtipos o dimensiones de síntomas,*
  - *Más cercanos a la psicopatología ansiosa.*
  - *Otros más a la esfera depresiva.*
  - *Otros más a la esfera psicótica.*
  - *Otros más a los trastornos neurológicos (TiCs).*
  - *Otros más a los problemas de inhibición-control de impulsos.*
    - *.....*


ESPECTRO IMPULSIVO
ESPECTRO PSICÓTICO
ACUMULACIÓN
ORDEN
COMPROBACIÓN
DUDAS
MAGIA
CONTAMINACIÓN
LAVADO
ESPECTRO DEPRESIVO
RELIGIÓN
SEXO
AGRESIÓN
ESPECTRO ANSIEDAD

EL TOC, NO ES UN TRASTORNO UNITARIO

- *Ciertos subtipos o dimensiones de síntomas,*
  - *Más cercanos a la psicopatología ansiosa.*
  - *Otros más a la esfera depresiva.*
  - *Otros más a la esfera psicótica.*
  - *Otros más a los trastornos neurológicos (TiCs).*
  - *Otros más a los problemas de inhibición-control de impulsos.*
  - ***La respuesta al tratamiento difiere según subtipos***

EL TOC ES HETEROGÉNEO, PERO LOS SUBTIPOS O DIMENSIONES NO SE TIENEN EN CUENTA EN LAS GUÍAS CLÍNICAS (p.ej., NICE), NI EN ESTUDIOS DE EFICACIA

Journal of Anxiety Disorders 24 (2010) 573–580

Contents lists available at ScienceDirect

Journal of Anxiety Disorders

Cognitive therapy for autogenous and reactive obsessions: Clinical and cognitive outcomes at post-treatment and 1-year follow-up

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[b] Mental Health Outpatient Clinic, Department 05, Agencia Valenciana de Salud, Foios, Valencia, Spain
[c] Mental Health Outpatient Clinic, Department 06, Agencia Valenciana de Salud, Burjassot, Valencia, Spain
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Neutralizing Strategies

ABSTRACT

This study provides data about the differential effectiveness of cognitive therapy (CT) for obsessive-compulsive disorder (OCD) symptom presentation. Two OCD manifestations, autogenous and reactive, are considered. Seventy OCD patients started CT: 81.40% completed it and 72.85% were available 1 year later. Fifteen of the 57 treatment completers had autogenous obsessions, whereas 33 had reactive obsessions. Nine patients had both obsession modalities. Reactive patients were more severe, as they scored higher on thought suppression and on the dysfunctional beliefs of intolerance to uncertainty and perfectionism. Autogenous patients scored higher on the over-importance of thoughts beliefs. Although CT was effective in reducing OCD severity and the ascription to dysfunctional beliefs and neutralizing strategies in both the autogenous and the reactive patients, a significantly better outcome was observed for the autogenous patients, both at post-treatment (with 73.33% recovering versus 33.33% for reactives) and 1 year later.

1. Introduction

It is widely assumed by researchers and clinicians that obsessive–compulsive disorder (OCD) is a heterogeneous condition. OCD diversity is demonstrated through a broad range of obsessional contents and neutralizing strategies, response to the available treatments, age at onset, comorbidity, and family history, among others. In the last decade, the acknowledgment of this heterogeneity has led to efforts to establish subgroups of patients (e.g., Abramowitz, Franklin, Schwartz, & Furr, 2003; Calamari et al., 2004) or, alternatively, symptom dimensions that would adequately capture the OCD diversity (e.g., Bloch, Landeros, Rosario-Campos, Pittenger, & Leckman, 2008; Mataix-Cols, Rauch, Manzo, Jenike, & Baer, 1999; Mataix-Cols, Rosario-Campos, & Leckman, 2005; Summerfeldt, Richter, Antony, & Swinson, 1999).

A somewhat different approach to heterogeneity of OCD has been suggested by Lee and Kwon (2003). These authors have proposed a cognitive model that classifies obsessions into two subtypes, namely "autogenous" or "reactive" on the basis of the differences in their respective contents, emotional reactions, evaluative appraisals, neutralizing or control strategies, trigger stimuli, ego-dystonicity caused by the obsessions and/or compulsions, and the perceived rationality of the obsessive thought content (Lee & Telch, 2005). Common themes of autogenous obsessions would be highly aversive and unrealistic thoughts, images or impulses about aggressive, sexual, blasphemous, immoral or repulsive themes, which are perceived as highly ego-dystonic and elicit efforts to remove or control the thoughts themselves. These obsessions are activated without clearly perceived triggers, or by triggers only symbolically related to the thoughts. Autogenous themes resemble an OCD symptom dimension or, alternatively, an OCD subtype identified in most of the studies as "unacceptable" or "forbidden" thoughts (e.g., Abramowitz, Franklin, et al., 2003; Abramowitz, Whiteside, Kalsy, & Tolin, 2003; Bloch et al., 2008) or obsessions (e.g., Calamari et al., 2004). Moreover, the contents of the autogenous obsessions are consistent with Rachman (1997, 1998, 2003) proposal about obsessions without overt compulsive rituals. In contrast, reactive obsessions are relatively more realistic aversive thoughts, images or impulses, and the main source of perceived threat is not the obsession itself but its possible negative consequences. The main themes would be contamination, mistakes, accidents, asymmetry or disarray, and they lead to overt and/or covert behaviours aimed to avoid or prevent the feared consequences (e.g., washing, checking, ordering, arranging, repeating or counting actions).

Hypothesized differences between autogenous and reactive obsessions have received support in studies with non-clinical samples (Belloch, Morillo, & García Soriano, 2007; Lee, Lee, Kim, Kwon,

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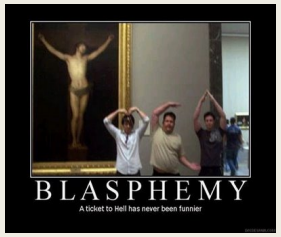
TCE VS. EPR SEGÚN SUBTIPOS: AUTÓGENOS VS. REACTIVOS

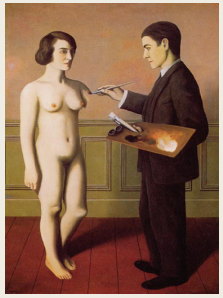
SUBTIPOS TOC

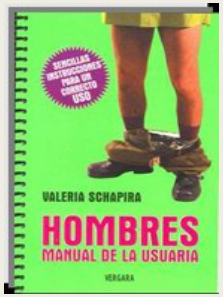
(Lee & Kwon, 2003)

Tipo I: AUTÓGENAS

Agresión, sexuales, religiosas/inmorales



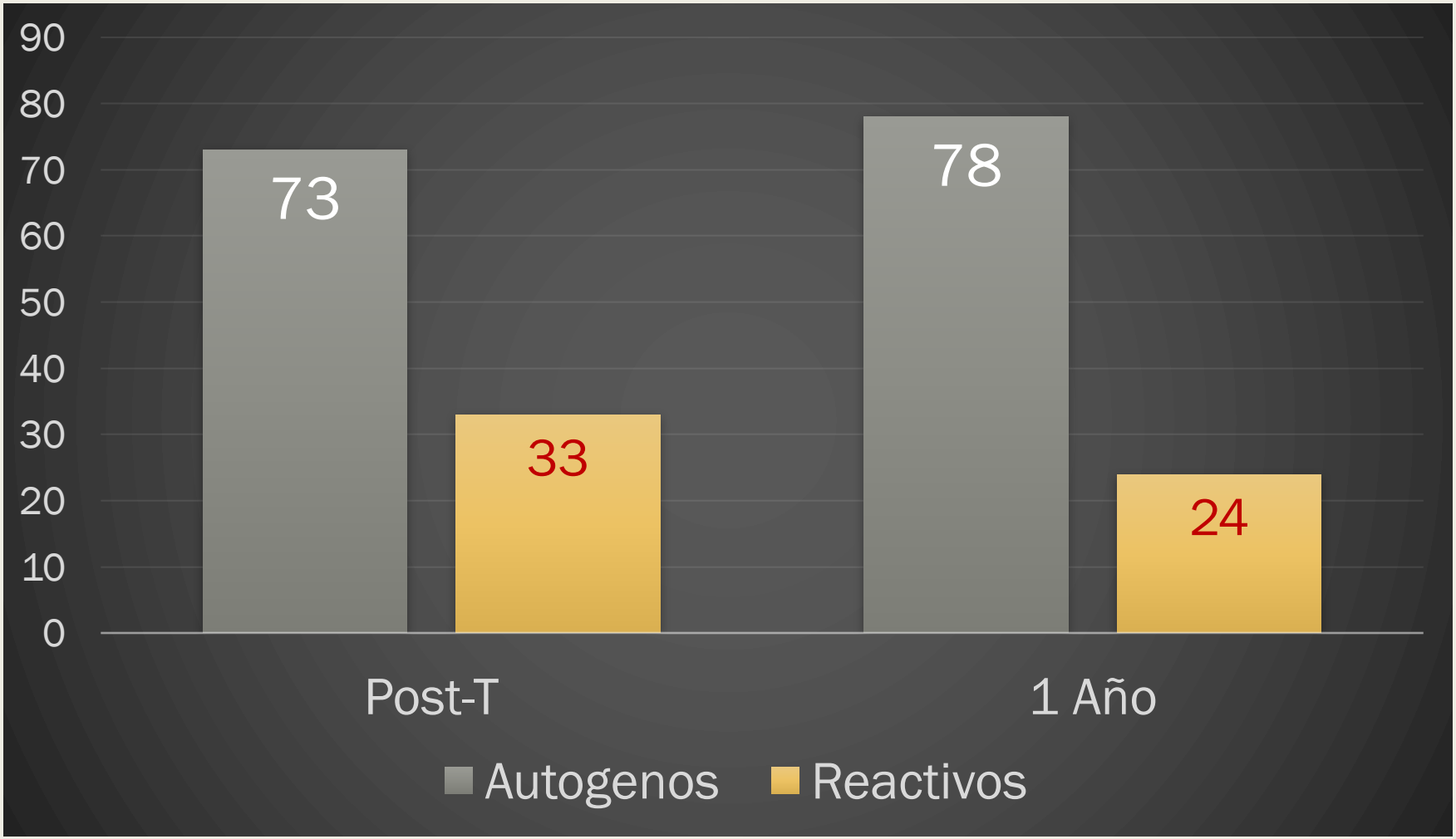




Tipo II. REACTIVAS

Contaminación-limpieza, dudas, orden, comprobación

% Recuperados (YBOCS)



LA ANSIEDAD NO ES SIEMPRE EL PRINCIPAL MOTIVADOR DE LOS SÍNTOMAS

1. *En un subgrupo de pacientes, las sensaciones físicas no ansiosas ("sensory phenomena"), las de incompletud y "not just right" son la fuente motivadora de las compulsiones.*
   - *En estos pacientes, la TCC requiere una adaptación específica: control de impulsos*

2. *El Asco (y no la ansiedad) es la emoción predominante en muchos pacientes de contaminación-lavado*

Psychiatry Research 236 (2016) 1–8

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Incompleteness and not just right experiences in the explanation of Obsessive–Compulsive Disorder

Amparo Belloch[a,b,*], Gertrudis Fornés[a,b], Angel Carrasco[b,c], Clara López-Solá[d,e], Pino Alonso[d,e], Jose M. Menchón[d,e]

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[b] Obsessive-Compulsive and Related Disorders Research Unit, I'TOC, Faculty of Psychology, University of Valencia, Valencia, Spain
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J. Behav. Ther. & Exp. Psychiat. 57 (2017) 103–112

Contents lists available at ScienceDirect

Journal of Behavior Therapy and Experimental Psychiatry

journal homepage: www.elsevier.com/locate/jbtep

Induced not just right and incompleteness experiences in OCD patients and non-clinical individuals: An in vivo study

Gertrudis Fornés-Romero, Amparo Belloch*

Department of Personality Psychology, Faculty of Psychology, Research and Treatment Unit for Obsessive-Compulsive and Related Disorders, I'TOC. University of Valencia, Spain

Cognitive Therapy and Research
https://doi.org/10.1007/s10608-019-10029-8

ORIGINAL ARTICLE

Not Just Right Experiences, Disgust Proneness and Their Associations to Obsessive–Compulsive Symptoms: A Stringent Test with Structural Equation Modeling Analysis

Claudio Sica[1] · Corrado Caudek[2] · Amparo Belloch[3] · Gioia Bottesi[4] · Marta Ghisi[4] · Gabriele Melli[5] · Gemma García-Soriano[3] · Bunmi O. Olatunji[6]

Abstract

El nº y la gravedad de las experiencias de incompletud o "not just right"…,

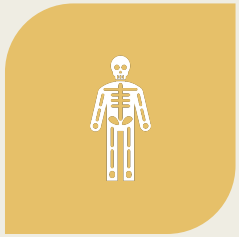
- Se asocian a mayor gravedad del TOC-compulsiones
- Se asocian con síntomas de orden y acumulación
- Mayores en pacientes más resistentes a tratamiento (TCC e ISRS)
- Predicen síntomas TOC (indicador vulnerabilidad)
- Más importantes que las creencias metacognitivas
- Más importantes que el Asco (*más asociación con síntomas TOC que el Asco)*

¿Subtipos o dimensiones de síntomas?

- Problemas para identificar subtipos homogéneos
- Muchos pacientes, síntomas de varios subtipos
  - *Transición de unos subtipos a otros a lo largo de la evolución del trastorno*
- Una misma obsesión (mismo contenido) da lugar a compulsiones diferentes:

  - *Ob. Agresivas:*
  - *Ob. Contaminación:*
  - *Ob. Sexuales:*

} *Compulsiones de: Lavado/limpieza, Comprobación, Orden, Reaseguro…*



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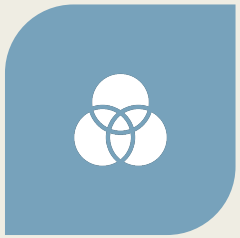

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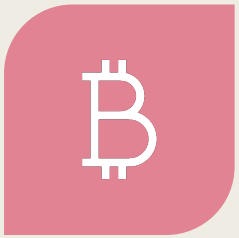
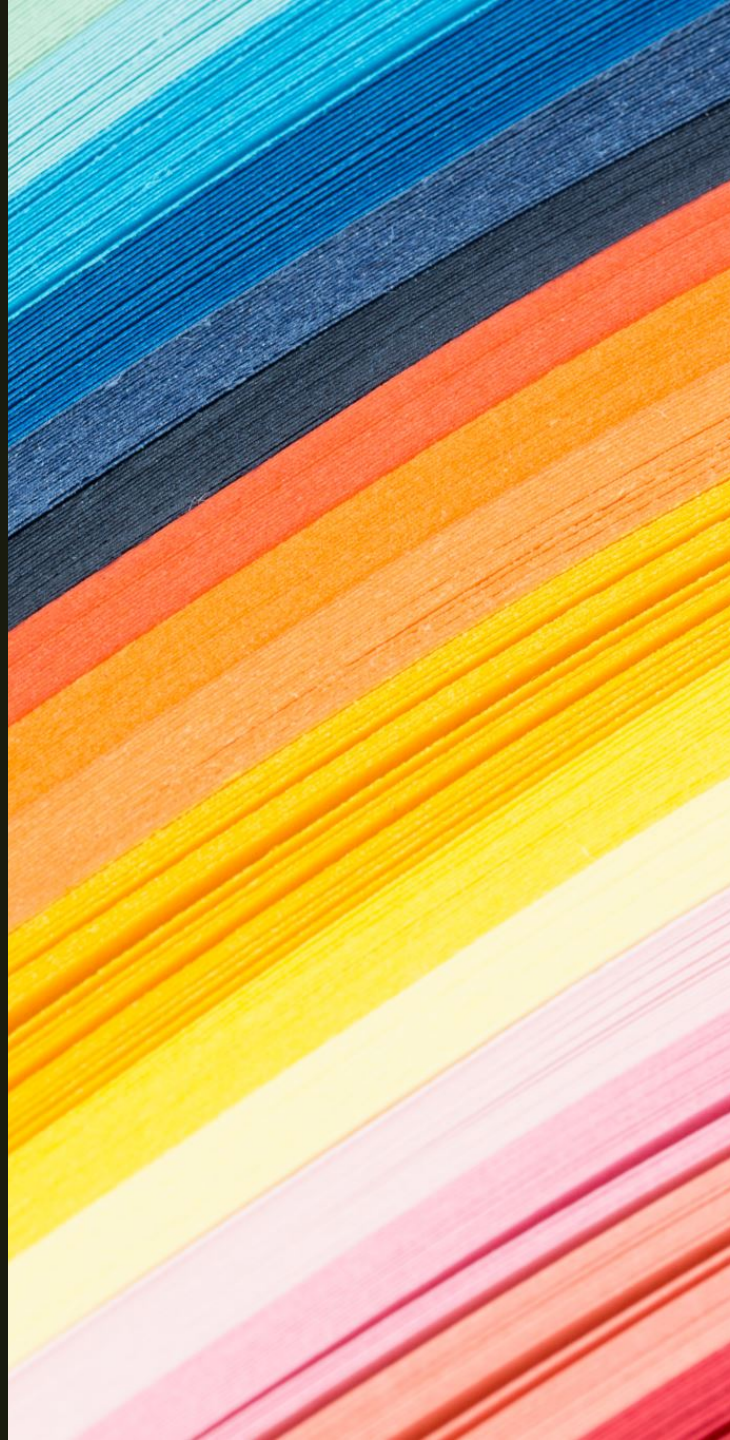


¿POR QUÉ SE PRODUCE?

¿TIENE TRATAMIENTO?

TRASTORNO MULTI-FACTORIAL

- ✓ FACTORES GENÉTICOS
- ✓ FACTORES NEUROLÓGICOS
- ✓ FACTORES NEUROQUÍMICOS
- ✓ FACTORES DE VIDA / HISTORIA PERSONAL
- ✓ OTROS TRASTORNOS
- ✓ FACTORES PSICOLÓGICOS



TOC: LA EXPLICACIÓN COGNITIVA

1

A) TODAS LAS PERSONAS TENEMOS PENSAMIENTOS INTRUSOS

B) LAS OBSESIONES SON UNA MODALIDAD DE PENSAMIENTOS INTRUSOS: P.I.OBSESIVOS

Clinical Psychology and Psychotherapy
Clin. Psychol. Psychother. 11, 100–110 (2004)

Intrusive Thoughts in Non-Clinical Subjects: The Role of Frequency Unpleasantness on Appraisal Ratings and Control Strategies

Amparo Belloch,*[1] Carmen Morillo,[1] Marle
Elena Cabedo[3] and Carmen Carrió[4]

[1]Department of Personality, University of Valencia, Spain
[2]Department of Psychology, University of San Luis, Arg
[3]Adult Mental-Health Outpatient Service, Area 4, Valen
[4]Adult Mental-Health Outpatient Service, Area 5, Valen

This study explores the frequency of the appe
thoughts in normal people, as well their associ
appraisals and control strategies. A total of 336 su
Spanish adaptation of the Obsessional Intrusio
(ROII), designed by Purdon and Clark (19
the subjects (99.4%) reported experiencing
sionally, but only 13% reported having th
The intrusions were included in two facto
socially inappropriate behaviours, and do
frequency of appearance of th
with the likelihoo

Journal of Obsessive-Compulsive and Related Disorders ▮ (▮▮▮▮) ▮▮▮–▮▮▮

Contents lists available at ScienceDirect

Journal of Obsessive-Compulsive and Related Disorders

journal homepage: www.elsevier.com/locate/jocrd

Part 1—You can run but you can't hide: Intrusive thoughts on six continents

Adam S. Radomsky[a,*], Gillian M. Alcolado[a], Jonathan S. Abramowitz[b], Pino Alonso[c], Amparo Belloch[d], Martine Bouvard[e], David A. Clark[f], Meredith E. Coles[g], Guy Doron[h], Hector Fernández-Álvarez[i], Gemma García-Soriano[d], Marta Ghisi[j], Beatriz Gómez[i]

Journal of Obsessive-Compulsive and Related Disorders 3 (2014) 280–291

Contents lists available at ScienceDirect

Journal of Obsessive-Compulsive and Related Disorders

journal homepage: www.elsevier.com/locate/jocrd

Part 2. They scare because we care: The relationship between obsessive intrusive thoughts and appraisals and control strategies across 15 cities ☆

Richard Moulding[a,b,*], Meredith E. Coles[c], Jonathan S. Abramowitz[d], Gillian M. Alcolado[e], Pino Alonso[f], Amparo Belloch[g], Martine Bouvard[h], David A. Clark[i], Guy Doron[j], Héctor Fernández-Álvarez[k], Gemma García-Soriano[g], Marta Ghisi[l], Beatriz Gómez[k], Mujgan Inozu[m], Adam S. Radomsky[e], Giti Shams[n], Claudio Sica[o], Gregoris Simos[p], Wing Wong[q]

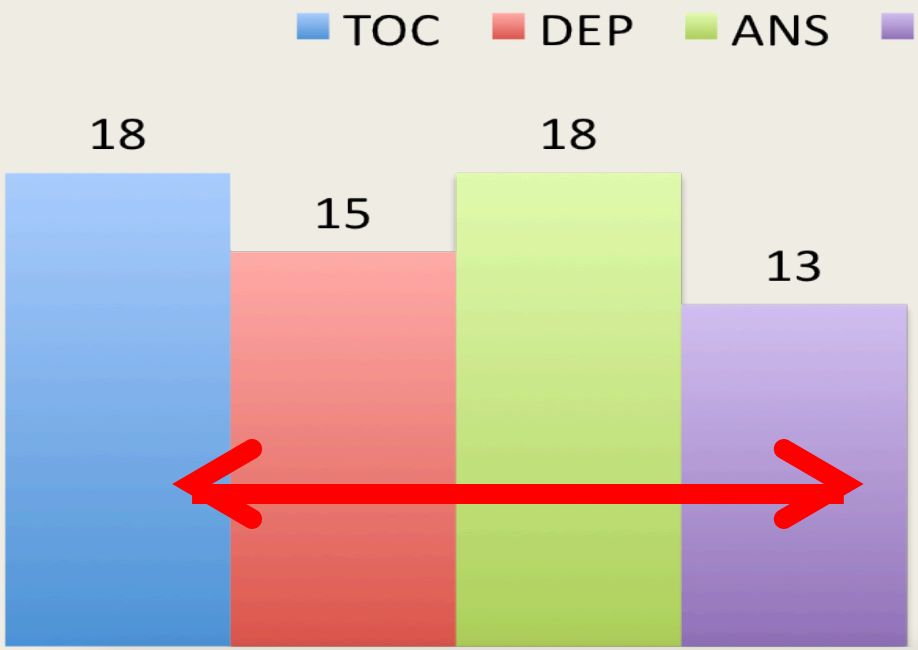
International Journal of Clinical and Health Psychology

Inter
of Clinical a

ORIGINAL ARTICLE

The cross-cultural and transdiagnostic nature of unwanted mental intrusions

Belén Pascual-Vera[a], Burcin Akin[b], Amparo Belloch[a,*], Gioia Bottesi[c], David A. Clark[d], Guy Doron[e], Héctor Fernández-Alvarez[f], Marta Ghisi[c], Beatriz Gómez[f], Mujgan Inozu[b], Antonia Jiménez-Ros[g], Richard Moulding[h], M. Angeles Ruiz[i], Giti Shams[j], Claudio Sica[k]



Nº PIOs

ELSEVIER

Available online at www.sciencedirect.com
ScienceDirect

Behaviour Research and Therapy 45 (2007) 1319–1333

BEHAVIOUR RESEARCH AND THERAPY

www.elsevier.com/locate/brat

Clinical obsessions in obsessive–compulsive patients and obsession-relevant intrusive thoughts in non-clinical, depressed and anxious subjects: Where are the differences?

Carmen Morillo[a], Amparo Belloch[b,*], Gemma García-Soriano[b]

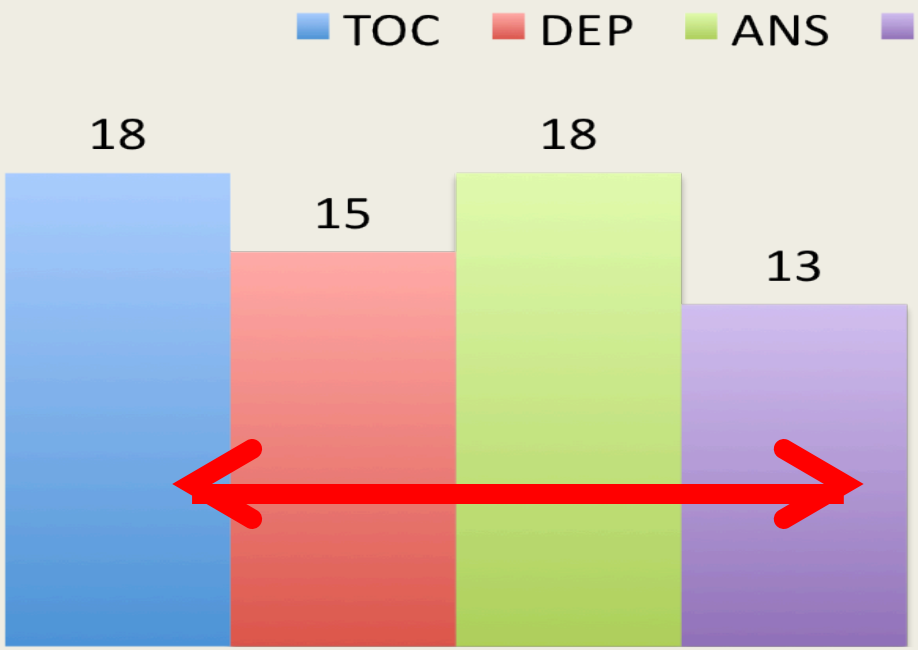
[a]*Faculty of Psychology. University Jaume I Castellón, Spain*
[b]*Faculty of Psychology, University of Valencia, Valencia, Spain*

Received 15 June 2006; received in revised form 21 November 2006; accepted 21 November 2006

2

SÓLO EN ALGUNOS CASOS, LOS PENSAMIENTOS INTRUSOS OBSESIVOS SE CONVIERTEN EN OBSESIONES

(Prevalencia vital : 2% - 3%)



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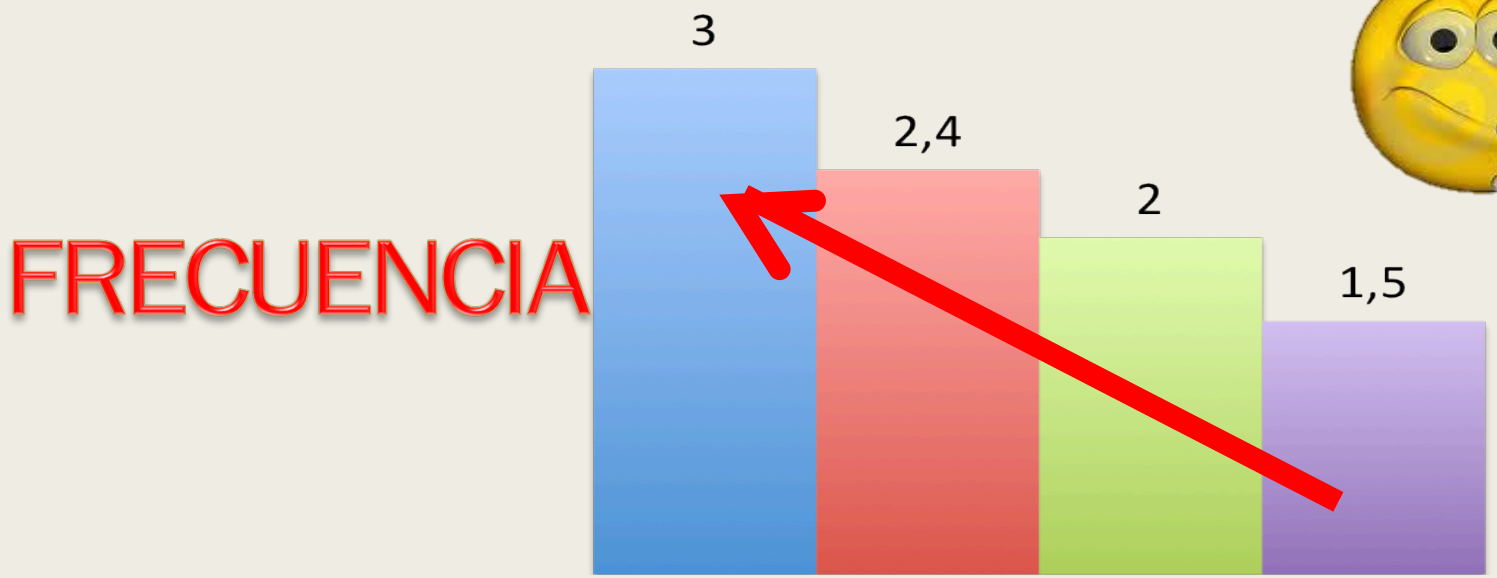
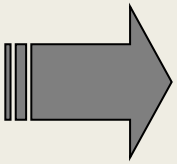


3

LOS PENSAMIENTOS INTRUSOS SE CONVIERTEN EN OBSESIONES CUANDO LA PERSONA:

(1º) LOS VALORA DE UN MODO DISFUNCIONAL



(2º) INTENTA CONTROLARLOS Y/O NEUTRALIZARLOS

Antecedentes familiares, aprendizajes y experiencias previas, vulnerabilidad genética, p

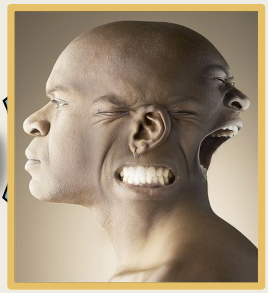
LÓGICO…

Estímulo (o suceso) desencadenante

Estado de ánimo alterado, malestar emocional

Intrusión mental no deseada de temática obsesiva (PIO)

Amenaza para el sí-mismo
Creencias disfuncionales sobre los PIO
Sensibilidad a la Ansiedad, al asco, etc..
Otras características personales (perfeccionismo, indecisión…)



OBSESIÓN

rebote

Fracaso control, o imposibilidad de persistir en control tiempo suficiente

Mejora malestar emocional

Sensación de Control

Valoraciones disfuncionales del PIO: Búsqueda /atribución de significado personal

Estrategias para controlar el PIO

Malestar emocional

Creencias disfuncionales típicas sobre las obsesiones

- “Si lo pienso (o siento), puede suceder”
- “Si lo pienso (o siento), es importante, he de hacerle caso”
  - “Si no hago lo que pienso (o siento) pasará algo malo”
- “Si no consigo parar este pensamiento (sensación, impulso…), sucederá”
- “Si lo pienso o lo siento, es verdadero”
- “Pensar algo peligroso, es peligroso”
- “Si lo pienso es porque quiero o puedo hacerlo”
- “Si fuera una persona normal, no pensaría estas cosas”
- “Pensar algo malo es lo mismo que hacerlo”

“si pienso que mis padres pueden tener un accidente y no les impido que vayan con el coche y luego les pasa algo, la culpa será mía”

“si no compruebo que he cerrado bien la puerta de mi casa y entran a robar cuando no esté, la culpa será mía”

“si pienso que se me puede clavar un cuchillo en un ojo es porque se me puede clavar”

“si pienso que he atropellado a alguien y no doy la vuelta para comprobarlo, soy mala persona”

“si siento asco cuando veo a un niño deforme, significa que me puede contagiar una enfermedad grave”

“si me viene la imagen de que golpeo a mi bebé, es porque soy mala y quiero golpearlo”

- “tener el impulso de empujar a alguien, es lo mismo que hacerlo”

“si pienso que puedo dar asco o ser rechazada por no ir muy limpia, tengo que asegurarme de que todo está muy limpio”

- “si pienso que puedo haber hecho algo malo a un niño, he de comprobar que no lo hice”

“si siento que debo hacer o comprobar algo y no lo hago, mi madre enfermará”

”si piso algo sucio en la calle y no me lavo enseguida, mi futuro marido se reencarnará en un cerdo después de muerto”

QUÉ ES EL TOC, EN QUÉ CONSISTE

¿CUÁNTAS PERSONAS LO SUFREN?

¿QUÉ IMPACTO TIENE EN LA VIDA DIARIA?

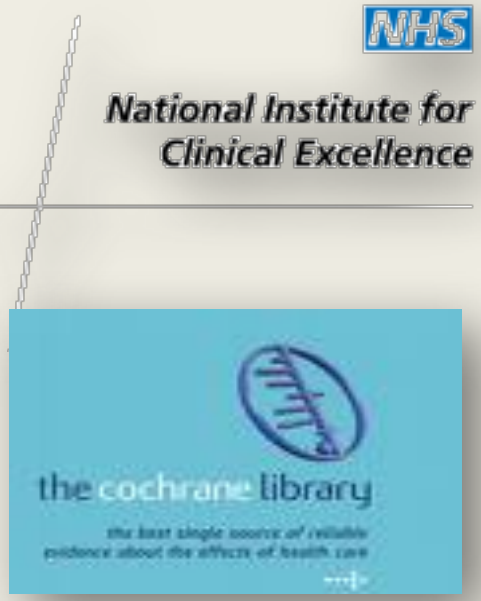
¿SON TODOS LOS CASOS IGUALES?

¿POR QUÉ SE PRODUCE?

¿TIENE TRATAMIENTO?

QUÉ NO HACER O NO DECIR

- “Intenta no pensar en esas cosas, distráete”
- ”No pienses (*hagas, digas*) tonterías”
- “Si te esforzaras un poco, no te pasaría nada de eso”
- ”Si no hubieras empezado a hacer esas cosas cuando te lo advertí, ahora no estarías así”
- “Cuando te vengan esas ideas, te dices: “Para, no pienses más en eso”
- “Lávate (u ordena, cuenta, comprueba…) solo cuando lo necesites”
- “Todos tenemos manías, no te preocupes, ya pasará, no hagas caso…”
- “Vale, yo lo haré, quédate tranquilo”
- Dar medicación o remitir al especialista sin explicar en qué consiste el TOC



- TCC TRATAMIENTO DE ELECCIÓN EN TODOS LOS NIVELES DE GRAVEDAD
- EPR (EXPOSICIÓN CON PREVENCIÓN DE RESPUESTA), COMPONENTE NECESARIO:
  - ✓ Habituación progresiva al malestar
  - ✓ Focalizada en rituales (*PR*)

Randomized, Placebo-Controlled Trial of Exposure and Ritual Prevention, Clomipramine, and Their Combination in the Treatment of Obsessive-Compulsive Disorder

Journal of Obsessive-Compulsive and Related Disorders 2 (2013) 207–218

Contents lists available at SciVerse ScienceDirect

Journal of Obsessive-Compulsive and Related Disorders

journal homepage: www.elsevier.com/locate/jocrd

An update on the efficacy of psychological treatments for obsessive–compulsive disorder in adults

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ARTICLE INFO

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Keywords:
Empirically supported
Psychological therapies
Randomized controlled trials
OCD
Qualitative review

ABSTRACT

We conducted a review to provide an update on the efficacy of psychological treatments for OCD in general and with regard to specific symptom presentations. The PubMed and PsycINFO databases were searched for randomized controlled trials (RCTs) published up to mid February 2012. Forty-five such studies were identified. Exposure and response prevention (ERP) and cognitive-behavioral therapy (CBT) were found to be efficacious and specific for OCD. More purely cognitive interventions that did not include ERP or behavioral experiments were found to be possibly efficacious, as were Acceptance and Commitment Therapy, Motivational Interviewing as an adjunct to the established treatments, Eye Movement Desensitization and Reprocessing, and Satiation Therapy. There was little support for Stress Management or Psychodynamic Therapy. Although the majority of the studies recruited mixed or unspecified samples of patients and did not test for moderation, CBT was efficacious for obsessional patients who lacked overt rituals. One more purely cognitive intervention named Danger Ideation Reduction Therapy was found to be possibly efficacious for patients with contamination obsessions and washing compulsions. Although ERP and CBT are the best established psychological treatments for OCD, further research is needed to help elucidate which treatments are most effective for different OCD presentations.

Figure 1: The stepped care model

Who is responsible for care?	What is the focus?	What do they do?
Step 6 Inpatient care or intensive treatment programmes CAMHS Tier 4	OCD or BDD with risk to life, severe self-neglect or severe distress or disability	Reassess, discuss options, care coordination, SSRI or clomipramine, CBT (including ERP), or combination of SSRI or clomipramine and CBT (including ERP), augmentation strategies, consider admission or special living arrangements
Step 5 Multidisciplinary care with expertise in OCD/BDD CAMHS Tier 3/4	OCD or BDD with significant comorbidity, or more severely impaired functioning and/or treatment resistance, partial response or relapse	Reassess, discuss options. **For adults:** SSRI or clomipramine, CBT (including ERP), or combination of SSRI or clomipramine and CBT (including ERP); consider care coordination, augmentation strategies, admission, social care. **For children and young people:** CBT (including ERP), then consider combined treatments of CBT (including ERP) with SSRI, alternative SSRI or clomipramine. For young people consider referral to specialist services outside CAMHS if appropriate
Step 4 Multidisciplinary care in primary or secondary care CAMHS Tier 2/3	OCD or BDD with comorbidity or poor response to initial treatment	Assess and review, discuss options. **For adults:** CBT (including ERP), SSRI, alternative SSRI or clomipramine, combined treatments. **For children and young people:** CBT (including ERP), then consider combined treatments of CBT (including ERP) with SSRI, alternative SSRI or clomipramine
Step 3 GP, primary care team, primary care mental health worker, family support team CAMHS Tier 1/2	Management and initial treatment of OCD or BDD	Assess and review, discuss options. **For adults according to impairment:** Brief individual CBT (including ERP) with self-help materials (for OCD), individual or group CBT (including ERP), SSRI, or consider combined treatments; consider involving the family/carers in ERP. **For children and young people:** Guided self-help (for OCD), CBT (including ERP), involve family or carers and consider involving school
Step 2 GP, practice nurses, school health advisers, health visitors, general health settings (including hospitals) CAMHS Tier 1	Recognition and assessment	Detect, educate, discuss treatment options, signpost voluntary support organisations, provide support to individuals/families/work/schools, or refer to any of the appropriate levels
Step 1 Individuals, public organisations, NHS	Awareness and recognition	Provide, seek and share information about OCD BDD and its impact on individualsand families/carers

- 69% mejoría clínicamente significativa
- 38% recuperación
- 76% mantienen ganancia al año
- EPR + Farmacoterapia:
  - ✓ *No más eficaz que solo ERP*
  - ✓ *Reduce más recaídas que solo Farmacoterapia*
- ERP *vs*. Farmacoterapia: mejoría más sostenida en el tiempo con ERP
- EPR + Farmacoterapia: si DM comórbida

EPR: Problemas

Journal of Obsessive-Compulsive and Related Disorders 1 (2012) 251–257

Contents lists available at SciVerse ScienceDirect

Journal of Obsessive-Compulsive and Related Disorders

journal homepage: www.elsevier.com/locate/jocrd

Clinical Report

Common pitfalls in exposure and response prevention (EX/RP) for OCD

Seth J. Gillihan [a,*], Monnica T. Williams [b], Emily Malcoun [a], Elna Yadin [a], Edna B. Foa [a]

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[b] Center for Mental Health Disparities, University of Louisville, 2301 South Third Street, Louisville, KY 40292 USA

- ✓ Síntomas residuales en post-tratamiento *(Whittal & McLean, 2002)*
- ✓ Incluso combinado con Farmacoterapia, 25% recaen y 25% no mejoran
- ✓ **20-30% rehúsan**
- ✓ **3-12% abandonan**
- ✓ La mayoría de estudios con comprobadores y lavadores
- ✓ Tasas muy altas de abandono con otros subtipos (acumuladores) (*Mataix et al., 2002)*

PRACTICE GUIDELINE FC

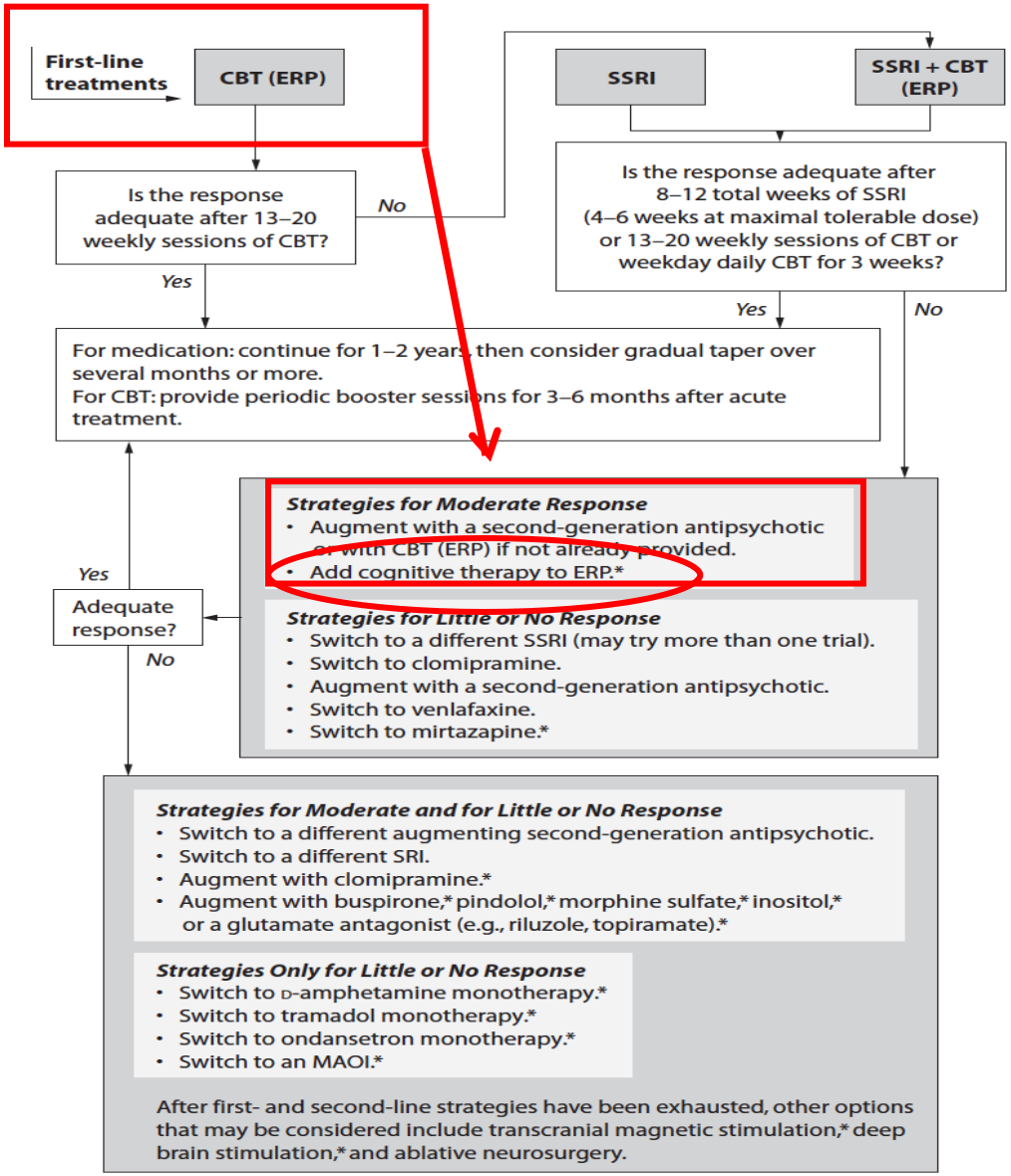
Treatment of Patien

Obsessive-Compulsi

WORK GROUP ON OBSESSIVE-COMPULSIVE DISORDER

Lorrin M. Koran, M.D., Chair
Gregory L. Hanna, M.D.
Eric Hollander, M.D.
Gerald Nestadt, M.D.
Helen Blair Simpson, M.D., Ph.D.

Practice Guideline for the Treatment of Patients With Obsessive-Compulsive Disorder



OBJETIVOS TRATAMIENTO COGNITIVO-CONDUCTUAL

Dejar de HACER "lo que sea" para :

- Impedir el malestar (ansiedad) que provoca la O cuando aparece
- Evitar que aparezca la Obsesión

EPR

Resituar LAS OBSESIONES en su contexto:

pensamientos desagradables que provocan malestar

TCE

Terapia Cognitiva Específica

- Normalización de las obsesiones:
  - ✓ Intrusiones mentales desagradables, universalidad, …
- Explicación de las creencias disfuncionales que mantienen el TOC
- Debate/discusión con el paciente sobre las creencias que mantiene realmente:
  - ✓ *Búsqueda de explicaciones alternativas, probabilidades de ocurrencia de lo temido, etc..*
- "Experimentos conductuales" entre sesiones: Poner a prueba lo aprendido en la vida real
- 1 hora/semana en 6 - 8 meses consecutivos
- Requiere formación en TCE
- Siempre que sea possible, implicación familiar (evitar acomodación, co-terapeutas, registros, etc.)

Behavioural and Cognitive Psychotherapy, 2008, 36, 521–540
Printed in the United Kingdom First published online 19 June 2008 doi:10.1017/S1352465808004451

Empirically Grounded Clinical Interventions

Cognitive Versus Behaviour Therapy in the Individual Treatment of Obsessive-Compulsive Disorder: Changes in Cognitions and Clinically Significant Outcomes at Post-Treatment and One-Year Follow-Up

Amparo Belloch

University of Valencia, Spain

Elena Cabedo

Agencia Valenciana de Salud, Spain

Carmen Carrió

Diputacion de Valencia, Spain

Behavioural and Cognitive Psychotherapy, 2010, 38, 227–232
First published online 22 December 2009 doi:10.1017/S135246580999066X

Group Versus Individual Cognitive Treatment for Obsessive-Compulsive Disorder: Changes in Severity at Post-Treatment and One-Year Follow-up

Elena Cabedo

Agencia Valenciana de Salud, USM Foios, Spain

Amparo Belloch

University of Valencia, Spain

Carmen Carrió

Agencia Valenciana de Salud, USM Burjassot, Spain

Christina Larsson

Agencia Valenciana de Salud, USM Vinaroz, Spain

Héctor Fernández-Alvarez and Fernando García

Aiglé Institute, Buenos Aires, Argentina

Journal of Anxiety Disorders 24 (2010) 573–580

Contents lists available at ScienceDirect

Journal of Anxiety Disorders

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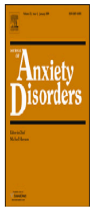


Cognitive therapy for autogenous and reactive obsessions: Clinical and cognitive outcomes at post-treatment and 1-year follow-up

Amparo Belloch[a,*], Elena Cabedo[b], Carmen Carrió[c], Christina Larsson[d]

Contents lists available at ScienceDirect

Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

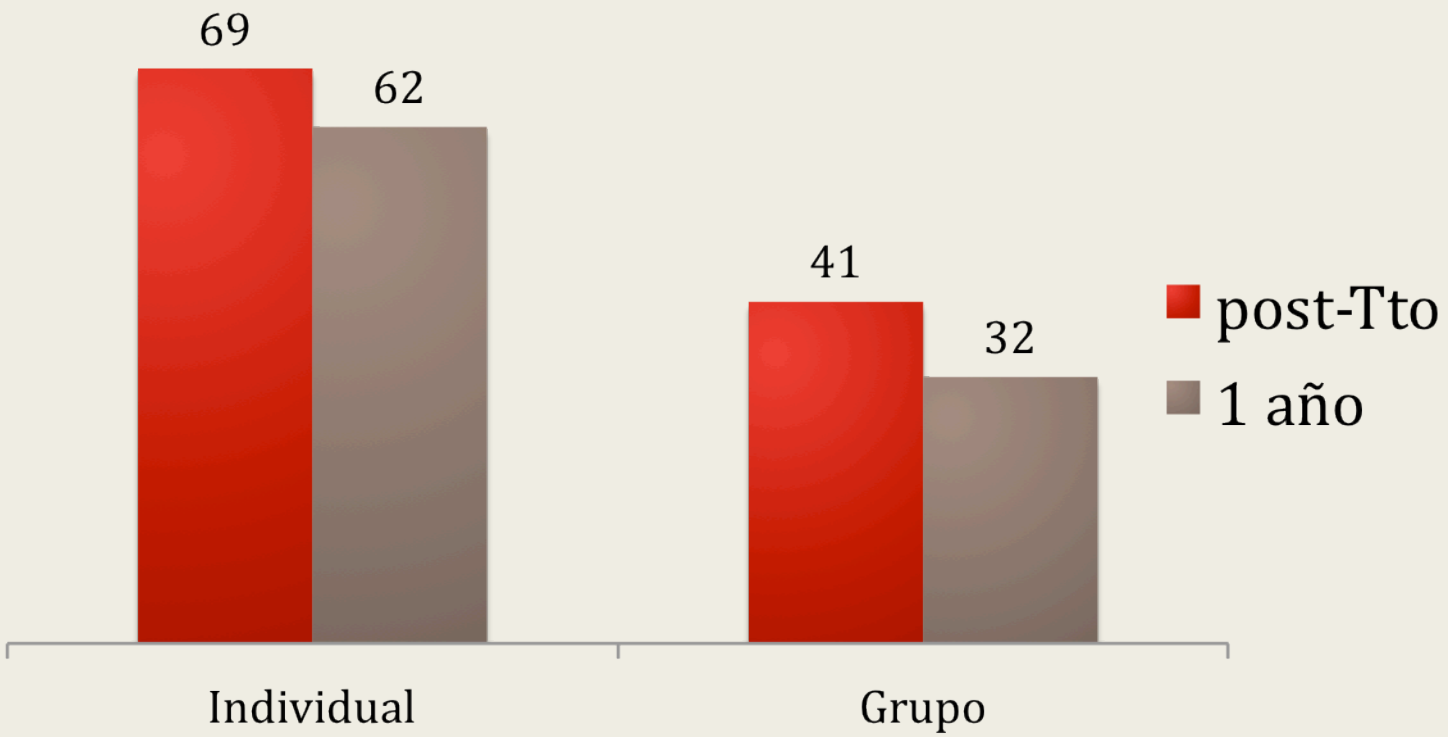
ELSEVIER

Group versus individual cognitive treatment for Obsessive-Compulsive Disorder: Changes in non-OCD symptoms and cognitions at post-treatment and one-year follow-up

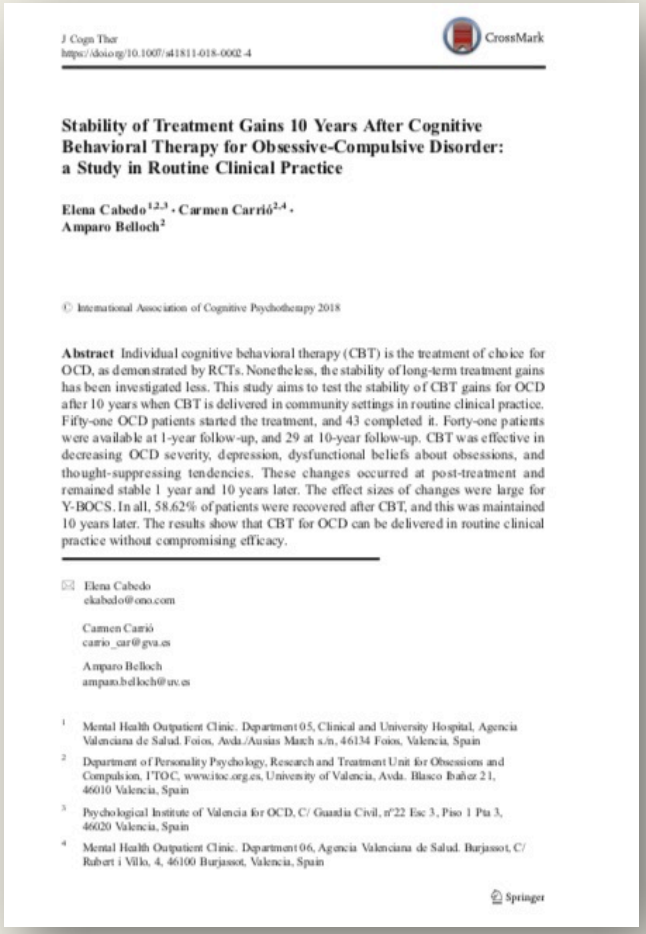
Amparo Belloch[a,*], Elena Cabedo[b], Carmen Carrió[c], Héctor Fernández-Alvarez[d], Fernando García[d], Christina Larsson[e]

Estudios con pacientes tratados en “la pública” (SNS o I’TOC)

TCE: ¿% RECUPERADOS?



- Individual, claramente superior
- Grupo, tasa de recuperación similar a EPR
- Individual, tasa de recuperación superiores a EPR



J Cogn Ther
https://doi.org/10.1007/s41811-018-0002-4

CrossMark

Stability of Treatment Gains 10 Years After Cognitive Behavioral Therapy for Obsessive-Compulsive Disorder: a Study in Routine Clinical Practice

Elena Cabedo[1,2,3] · Carmen Carrió[2,4] · Amparo Belloch[2]

Abstract Individual cognitive behavioral therapy (CBT) is the treatment of choice for OCD, as demonstrated by RCTs. Nonetheless, the stability of long-term treatment gains has been investigated less. This study aims to test the stability of CBT gains for OCD after 10 years when CBT is delivered in community settings in routine clinical practice. Fifty-one OCD patients started the treatment, and 43 completed it. Forty-one patients were available at 1-year follow-up, and 29 at 10-year follow-up. CBT was effective in decreasing OCD severity, depression, dysfunctional beliefs about obsessions, and thought-suppressing tendencies. These changes occurred at post-treatment and remained stable 1 year and 10 years later. The effect sizes of changes were large for Y-BOCS. In all, 58.62% of patients were recovered after CBT, and this was maintained 10 years later. The results show that CBT for OCD can be delivered in routine clinical practice without compromising efficacy.

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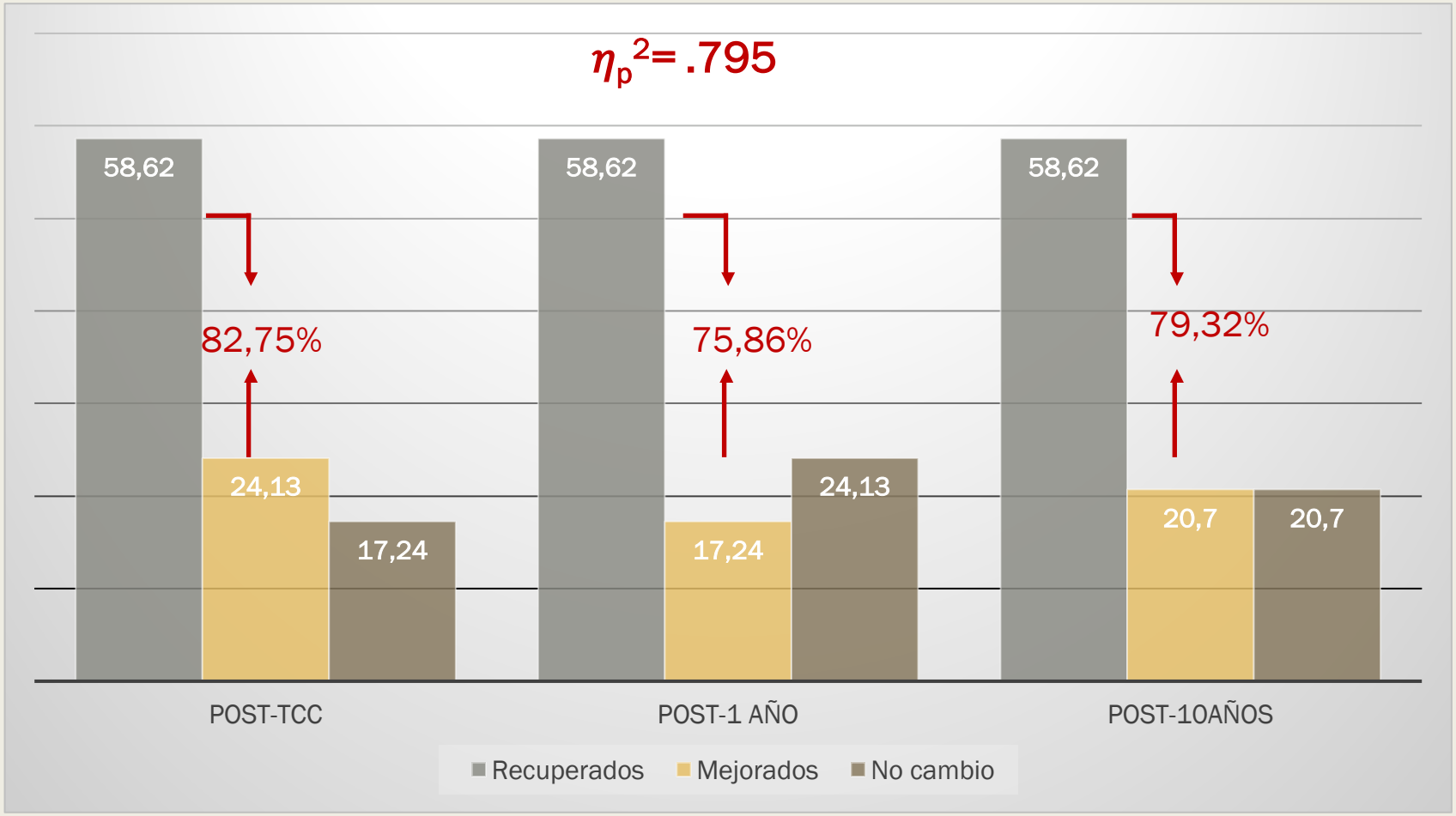
[4] Mental Health Outpatient Clinic. Department 06, Agencia Valenciana de Salud. Burjassot, C/ Rubert i Villo, 4, 46100 Burjassot, Valencia, Spain

LA TCE MANTIENE EFICACIA A LARGO PLAZO

CAMBIO CLÍNICO Y ESTABILIDAD (YBOCS)



- LOS CAMBIOS SE PRODUCEN EN EL POST- TCC
- Y SE MANTIENEN ESTABLES 10 AÑOS DESPUÉS

...Y HAY NUEVAS ESTRATEGIAS DE TRATAMIENTO PROMETEDORAS

Revista de Psicopatología y Psicología Clínica Vol. 19, N.º 1, pp. 37-44, 2014
www.aepcp.net ISSN 1136-5420/14

VIRTUAL REALITY EXPOSURE FOR OCD: IS IT FEASIBLE?

AMPARO BELLOCH[1], ELENA CABEDO[2], CARMEN CARRIÓ[3], JOSE A. LOZANO-QUILIS[4], JOSE A. GIL-GÓMEZ[4], AND HERMENEGILDO GIL-GÓMEZ[4]

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Abstract: Virtual reality exposure therapy (VRET) is receiving increased attention, especially in the fields of anxiety and eating disorders. This study is the first trial examining the utility of VRET from the perspective of OCD patients. Four OCD women assessed the sense of presence, emotional engagement, and reality judgment, and the anxiety and disgust levels they experimented in four scenarios, called the Contaminated Virtual Environment (COVE), in which they had to perform several activities. The COVE scenarios were presented on a Full HD 46in TV connected to a laptop and to a Kinect device. Results indicate that the COVE scenarios generated a good sense of presence. The anxiety and disgust levels increased as the virtual contamination increased, and the anxiety produced was related to the emotional engagement and sense of presence.

Keywords: Virtual reality; virtual exposure therapy; obsessive-compulsive disorder; contaminated virtual environment; anxiety disorders.

Exposición mediante realidad virtual para el TOC: ¿Es factible?

Resumen: La Exposición mediante Realidad Virtual (ERV) está recibiendo una atención cada vez mayor, especialmente para los trastornos de ansiedad y los alimentarios. Este estudio es el primer ensayo que evalúa la utilidad de la ERV desde la propia perspectiva de pacientes con Trastorno Obsesivo-Compulsivo (TOC). Cuatro mujeres con TOC evaluaron la sensación de presencia, implicación emocional, el juicio de realidad, y los niveles de ansiedad y asco que experimentaban en cuatro escenarios virtuales, que denominamos Entorno Virtual Contaminado (EVCO), en los que debían realizar varias actividades. Los escenarios se presentaron en una TV Full HD de 46'', conectada a un ordenador y a un dispositivo Kinect. Los resultados indican que EVCO produjo una buena sensación de presencia. Los niveles de ansiedad y asco aumentaron a medida que aumentaba la «contaminación» de los escenarios, y la ansiedad se asoció con la sensación de presencia y la implicación emocional.

Palabras clave: Realidad virtual; terapia de exposición virtual; trastorno obsesivo-compulsivo; entorno virtual contaminado; trastornos de ansiedad.

INTRODUCTION

Cognitive-Behaviour Therapy is the empirically established therapy of choice for Obsessive-Compulsive Disorder (OCD) (e.g., Abramowitz, 1997; American Psychiatric Association, 2007; NICE, 2005), and exposure and response prevention (ERP) is an essential treatment component. Nonetheless, published controlled studies and meta-analyses report that nearly 50% of patients do not respond to CBT as expected, even when pharmacotherapy is added (Cottraux, Bouvard, & Milliery, 2005; Eddy, Dutra, Bradley, & Westen, 2004; Leonard et al., 1993; Stanley & Turner, 1995). A large percentage of non-responders refuse or drop out of ERP (near 20%), do not reach clinically sig-

Recibido: 9 diciembre 2013; aceptado 15 enero 2014.

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A novel approach to challenging OCD related beliefs using a mobile-app: An exploratory study

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ARTICLE INFO

Keywords:
Obsessive compulsive disorder (OCD)
Cognitive therapy
Maladaptive beliefs
Mobile apps
Relationships

ABSTRACT

Background and objectives: According to cognitive models, obsessive compulsive symptoms result from catastrophic misinterpretations of commonly occurring intrusive experiences and the use of counterproductive strategies to manage them. Obsessive Compulsive Disorder (OCD) related beliefs such as inflated responsibility, importance of thoughts and perfectionism increases the likelihood of such misinterpretations. Consistent with a growing body of literature supporting the usefulness of mobile delivered technologies in fostering cognitive behavior change, the present study assessed the effectiveness of a novel cognitive training exercise designed to challenge OCD-related beliefs. This mobile app training exercise consists of users having to pull statements challenging OCD-beliefs towards themselves (downwards) and to throw away (push upwards) contra-productive self-statements.

Methods: 36 third-year BA students started the trial. Twenty completed pre and post measures of OCD-beliefs, mood and OCD symptoms including relationship-obsessions. Participants were instructed to complete 3min of daily training for a period of 15 days.

Results: No significant differences were found between completers and non-completers on demographic and most symptom related measures at Time 1. Repeated-measures MANOVA of the 20 completers showed a significant reduction on all OCD symptoms measures and on OCD-beliefs. No significant reduction was found in depression symptoms. Regression analysis showed changes in levels of OCD-beliefs was associated with reduction in OCD symptoms at Time 2 over and above OCD symptoms at Time 1.

Limitations: The study is an open trial with non-clinical participants.

Conclusions: This mobile delivered training exercise may be useful for the reduction and relapse prevention of OCD-related beliefs and symptoms.

1. Introduction

Obsessive-Compulsive Disorder (OCD) is an incapacitating disorder defined by persistent unwanted and disturbing intrusive thoughts, images or urges (obsessions), and/or ritualistic and repetitive acts (compulsions; American Psychiatric Association, 2013). OCD may include a variety of themes such as scrupulosity, repugnant obsessions, moral and physical contamination fears and cleaning compulsions and relationship-related obsessions (e.g., Abramowitz & Jacoby, 2014; Doron, Derby, & Szepsenwol, 2014).

Cognitive behavior therapy (CBT) has been shown to be an effective OCD treatment (NICE, 2005). According to cognitive models of OCD, obsessions and compulsion are the result of the mismanagements of commonly occurring intrusive thoughts, images and urges (Clark & Radomsky, 2014; Rachman & de Silva, 1978; Salkovskis, 1985). Catastrophic misinterpretation of such intrusive experiences and the use of counterproductive cognitive and behavioural strategies to manage them lead to their escalation into chronic obsessions.

Several maladaptive beliefs have been associated with increased catastrophical interpretations of intrusions, such as responsibility, overimportance of thoughts, desire to control one's thoughts, overestimation of threat, need for certainty, and perfectionism (OCCWG., 1997, 2005). Indeed, CBT includes a variety of strategies for challenging OCD-related beliefs including psychoeducation regarding their role in the maintenance of OCD, cognitive reconstruction, Exposure and Response Prevention (ERP), behavioral experiments and more recently cognitive bias modification (CBM). These strategies facilitate the processing of alternative explanations of events, thoughts and emotions, allowing clients to re-evaluate their rigid maladaptive beliefs and reduce compulsive behaviors (e.g., Abramowitz, 2006; Teachman, Beadel, &

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Journal of Medical Internet Research

The leading peer-reviewed journal for digital medicine, and health & healthcare in the Internet age

Assisting relapse prevention in OCD using a novel mobile app-based intervention: A case report.

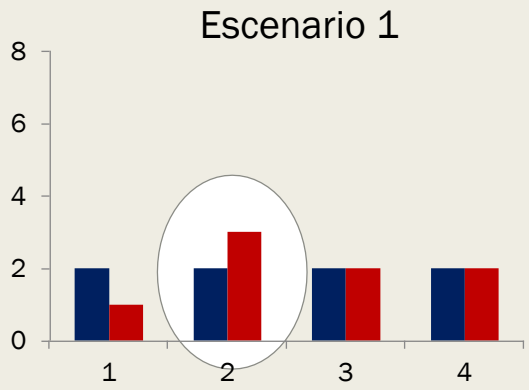
Pascual-Vera, B., Roncero, M., Doron, G., & Belloch, A.

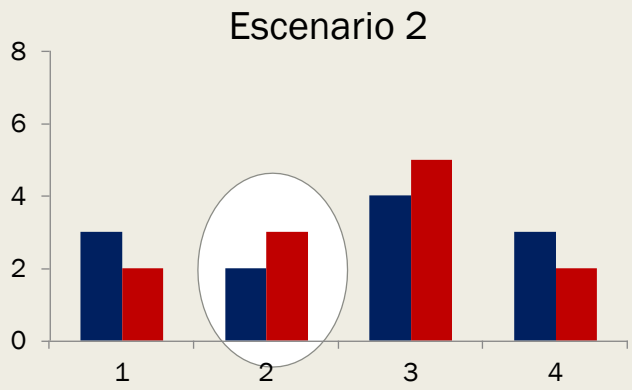
EPR-TC MEDIANTE REALIDAD VIRTUAL

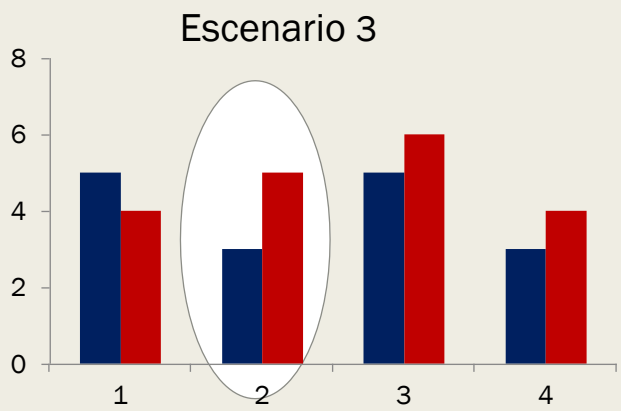
4 Mujeres con TOC- Contaminación/lavado

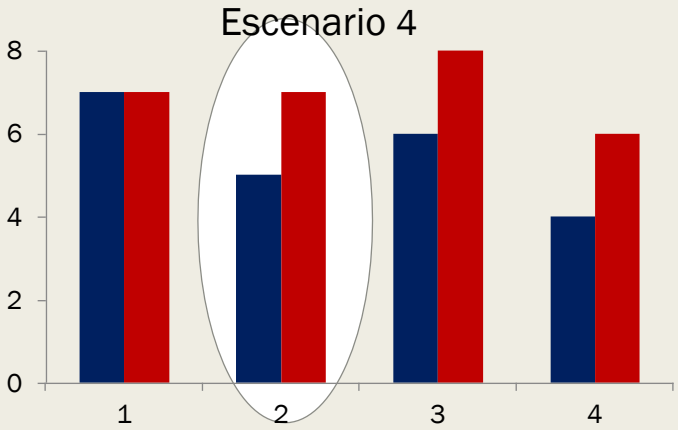
Datos	# 1	# 2	# 3	# 4
Edad	22	42	22	38
Estudios	Universidad	Medios	Universidad	Medios
Y-BOCS pre-	20	30	17	21
Y-BOCS actual	3	20	6	3
Fase de TCC	Post-3 meses	En tto. CTE Rehúsa EPR	Post- TCC CBT	Post-3 meses
Medicación	Ninguna	Ninguna	Ninguna	Ninguna

Ansiedad y Asco









Journal of Behavior Therapy and Experimental Psychiatry

A novel approach to challenging OCD related beliefs using a mobile-app: An exploratory study

María Roncero*, Amparo Belloch*, Guy Doron**

ARTICLE INFO

ABSTRACT

1. Introduction

DESARROLLO Y PUESTA A PRUEBA DE UNA APP- MÓVIL PARA EL CAMBIO DE CREENCIAS DISFUNCIONALES RELACIONADAS CON TOC

- 20 ESTUDIANTES UTILIZAN LA APP DURANTE 15 DÍAS
- 3 MINUTOS/DÍA

MEDIDAS	PRE-APP M (SD)	POST-APP M (SD)	$F_{(1,19)}$	p	*d*
CREENCIAS	2.96 (1.14)	2.23 (0.91)	16.69	.001	0.71
SINTOMAS TOC	1.72 (0.39)	1.42 (0.34)	21.13	<.001	0.85
DEPRESIÓN	1.51 (0.51)	1.41 (0.34)	1.69	.21	0.23

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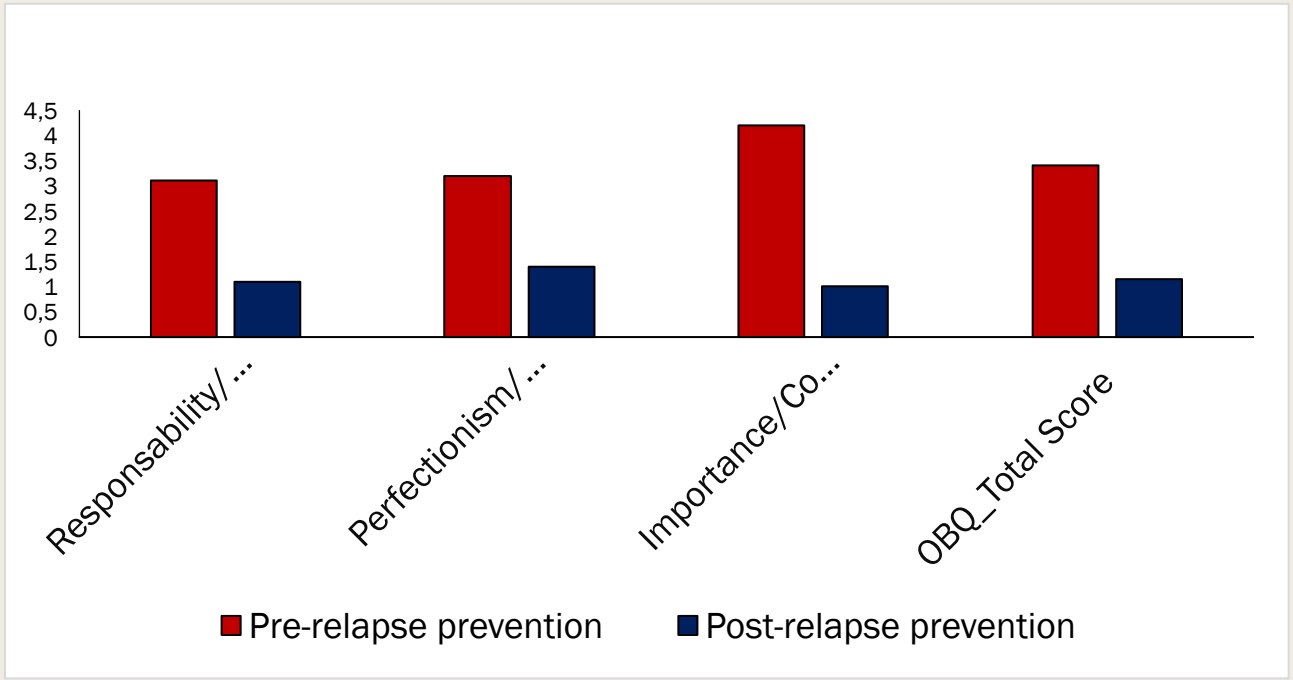
Pascual-Vera, B., Roncero, M., Doron, G., & Belloch, A.

PUESTA A PRUEBA DE LA APP COMO SUSTITUTO DE 2 SESIONES DE PREVENCIÓN DE RECAÍDAS EN 1 PACIENTE



TERAPIAS DE TERCERA GENERACIÓN

J Anal Res Clin Med, 2016, 4(4), 196-202.
doi: 10.15171/jarcm.2016.033, *http://journals.tbzmed.ac.ir/JARCM*

Original Article

Is mindfulness a mediator factor in obsessive compulsive disorder?

Fatemeh Alem-Dianati[1], Naeimeh Moheb[*2], Shahrokh Amiri[3]

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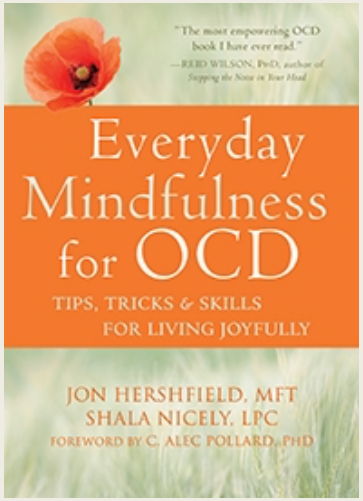
Keywords:
Cognitive Emotion Regulation Questionnaire, Mindfulness-Based Cognitive Therapy, Obsessive Compulsive Disorder, Positive Reappraisal

Abstract
Introduction: The aim of this study was to determine the effectiveness of mindfulness-based cognitive therapy (MBCT) on positive reappraisal in patients suffering from obsessive compulsive disorder (OCD).
Methods: The research design was quasi-experimental of pre-test and post-test type with control group. The statistical population of present study involved all patients referring to psychiatry clinics of Tabriz University of Medical Sciences who received obsessive-compulsive disorders diagnosis. Thirty available patients were selected that filled cognitive emotion regulation questionnaire (CERQ) after being randomly assigned to experimental and control groups. The experimental group attended 8 sessions of MBCT. The cognitive emotional regulation questioner was administered after completion of the sessions and data of both states (before and after sessions) were collected and analyzed using covariance analysis test.
Results: The MBCT was effective in increasing positive strategies (positive reappraisal, positive refocusing, planning, putting into perspective) and decreasing negative strategies (self-blame, blaming others, catastrophizing, rumination, and acceptance) in patients with obsessive-compulsive disorder ($P < 0.05$).
Conclusion: This study indicated that it is possible to increase positive strategies of emotion regulation through training MBCT.

Citation: Alem-Dianati F, Moheb N, Amiri S. **Is mindfulness a mediator factor in obsessive compulsive disorder?** J Anal Res Clin Med 2016; 4(4): 196-202. Doi: 10.15171/jarcm.2016.033



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Challenges using motivational interviewing as an adjunct to exposure therapy for obsessive-compulsive disorder

Helen Blair Simpson[a,b,*], Allan M. Zuckoff[c,d], Michael J. Maher[a], Jessica R. Page[a], Martin E. Franklin[e], Edna B. Foa[e], Andrew B. Schmidt[a], Yuanjia Wang[f]

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Strauss *et al. Trials* (2015) 16:167
DOI 10.1186/s13063-015-0664-7

TRIALS

STUDY PROTOCOL Open Access

Mindfulness-based exposure and response prevention for obsessive compulsive disorder: study protocol for a pilot randomised controlled trial

Clara Strauss[1,2*], Claire Rosten[3], Mark Hayward[1,2], Laura Lea[2], Elizabeth Forrester[4] and Anna-Marie Jones[2,3]

Abstract
Background: Obsessive Compulsive Disorder (OCD) is a distressing and debilitating condition affecting 1-2% of the population. Exposure and response prevention (ERP) is a behaviour therapy for OCD with the strongest evidence for effectiveness of any psychological therapy for the condition. Even so, only about half of people offered ERP show recovery after the therapy. An important reason for ERP failure is that about 25% of people drop out early, and even for those who continue with the therapy, many do not regularly engage in ERP tasks, an essential element of ERP. A mindfulness-based approach has the potential to reduce drop-out from ERP and to improve ERP task engagement with an emphasis on accepting difficult thoughts, feelings and bodily sensions and on becoming more aware of urges, rather than automatically acting on them.
Methods/Design: This is a pilot randomised controlled trial of mindfulness-based ERP (MB-ERP) with the aim of establishing parameters for a definitive trial. Forty participants diagnosed with OCD will be allocated at random to a 10-session ERP group or to a 10-session MB-ERP group. Primary outcomes are OCD symptom severity and therapy engagement. Secondary outcomes are depressive symptom severity, wellbeing and obsessive-compulsive beliefs. A semi-structured interview with participants will guide understanding of change processes.
Discussion: Findings from this pilot study will inform future research in this area, and if effect sizes on primary outcomes are in favour of MB-ERP in comparison to ERP, funding for a definitive trial will be sought.
Trial registration: Current Controlled Trials registration number ISRCTN52684820. Registered on 30 January 2014.

Keywords: OCD, obsessive compulsive, ERP, exposure therapy, mindfulness

Article

JHP

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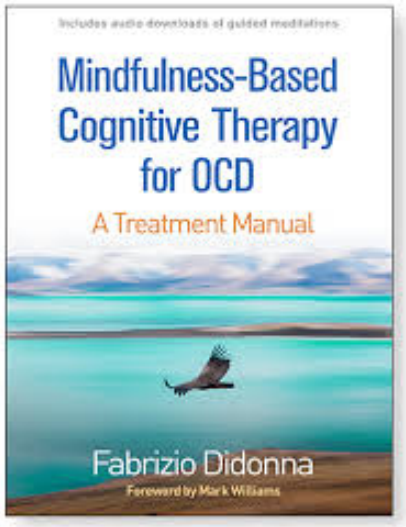
DOI: 10.1177/1359105318780540
journals.sagepub.com/home/hpq
SAGE

Mindfulness-based cognitive therapy for obsessive-compulsive disorder: Study protocol for a randomized controlled trial with functional magnetic resonance imaging and a 6-month follow-up

Lu Lu[1], Tianran Zhang[1], Rui Gao[1], Zongfeng Zhang[1], Xuan Cao[1], Yongjun Chen[1], Ying Liu[1], Fei Zhang[1], Yue Zheng[1], Yan Sun[1], Yanle Bai[1], Jianyu Wang[1], Fabrizio Didonna[2], Haiyin Zhang[1] and Qing Fan[1]



Journal of Obsessive-Compulsive and Related Disorders 16 (2018) 8–13

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Journal of Obsessive-Compulsive and Related Disorders

journal homepage: www.elsevier.com/locate/jocrd

Preliminary test of group acceptance and commitment therapy on obses… compulsive disorder for patients on optimal dose of selective seroton… reuptake inhibitors

Farzaneh Rohani[a], Morad Rasouli-Azad[a,*], Michael P. Twohig[b], Fatemeh Sadat Ghor… Eric B. Lee[b], Hossein Akbari[d]

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[b] Utah State University, United States
[c] Department of Psychiatry, Faculty of Medicine, Kashan University of Medical Sciences, Kashan, Islamic Republic of Iran
[d] Department of Biostatistics and Public Health, Faculty of Health, Kashan University of Medical Sciences, Kashan, Islamic Republic of Ir…

Behaviour Research and Therapy 50 (2012) 469–…

Contents lists available at SciVerse Sci…

Behaviour Research an…

journal homepage: www.elsev…

…ngitudinal treatment mediation of tradi… …ceptance and commitment therapy fo…

Joanna J. Arch[a,*], Kate B. Wolitzky-Taylor[b], Georg…

[a] University of Colorado Boulder, Department of Psychology and Neuroscience, 34…
[b] University of California, Los Angeles, Department of Psychology, 405 Hilgard Av…
[c] Chapman University, Department of Psychology, One University Drive, Orange…

…rnal of Contextual Behavioral Science 4 (2015) 196–202

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…al of Contextual Behavioral Scienc…

journal homepage: www.elsevier.com/locate/jcbs

…ogical flexibility during acceptance and …apy for obsessive compulsive disorder

…, Jennifer C. Plumb Vilardaga[b], Michael E. Levin[a], Steven…

…State University, 2810 Old Main Hill, Logan, UT 84322-2810, United States
…stem, Seattle Division, United States
…iversity of Nevada, United States

Journal of Obsessive-Compulsive and Related Disorders 6 (2015) 167–173

Contents lists available at ScienceDirect

Journal of Obsessive-Compulsive and Relate…

journal homepage: www.elsevier.com/locate/jo…

…herapy for OCD from an acceptance and … …CT) framework

…ohig[a,*], Jonathan S. Abramowitz[b], Ellen J. Bluett…, Kate L. Morrison[a], Lillian Reuman[b], Brooke …

…United States
…olina at Chapel Hill, United States

Clinical Psychology Review 33 (2013) 965–978

Contents lists available at ScienceDirect

Clinical Psychology Review

…nd Commitment Therapy in the treatment of … …c review

…a,b,*, Karen Hancock[a,b], Cassandra Hainsworth[a], Jenny Bo…

…chological Medicine, The Children's Hospital Westmead, Sydney, NSW 2145, Australia
…gy, The University of Newcastle, Newcastle, NSW 2308, Australia

…IGHTS

…s been empirically evaluated for the spectrum of anxiety disorders.

Journal of Anxiety Disorders 28 (2014) 612–624

Contents lists available at ScienceDirect

Journal of Anxiety Disorders

…e and commitment therapy for anxiety and OCD spectru… …: An empirical review

…uett, Kendra J. Homan, Kate L. Morrison, Michael E. Levin, Michael P. Twohi…

…versity, United States

PRINCIPALES CONCLUSIONES

Available online at www.sciencedirect.com
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Behaviour Research and Therapy 46 (2008) 296–321
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www.elsevier.com/locate/brat

Efficacy of the third wave of behavioral therapies:
A systematic review and meta-analysis

Lars-Göran Öst*

Department of Psychology, Stockholm University, S-106 91 Stockholm, Sweden

Received 17 September 2007; received in revised form 11 December 2007; accepted 14 December 2007

METANÁLISIS
ECAs

Journal of Obsessive-Compulsive and Related Disorders 19 (2018) 6–14
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journal homepage: www.elsevier.com/locate/jocrd

CBT-Plus: A meta-analysis of cognitive behavioral therapy augmentation strategies for obsessive-compulsive disorder

Andrew G. Guzick[a,b,c], Danielle L. Cooke[a,b], Nicholas Gage[c], Joseph P.H. McNamara[a,b,d]

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[d] University of Florida Department of Psychology, 945 Center Dr., Gainesville, FL 32603, United States

1. TCC + d-cycloserina o ISRS, no más eficaz que TCC sola (g= 0,043, p= ,65 y g= 0,11, p= ,30)

2. TCC + Mindfulness no más eficaz que TCC sola (g= -0,22; p = ,57) (4 ECA)

3. ACT:
   - Comparada con relajación muscular progresiva
   - Añadida a ISRS vs. solo ISRS
   - Estudios de caso (6 pacientes en dos estudios)

→

- ✓ Aumento flexibilidad cognitiva
- ✓ Mayor reducción de síntomas que solo ISRS (y estabilidad)
- ✓ Efectos positivos en YBOCS

PRINCIPALES CONCLUSIONES

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Behaviour Research and Therapy 46 (2008) 296–321
BEHAVIOUR RESEARCH AND THERAPY
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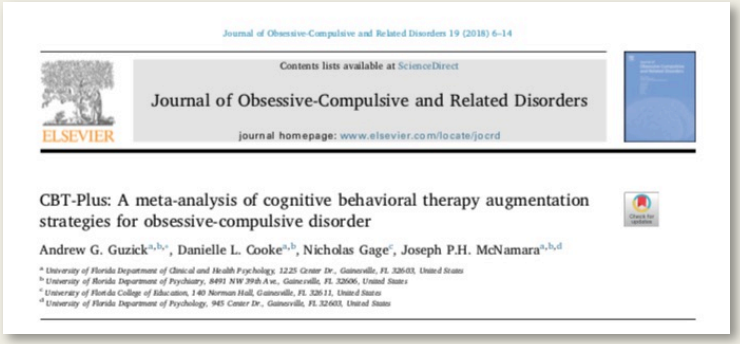
Efficacy of the third wave of behavioral therapies:
A systematic review and meta-analysis

Lars-Göran Öst*

Department of Psychology, Stockholm University, S-106 91 Stockholm, Sweden

Received 17 September 2007; received in revised form 11 December 2007; accepted 14 December 2007

METANÁLISIS
ECAs



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CBT-Plus: A meta-analysis of cognitive behavioral therapy augmentation strategies for obsessive-compulsive disorder

Andrew G. Guzick[a,b,*], Danielle L. Cooke[a,b], Nicholas Gage[c], Joseph P.H. McNamara[a,b,d]

[a] University of Florida Department of Clinical and Health Psychology, 1225 Center Dr., Gainesville, FL 32603, United States
[b] University of Florida Department of Psychiatry, 8491 NW 39th Ave., Gainesville, FL 32606, United States
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[d] University of Florida Department of Psychology, 945 Center Dr., Gainesville, FL 32603, United States

4. **TCC + Intervenciones psicosociales, más eficaces que TCC sola:**

- Implicación familiar: g= 0,60; p =,001 (4 ECA)
- Entrevista motivacional: g = 0,77; p = ,001 (3 ECA)

Mayor eficacia cuanto mayor gravedad, y dispensadas independientemente de TCC (i.e., no incluidas en el protocolo de TCC)

PAUTAS GENERALES

- AMBIENTE DE APOYO: No criticar, no juzgar, no comparar
- COMUNICACIÓN CLARA Y SENCILLA: animar a hablar de los miedos, preocupaciones, explicar en qué consiste, todos tenemos intrusiones, manías, etc.
- PREGUNTAS QUE LE HAGAN CONSCIENTE DEL PROBLEMA: "*¿Qué crees que pasaría si no lo repitieras?"*
- SEGUIR CON LA RUTINA: No interrumpir la vida familiar, escolar, laboral, etc., por el TOC
- APOYAR LAS MEJORÍAS
- SER FLEXIBLE, PERO NO "INVOLUCRARSE": no asumir las tareas del paciente, no eximirle de responsabilidades, no permitir que se lave sin más, etc.
- No "DESESPERARSE" ante la lentitud de los avances o los (probables) retrocesos
- COLABORAR CON EL PROFESIONAL

- *Trabaje conjuntamente con el afectado, siguiendo las recomendaciones del especialista,*
- *En caso de niños o adolescentes, fundamental la colaboración con los padres y los maestros*
- *En caso de duda, consulte con el especialista*
- *No tolere ningún comportamiento de burla o acoso.*


IMPEDIR EL
AISLAMIENTO

CONCLUYENDO PARA AVANZAR

1. NECESIDAD DE CONSIDERAR LA HETEROGENEIDAD DEL TOC PARA ESCOGER EL TRATAMIENTO MÁS ADECUADO A CADA PACIENTE

2. NECESIDAD DE SEGUIR EXPLORANDO LAS RAZONES DE LOS FRACASOS TERAPÉUTICOS

3. TERAPIA COGNITIVA ADAPTADA A TOC, EFICAZ A LARGO PLAZO PARA MUCHOS PACIENTES
   - Profesionales con entrenamiento específico y especializado

4. ESPECIAL INTERÉS DE

- NUEVAS TECNOLOGÍAS
- INTERVENCIÓN FAMILIAR, Y
- ENTREVISTA MOTIVACIONAL

} **ESTRATEGIAS COADYUVANTES QUE AUMENTAN EFICACIA DE TCC**

5. TERAPIAS DE “3ª GENERACIÓN”:

- ESCASEZ DE ESTUDIOS AMPLIOS Y CONTROLADOS PARA VALORAR LA APORTACIÓN REAL EN COMPARACIÓN CON TCC.
- LOS DATOS ACTUALES NO APOYAN SU SUPERIORIDAD A TCC

6. NADA DE “LO NUEVO” ES MEJOR QUE LO CONOCIDO (TC Y/O ERP), PERO

7. “LO NUEVO” PUEDE AYUDAR A MEJORAR LO QUE SABEMOS QUE FUNCIONA

“El saber que no aumenta cada día, disminuye un poco todos los días”

Los trastornos obsesivos y compulsivos: perspectivas actuales

MUCHAS GRACIAS

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