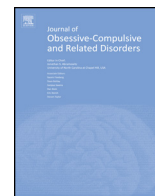




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## Journal of Obsessive-Compulsive and Related Disorders

journal homepage: [www.elsevier.com/locate/jocrd](http://www.elsevier.com/locate/jocrd)

Short communication

## A new model for the initiation of treatment for obsessive-compulsive disorder: An exploratory study

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## ARTICLE INFO

## Article history:

Received 9 April 2014

Received in revised form

14 August 2014

Accepted 18 August 2014

## Keywords:

Obsessive-compulsive Disorder

OCD

Treatment

## ABSTRACT

Exposure and response prevention is a first-line treatment for obsessive-compulsive disorder (OCD). Despite its efficacy, patients often refuse or drop out, and it can require a substantial amount of time and cost. The current study examined the efficacy of a new model for initiating treatment for OCD, which might produce a rapid decrease in symptoms and experiential avoidance. This model uses a brief, intensive group intervention to reduce OCD and related symptoms by modifying OCD-related beliefs and then engaging in behavioral experiments. Cognitive components of treatment are emphasized and patients are encouraged to adopt a simple yet paradoxical mindset. Thirty-three individuals with OCD participated and completed measures of OCD-related beliefs and symptoms, depressive and anxiety symptoms, and experiential avoidance at three time intervals – pre-treatment, post-treatment, and one-month follow-up. Results indicated significant reductions from pre-treatment to post-treatment on nine out of 10 measures. All gains were maintained or decreased further from post-treatment to follow-up. There were significant reductions on all 16 measures from pre-treatment to follow-up, providing preliminary support for the efficacy of this model. It will be important to continue to examine the efficacy of this model in randomized controlled trials.

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## 1. Introduction

Expert consensus treatment guidelines propose that cognitive behavior therapy (CBT), specifically exposure with response prevention (ERP), is the first-line psychosocial intervention for obsessive-compulsive disorder (OCD; March, Frances, Kahn, & Carpenter, 1997), and meta-analysis supports the efficacy of ERP for OCD (Abramowitz, Franklin, & Foa, 2002). Yet, there are several challenges to implementing ERP, such as patients often refusing or dropping out of the treatment (Foa et al., 2005). Other obstacles to implementing CBT or ERP include the cost (averaging \$4300) and time consuming nature (approximately 30 clinical hours) (Turner, Beidel, Spaulding, & Brown, 1995) as well as the possibility that patients with strongly held or overvalued ideation (in which the belief is held with strong conviction, minimal doubt, and little resistance) perceive it as a less acceptable and less effective treatment (Foa, Abramowitz, Franklin, & Kozak, 1999). Thus, augmenting current ERP protocols with strategies designed to address these limitations has the potential to increase the number

of patients who are willing to engage in ERP and, in turn, reap the benefits.

A form of CBT, cognitive therapy (CT) has also been used to treat OCD. CT focuses on challenging maladaptive thoughts and beliefs (Clark, 2004) and often includes behavioral experiments, which are exercises used to test beliefs (Abramowitz, Taylor, & McKay 2005). Meta-analyses support the efficacy of both CT alone and CT combined with ERP (Abramowitz et al., 2002; Rosa-Alcázar, Sánchez-Meca, Gómez-Conesa, & Marín-Martínez, 2008). Importantly, treatments that include a cognitive component may be better tolerated and result in less dropout than ERP alone (Whittal, Robichaud, Thordarson, & McLean, 2008; Abramowitz et al., 2005), which has been theorized to be the result of patients perceiving ERP as an aversive treatment (Jones & Menzies, 1998). CT may be a preferred treatment approach for some patients, such as those with overvalued ideation (Neziroglu, Slavin Mashaal & Mancusi, 2013).

Within CT, the process of reappraisal, a form of cognitive distancing (Beck, 1970), aims at changing the interpretation of an emotional situation in such a way that it changes the event's emotional impact (Gross & John, 2003). In their recent review of the reappraisal literature, Jamieson, Mendes, and Nock (2013) suggested that it has the potential to serve as a powerful tool to

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1 shift negative stress states into positive ones. Reappraisal may  
2 assist OCD patients to gain distance from their faulty beliefs and  
3 enable them to address two vulnerability factors that are present  
4 in anxiety disorders: intolerance of uncertainty and anxiety  
5 sensitivity (Carleton, Sharpe & Asmundson, 2007).

6 Preliminary studies have explored the efficacy of brief and  
7 intensive interventions for OCD, offering the possibility that  
8 patient contact and cost can be reduced. Abramowitz, Foa and  
9 Franklin (2003) showed that daily treatment over three weeks and  
10 twice-weekly treatment over eight weeks were both effective. Two  
11 meta-analyses of psychosocial treatments for OCD (Abramowitz,  
12 1996; Rosa-Alcázar et al., 2008) suggested that shorter interven-  
13 tions might be just as efficacious as longer interventions. Group  
14 treatments may offer timelier, cost-effective therapy, as well as  
15 other benefits, including modeling and group pressure to enhance  
16 compliance with exposure practice. Anderson and Rees (2007)  
17 reviewed seven studies of successful OCD group treatment and  
18 then showed that a protocol with as few as seven two-hour group  
19 sessions can produce comparable results as individual treatment.  
20 Even structured self-help materials show potential. For instance,  
21 Andersson et al. (2011) found that a 15-week internet-based CBT,  
22 with only email contact with the therapist, significantly reduced  
23 OCD symptoms and depressive symptoms. Results such as these  
24 lend support to the stepped care approach to treatment (Davison,  
25 2000), currently in a large-scale initiation in England (Clark, 2011),  
26 where patients begin with the least expensive and least time-  
27 consuming treatment and progress to more costly treatment as  
28 needed. In a pilot study, Tolin, Diefenbach, Maltby and Hannan  
29 (2005) indicated that stepped care within OCD treatment may be  
30 both effective and cost-effective.

31 In a recent article, Rotheram-Borus, Swendeman and Chorpita  
32 (2012) suggested that evidence-based interventions can be dis-  
33 tributed more broadly and quickly through “disruptive innova-  
34 tions” that refine our understanding of a problem’s causes and  
35 solutions. They suggest one way to accomplish this is through  
36 models that simplify the protocol. Two tactics that show promise  
37 in other domains might enhance and even simplify current OCD  
38 treatment. First is the introduction of an emotional state that  
39 competes with the anxiety of approaching a threatening event.  
40 Several researchers have explored novel ways to modify the  
41 primacy of dysfunctional emotions by activating competing emo-  
42 tions. A summary of their theories is shown in Table 1. A second  
43 strategy is to take advantage of self-talk cues (Brinthaup, Hein, &  
44 Kramer, 2009) to direct and support the behavioral goals in OCD  
45 treatment. The therapeutic use of self-talk has been well estab-  
46 lished and is outlined in Table 2.

47 If patients can experience a significant reduction in symptoms  
48 at the initial phase of treatment through self-directed activity that  
49 is congruent with a newly acquired belief system, then this  
50 approach might increase the number of individuals with OCD  
51 who are willing to remain in treatment long enough to benefit  
52 clinically. The current study explored the efficacy of such a model of  
53 treatment initiation, delivered through a brief (two-day), intensive

(15-h) group (eight participants) cognitive-behavioral intervention  
for OCD. The primary goal of the intervention was to provide  
patients with a protocol in which they could challenge their OCD  
beliefs and then help them to engage in behavioral experiments to  
discover if they could rapidly reduce their obsessions and compul-  
sions. It was hypothesized that an intervention model that employs  
cognitive distancing, reappraisal, activating competing emotions,  
and self-talk would lead to rapid reduction in OCD symptoms as  
well as anxiety symptoms and experiential avoidance.

## 2. Methods

### 2.1. Participants

Thirty-three individuals with a primary diagnosis of OCD (21  
female, 12 male) participated in an intensive two-day cognitive-  
behavioral group treatment for OCD. Participants were recruited  
through requests for study volunteers within seven treatment  
groups from two sources – the annual International Obsessive-  
Compulsive Foundation conference and the first author’s treat-  
ment clinic – over a two-year period. All participants required  
diagnosis and referral from a health professional who then  
submitted a written statement confirming the diagnosis. Thirteen  
participants (39%) had co-morbid diagnoses. Twenty-nine partici-  
pants (88%) were currently taking psychotropic medications and  
32 participants (97%) had received other types of psychotherapy in  
the past. Their ages ranged from 17 to 73 ( $M=39.58$ ,  $SD=14.80$ ).  
All participants gave consent to participate in the treatment and  
study and completed all measures. Inclusion criteria were limited  
to an OCD diagnosis and age of at least 17 years.

### 2.2. Measures

The following self-report measures were administered to assess  
OCD-related beliefs, OCD symptoms, depressive symptoms, anxious  
symptoms, and experiential avoidance.

*Obsessive Beliefs Questionnaire – 44 (OBQ-44; Obsessive Compulsive  
Cognitions Working Group, 2005)*. The OBQ-44 is a 44-item self-  
report measure designed to assess dysfunctional cognitions that  
commonly occur among OCD patients. The OBQ-44 uses three

**Table 2**  
Protocols of self-talk in treatment.

Authors	Benefits found in protocol
Meichenbaum (1977) Callicott and Park (2003)	Behavior change in children Students with emotional and behavioral disorders
Sanders, Shepherd, Cleghorn, and Woolford (1994) Kendall (2006) and Treadwell and Kendall (1996)	Coping with pain Anxiety and depression in children

**Table 1**  
Theories of modifying dysfunctional emotions with competing emotions.

Authors	Theory
Greenberg (2012) Davidson (2000)	Withdrawal emotions such as fear, once accessed, can be modified by approach tendencies, such as activating anger Within brain mechanisms associated with affective style, right hemispheric withdrawal-related negative affect can be modified by activating the approach system of the left prefrontal cortex
Harmon-Jones, Vaughn-Scott, Mohr, Sigelman and Harmon-Jones (2004) Fredrickson, Mancuso, Branigan and Tugade (2000) Fredrickson (2001)	Fear or shame can be overridden by anger Activating a positive emotion has the ability to loosen the dominance of a negative emotion Activating positive emotions enhances recovery from anxiety-related sympathetic arousal

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