

# **Psychotherapeutic Treatments to Relieve the Symptoms of Obsessive-Compulsive Disorder (OCD): A Review of Clinical Reports**

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## **ABSTRACT**

**Obsessive-compulsive disorder (OCD) is a psychopathological condition with high prevalence, characterised by the presence of obsessions, compulsions or both and it is known that psychotherapeutic interventions would allow for the relief of some of the OCD's symptoms. The aim of the present review of clinical reports published between 2014 and 2019 in journals indexed in the Online Library of Knowledge (B-on) was to provide an overview of psychotherapeutic treatments that were put into service, by psychologists or other health professionals, in order to help OCD patients. Considering that clinical reports are so diverse in terms of reported strategies of intervention and of changes in cognitions, symptoms and behaviours, a narrative approach seemed to be better fitted for capturing the psychotherapeutic treatments reported. Results detected the predominance of the cognitive-behavioural approach with strategies and procedures derived from the cognitive-behavioural model of learning.**

**Keywords:** Obsessive-Compulsive Disorder, OCD, Psychotherapeutic Treatments, Clinical Reports, Cognitive-Behavioural Strategies, Cognitive-Behavioural Model of Learning

## **INTRODUCTION**

### **Obsessive-Compulsive Disorder (OCD)**

According to both DSM-5 [1] and ICD-11 [2], Obsessive-Compulsive Disorder (OCD) is characterised by the presence of obsessions, compulsions or both. That means that OCD patients experience persistent and recurring cognitions and associated emotions that cause anxiety and psychological suffering and contribute to the emission of certain trivial or repetitive actions or behaviours. OCD's compulsive rituals performed by a single member of the family may also affect the whole family, for instance, with parents participating in their children's rituals with consequences such as increased symptoms and impairment, and poorer treatment outcomes [3, 4, 5, 6]. Besides, the coexistence of two or more related medical

conditions, that is, comorbidity, is frequently encountered (50% - 60%) in OCD patients [7], with consequent worsening prognosis, treatment outcomes, and higher suicide rates [8, 9].

### **Psychotherapeutic Treatments**

In recent decades there has been considerable progress in the development of effective treatments for OCD, including psychotherapeutic interventions [10, 11]. Such interventions are non-pharmacological psychological methods designed to improve the patient's mental or health-related outcomes producing lasting changes in cognitions and behaviours [12, 13, 14].

### **Clinical Reports**

The main goal of the present review of clinical reports was to enquire about the specific psychotherapeutic treatments applied to relieve the symptoms of OCD. A review of clinical reports produced by psychologists or other qualified health professionals was carried out through: a) Retrieving clinical reports on psychotherapeutic treatments for OCD patients; b) Extracting all the relevant information from each of the clinical reports; c) Synthesising all the relevant information extracted from those clinical reports retrieved; d) Ascertaining specific psychotherapeutic approaches and strategies reported for the treatment of OCD patients.

## **METHOD**

### **Participants**

The clinical reports about 21 patients (between four and 64 years of age) diagnosed with OCD (12 females and nine males) and submitted to psychotherapeutic treatments were reviewed.

### **Materials and Procedure**

For the purpose of the present study, a review of clinical reports published in indexed journals from the Online Library of Knowledge (B-on) on the interventions applied, put into service, by psychologists or other health professionals in the psychotherapeutic treatment of OCD was used. The present review adopted the following steps:

#### **Step 1**

Electronic search on B-on, using Google Chrome Internet browser (version 84.0.4147.105) connected to the Virtual Private Network (VPN) service. On B-on homepage, the researcher's session was started and the option "Research Service" was selected. The "Advanced search" tool was chosen, which allowed for the combination of terms and the application of limits, which were previously defined. On this second page, the terms "OCD" (first text field) and "Psychotherapy" (second text field) were inserted, while in the Search modes and expanders section, the option "Apply related words" was selected. The search was also limited to full text articles published in academic journals between 2014 and 2019 in English language. This electronic search on B-on was carried out on November 17th 2019 at 16:14 hours.

#### **Step 2**

Step 2 involved analysing and evaluating titles and abstracts of all those publications identified by the electronic search. Case reports related to the effects of psychotherapy on the neural fields and brain areas of patients who suffer from OCD, of psychotherapeutic interventions on cognitive, emotional or behavioural functioning were considered and included in this review. Comorbidity, if any, was also considered.

Amongst the exclusion criteria were the following: lack of relation to the subject in question, studies in languages other than English, repeated publications, publications such as systematic literature reviews, meta-analyses, dissertations and theses, symposia, communications, editorials, comments, letters, conferences, studies unavailable for viewing, reports lacking details, errata, studies debating DSM and ICD diagnostic criteria, empirical studies, non-empirical studies, studies not included in scientific journals, studies addressing the psychometric properties of psychological instruments, theoretical debates over interventions, case studies that did not refer to OCD, case studies about the damage in the neural fields and brain areas of individuals who suffer from OCD (but that did not make reference to the effects of psychotherapy), case studies that focused only on the effects of psychotherapy on the physiological symptoms of the disorder in question, case studies on the effectiveness of treatments other than psychotherapeutic treatments (including pharmacological, biological, chemical, or using the Internet and technologies), studies carried out with animals, and studies that only made reference to the barriers, risks and protection factors, symptoms and prevalence of the disorder.

### ***Step 3***

All eligible articles included for this review of clinical reports were read in full and a careful analysis of the information presented in each of them was carried out. In the analysis of each article, the following aspects were observed: (1) authors and year of publication; (2) objectives of the interventions; (3) sample size; (4) clinical characteristics of the patients, such as sex, age, symptoms of OCD and comorbidity; (5) type of intervention; (6) main results. Given the enormous amount of clinical reports obtained, an analysis of the bibliographic references contained in each of the articles included in this review was not carried out.

## **RESULTS**

### **Clinical reports**

Twenty clinical reports were identified describing psychotherapeutic treatments for OCD. Of those, one was excluded due to the lack of details about treatment procedures [15]. Figure 1 shows a detailed flowchart for selecting the studies included in this review.

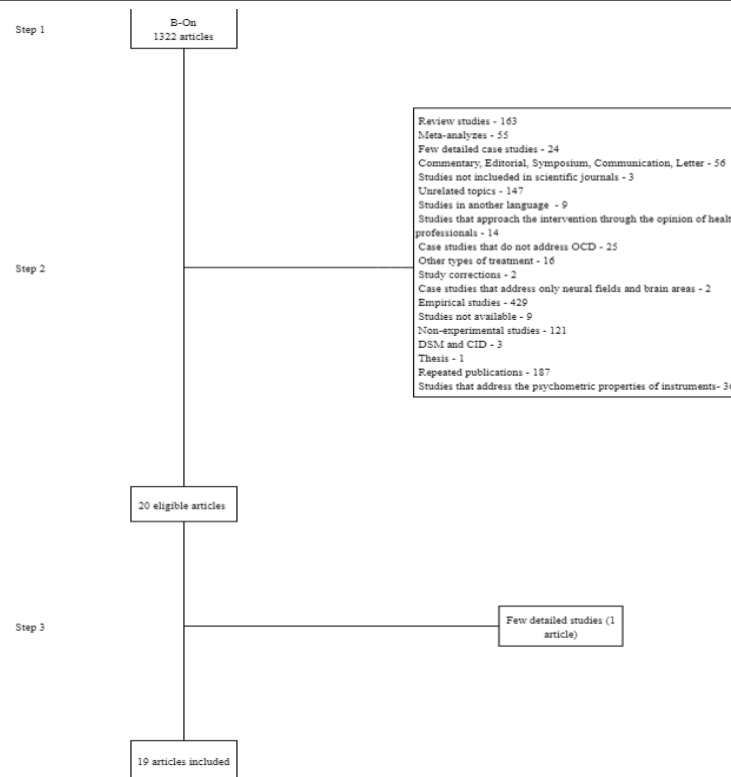


**Figure 1. Flowchart of the selection process of the clinical reports to be included in this review**

Table 1 synthesises the characteristics of the clinical reports included in this review. The contents of the participants' obsessions and compulsions were related to excessive fear that something negative would happen to other people [16, 17, 18, 19], to the appearance and cleanliness of their eyebrows [20], to fear of contamination [21, 22, 23, 24, 25, 26, 27, 28, 29], sexual themes [30], verification behaviours [31], belief in being sick [32], excessive concern with right and wrong, ordering and organisation [33] and repetitive behaviours [33, 34]. The OCD patients in 12 clinical reports did not present any comorbidity. In relation to the remaining reports, the participants had other pathologies such as major depressive disorder (n=2), oppositional defiant disorder (n=1), borderline intellectual functioning (n=1), separation anxiety disorder (n=1), generalised anxiety disorder (n=1), autism spectrum disorder (n=3), Tourette syndrome (n=1), dyslexia (n=1), specific phobia (n=2), Attention Deficit Hyperactivity Disorder (ADHD) (n=1), social phobia (n=1), and anxiety disorder (n=1).

**Table 1. General characteristics of Obsessive-Compulsive Disorder patients**

| <b>Clinical Report Reference Number</b> | <b>Patient</b>       | <b>Symptoms</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>Comorbidity</b> |
|-----------------------------------------|----------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|
| [20]                                    | Female, 17 years old | a) Compulsions and obsessions regarding appearance and cleanliness of eyebrows. Excessive time spent performing rituals associated with this part of the body (3 to 7 hours/day);<br>b) Excessive elaboration of lists, mental rituals, ordering/reorganisation, re-reading and rewriting when completing academic tasks or assignments (3 hours each);<br>c) Anxiety associated;<br>d) Anhedonia, reduced energy, disturbance of the normal sleep pattern, difficulties with concentration, abulia, and isolation. | MDD                |
| [22]                                    | Female, 19 years old | a) Intense fear of being contaminated;<br>b) Frequent and excessive hand washing related to the professional context;<br>c) Avoidance of contact with people or places believed to contain germs.                                                                                                                                                                                                                                                                                                                   | None               |
| [26]                                    | Male, 4 years old    | a) Alignment of toys in rows, by colour or categories;<br>b) Behavioural outbursts due to the fact that things are not "right";<br>c) Demanding the parental figures to squeeze his sneakers repeatedly because they were "crooked";<br>d) Aversion to sticky things and crying if his hands were not completely clean;<br>e) Anxiety symptoms associated.                                                                                                                                                          | ODD                |
| [17]                                    | Male, 27 years old   | a) Intrusive images of people with their eyes gouged out (including his girlfriend) after watching the Game of Thrones series;<br>b) Fear that his impulses would lead him to violent actions against his girlfriend;<br>c) Intrusive thoughts about serious injuries at work and anxiety when passing by sharp objects, since he imagined them trapped in the eyes of his colleagues;<br>d) Feeling sick, experiencing panic attacks, and missing work.                                                            | None               |
| [19]                                    | Female, 46 years old | a) Intrusive thoughts about threats and damage to friends, strangers and even to inanimate objects;<br>b) Fear that her house would be invaded and her belongings damaged or stolen;                                                                                                                                                                                                                                                                                                                                | None               |

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|      |                      | <p>c) Fear that her house would burn down due to carelessness;</p> <p>d) Checking twice whether doors were locked and the electrical cables had been disconnected from the sockets before leaving the house (time spent: 20-30 minutes);</p> <p>e) Avoiding driving so as not to cause an accident or injure to anyone, including animals;</p> <p>f) Anxiety symptoms associated;</p> <p>g) Difficulties in going to work for fear of what would happen if she looked at the strangers on the streets. Missing work as a consequence as well as activities (alone or even with her family).</p>                                                                                                                                                                                                                                                                                                                                                                                          |                                     |
| [30] | Female, 8 years old  | <p>a) Thoughts that she could have lied or violated a rule, thoughts containing sexual themes (about kissing boys), "bad words" and damage done to the maternal figure;</p> <p>b) Anxiety in situations with male colleagues due to fear of having intrusive sexual thoughts about them;</p> <p>c) Compulsive behaviours consisted mainly of confessing to her maternal figure when she had "bad thoughts" several times a day.</p> <p>d) Avoidance of direct questions (answering "maybe yes or maybe no") to avoid lying.</p> <p>e) Avoidance of school and difficulties in staying at meetings and parties with friends.</p> <p>f) Symptoms of anxiety and depression associated.</p>                                                                                                                                                                                                                                                                                                 | None                                |
| [16] | Female, 14 years old | <p>a) Sleep disorders, fear, irritability, school refusal and symptoms of separation anxiety;</p> <p>b) Excessive dependence on maternal figure.</p> <p>c) Ordering the mother to walk from the car to the house in circular lines; to walk inside the house close to the walls (her shoulder would have to touch the walls); to go up the stairs by the middle line; that orders were said in a negative way (e.g., "don't brush your teeth"); placing the dishes and utensils in a specific order on the table or on the tray; placing her belongings in specific and fixed locations; hitting hands 3 to 5 times each time she uses or removes something;</p> <p>d) If these actions were not completed in the way the patient instructed, she would react with severe physical and verbal attacks of anger that could last for an entire day;</p> <p>e) Believed that if things were not done in a certain way, something negative would happen to her, her mother or the house.</p> | Borderline Intellectual Functioning |
| [23] | Female,              | a) The underlying fear of contamination focused on the fact that the patient would become                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | SAD and GAD                         |

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|      | 12 years old       | <p>extremely ill, which would result in a violent episode of vomiting;</p> <p>b) Checking and repeated reorganisation of toothbrushes, so that they would not face out of the toothbrush holder, because it reminded her of someone leaning over a toilet and vomiting;</p> <p>c) Avoiding contact with her father for the last six months, due to the fact that he is in contact with asbestos at work;</p> <p>d) Fear of being physically disabled or debilitated; fear that she or any family member would be diagnosed with cancer;</p> <p>e) Fear of waking up deaf or blind if she had been exposed to loud noises or bright lights and that she would have a disability when coming into contact with other people with disabilities;</p> <p>f) Obsessions and compulsions in order to prevent cancer such as checking her writing to ensure that each letter she writes is clearly separated; fear of numbers 12, 17 and 21 (the patient believed that these numbers caused cancer to her or a loved one). Interruption or avoidance of many of her daily or school activities;</p> <p>g) Rituals used to counteract fears associated with cancer: telling oneself the name of each member of one's family in relation to not getting cancer (e.g., "the mother does not get cancer"). If this ritual was interrupted, the patient needed to start over;</p> <p>h) Persistent thoughts that she wouldn't wake up in the morning if she didn't believe in God;</p> <p>i) Excessive search for the maternal figure; avoiding sleeping when spending nights at her grandparents or friends homes. Failing to answer the set of ritualised questions before bed resulted in extreme levels of distress in the form of intense crying and screaming, which could last up to one hour;</p> <p>j) Anxiety symptoms associated.</p> |                   |    |
| [25] | Male, 14 years old | <p>a) Repeated personal injuries and several suicide attempts;</p> <p>b) Fear of contamination, of harming his parents and of being overly concerned about his iPad and Xbox;</p> <p>c) He avoided being outside whenever possible; he avoided going to the bathroom away from home; repeatedly sought the safety of his parents and telephoned them during the day; mental rituals that involved counting and over-checking his iPad and Xbox;</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ASD, and Dyslexia | TS |

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|      |                           | <p>d) He was late for school every day due to his checking rituals. Two or three hours later, he needed to return home due to anxiety and panic attacks,</p> <p>e) Sensitivity to noise, poor relationship with colleagues and difficulties in dealing with changes in their schedule (characteristics of the ASD);</p> <p>f) When he could not practice his rituals, he attacked objects and people close by or tried to escape the situation at any cost.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |      |
| [24] | Male,<br>7 years<br>old   | <p>a) Frequent obsessions related to contamination (e.g., germs), aggression (e.g., damage to oneself and others, violent images, fear of acting on unwanted impulse), sexual thoughts and scrupulousness (e.g., wrong decision making, breaking rules);</p> <p>b) Compulsions such as washing hands, going to the bathroom and other cleaning rituals, avoiding, checking, looking for security and confessing;</p> <p>c) Significant attention difficulties that worsened throughout the school year;</p> <p>d) Increased tension in the relationship between parents and child due to conflicts over rituals;</p> <p>e) Feelings of anguish on the part of the patient when he did not share what he wanted;</p> <p>f) Avoidance of a specific set of toys, since the patient associated them with a part of the female body (symptom presented in session 17).</p>                                                                                                                                            | None |
| [27] | Female,<br>6 years<br>old | <p>a) Early in life (three years and 10 months old) often refused to go to kindergarten; lost patience very easily and got involved in compulsive looking for her mother, wondering if she would pick her up from school or if something terrible would happen to family members;</p> <p>b) At four years and 5 months, fear of any black marks on food and ghosts in illustrated books. Frequent hand washing and excessive checking of the doors. Fear of contamination and germs and aggression. Compulsions of washing and cleaning, avoiding objects that he considered dirty and repeated questions to parents about serious illnesses;</p> <p>c) At six years and 2 months, worsening obsessive fears and lingering compulsions in relation to dirt and environmental toxins, disgust for bodily secretions and fear of tragedies (e.g., being attacked by intruders), death and serious illnesses;</p> <p>d) Reluctance to eat food, swallow her saliva, wear clothes and touch things she considered</p> | None |

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|      |                            | dirty, resulting in keeping naked, restrictive in her diet, and spitting;<br>e) Frequent crying and suicidal ideation;<br>f) OCD symptoms led the patient to a severe state of dehydration and malnutrition.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                  |
| [29] | Male,<br>12 years<br>old   | a) Cleaning obsessions and compulsions that involved repeated washing of hands or other parts of the body, after being exposed to something dirty;<br>b) Anxiety associated with dirty areas and trash, which led to the avoidance of "dirty" objects and areas with trash;<br>c) Symptoms of OCD and anxiety limited family activities and were significantly detrimental at events, school and at home;<br>d) Sensory intolerance (including items with sticky texture), obsessive interests (theme parks and the Minecraft computer game) and impaired daily functioning (symptoms of ASD);<br>e) Needed assistance in various daily activities that involved fine motor skills (e.g., tightening shoes) and the need to be reminded of other activities of daily living (e.g., brushing teeth and waking up in the morning);<br>f) Excessive checking of the computer screen for stains before and after using it. | ASD, SP<br>(storms/li<br>ghtning,<br>loud<br>noises)<br>and ADHD |
| [21] | Male,<br>10 years<br>old   | a) Fear of getting sick ordying after touching things;<br>b) Excessive hand washing;<br>c) Symptoms of anxiety associated;<br>d) Dermatitis caused by excessive washing;<br>e) Avoidance, looking for guarantees to share responsibility and focused his attention on germs and dirt to ensure that he remained alert to any danger.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | None                                                             |
| [31] | Female,<br>18 years<br>old | <b>Female (18 years old):</b><br>a) Verification behaviours since the age of nine;<br>b) Trend in checking in multiples of three;<br>c) Negative impact on her concentration and studies as well as physical tiredness;                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | None                                                             |
|      | Female,<br>40 years<br>old | d) Difficulties in driving in the dark, checking repeatedly that the headlights of her car were on.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                  |
|      | Female,<br>50 years<br>old | <b>Female (40 years old):</b><br>a) Symptoms of OCD present for the last 20 years;<br>b) Checking behaviours;<br>c) Before going to sleep, the patient sometimes asked her husband if he had locked the door and checked the stove and the lights. She also checked her son's room to see if there was anything dangerous or unusual in his crib.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                  |

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| <b>Female (50 years old):</b>                                                                                       |                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  |
| a) Chronic cystitis (wakes up two to three times a night to use the bathroom), irritable bowel syndrome and eczema; |                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  |
| b) Verification behaviours when leaving the house, at bedtime, when having to lock the door to the workplace;       |                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  |
| c) Hoard behaviours and associated problems (excessive hand washing and not touching the handles outside the home). |                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  |
| [32]                                                                                                                | Female, 15 years old | a) Belief that she had cancer. Dysfunctional assumptions about the disease (e.g., "if someone has a bald head, it means they have cancer");<br>b) Being unable to write down certain words related to the disease/blood and to her friendships;<br>c) Specific rituals (e.g., praying, repeating words/numbers until it is "correct");<br>d) Believing to be a strange person, believing that others considered her to be strange and that the world was an unsafe place.                                                                                                                                                                                                                                                                                                                                                                                                                                  | Health Anxiety   |
| [18]                                                                                                                | Female, 11 years old | a) Concern about bad things happening to her family, about harassing or offending other people, and about security at home (e.g., intruders);<br>b) Significant changes in sleep level;<br>c) Avoidance, checking and seeking behaviours as well as a need to "balance things" (e.g., if the patient accidentally touched something with one side of her body, she would have to touch the same place with the opposite side of her body).                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | None             |
| [33]                                                                                                                | Male, 9 years old    | a) Moderate levels of distress related to the difficulty in controlling anxiety-provoking thoughts and ritualised behaviours;<br>b) Aggressive intrusive thoughts (fear of acting on impulse), fear of losing things, an excessive concern with right and wrong and various obsessions (need to know/remember, fear of saying certain things, intrusive images);<br>c) Compulsions consisted of repetition of activities (e.g., verbally repeating a litany of routine events planned for a given day, repeatedly discussing the travel routes to be taken for these activities), seeking guarantees from parents and other adults regarding their actions and words used throughout the day, ordering and organising and various compulsions (need to count, ask or confess; make excessive lists; avoid/refuse to wear clothes associated with negative social interactions; need to touch, hit or rub); | ASD, SOCP and SP |

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|------|--------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|
|      |                    | d) Repetitive behaviours, stereotyped and restrictive interests, echolalia, difficulties with pragmatic language, deficits in social reciprocity and poor visual contact (ASD).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |      |
| [34] | Male, 9 years old  | <p>a) Feeling faint, shortness of breath and increased heart rate;</p> <p>b) Excessive time spent touching certain items in a room, brushing teeth in a specific way and dressing so that clothes do not touch his body;</p> <p>c) Keeping drawers and doors open at certain angles, sleeping in the middle of the floor and a need to follow a specific routine every morning and night;</p> <p>d) Demanding parents to participate in routines which interfered with homework;</p> <p>e) Suicidal ideation, tantrums and crying crises;</p> <p>f) Reciting a "game plan" five times and several times throughout the day to increase the likelihood of success at school. Repetition of security statements (e.g., "I'll be fine in the morning"), which most of the time was part of his "game plan";</p> <p>g) Excessive thoughts about being dirty;</p> <p>h) Underweight.</p>                                                                                                                                                                  | None |
| [28] | Male, 64 years old | <p>a) The patient's symptoms started at the age of five, when he developed a phobia of birds and animals;</p> <p>b) Fears of contamination that led to hand washing rituals and psychiatric hospitalisation at the age of 13;</p> <p>c) He stayed at home for the past 13 years due to his multiple disabilities (he didn't even go out to see the doctor);</p> <p>d) Careless with his own hygiene (bad odour, he did not shave, long, matted hair and only changed his clothes once a year);</p> <p>e) The patient wore gloves and was careful not to touch anything;</p> <p>f) It took one to two hours to wash after going to the bathroom, one hour or more hours to get ready to eat and then another hour to wash after eating;</p> <p>g) Extreme social isolation, severe depressive symptoms, hypervigilance to the negligence of others and, when his demands could not be met, the patient would come to the conclusion that people were deliberately mistreating him and sabotaging his treatment;</p> <p>h) Distrust of caregivers.</p> | MDD  |

**Abbreviations: MDD-Major Depressive Disorder; ODD-Oppositional Defiant Disorder; SAD-Separation Anxiety Disorder; GAD-Generalised Anxiety Disorder; ASD-Autism Spectrum**

**Disorder; TS-Tourette Syndrome; OCD-Obsessive-Compulsive Disorder; SP-Specific Phobia; ADHD-Attention Deficit Hyperactivity Disorder; SOCP-Social Phobia**

Table 2 shows the strategies applied or put into service in the psychotherapeutic treatment of OCD patients and the main effects of those interventions. From the analysis of Table 2, one can see that Clinical Report Reference Number [20] adopted exposure and response prevention as well as behavioural activation. During the sessions, psychoeducation was used, building a hierarchy of challenges, exposure and response prevention exercises (for both Body Dimorphic Disorder and OCD), activity programming, written records of automatic thoughts and cognitive restructuring (for Major Depressive Disorder), affirmation of the patient's self-efficacy, summary of her achievements and clarification of goals and values. During the period when the patient began to show resistance to the treatment and tried to avoid exposures due to the increasing level of difficulty, the patient was challenged with open questions in order to identify the treatment barriers. The patient exposed to these two types of interventions demonstrated a reduction in the symptoms of OCD, sensitivity to anxiety and social anxiety. With these psychotherapeutic strategies, no changes were found in depressive symptoms. Despite a significant reduction in the time spent on rituals associated with eyebrows, the patient did not achieve complete remission and continued to practice the rituals daily.

Cognitive-behavioural therapy was also applied, put into service, by several therapists [18, 19, 22, 23, 25, 32, 34] and in one particular case pharmacotherapy was also included [28]. The sessions focused on psychoeducation, externalisation of OCD and anxiety, written records of automatic thoughts, cognitive restructuring, monitoring catastrophic cognitions, fear thermometer, construction of a diary of concerns (and in other cases a daily self-report card), diaphragmatic breathing, relaxation, building a hierarchy of stimuli, exposure and response prevention exercises, additional strategies (positive self-talk and saturation), future planning and relapse prevention. Patients exposed to these strategies exhibited a significant reduction in the symptoms of OCD. However, some differences were detected between the different cases. The intervention in Clinical Report Reference Number [25], the patient did not achieve complete remission, while in two other cases, the patients did [18, 23]. Clinical Reference Number [32] reported an increase in the score of the disorder when the patient agreed to postpone a visit to the doctor, thus increasing levels of anxiety.

Family-based cognitive-behavioural therapy was adopted by other therapists [16, 24, 26], although pharmacotherapy was also included in one of these procedures [27]. The sessions were structured as follows: psychoeducation (for patients and their parental figures), externalisation of OCD, written records of automatic thoughts and behaviours, parental training, fear thermometer, introduction of coping skills, Socratic questioning, presentation of cognitive challenges and behavioural experiences to test alternative thoughts, construction of a hierarchy of stimuli, exposure and response prevention exercises, future planning and relapse prevention. Patients showed a significant reduction in OCD symptoms, although one of the studies reported that the patient was unable to achieve complete remission [26]. In another case, the patient achieved complete remission six months after treatment [27], while in the remainder no reference is made to this issue.

Eye Movement Desensitisation and Reprocessing (EMDR), psychoeducation, self-relaxation strategies, identification of a representative image of the disturbing experience and the

emotions and bodily sensations associated with it, bilateral stimulation, processing somatic responses and recording any disturbing material that might arise between sessions were used [17]. As for psychodynamic psychotherapy, it focused on exploring the relationship between the patient and the parental figure (as well as the patient's feelings), the current marital relationship, and the desire to be loved by everyone versus the fear of rejection (unconscious conflicts). These were followed by the Exposure and Response Prevention in which a hierarchy of dreaded situations was constructed, exposure exercises, written records of thoughts and feelings, and assessing the difficulties experienced. Cognitive therapy with psychoeducation and challenging cognitions associated with danger was also implemented. The patient exhibited a significant reduction in OCD and post-traumatic stress symptoms, which were maintained in the six-month and one-year follow-ups [17]. In addition, there was an improvement in the patient's quality of life as well as in the parent-child relationship and self-efficacy.

Clinical Report Reference Number [30] reported using cognitive-behavioural therapy and the narrative approach strategies in conjunction. The sessions focused on psychoeducation (both for the patient and for the parental figures), cognitive training (using the fear thermometer, discussing situations in which the OCD was more or less likely to win), building a hierarchy of stimuli, written records and classification of automatic obsessive thoughts, cognitive restructuring, parental training (ways in which parents could support the patient's emotions, while avoiding reinforcing their compulsions; building statements that parents could use to validate the patient's emotional experience, providing support and directing it to cognitive skills to deal with distress), exposure and response prevention exercises, externalisation of the problem and construction of stories about the patient and the disorder (Narrative Approach strategies). It was reported a significant reduction in the symptoms of OCD and the patient continued to show remission of these same symptoms during the follow-up period. In addition, there was a reduction in the symptoms of anxiety and depression, atypical behaviours and deficits in social skills and in general adaptive functioning.

Clinical Report Reference Number [21] applied a similar psychotherapeutic procedure: Cognitive-behavioural therapy and narrative therapy strategies. In this specific case, psychoeducation was used (both for the patient and for the maternal figure), externalisation (the patient gave the disorder a name and labelled his obsessions and compulsions) and conceptualised the OCD (debate about what activated the disorder, what activated obsessions, their meaning for the patient and how the disease led him to complete compulsions), building a hierarchy of fears and classifying them, role-playing, relaxation strategies (breathing exercises and muscle relaxation), construction of a list of statements that the patient could use to "dismiss OCD", decatastrophising, exposure and response prevention exercises, construction of a "self-help" guide for family members, and prevention of relapses. There was a significant reduction in the symptoms of OCD and improvements in mental health [21]. The parental scale (RCADS-P) showed a clinically significant reduction in scores, except for social phobia. Although these results were maintained in the one-month follow-up, there was a setback after four months.

Other therapists applied behavioural strategies through the Behavioural Interventions for Anxiety in Children with Autism (BIACA) Program [29, 33]. The sessions of one of the cases focused on psychoeducation, development of coping skills and training parenting skills using CALM strategies (recovery of breath, acceptance of negative feelings, labelling of emotions and

modulation of calm behaviour), and planned ignoring (use of role-play to practice reducing attention to anxious behaviours). In addition, skills training was also used to help the patient do things more independently (e.g., tighten shoes), construction of a hierarchy of feared situations, classification of the patient's fears, exposure and response prevention in vivo exercises, a program of token economy system, training social skills and planning the future. Clinical Report Reference Number [33] included psychoeducation (for the patient and parental figures), affective education (use of faces and cartoon figures to provide characters in various mood states; creation of fictional vignettes that used themes congruent with the patient's range of interests, as well as statements about things the patient liked and disliked), coping plan (helping the patient to identify relevant physiological cues for anxiety; providing elementary cognitive strategies for dealing with anxiety; preparing for exposure-based activities; use of the feelings thermometer to determine levels of anxiety), a program of token economy system (the patient's rewarding items and activities were identified and delivered in response to involvement in exposure-based activities) and the fear thermometer (to classify the fear of each item and build a hierarchy of feared stimuli), exposure and response prevention in vivo exercises and relapse prevention. This intervention caused a significant reduction in the patient's OCD symptoms [29, 33].

Finally, Clinical Report Reference Number [31] adopted Eye Movement Desensitisation and Reprocessing in the treatment of the three patients. The 18-year-old patient was asked to imagine a recording of her own verification behaviours and, when she noticed any feeling of affective or somatic suffering, she had to stop the recording for the processing to take place (alternating bilateral stimulation). In addition, she was asked to imagine a successful future action, a preferred emotion and a positive cognition to use during the verification behaviours. Finally, memories related to the past were processed and psychoeducation and discussion of the advantages and disadvantages of continuing with verification behaviours were also included. Regarding the 40-year-old patient, breathing exercises were used and the patient was asked to imagine a recording of her own verification behaviours. When she realised any feeling of affective or somatic suffering, she would have to stop recording for processing to occur. The floatback strategy was also used with this patient, and she was instructed to recall past events with similar thoughts, affective and somatic suffering. The patient tried, on her own initiative, to resist checking behaviours between sessions which turned out to be somewhat successful. In order to support this approach of the patient herself, it was suggested that she tried to understand the bodily sensations and emotions outside the sessions, instead of trying to cognitively resist the verification impulse. Subsequently, future models (imagining a successful future action) were used to leave the house, bedtime routines and other current triggers. It was also tried to work on the memory of the past (of the housemates leaving the doors open/unlocked), but without success. In order to prevent relapse, the 50-year-old patient was asked to imagine a recording of her own verification behaviours and, when she noticed any feeling of emotional or somatic suffering, she would have to stop the recording for the processing to take place. Future models were also used with this patient, following the Blind to Therapist protocol (method of reprocessing an agonising memory without the patient revealing the content of the trauma).

Clinical Report Reference Number [31] found different results among patients. While two of the patients exhibited a significant reduction in OCD symptoms and these results were maintained at the six-month follow-up, the other patient demonstrated only a slight reduction in the

symptoms of the disorder. In addition, this patient also exhibited a slight increase in symptoms during the follow-up period.

**Table 2. Strategies applied and its results in the psychotherapeutic treatment of OCD**

| <b>Clinical Reference Number</b> | <b>Session Planning</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Main effects of the intervention</b>                                                                                                                                         |
|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| [20]                             | <b>6 weeks (27 sessions)</b><br>a) Psychoeducation;<br>b) Construction of a hierarchy of ERP challenges and exercises;<br>c) Programming of activities, written records of automatic thoughts and cognitive restructuring                                                                                                                                                                                                                                                                                                                                            | a) Reduction of OCD symptoms, sensitivity to anxiety and social anxiety;<br>b) No changes were found in depressive symptoms.                                                    |
| [22]                             | <b>5 weeks (18 sessions)</b><br>a) Construction of a hierarchy of stimuli and ERP exercises;<br>b) Relaxation strategies.                                                                                                                                                                                                                                                                                                                                                                                                                                            | a) Reduced time spent washing hands and surfaces around;<br>b) improvement in daily task;<br>b) Significant reduction in OCD symptoms.                                          |
| [26]                             | <b>6 weeks (12 sessions)</b><br>a) Psychoeducation and parental training (positive play activities and strategic ignoring);<br>b) Construction of a hierarchy of fears and ERP exercises;<br>c) Relapse prevention.                                                                                                                                                                                                                                                                                                                                                  | a) Significant reductions in the symptoms of OCD, OOD and anxiety;<br>b) Improvements in general functioning and family functioning;<br>c) Complete remission was not possible; |
| [17]                             | <b>EMDR (sessions 1-11, 15, 19)</b><br>a) Psychoeducation and self-relaxation strategies;<br>b) Bilateral stimulation and processing of somatic responses.<br><br><b>PP (sessions 12-14, 16-17)</b><br>a) Exploration of the relationship between the patient and the parental figure as well as the patient's feelings;<br>b) Exploration in the current marital relationship as well as the "desire to be loved by everyone versus the fear of rejection".<br><br><b>ERP (18, 20-24)</b><br>a) Construction of a hierarchy of feared situations and ERP exercises; | a) Significant reduction in obsessive-compulsive and post-traumatic stress disorder symptoms;<br>b) Results were maintained at the 6-month and 1-year follow-up.                |

|      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |
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|      | b) Written records of automatic thoughts, emotions, and assessment of difficulties experienced.                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |
|      | <b>CT (sessions 21-25)</b><br>a) Psychoeducation;<br>b) Challenging cognitions.                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |
| [19] | <b>Individual CBT (8 sessions; twice a week, 60-90 minutes)</b><br>a) Psychoeducation and formulations about the patient's obsessions and compulsions;<br>b) ERP exercises.<br><br><b>Group CBT (3 sessions; first session: 5h; remaining sessions: 2h each)</b><br>a) Psychoeducation;<br>b) Debate on the advantages and disadvantages of therapeutic change;<br>c) Relapse prevention.                                                                           | a) Significant improvements in OCD symptoms and anxiety;<br>b) At the 1-month follow-up, there was an increase in symptoms, but these improved at the 2-month follow-up.                                                      |
| [30] | <b>12 sessions (50 minutes)</b><br>a) Psychoeducation;<br>b) Cognitive training and construction of a hierarchy of stimuli;<br>c) Written records and classification of automatic obsessive thoughts (homework);<br>d) Cognitive restructuring;<br>e) Parental training;<br>f) ERP exercises;<br>g) Externalisation of the problem and construction of stories about the patient and the OCD.                                                                       | a) Significant reduction in OCD symptoms;<br>b) Reduction of anxiety and depressive symptoms, atypical behaviours and deficits in social skills and in general adaptive functioning.                                          |
| [16] | <b>4 months (16 weekly sessions)</b><br>a) Written records of obsessions and compulsions (homework);<br>b) Psychoeducation and recording of thoughts and behaviours (for both mother and the patient - homework);<br>c) Construction of a hierarchy of compulsions and ERP exercises;<br>d) Coping skills to deal with anxiety (e.g. breathing);<br>e) Examination of underlying thoughts and interpretations, Socratic questioning and presentation of behavioural | a) Significant reduction in obsessive-compulsive, depressive and anxiety symptoms;<br>b) Increased awareness of the mother figure about her role in this dynamic;<br>c) Increased social activity independent of the patient. |

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|      | <p>experiences to test alternative thoughts;</p> <p>f) Cognitive challenges and behavioural experiences (homework);</p> <p>g) Relapse prevention and development of a future plan;</p> <p>h) Homework: explore hobbies and expand her social network.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                       |
| [23] | <p><b>3 intensive weekly sessions (3 h each), except the psychoeducation session (1.5h)</b></p> <p>a) Psychoeducation and use of the fear thermometer;</p> <p>b) Construction of a hierarchy of exposures and ERP exercises;</p> <p>c) Strategies to challenge her thoughts and gain more control over OCD (e.g., "go away, OCD, you're just playing with me again!");</p> <p>d) Construction of a hierarchy of the contents of obsessive fears related to cancer and writing of a detailed script about her worst fears conceivable of her mother dying of this disease;</p> <p>e) Voice recording reading the script the patient had to hear in a continuous loop until her anxiety subsided (homework).</p> <p>f) Relapse prevention.</p> | <p>a) Significant decrease in OCD symptoms;</p> <p>b) The patient no longer met the criteria for OCD, SAD and GAD.</p>                                                                                |
| [25] | <p><b>4 months (18 sessions)</b></p> <p>a) Psychoeducation;</p> <p>b) Decatastrophising;</p> <p>c) Construction of a hierarchy of compulsions;</p> <p>d) Records of sessions by the patient;</p> <p>e) ERP exercises (through the involvement of parental figures);</p> <p>f) Use of incentives to motivate the patient;</p> <p>g) Future planning and relapse prevention.</p>                                                                                                                                                                                                                                                                                                                                                               | <p>a) Reduction of symptoms of OCD with results maintained at the 12-month follow-up;</p> <p>b) Results were maintained at the 12-month follow-up;</p> <p>c) Complete remission was not achieved.</p> |
| [24] | <p><b>10 months (24 sessions)</b></p> <p>a) Psychoeducation and use of the fear thermometer;</p> <p>b) Construction of a hierarchy of fears;</p> <p>c) ERP exercises and gradual reduction of parental involvement;</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <p>a) Reduction of symptoms of OCD with maintained at the 1-month follow-up;</p> <p>b) Reduction of anxiety and intensity of suffering;</p>                                                           |

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|      | d) Parental training;<br>e) Positive attention through compliments, externalisation of the OCD and positive self-talk;<br>f) Construction of a hierarchy around the patient's intrusive (sexual) concerns;<br>g) Relapse prevention;<br>h) Construction of a hierarchy of fear and ERP exercises;<br>i) Problem solving strategy;<br>j) Written records of automatic thoughts and classification of anxiety. | c) Improvement of the patient's general functioning and attention difficulties.                                                                                                                                                                                                         |
| [27] | <b>4 weeks</b><br>a) Psychoeducation;<br>b) Parental training;<br>c) ERP exercises;<br>d) Relapse prevention.<br><b>Pharmacotherapy:</b><br>Fluvoxamina (0.6– 2.5 mg/kg/day).                                                                                                                                                                                                                                | a) Significant reduction in OCD symptoms and improvement in general functioning with results maintained in the follow-ups of 1 and 4 months;<br>b) Complete remission at 6-month follow-up.                                                                                             |
| [29] | <b>16 sessions (90 minutes)</b><br>a) Psychoeducation;<br>b) Development of coping skills;<br>c) Parental skills training;<br>d) Construction of a hierarchy of feared situations;<br>e) ERP in vivo;<br>f) Rewards system;<br>g) Social skills training;<br>h) Planning for the future.                                                                                                                     | a) Significant reduction in OCD symptoms and anxiety with results maintained in the 1-month follow-up;<br>b) Decreased symptoms associated with specific comorbid storm/lightning phobia;<br>c) The diagnoses of subclinical comorbidity of noise phobia and ADHD remained subclinical. |
| [21] | <b>16 sessions</b><br>a) Psychoeducation;<br>b) Externalisation and conceptualisation of the OCD;<br>c) Building a hierarchy of fears and classifying them;<br>d) Role-play;<br>e) Relaxation strategies;<br>f) Decatastrophising;<br>g) ERP exercises;<br>h) Relapse prevention.                                                                                                                            | Significant reduction in OCD symptoms and improvements in the patient's mental health with results maintained in the follow-ups.                                                                                                                                                        |
| [31] | <b>11 sessions (18 years old)/12 sessions (40 years old)/17 sessions (50 years old)</b><br>a) Alternating bilateral stimulation;                                                                                                                                                                                                                                                                             | <b>Female (18 years old):</b><br>Significant reduction in OCD symptoms with results                                                                                                                                                                                                     |

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|------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|      | <ul style="list-style-type: none"> <li>b) Psychoeducation;</li> <li>c) Floatback technique;</li> <li>d) Blind to Therapist Protocol;</li> <li>e) Relapse prevention.</li> </ul>                                                                                                                                                                                                                                                                             | <p>maintained in the 6-month follow-up.</p> <p><b>Female (40 years old):</b><br/>Only a slight reduction in the symptoms of OCD. At the 6-month follow-up, there was a slight increase in symptoms (the score 7 on the scales went to 8).</p> <p><b>Female (50 years old):</b><br/>Significant reduction in OCD symptoms with results maintained in the 6-month follow-up.</p>                                             |
| [32] | <p><b>13 sessions</b></p> <ul style="list-style-type: none"> <li>a) Psychoeducation and written records of automatic thoughts. Challenge the evidence for and against negative thoughts;</li> <li>b) Experiences of selective attention in vivo;</li> <li>c) Experiences of suppression of thought;</li> <li>d) Construction of a hierarchy of fears and ERP exercises;</li> <li>e) Externalisation of the OCD. Review session and future plans.</li> </ul> | <ul style="list-style-type: none"> <li>a) Reduced anxiety about health;</li> <li>b) Improvements in emotional well-being;</li> <li>c) Significant reduction in OCD symptoms. However, there was an increase in the score of the disorder when the patient agreed to postpone a visit to the doctor, thereby increasing her anxiety;</li> <li>d) Reduction of symptoms of depression and anxiety.</li> </ul>                |
| [18] | <p><b>15 sessions</b></p> <ul style="list-style-type: none"> <li>a) OCD mapping and externalisation of anxiety;</li> <li>b) Psychoeducation, construction of a hierarchy of exposures and ERP exercises;</li> <li>c) Cognitive restructuring and relapse prevention.</li> </ul>                                                                                                                                                                             | <ul style="list-style-type: none"> <li>a) Significant decrease in OCD symptoms, depression and anxiety of the patient as well as anxiety of the maternal figure;</li> <li>b) The patient no longer met the criteria for clinically significant symptoms of any disorder.</li> </ul>                                                                                                                                        |
| [33] | <p><b>4 months (16 weekly sessions, 35-70 minutes each)</b></p> <ul style="list-style-type: none"> <li>a) Psychoeducation;</li> <li>b) Affective Education, coping plan and rewards system;</li> <li>c) Thermometer of fear;</li> <li>d) ERP exercises in vivo;</li> <li>e) Relapse prevention.</li> </ul>                                                                                                                                                  | <ul style="list-style-type: none"> <li>a) Significant reduction in OCD symptoms. The patient achieved remission of the diagnosis;</li> <li>b) Significant reduction in symptoms of anxiety and depression;</li> <li>c) Social phobia in remission;</li> <li>d) The diagnosis of specific phobia was maintained, although there was a decrease in symptoms;</li> <li>e) Improvements in awareness, communication</li> </ul> |

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|      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | and social motivation and in the mannerisms of the autism spectrum.                                                                                                                                                                                                                                                                                                                                                             |
| [34] | <p><b>22 weekly sessions and 12 fortnightly reinforcement sessions</b></p> <p><b>Treatment phase 1:</b></p> <p>a) Psychoeducation, externalisation of OCD, fear thermometer and construction of a diary of concerns;</p> <p>b) Development of a hierarchy of obsessions and compulsions;</p> <p>c) Diaphragmatic breathing, progressive muscle relaxation and building statements to help control OCD;</p> <p>d) ERP exercises;</p> <p>e) Positive self-talk and saturation (repeat obsessive thinking until the suffering related to it subsides);</p> <p>f) Parental component.</p> <p><b>Treatment phase 2:</b></p> <p>a) Daily self-report card and reward system;</p> <p>b) Cognitive restructuring and written records of automatic thoughts.</p> | <p><b>Treatment phase 1:</b></p> <p>a) Significant reduction in OCD symptoms;</p> <p>b) Reduction of suicidal ideation;</p> <p>c) Although his compulsions were practically non-existent, some obsessions were still problematic.</p> <p><b>Treatment phase 2:</b></p> <p>Further improvements in OCD symptoms and overall functioning.</p>                                                                                     |
| [28] | <p><b>18 months (20 sessions of 1h) CBT:</b></p> <p>a) Psychoeducation;</p> <p>b) Identification of automatic thoughts and underlying beliefs and assessment of emotions. Challenging thoughts and beliefs;</p> <p>c) Construction of a hierarchy of stimuli and ERP exercises;</p> <p>d) Development of a weekly plan with a focus on patient self-care. Identification and alteration of dysfunctional beliefs that interfered with self-care;</p> <p>e) Construction of a list of leisure activities and incentive to practice them;</p> <p>f) Relapse prevention.</p> <p><b>Pharmacotherapy:</b></p> <p>Escitalopram (40 mg), aripiprazole (15 mg) e lorazepam (1 mg).</p>                                                                          | <p>a) Improvements in self-care: Began taking a bath every 3 weeks and shaved once a week;</p> <p>b) Improvements in social functioning: Began leaving the house for a walk, went to consultations and contacted his primary care doctor and other specialists in his offices, participated in the church service with his mother and visited his sister;</p> <p>c) Improvements in self-esteem and reduction of suffering.</p> |

**Abbreviations:** ERP – Exposure and Response Prevention; OCD – Obsessive-Compulsive Disorder; ODD – Oppositional Defiant Disorder; EMDR – Eye Movement Desensitisation and Reprocessing; PP – Psychodynamic Psychotherapy; CT – Cognitive Therapy; CBT – Cognitive-Behavioural Therapy; SAD – Separation Anxiety Disorder; GAD – Generalised Anxiety Disorder; ADHD – Attention Deficit Hyperactivity Disorder;

**Note:** “Psychoeducation” or learning information about one’s disorder, about the psychotherapeutic strategies and about the process of change is seen as a worthy psychotherapeutic tool.

## DISCUSSION

This review of clinical reports allowed for expanding the knowledge regarding the interventions applied, put into service, by psychologists or other health professionals, in the psychotherapeutic treatment of obsessive-compulsive disorder (OCD). The 19 clinical reports on psychotherapeutic treatments of OCD patients, the vast majority employed the cognitive-behavioural therapy, strategies of cognitive therapy, strategies of behaviour therapy, and strategies derived from the cognitive-behavioural model of learning [35, 36]. Some strategies appeared recurrently in the vast majority of the clinical reports reviewed, such as the so called psychoeducation of patients and, in some cases, of their families, allowing them all to grasp the relationship amongst activating contexts, flowing of dysfunctional automatic thoughts or images, symptoms, and behaviours. The strategies of construction of a hierarchy of feared stimuli, exercises of exposure and response prevention were also frequently reported in the psychotherapeutic treatment of OCD patients [35]. These exercises served the purpose of reducing anxiety by habituating to feared stimuli, that is, exposure involves the activation of fear, minimising compulsive behaviours that are emitted to reduce anxiety, providing to the patients some tools just in case the symptoms may reappear in the future [37]. Amongst the other strategies identified in this review of clinical reports was the so called “Eye Movement Desensitisation and Reprocessing (EMDR)”, a strategy designed to alleviate or remove the psychological suffering elicited by traumatic memories [38].

## CONCLUSIONS

The results of the present review of clinical reports revealed a diversity of psychotherapeutic strategies applied or put into service of treating OCD patients. Nevertheless, strategies governed by the cognitive-behavioural model of learning proved to be the most employed. Despite this, the vast majority of the strategies reported brought significant changes in the symptoms of OCD as well as in the patients’ comorbid symptoms. The present review constitutes a significant contribution to the psychological clinical and educational practice.

Some obvious limitations of the procedure adopted for this review are: a) It is possible that some relevant clinical reports of interest were not included in the present review due to the fact that the bibliographic search was carried out in one single database (B-on); b) The clinical reports included were the ones published during the last five years only.

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