



Let truth be thy aim, not victory: Comment on theory-based exposure process

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ABSTRACT

The successful application of cognitive-behavior therapy (CBT) to treat obsessive-compulsive disorder (OCD) and other anxiety problems is arguably one of the greatest recent success stories in psychotherapy research and practice. Several large clinical trials, multiple meta-analyses, and several effectiveness studies have shown variations of CBT to be effective for treating OCD in both children and adults. Unfortunately, there is also evidence that many individuals who receive the recommended “dose” of CBT experience significant and problematic residual symptoms and relapse after treatment. So it is important that we also make efforts to improve treatment engagement, response, and maintenance. This timely series brought together leading authorities on CBT for OCD to begin to explore whether a better understanding of how exposure-based techniques are incorporated into treatment might provide valuable insights into how to improve outcomes.

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1. Introduction

Cognitive behavioral therapy (CBT), usually involving some form of exposure to fear- and anxiety-eliciting stimuli, is widely recommended as the go-to intervention for a range of anxiety-based problems and there is ample evidence to support its efficacy for treating OCD (Abramowitz, Whiteside, & Deacon, 2006; Houghton, Saxon, Bradburn, Ricketts, & Hardy, 2010; Rosa-Alcazar, Sanchez-Meca, Gomez-Conesa, & Marin-Martinez, 2008). As Conelea and Freeman (2015) note, however, even when therapists are delivering treatment from the same protocol within a carefully controlled and supervised setting (e.g., an RCT), studies have shown variability in patient outcomes between therapists (Pediatric OCD Treatment Study Team, 2004). While some of this variation is likely due to client characteristics, this series makes a compelling proposition that exposure processes, defined as the specific and nuanced therapist and client behaviors and interactions that occur when implementing exposure therapy, also warrant consideration. Such exposure processes include, among other things, how to select, construct, and order exposure tasks, the rationale and instructions for how, when, and where to engage in exposure tasks, the pace and timing of exposure implementation, and what ancillary procedures (e.g., cognitive and

instructional techniques) to use, or refrain from using, when conducting an exposure. These nuanced aspects of treatment have thus far received little empirical investigation, vary across CBT models, and are less explicitly outlined in existing “how to” procedural manuals. The overarching theme of this set of manuscripts is that a better understanding why and how to implement exposure tasks across CBT approaches might provide valuable insights into how to enhance treatment outcomes.

2. Understanding exposure processes by connecting the “how” with the “why”

In this series, the application of exposure-based treatment for OCD is described from within four different models, all of which fall under the umbrella of CBT: the habituation model (Benito & Walther, 2015), the cognitive model (CT; Berman, Fang, Hansen, & Wilhelm, 2015), the acceptance and commitment model (ACT; Twohig et al., 2015), and the inhibitory learning model (Arch & Abramowitz, 2015). In contrast to other series on this topic, this set of manuscripts goes beyond simply comparing and contrasting the similarities and differences in how exposure is applied across various CBT models, but also uses the case of Monica to highlight the underlying reasons for procedural variations. Others have commented rather extensively on the similarities of the various models and their techniques, which has led some to hypothesize that the different approaches might activate a shared underlying

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mechanism of action (Arch & Crask, 2008; Tolin, 2009). While this may indeed be the case, and remains an empirical question, this series emphasizes that we might learn just as much by focusing on the differences between the various approaches. In this commentary I highlight some of the important differences in how the various CBT models conceptualize and implement exposure in the treatment of OCD with particular emphasis on how differences in exposure processes relate to each model's purported mechanism of action. Specifically, I will use the model descriptions and their case presentations to focus my comments around four exposure-process themes: (1) the rationale for exposure therapy, (2) designing and implementing exposure tasks, (3) what the therapist and client actually do during and after an exposure, and (4) how to know if exposure is activating the presumed underlying mechanism of change.

3. The rationale for exposure therapy: starting with the “why?”

Any discussion of how to best conduct exposure therapy for OCD necessarily begins with consideration of the rationale for conducting exposures in the first place. One common theme that emerged across all of the CBT approaches in this series is that the purpose of utilizing exposure tasks during therapy is to teach an individual with OCD to confront feared situations, experience fear and anxiety, and behave differently in their presence. In doing so, corrective learning of one form or another is presumed to take place. But the models differ fairly substantially regarding their specific reasons for employing exposure tasks. These differences are not merely matters of preference for a specific set of techniques, but rather speak directly to what is presumably learned during exposures, as well as how corrective learning can best be facilitated.

In the habituation and inhibitory learning models, exposure to fear-eliciting stimuli is thought to be the optimal way to directly facilitate corrective learning regarding stimulus–stimulus and stimulus–response associations. Despite their similarities, they differ in their views of what is necessary and sufficient for learning to take place. The habituation approach described by Benito and Walther (2015) maintains there are two necessary and sufficient conditions: the patient must repeatedly encounter fear- or anxiety-eliciting stimuli and she must remain in contact with the stimulus long enough for anxiety to reduce on its own (i.e., habituation). When these conditions are met, corrective learning of one form or another is thought to occur. In contrast, while the inhibitory learning approach also emphasizes the importance of encountering feared stimuli and anxiety/fear induction, it does not consider habituation an essential part of the learning process and even suggests that an overemphasis on anxiety reduction might interfere with learning. Rather, from this approach the goal of exposure is to teach the individual new expectations about what will happen when the feared stimulus is encountered, for example that the feared outcome will not be realized or that anxiety and uncertainty are tolerable. If done repeatedly and across a variety of contexts, it is believed that the individual will learn competing non-threat associations about the feared stimulus that are stored in memory along with traces of the original threat-based association (Crask et al., 2008 for a review). If insufficient learning takes place during exposure, the new non-threat associations will fail to inhibit the original threat association, which could result in reinstatement of fear following the passage of time (spontaneous recovery), when the feared stimulus is presented unexpectedly, or if the threat cue is encountered or in a context that differs from the context in which exposure took place (fear renewal). These conceptual differences translate into important procedural

differences in how, when, and where exposure tasks take place (described below).

In contrast, the CT and ACT models conceptualize exposure as a valuable opportunity for the patient to practice a broader set of therapeutic skills. Within the CT approach, it is thought that corrective learning takes place not through mere exposure to feared stimuli, but rather by actively processing, at the cognitive and emotional level, what the individual learns in the process. Through behavioral experiments and cognitive restructuring strategies, the individual learns to identify, challenge, and change his/her distorted cognitions and maladaptive beliefs by subjecting them to logical analysis and empirical hypothesis testing. These active cognitive strategies are thought to be as essential (if not more so) than direct exposure to the feared stimulus for facilitating corrective learning before, during, and after the exposure exercise. Likewise, as Twohig et al. (2015) note that when treating OCD from an ACT perspective, direct exposure to feared stimuli (and the resulting thoughts and anxiety) is not viewed as an essential procedural element to facilitate learning per se, but rather as an experiential opportunity for the individual to practice experiencing the distressing thoughts and feelings that arise during the exposure task. However in contrast to the CT approach, ACT is less focused on identifying and altering the meaning, content, or expectations associated with specific fear-eliciting stimuli (i.e., the likelihood of feared outcomes) during exposures. Rather it focuses more generally on increasing psychological flexibility and acceptance, which refers to experiencing the present moment (with all of the associated thoughts, feelings, etc.) and choosing to change or persist in a particular behavior based on chosen values (i.e., engaging in compulsive rituals vs. going to an important event). In other words, the individual is encouraged to engage in meaningful behaviors rather than attempting to avoid difficult experiences and emotions (Twohig et al., 2010). From a learning perspective, ACT focuses on altering a more generalized rule-governed relationship between thoughts, feelings, and behavior.

In summary, while each of the approaches shares some degree of conceptual overlap, their reasons for including exposure work in therapy are quite different. Within the habituation and inhibition models, exposure tasks are viewed as essential because they directly facilitate learning regarding the association between feared stimuli, the meaning of anxiety, and expected outcomes. Within the CT and ACT approaches, exposure is viewed as a valuable experiential opportunity to practice what the patient is taught within a broader therapeutic approach. Given these conceptual differences, it is not surprising that the approaches also differ in how exposures are actually conducted. With that in mind, we turn our attention how these conceptual differences translate into variations in specific exposure processes.

4. Designing and implementing exposure tasks: the “what, when, and where?”

One procedural element that is common to each of the models described in this series is that treatment begins with the careful identification of relevant internal and external stimuli that elicit fear, anxiety, and distress and thus motivate the performance of compulsions or other avoidance behavior. Across all models, identifying relevant stimuli is an idiosyncratic process that is based on a careful individualized assessment, taking account the functional relationships between fear-eliciting cues (and the context in which they occur), obsessions, expectations, avoidance behavior, and resultant undesirable or maladaptive outcomes. Despite sharing this common goal, the approaches differ regarding when exposure tasks are introduced in the course of therapy, how

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