Journal of Obsessive-Compulsive and Related Disorders xxx (xxxx) xxx–xxx

Contents lists available at ScienceDirect

Journal of Obsessive-Compulsive and Related Disorders

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

Short communication

Biomedical causal attributions for obsessive-compulsive disorder: Associations with patient perceptions of prognosis and treatment expectancy

Marina Gershkovich[a], Brett J. Deacon[b], Michael G. Wheaton[c,a,*]

[a] New York State Psychiatric Institute/Columbia Psychiatry, New York, NY, USA
[b] Illawarra Anxiety Clinic, Mount Pleasant, NSW, Australia
[c] Barnard College, Columbia University, New York, NY, USA

ARTICLE INFO

Keywords:
Obsessive compulsive disorder
Biomedical model
Cognitive-behavioral
Exposure and response prevention
Treatment expectancy

ABSTRACT

In recent years, with scientific advances and growing understanding of neurobiological processes, biomedical explanations of psychiatric disorders, including obsessive-compulsive disorder (OCD), have become more prominent in research and in clinical care. Patient perceptions of biomedical models of OCD have been understudied, particularly in how they relate to patients' beliefs about prognosis and treatment expectancy. The current study measured self-identified OCD patients' (N = 130) current beliefs about their own prognosis and treatment and how believable they found two explanatory models of OCD: 1) a biomedical model that attributes OCD to biological functioning in the brain and 2) an integrative biopsychopsychocial model. Correlational results indicated that patients who found the biomedical model to be highly believable expected that their OCD would be chronic and require long-term treatment. In contrast, ratings of believability in the model that integrated biological, psychological and social factors in explaining OCD were not associated with prognostic pessimism. Instead, we observed a trend in which stronger belief in the biopsychosocial model was associated with the belief that behavioral changes could improve symptoms of OCD. Notwithstanding limitations inherent in the correlational nature of this study, the current findings highlight the need to further investigate the clinical implications of OCD causal models

1. Introduction

Obsessive-compulsive disorder (OCD) affects approximately 2% of the population and is associated with significant distress and impairment in functioning (Ruscio, Stein, Chiu, & Kessler, 2010). Fortunately, effective treatments exist for OCD, including both psychotherapy and pharmacotherapy. The American Psychiatric Association's Practice Guidelines recommend either cognitive-behavioral therapy (CBT) consisting of exposure and response prevention (EX/RP) or pharmacotherapy with serotonin reuptake inhibitors (SRIs) as first-line OCD treatments (Koran & Simpson, 2013). In clinical practice, treatment usually begins with psychoeducation about OCD, including discussion of a model for how OCD symptoms are acquired and maintained. Such explanatory models are often presented by the clinician in order to provide the rationale for a given treatment. Several models have been proposed, including both biological and cognitive-behavioral models. However, very little research has focused on patient perceptions of these explanatory models and how they relate to patient beliefs regarding prognosis and treatment expectancy. This is an important issue, as substantial research suggests that patient beliefs and expectations affect treatment response and symptom course (Kirsch, 1999). Thus the present study aimed to explore patient perceptions of two OCD explanatory models (specifically, biomedical and integrative biopsychosocial models) and how perceptions of these models relate to beliefs regarding OCD prognosis and treatment effectiveness.

In recent years, with scientific advances and growing understanding of neurobiological processes, biomedical explanations of psychiatric disorders, including OCD, have become more salient in research and in clinical care (Hyman, 2007). The biomedical approach attributes OCD to neurological, neurochemical, and genetic causal factors and emphasizes targeting these biological processes in treatment. Proponents of biomedical attributions suggest that this view may alleviate stigma associated with "mental illnesses" by emphasizing that these conditions are similar to medical illnesses (Corrigan & Watson, 2004). However, data on the effects of biomedical models on patient and public perception of psychological disorders are mixed (For review and critical analysis, see Deacon, 2013 and Schultz, 2015). Although biomedical explanations are associated with decreased self-blame and reduced shame (e.g., Deacon & Baird, 2009; Phelan, Cruz-Rojas, & Reiff, 2002; Lebowitz & Pyun, 2014), some studies indicate that biomedical

* Corresponding author at: Department of Psychology, Barnard College, USA.
E-mail address: mwheaton@barnard.edu (M.G. Wheaton).

https://doi.org/10.1016/j.jocrd.2018.03.001
Received 9 October 2017; Received in revised form 8 February 2018; Accepted 4 March 2018
2211-3649/ © 2018 Elsevier Inc. All rights reserved.

attributions increase stigma, perceived dangerousness, and reduce empathy from others (e.g. Angermeyer, Holzinger, Carta, & Schomerus, 2011; Kvaale, Gottdiener, & Haslam, 2013; Lebowitz & Ahn, 2014; Read, Haslam, Sayce, & Davies, 2006). Haslam and Kvaale (2015) propose that biomedical and biogenetic explanations are associated with "mixed blessings," that is, they have both positive and negative effects on stigma. Attributing the cause of the psychological disorder to biogenetic factors outside of the person's control (attribution of uncontrollability) may help to reduce self-blame. On the other hand, biomedical explanations may cause an essentialist view of the problem (belief that it is inherent and unmalleable), thereby increasing desire for social distance from sufferers, as well as prognostic pessimism, low self-efficacy in addressing the issue oneself, and the perception that medication is more effective and necessary than psychosocial approaches. For this reason, biomedical models can have implications for how people view themselves as well as how they are viewed by clinicians and the public. Some argue that by solely adopting the biomedical conceptualization, we run the risk of biological reductionism or neurocentrism with adverse consequences, including increasing pessimism regarding prognosis and efficacy of treatment (e.g. Deacon, 2013; Lam & Salkovskis, 2007; Kemp, Lickel, & Deacon, 2014; Lebowitz, Ahn, & Nolen-Hoeksema, 2013; Lebowitz, 2014; Lebowitz et al., 2014; Kvaale, Haslam, & Gottdiener, 2013).

The biomedical model of OCD is often communicated to patients as part of the rationale for treating OCD with SRI medications: these medications alter the functioning of serotonin, a neurotransmitter relevant in the functioning of neural circuits implicated in OCD. However, this rationale may make some individuals believe that their symptoms cannot be changed without an intervention targeting these biological systems (e.g., medication, brain surgery) due to perceived genetic or biological determinism of their condition. As such, biological attributions may make some patients feel that non-biological interventions (e.g., changes in behavior and thought patterns promoted in psychotherapy) will be unlikely to help them. To date, most studies examining biomedical explanations of psychopathology have utilized non-clinical samples. Furthermore, these survey studies have examined causal explanations of general psychopathology (disorder-nonspecific), or focused on depression (e.g. Lebowitz et al., 2013) or schizophrenia (e.g. Read et al., 2006). In several studies with more clinically-relevant samples, focusing on individuals with depressive symptoms, generalized anxiety disorder, and eating disorder symptoms, biological attributions were associated with pessimism about prognosis (Farrell, Lee, & Deacon, 2015; Kemp et al., 2014; Lebowitz et al., 2014). As yet, however, no study has investigated patient perceptions of biological attributions in OCD specifically.

In parallel to the biomedical model, the cognitive-behavioral approach to OCD presents an alternative model of the factors involved in the development and maintenance of OCD. Most CBT models are biopsychosocial (non-reductionist) in that they are not overly deterministic as to the exact origin of the disorder, and instead emphasize the potential role of multiple factors and their combination, including biological or genetic factors as well as social and developmental learning. The CBT model primarily focuses on behavioral (and modifiable) factors that maintain symptoms and that serve as the targets for treatment. For example, the CBT model emphasizes the functional connection between obsessions and compulsions (i.e., compulsion relieve distress and are therefore negatively reinforced). This approach is frequently presented in the psychoeducation phase of CBT, as it supports the rationale for EX/RP: prolonged and repeated confrontations with distress-provoking stimuli without engaging in rituals may allow one to break out of the cycle of obsessions and compulsions.

In the current study, we investigated patient perceptions of these OCD explanatory models and their associations with patient beliefs about prognosis and treatment expectancy in a sample of individuals with self-identified OCD. Rather than experimentally manipulating which explanatory model participants saw (as in Deacon & Baird, 2009), we instead elected to present participants with both models and ask how believable each seemed to them as described below. The first model involved a biological attribution for OCD, while the second was an integrative model consisting of biological, cognitive, behavioral, and environmental elements (i.e., biopsychosocial model). Based on the findings reviewed above, we hypothesized that higher believability ratings in the biomedical model would be associated with greater prognostic pessimism and lower perceived efficacy of psychotherapeutic interventions. In contrast, we hypothesized that a higher belief in the integrative biopsychosocial model would be associated with lower prognostic pessimism and higher perceived efficacy of psychotherapeutic interventions.

2. Method

This study was administered via online survey, hosted by Qualtrics, an online survey development tool. Participants were adults (aged ≥18 years) who self-identified as having OCD who were recruited via study advertisements placed online at the following sites: the International OCD Foundation (IOCDF) website, social media groups (e.g. Facebook), and web forums for individuals who self-identify as having OCD. Full details of the recruitment materials and sources are available upon request from the authors. The survey was open to all individuals who chose to participate. Upon completion of the survey, participants were given the option to enter a raffle for a chance to win a $50 gift card. Statistical analyses were run using IBM SPSS (Version 23). All study procedures were approved by the appropriate Institutional Review Board (IRB).

The sample consisted of 105 women and 24 men (total $N = 130$; one participant did not report a gender) with a mean age of 38.1 years ($SD = 12.8$, range 18–83). The sample was 84.6% non-Hispanic White, 8.5% Hispanic, 4.8% Asian/Pacific Islander, and 2.1% "other." Most (60.8%) of the sample endorsed currently being in treatment for OCD, and 89.2% had a previous history of treatment.

3. Measures

After providing consent, participants completed the online survey consisting of demographic questions, treatment history, and the following measures. Treatment history questions included two questions that asked (Yes/No) if participants had ever received medication for their OCD or had tried CBT consisting of EX/RP.

Dimensional Obsessive Compulsive Scale (DOCS, Abramowitz, 2010) is a 20-item self-report measuring the severity of OCD symptoms across four dimension: contamination, responsibility for harm and mistakes, symmetry/ordering, and unacceptable thoughts. For each symptom dimension, five items (rated 0–4) assess severity in terms of: (1) time occupied by obsessions and compulsions, (2) avoidance, (3) distress, (4) functional impairment, and (5) difficulty disregarding the obsessions and refraining from compulsions. The four DOCS subscales are summed to create a total score reflecting overall OCD severity. The DOCS total score converges well with other measures of OCD symptoms and has excellent psychometric properties (Abramowitz et al., 2010).

Causal explanations (Deacon & Baird, 2009). Participants were presented with two causal explanations of OCD adapted from a similar study in depression by Deacon and Baird (2009). Participants read the following explanations:

3.1. Biological (brain) explanation

Research suggests that OCD is caused by problems in the brain. Specifically, data from brain imaging studies show that in individuals with OCD there are problems in communication between the front part of the brain (which involves planning and control over one's actions) and deeper brain structures (which involve emotions such as fear and anxiety). These brain structures use neurotransmitters (basically,

Download English Version:

https://daneshyari.com/en/article/7268973

Download Persian Version:

https://daneshyari.com/article/7268973

Daneshyari.com