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Cognitive Behavioral Therapy via Exposure and Response Prevention

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Obsessive Compulsive Disorder:

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Obsessive-compulsive disorder, otherwise known as OCD, affects millions of people across the globe every year; and the obsessions/compulsions associated with this disorder can have a negative impact on one's day to day living (Clark, 2000). Seeing that many people suffer from this disorder, researchers have attempted to determine which treatment methods (e.g., behavioral or pharmacological) are more effective at treating the symptoms/behaviors associated with it. One cognitive-behavioral technique that has shown a lot of promise is exposure and response (or ritual) prevention (ERP) (Allen, 2006). Although ERP may not be 100% effective at treating the symptoms of OCD, the research has consistently shown that it remains one of the most effective treatments out there for those suffering from OCD (Abramowitz, 1997; Abramowitz, Foa, & Franklin, 2003; Allen, 2006). Although the research regarding OCD and the different treatment methods available could never be completely delineated here, this paper will attempt to describe the course of OCD, how it impacts one's life, and which treatment method has been found to be more effective at treating it.

Obsessive Compulsive Disorder Defined

According to Maltby and Tolin (2003), OCD is a "chronic anxiety disorder, marked by recurrent, intrusive, and distressing thoughts (obsessions) and/or repetitive behaviors (compulsions)" (p. 127). Consequently, it is listed as an anxiety disorder under Axis I of the American Psychological Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR). Obsessive-compulsive disorder is usually diagnosed once a client presents with symptoms that impair his or her [social and/or occupational] functioning for more than an hour a day (Comer, 2008; American Psychological Association, 2000 as cited in Koran, Hanna,

Hollander, Nestadt, & Simpson, 2007). In general, OCD symptoms do not appear all at once; instead, patients who suffer from OCD tend to experience unexpected and unwanted, thoughts, ideas, impulses or images. In addition, comorbidity is somewhat common; between one and two-thirds of OCD sufferers also suffer from depression (Greist, 1998; Marks, 1997).

Symptoms Associated with OCD

Obsessions

Obsessive-compulsive disorder is characterized by two distinct symptoms: obsessions and compulsions (Abramowitz, 1997; Allen, 2006; Clark, 2000; Cordioli, 2008; Maltby & Tolin, 2003). Obsessions can include persistent, unwanted and/or bizarre thoughts, impulses, or images that can cause the person experiencing them a significant amount of distress and/or anxiety (Abramowitz, 2006; Clark, 2000). According to Clark (2000), the content of these obsessions may be idiosyncratic or may deal with incidents that are completely foreign to the individual. An example of an obsession would be the belief that one is incredibly dirty and has been, or is constantly being, contaminated by one's environment. Although some of the people who suffer from OCD may be aware that their obsessions are illogical (Foa & Kozak, 1995), they may still be incapable of controlling them due to their fear of the perceived negative consequences (Abramowitz & Luenzmann, 2004).

Compulsions

Compulsions, on the other hand, involve repetitive, ritualistic behaviors that are performed in order to, at least temporarily, reduce the anxiety that one is feeling (Abramowitz, 1997; Clark, 2000). Not surprisingly, due to their anxiety-reducing effects, compulsions are continually reinforced because they neutralize the distress that one experiences because of one's obsessions (Clark, 2000). An example of a compulsion would be the stereotypical hand-washing

behaviors that some OCD sufferers participate in after coming into contact with something they deem to be ‘contaminated.’ So in other words, whereas obsessions elicit anxiety or distress, compulsions decrease the anxiety, or at the very least help those suffering from OCD to hinder any supposed consequences (Maltby & Tolin, 2003).

Relationship between Obsessions and Compulsions

In general, obsessions and compulsions go hand in hand or are phenomenologically related (Abramowitz & Luenzmann, 2004). For example, one may have 1) obsessions about contamination (which are followed by decontamination behaviors), 2) obsessions about improper/profane beliefs (which are then followed by prayer or thought suppression), and 3) obsessions regarding whether or not one has caused a catastrophe or harm (which is then followed by reassurance seeking behaviors such as compulsive checking) (Abramowitz, 2006). Although the majority of OCD sufferers experience both of these symptoms, some of them do not experience any overt compulsions – only obsessional beliefs (Foa & Kozak, 1995).

Age of Onset of OCD

Although the age of onset varies from individual to individual, many people experience their first few symptoms of OCD during childhood or near the end of adolescence (it is extremely rare after the age of forty) (Cordioli, 2008); Abramowitz and Luenzmann (2004) state that in some cases, OCD may even begin as early as preschool. According to Cordioli (2008) and Geffken, Storch, Gelfand, Adkins, and Goodman (2004), roughly 2.5% of the population suffers from OCD. When the numbers are broken down even further, researchers suggest that between 1-2% of children are affected by OCD and roughly 2-3% of adults are affected by OCD (Abramowitz & Luenzmann, 2004). In addition, males, in contrast to females, have a tendency to develop OCD at a younger age (Abramowitz & Luenzmann, 2004).

Etiology

Psychoanalytical Theory

Many different theories have been proposed in regards to the etiology of OCD. Not surprisingly, each school of thought has their own views. For example, many psychoanalysts believe that OCD comes about as a result of unresolved or unsettled conflicts that occurred during one's respective childhood (Freud believed that these conflicts were found in the anal-sadistic phase) (Cordioli, 2008); this eventually contributes to the development of the obsessions and compulsions that are characteristic of OCD (Abramowitz & Luenzmann, 2004).

Biological Theory

On the other hand, some biological theories regarding OCD posit that the symptoms associated with OCD come about as a result of abnormal serotonin functioning (Abramowitz & Luenzmann, 2004; Maltby & Tolin, 2003). This is mostly due to the finding that patients who suffer from OCD tend to respond more to serotonin reuptake inhibitors (SRIs) versus placebos or other pharmacotherapies (e.g., nonserotonergic medicines) (Abramowitz & Luenzmann, 2004; Maltby & Tolin, 2003). However, although some studies have shown a link between serotonin levels and OCD, others have not supported the serotonin hypothesis (Abramowitz & Luenzmann, 2004).

Cognitive Theory

In contrast, cognitive models of OCD suggest that OCD (and many other disorders) involves distorted, intrusive thoughts or assumptions; on the other hand, behavioral models of OCD involve the maintenance of obsessions due to the anxiety-reducing nature of the compulsive behaviors (Abramowitz, 2004; Maltby & Tolin, 2003). In this sense, erroneous assumptions, such as perfectionism, the need to control one's thoughts, miscalculations of

perceived threats, and an intolerance of ambiguity (Obsessive Compulsive Cognitions Working Group, 1997), help to maintain the disorder and its symptoms (Maltby & Tolin, 2003). In addition, this theory suggests that compulsions are even more potent for OCD sufferers because in addition to reducing the person's anxiety they also prevent the person from seeing how unrealistic their fears were at first glance (Abramowitz & Luenzmann, 2004).

Treatment

Seeing that there are different theories as to what causes OCD, it is only natural that there would also be different treatment options for OCD sufferers. Currently, treatment options can range from pharmacotherapy, cognitive therapy, or even anxiety management training, just to name a few (Maltby & Tolin, 2003). However, one treatment option that has been shown to be incredibly effective at treating OCD is exposure and response (or ritual) prevention (ERP) (Abramowitz, 1997; Abramowitz, Foa, & Franklin, 2003; Allen, 2006); and this technique falls under the umbrella of cognitive-behavioral therapy (CBT).

Cognitive Behavioral Therapy

Although different authors may define cognitive behavioral therapy in different ways, the basic premise is just the same. Allen (2006) defines CBT as “a term that refers to a general approach to therapy that focuses on current problems and symptoms and uses techniques based in learning theory to change the patient's problematic thoughts and behaviors” (p. 475). Moreover, CBT can be further divided into three sections: cognitive, behavioral, and physiological. The cognitive component of CBT involves helping the client to both identify and modify his or her maladaptive cognitions or thoughts (Allen, 2006). In comparison, the behavioral component of CBT involves helping the client to change his or her maladaptive behaviors (Allen, 2006). Lastly, the physiological aspect of CBT zones in specifically on one's

physical reactions and involves teaching the client techniques (e.g., gradual muscle relaxation, or deep breathing) that will help him or her to alleviate the anxiety he or she experiences (Allen, 2006).

Efficacy of CBT

Numerous researchers have detailed how effective CBT is in treating various psychological disorders (Beck, 1997; Salkovskis, 1996 as cited in Butler, Chapman, Forman, & Beck, 2006; Dobson, 2009). For example, an investigation of sixteen different meta-analyses found that CBT is incredibly effective at treating disorders such as depression, social phobia, posttraumatic stress disorder (PTSD), and panic disorder (Butler, Chapman, Forman, & Beck, 2006). In addition, Abramowitz & Luenzmann (2004) state that the research has shown that CBT is the most efficacious method (both in the short and long-term) for treating OCD. Consequently, one of the most effective treatment methods for OCD sufferers falls underneath the behavioral aspect of CBT.

Exposure and Response Prevention

Exposure and response (or ritual) prevention is a therapeutic technique that involves two distinct steps (Allen, 2006; Clark, 2000). Firstly, the psychologist/therapist exposes the client to the situation [or object] that causes him or her the most anxiety or discomfort; and secondly, the client is prevented from engaging in his or her compulsive, ritualistic behavior(s) (at least until the discomfort [or uneasiness] subsides) (Allen, 2006; Marks, 1997). Although the direct mechanisms by which ERP works may be unknown, Abramowitz (2006) suggests that three mechanisms of action may be involved: 1) a cognitive mechanism (which helps to correct the patient's flawed cognitions/beliefs), 2) a behavioral mechanism (which helps to extinguish the patient's conditioned fear responses), and 3) a change in one's perceived self-efficacy (which

occurs when patients acknowledge that they can conquer their obsessions without having to resort to compulsions). Additionally, some researchers have suggested that ERP is effective, because like any other behavioral treatment, “repeated exposure to the fear stimulus...will [and should] be accompanied by a natural decline or habituation of anxiety” (Clark, 2000, p. 131).

History of ERP

Although many psychologists are now familiar with this technique, ERP has a relatively short history. Exposure and response prevention was developed by Victor Meyer, a London psychologist, under the name ‘apotrepic therapy’ (de Silva & Rachman, 2004). This therapy, which was conducted in stages, combined (in vivo) exposure therapy with modeling and response prevention (Wilson, 1992). One of the first steps involved conducting a behavior analysis; consequently, nurses were utilized in order to help the patients stop engaging in their compulsions (Wilson, 1992). Once the ritualistic behaviors had been eliminated (under the nurses’ supervision), the patients were gradually exposed to anxiety-provoking stimuli or situations that would normally result in the compulsions (Wilson, 1992). Consequently, the therapist used modeling in order to show the patients what he wanted them to do; this involved having the therapist participate in the behavior (e.g., touching objects such as underwear that are thought to be contaminated) and then having the patient engage in the behavior as well (Wilson, 1992). Once the patients were comfortable under the situations that were deemed to be most difficult, their supervision was progressively decreased (Wilson, 1992).

After getting good results with his first few patients, Meyer used his apotrepic therapy on fifteen other OCD sufferers. After participating in the treatment, ten of the participants were reported as being “much improved or symptom free,” and the other five patients were found to be “moderately improved” (Mavissakalian, Turner, & Michelson, 1985, p. 73). Consequently, in

the 1970s, researchers such as Rachman, Marks and Foa began to improve on Meyer's apotrepic therapy, and eventually they turned it into the exposure and response prevention therapy that most therapists are familiar with today (Clark, 2000).

Efficacy of ERP in regards to OCD

Many researchers have shown how effective ERP techniques are at treating the symptoms associated with OCD (Foa et al., 2005; Simpson, Huppert, Petkova, Foa, Liebowitz, 2006). For example, one study, conducted by Abramowitz et al. (2003) attempted to determine whether or not a twice-weekly session of ERP (over 8 weeks) would be as effective as intensive ERP (15 sessions over the course of three weeks). They found that participants in both groups experienced significant short and long-term reductions in OCD symptoms (Abramowitz et al., 2003). In another study, Foa et al. (2005) conducted a randomized controlled trial where they compared 1) clomipramine (an SRI), 2) ERP, 3) both of them in conjunction with each other, and 4) a placebo. They found that ERP, with and without clomipramine, was superior than both the placebo and the clomipramine.

In all, a variety of studies, which have included more than five-hundred patients from places such as Holland, England, Greece, and the United States, have shown ERP's effectiveness when treating OCD (Abramowitz, 2006). Lastly, in addition to the obvious benefits associated with ERP, ERP is incredibly useful in the sense that it can be used with a variety of populations in a variety of different settings. For example, numerous studies have shown that ERP can be used in family cotherapy (Mentha, 1990 as cited in Marks, 1997), and in group and individual therapy (Fals-Stewart, Marks, & Schafer, 1993 as cited in Marks, 1997); it can also be used with adults, adolescents/juveniles, and the elderly (Marks, 1997).

Limitations of ERP

Although ERP is extremely effective at treating OCD, it is not without its limitations. First of all, ERP is not risk free; in order for patients to overcome their compulsions they must be willing to expose themselves to those things or circumstances that cause them the most discomfort (Maltby & Tolin, 2003). In addition, although numerous studies have shown how effective ERP is, it can be incredibly time consuming and thus expensive; therefore, many people who would benefit from this procedure may be incapable of doing so (at least in an office setting) (Maltby & Tolin, 2003). Lastly, although the effects of ERP tend to persist over time, it is possible that some patients will eventually relapse. Therefore, it is extremely important that psychologists/therapists make relapse prevention a key component of ERP. As a matter of fact, one study found that patients who received ERP, followed by a relapse prevention program, had improvements both directly after intensive ERP and at 6-month follow-up; in contrast, the other patients (who did not receive relapse prevention) later displayed some return of symptoms (Hiss, Foa, & Kozak, 1994). In the end, Marks (1997) suggests that relapse prevention should involve having the patient “anticipate setbacks and [consequently] devise and rehearse ERP tasks in order to avoid incipient relapse” (p. 1022).

According to Cordioli (2008), 2.5% of the general population is affected by OCD; and Narrow, Rae, and Regier state that roughly 3.3 million Americans (between the ages of 18 and 54) suffer from OCD in any given year (as cited in National Institute of Mental Health [NIMH], 2001). It is characterized by anxiety-provoking obsessions (e.g., thoughts, images, or beliefs) that eventually lead the person to engage in repetitive, ritualistic behaviors, or compulsions (e.g., checking, hand washing, or cleaning), in order to reduce the anxiety. Although many different theories have been posited as to the etiology of OCD, it is possible that OCD comes about as an interplay of both nature and nurture. Many different treatment options are available for OCD

(e.g., pharmacotherapy, behavior therapy, cognitive therapy, etc.); however, one method that has been found to be extremely effective at treating OCD is exposure and response prevention.

Although many researchers have shown how effective ERP is at treating OCD, it does have its limitations (e.g., it can be time consuming, and costly); however, in all, ERP (especially when followed by relapse prevention) is incredibly useful when it comes to reducing or eliminating obsessions and compulsions in the OCD population.

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