



ELSEVIER

Targeting the function of inner experiences in obsessive compulsive and related disorders

Michael P Twohig and Brooke M Smith

Current versions of cognitive behavior therapy have been shown to be effective for obsessive compulsive and related disorders. Recently there has been an increased shift toward targeting the function of inner experiences (e.g. obsessions, urges to hair pull) over their form or content. A handful of treatments target the function of inner experiences to such a large extent that they might be considered a shift. This paper reviews these treatments and their supporting data in the treatment of obsessive compulsive and related disorders.

Addresses

Utah State University, United States

Corresponding author: Twohig, Michael P (michael.twohig@usu.edu)

Current Opinion in Psychology 2015, 2:32–37

This review comes from a themed issue on **Third wave behavioural therapies**

Edited by **Kevin E Vowles**

For a complete overview see the [Issue](#) and the [Editorial](#)

Available online 29th January 2015

<http://dx.doi.org/10.1016/j.copsyc.2014.12.033>

2352-250X/© 2015 Elsevier Ltd. All rights reserved.

Categorization of obsessive compulsive and related disorders (i.e. body dysmorphic disorder, hoarding, trichotillomania, and excoriation disorder) as separate from other anxiety disorders occurred in the Diagnostic and Statistical Manual of Mental Disorders 5 [1] because they appeared to represent a categorically different set of disorders than anxiety disorders [2]. Recent meta-analyses show that cognitive behavior therapy (CBT), significantly outperforms control conditions [3] and pharmacotherapy [4] in the treatment of obsessive compulsive disorder (OCD). While treatments for related disorders exist, they are more limited, with recent reviews suggesting greater efficacy over control conditions for trichotillomania [5], body dysmorphic disorder (BDD) [6], excoriation disorder [7], and hoarding, as that disorder is only recently officially being categorized outside of OCD. Nevertheless, while psychological interventions are successful, they are still far from being 100% successful.

Originally, the treatment of OCD was quite behavioral with treatment directly linked to learning theory [8]. The same was true for the treatment of trichotillomania and

excoriation disorder [9]. The treatment of OCD became less behavioral and more cognitive behavioral with the onset of the cognitive revolution and treatments such as exposure with response prevention (ERP) focusing on cognitive change as a central component [10]. Additionally, cognitive therapy alone for OCD grew in popularity as did cognitive conceptualizations of OCD [11]. At the core of these conceptualizations was the idea that there were different cognitive styles (e.g. importance of thoughts, responsibility, among others) that had corresponding treatment techniques that addressed those styles [11]. This also influenced the work in BDD [12], trichotillomania [13], and hoarding [14]. While there are multiple conceptualizations of what the focus is in cognitive therapy, one that is held by some is that particular cognitions lead to problematic behavior and that problematic behavior is reduced by correcting cognitive errors [15]. The position taken within behavior analysis, which is also part of the CBT tradition, is that cognitions (and other inner experiences) are examples of behavior that affect the likelihood of an action, but are not causal as both behaviors are the product of external stimuli. Thus while both conceptualizations are part of the CBT tradition, they may be distinct models of CBT [16].

Consistent with this behavioral view of cognitive activity, there has been an increased interest in versions of CBT for OCD that focus heavily on the function of cognitions and other inner experiences over their form. Specific examples include acceptance and commitment therapy (ACT), dialectical behavior therapy (DBT), mindfulness-based stress reduction (MBSR), mindfulness-based cognitive therapy (MBCT), and metacognitive therapy, to name the more common ones [16]. Target constructs in these types of therapies include acceptance (allowing inner experiences to occur with no attempts to regulate them), mindfulness (watching inner experiences occur), cognitive defusion (seeing inner experiences as an ongoing process), as well as reducing thought control (learning not to engage with thoughts and simply allowing them to occur), to name some central ones. There are also modern constructs that lean toward these topics but have elements that are not completely function-based such as tolerance (allowing inner experiences to occur without fight until they lessen) and tolerance of uncertainty (coming to terms with the belief that some things in life cannot be predicted or certain).

The increased emphasis on function-based treatment elements to our conceptualization of obsessive-compulsive and related disorders might be considered a more dramatic

turn versus the steady shift that is occurring in ERP and CBT based treatments [17]. Because these disorders are looked at functionally, treatments are becoming more uniform across presentations of one disorder (e.g. across subtypes of OCD) and across disorders (OCD, trichotillomania, among others). Hayes *et al.* [18] termed actions in the service of reducing or preventing inner experiences, that result in poor functioning, experiential avoidance. Consistent with this functional view, these newer approaches have more of a focus on *stepping back and watching than directly addressing* inner experiences. The central goal of this paper is to highlight some of the newer versions of CBT that we feel target the function of inner experiences over their form, frequency, or content.

Acceptance and commitment therapy

ACT aims to increase *psychological flexibility*, or the ability to let inner experiences occur and change or persist in behavior as doing so serves valued ends. ACT applied to obsessive compulsive and related disorders suggests that attempts to eliminate or control the frequency or content of obsessions and related inner experiences are not only ineffective, but become so central that they decrease quality of life. Therefore, ACT aims to increase psychological flexibility by promoting an open, flexible stance toward internal experiences, decreasing attempts to control these experiences, and increasing contact with naturally reinforcing, values-consistent behaviors [19].

Psychological flexibility is targeted through the use of six core processes of change: *present moment awareness, defusion, acceptance, self, committed action, and values*. All these skills reduce entanglement with inner experiences, allowing movement in meaningful directions; there is no concern for the content or veracity of the inner experiences themselves. A recent meta-analysis analyzing data from 66 laboratory studies found significant positive effects for present moment awareness, defusion, acceptance, and values [20]. Another recent meta-analysis found psychological inflexibility to be moderately and significantly correlated with OCD and related disorders, and moderate support for changes in psychological inflexibility as mediators in ACT for anxiety disorders studies [21•].

To date, there is one randomized clinical trial of ACT for OCD and many single subject designs of ACT for various subtypes of OCD. These studies have all excluded in-session exposure to determine whether the effects of ACT could be seen without the use of already supported procedures. In the randomized clinical trial, utilizing blind assessments, 79 participants with OCD completed 8, one-hour sessions of ACT or progressive relaxation training (PRT) [22••]. Participants in the ACT condition achieved a significantly greater rate of improvement in OCD symptom severity than those in PRT, with an effect size of 0.84. The ACT condition also had a significantly

greater number of treatment responders than PRT at post (ACT = 46–56%, PRT = 13–18%) and 3-month follow-up (ACT = 46–66%, PRT = 16–18%). Of participants with at least mild depression, those in the ACT condition were significantly less depressed than those in PRT at post and follow-up, with effect sizes of 1.40 and 1.52 respectively.

Two studies utilizing a multiple-baseline across participants design investigated the efficacy of the same ACT protocol without in-session exposures for chronic skin picking [23•] and problematic pornography viewing [24•]. Both studies showed large decreases in target behaviors at post, with results maintained at follow-up in most cases, and increases in psychological flexibility. A randomized clinical trial compared ACT plus habit reversal to a waitlist control for trichotillomania [25•]. In the ACT condition there was a 45% reduction in symptom severity (WL = 0%), a 33% reduction in impairment (WL = 6%), and a 58% reduction in hairs pulled per day (WL = 28% increase), along with a 13% increase in psychological flexibility (WL = 6% decrease), from pre to post. Similar results were seen following treatment for those in the waitlist control.

Metacognitive therapy

Metacognitive therapy is based on the idea that patterns of thinking characterized by worry and rumination, increased threat monitoring, and avoidant coping strategies are the product of certain metacognitions (or beliefs about thinking) and result in psychological disorders [26]. Three types of metacognitions are particularly problematic in OCD: thought-fusion beliefs, the need to engage in rituals, and ‘stop signals’ for ending rituals [27]. According to the model, the strength of these metacognitions will impact the degree to which obsessions are negatively appraised, and negative appraisals and attempts at suppression will make obsessions more likely. Therefore, treatment focuses on fostering a state of ‘detached mindfulness’ characterized by meta-awareness, cognitive decentering, attentional flexibility, low conceptual processing, and low goal directed coping [28]. Metacognitive beliefs are also challenged with brief exposure ‘experiments’ [29].

Metacognitive beliefs have been shown to predict obsessive-compulsive symptoms after controlling for worry [30,31], and a brief exposure experiment with a metacognitive rationale resulted in decreases in self-reported anxiety/distress, metacognitive beliefs, and the urge to neutralize, as opposed to a habituation rationale in which the same variables increased [29]. Changes in metacognition have also been shown to predict outcome following a course of ERP for OCD [32].

To date, there have been two small randomized clinical trials evaluating the efficacy of metacognitive therapy for OCD. One study compared the effects of metacognitive

Download English Version:

<https://daneshyari.com/en/article/879518>

Download Persian Version:

<https://daneshyari.com/article/879518>

[Daneshyari.com](https://daneshyari.com)