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Is exposure and response prevention treatment for obsessive–compulsive disorder as aversive as we think?

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Abstract

Background: Meta-analytical studies have confirmed that exposure and response prevention (ERP) is the psychological treatment of choice for obsessive–compulsive disorder (OCD). Anecdotal evidence suggests that patients drop out of ERP because of the aversive nature of the treatment.
Methods: In this study, eight individuals diagnosed with OCD described their experience of ERP treatment in one-to-one semi-structured interviews. Qualitative data analysis was used to identify common themes across participants.
Results: Common themes were categorised into a) Experience of ERP, b) specific treatment factors, c) non-specific treatment factors, and d) quality of life impact.
Conclusions: Several specific and non-specific variables emerged as significantly impacting on the experience of completing ERP. A number of important themes emerged that provide special areas for consideration for minimising distress to clients when treating OCD using ERP.

Obsessive–compulsive disorder (OCD) is a common psychological condition that was once thought to be a rare mental health problem (Beşiroğlu, Çilli, & Aşkın, 2004). OCD usually begins in adolescence or early adulthood, has a gradual onset, has high rates of co-morbidity with other psychological disorders, and causes marked distress and significant impairment in an individual's daily functioning (American Psychiatric Association, 2000).

Pharmacotherapy, cognitive therapy, behavioural treatment (including traditional exposure and response prevention (ERP)) and cognitive-behavioural therapy (CBT) are the main interventions that are used to treat OCD. CBT in the form of contemporary ERP is the current treatment of choice for the disorder (Fisher & Wells, 2005). This behavioural treatment involves the client confronting feared stimuli while refraining from completing his or her usual ritualistic responses. This form of treatment is associated with response rates between 63% and 90% after an average of 14 sessions (Stanley & Turner, 1995). However, it has been estimated that approximately 30% of clients either refuse or drop out of treatment (Maltby & Tolin, 2005). Besides treatment refusal and high dropout rate, other obstacles to ERP treatment include the inaccessibility of ERP because there are relatively few professionals who have specialised training in the technique (Tolin & Scott, 2005), and difficulties in accessing ERP as it is comparatively expensive in the short term (Turner, Beidel, Spaulding, & Brown, 1995).

Rosa-Alcázar, Sánchez-Meca, Gómez-Conesa, and Marín-Martínez (2008) undertook a meta-analytic investigation on the effectiveness of psychological treatments of OCD. They found that ERP, cognitive restructuring (cognitive therapy), and a combination of the two (CBT) were effective in reducing symptoms and showed similar effectiveness. They noted that ERP's simplicity makes it the treatment of choice for OCD compared with cognitive therapy, but also found that ERP did have higher levels of patient attrition.

Key Points

1. Exposure and response prevention therapy (ERP) is demanding and can be distressing for individuals.
2. Specific and non-specific factors that reduce the distress associated with ERP have been identified.
3. Participants generally reported that although challenging, ERP did improve their quality of life.

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One major hypothesis that has been put forward to explain the treatment refusal and dropout rates is that the treatment is experienced as too aversive for clients. Foa et al. (1983) have suggested that one of the reasons for the high refusal/dropout rate associated with ERP is the "lack of courage to undergo a stressful treatment," a view that is supported by other OCD clinical researchers (Mairwen & Menzies, 1998).

However, this explanation has largely been based on clinical observation and anecdotal evidence rather than on actual clinical data. To thoroughly address this issue it is necessary to explore the experience of clients who have completed ERP and secondly to interview clients who refused or dropped out of ERP treatment. As a first step in improving understanding of how clients view the experience of ERP, this study aimed to recruit participants who had recently participated in this type of treatment. The current study reports on preliminary investigations using a qualitative research methodology to explore participants' experience of ERP treatment for OCD.

Method

Participants

There were 99 potential participants drawn from adult OCD patients who had attended our university clinic for a specialist, structured OCD treatment programme conducted by psychologists. All participants had completed a standardised cognitive-behavioural treatment programme (Rees, 2009) in either a group or individual format that consisted of 10 sessions and a follow-up session 1 month after completion. The first treatment session introduced the rationale for ERP, and the ERP component of the treatment is introduced in session 2 when exposure hierarchies are collaboratively developed. Clients are then supported in the completion of exposure exercises both in session with the therapist modelling and providing support and also out of session, at home.

Participants were sent an invitation letter describing the research project and were followed up with a telephone call 1 week later. The essential inclusion criterion was that participants had completed ERP treatment in individual and/or group setting within the last 18 months. Approximately 25% of participants could not be contacted, which could be passive refusals or changes in address/contact details. Eight adults diagnosed with OCD according to DSM-IV criteria agreed to participate in the study.

Participant 1 was a 46-year-old female part-time university worker. She was diagnosed with OCD and obsessive–compulsive personality disorder (OCPD). Her obsessions concerned contracting sexual diseases and sexually abusing a child.

Participant 2 was a 50-year-old female volunteer worker. She was diagnosed with OCD and major depressive disorder. Her obsessions included doubting, religious ideas, and intrusive thoughts about getting panic attacks if rituals were not done correctly. Her compulsions included checking, repeating, washing, drinking water, showering, and making coffee.

Participant 3 was a 36-year-old working man diagnosed with OCD. His main intrusive thought was about being a rapist, and his obsessions included fear of urinating in public, diseases, cameras, and doubting whether he had locked the doors. His compulsions included checking, washing, and covering his mouth.

Participant 4 was a 42-year-old male full-time professional who was diagnosed with panic disorder without agoraphobia, OCD, major depressive disorder, and OCPD traits. His main obsession was preoccupation with physical sensations, accompanied by disturbing thoughts that he would bite his tongue off. He also had thoughts of harming his family members.

Participant 5 was a 78-year-old retired man. He was diagnosed with OCD, major depressive disorder, and generalised anxiety disorder. He experienced distressing images of violence and excessive worries about health, finances, and his future.

Participant 6 was a 50-year-old nurse diagnosed with OCD. Her main fear was harming people, and she worries that she might get toilet water on her while showering. Her main compulsive behaviour was reassurance seeking and checking.

Participant 7 was a 42-year-old full-time female security officer diagnosed with OCD, OCPD and schizotypal personality disorder. Her main obsession was contamination, and her compulsions included washing, checking, and hoarding.

Participant 8 was a 38-year-old female who was diagnosed with OCD and provisional diagnoses of general anxiety disorder, panic disorder with agoraphobia, dependent personality disorder, and schizotypal personality disorder. She was obsessed about death and HIV. She had checking compulsions and hoarding.

Measures

Structured clinical interview for DSM-IV (SCID-IV) (First, Spitzer, Gibbon, & Williams, 1997)

This structured clinical interview was used to determine the DSM-IV diagnosis for all participants. These interviews are widely used, and the SCID-IV has moderate reliability, with median test–retest reliability of .69 and inter-rater reliability of .68 (Zanarini et al., 2000).

Semi-structured interview

The primary researcher conducted semi-structured interviews individually with each participant. Interview questions included: (1) You completed exposure therapy for your OCD here at the clinic. Can you describe what the treatment involved? (2) What was it like to go through the exposure treatment? How did you feel about completing the treatment?

Procedure

Eight participants were interviewed. An information sheet was mailed to potential participants who were later contacted by telephone to invite them to attend an interview. Individuals who met inclusion criteria were then asked to complete a consent form. Interviews were recorded on audio tape and were later transcribed for analysis.

Research design

We used guidelines from Braun and Clarke (2006) for qualitative data analysis: (1) generating initial codes; (2) searching for themes; (3) reviewing themes; (4) defining and naming themes; and (5) final examination of the resultant conceptual framework.

Results and Discussion

Overview of Thematic Analysis

The aim of the study was to explore in detail the participants' experiences of ERP. Fig. 1 shows the "thematic map" that resulted from the qualitative analysis.

Experience of ERP

Participants reported that going through ERP treatment was confronting and associated with distressing emotions and physical sensations:

> It is horrible, horrible, I remember I sat through the sexual abusing feeling. . . . My anxiety level becomes quite high (Participant 1).

Participants also admitted to trying to avoid the exposure:

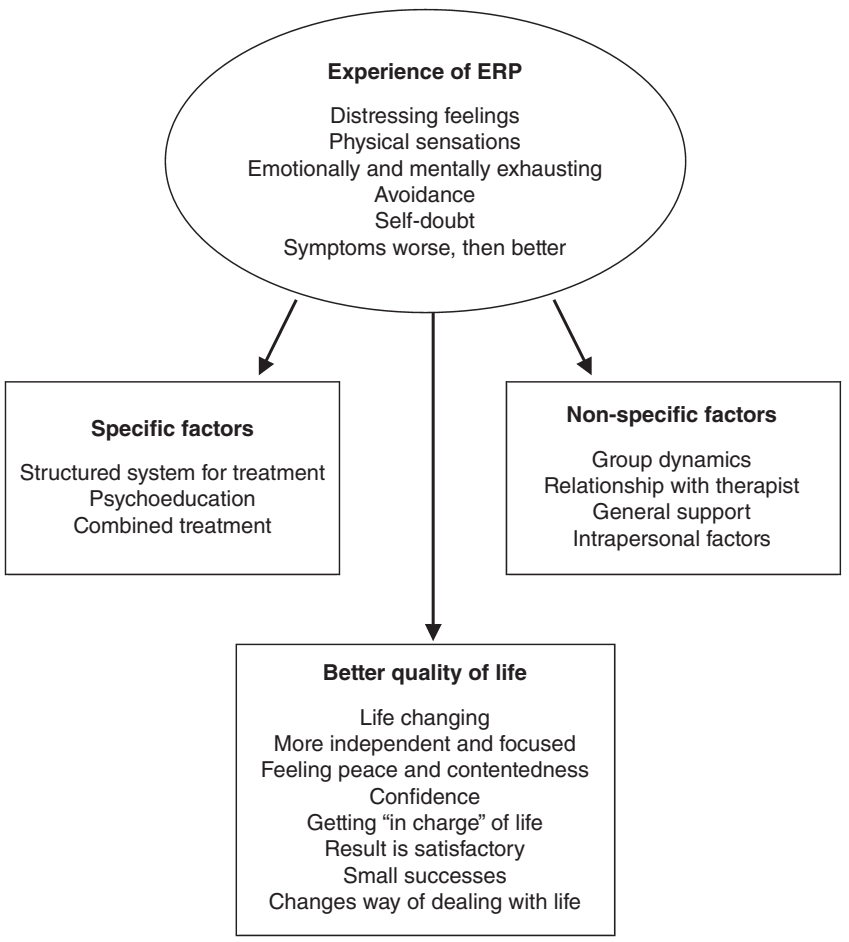

Figure 1 Thematic map of experience of exposure and response prevention therapy. ERP, exposure and response prevention.

> Even though I tried to distract myself . . . I will sit with it first then I will try to distract myself, but the thoughts will continue . . . (Participant 2).

As well as engaging in avoidance strategies, participants also indicated that their own self-doubt affected their ability to complete ERP:

> My head questioned it . . . did you do that, did you do that again, you know, after I've written it down . . . because the thoughts come . . . the compulsions of checking, you don't, you don't seem to trust yourself . . . (Participant 2).

Despite these difficulties, the majority of participants acknowledged that the distress of ERP reduced over time and was associated with an improvement in symptoms:

> . . . thoughts . . . that used to come to me, often in the middle of the night, often very, very violent, sometimes . . . it happened during the day and they gradually fade over, yes, six to twelve months (Participant 5).

Specific and Non-Specific Factors

A number of specific and non-specific factors were found to be vital in participants managing to remain in therapy. In terms of specific factors, a well-structured treatment combined with thorough psychoeducation regarding the use of ERP and the inclusion of additional treatment methods (cognitive therapy and medication) were all identified as important by participants. Participant 3 highlighted the value of a clear structure to ERP:

> . . . setup was from the easiest to the hardest . . . it is a good approach, yeah just to pace you into it . . . if they throw you in the deep end, you might give it away too easy.

Participant 1 highlighted the value of adding cognitive therapy to ERP:

> . . . rationalised thinking, looking at what these bizarre thoughts of what other people were doing, that's worked for me, in general, the two [Cognitive and ERP] combined . . .

Important non-specific factors that were identified by participants included the therapeutic relationship, general support, being in a group and interpersonal factors. As expected, the therapeutic relationship was mentioned by all participants as having a significant impact on their experience of ERP. As Participant 4 described:

> . . . my circumstances were treated with respect and also, with real interest and real concern.

Support came up as an important factor and consisted of general support from family and friends as well as from the therapist:

> . . . moral support, and I did not feel that I was on my own . . . (Participant 1).

Completing ERP in a small group setting was highlighted as very important for a number of participants. As described by participant 7, being in a group was noted as an important normalising and encouraging experience:

> . . . being able to talk to other people feels normal, it is really nice to have people validating me, . . . you are not crazy . . .

A final non-specific factor that emerged was the importance of intrapersonal factors such as an individual's level of motivation and courage. Participant 5 described the perseverance required to complete ERP:

> . . . I persevered, almost to the end, I persevered . . . and I wanted them to help me and it turned out they did.

Better Quality of Life

Seven out of eight participants felt that in general, their quality of life improved following ERP treatment. Participants generally perceived that dealing with OCD is a gradual process. This sense of global life improvement was reflected by Participants 1 and 8:

> It was the best thing I could have had. I described it to friends as life changing.

> . . . it changed how I parent, it changed how I work, it changed absolutely everything . . . which means I am now living again.

Conclusion

This study represents an initial exploratory investigation of the client-perceived experience of ERP. Several specific and non-specific variables emerged as significantly impacting on the experience of completing ERP. A number of important themes emerged that provide special areas for consideration when providing ERP treatment to clients with OCD.

It must be acknowledged that although clients did admit to finding the treatment distressing at times, the distress was countered by the perceived support of others and most predominantly of the therapist. As would be expected, the non-specific factors of the quality of the therapeutic relationship, support, normalisation, and encouragement enabled the present group of individuals

with OCD to successfully complete a challenging treatment. Attention to non-specific factors is therefore of critical importance for therapists who provide ERP. Even though ERP is a very technically involved treatment, the current results indicate that successful outcomes with ERP are heavily determined by appropriate attention to non-specific factors. Conducting ERP in a group setting also emerged as a particularly effective method for providing ERP.

A number of specific factors also emerged that deserve attention in the future application of ERP treatment. Specifically, therapists should pay attention to the structure and pace of exposure and negotiate with the client as to the length and frequency of sessions. Also, discussion of where to start on exposure hierarchies also appears to be an important factor influencing the client's satisfaction and willingness to partake in ERP. Taken together, the current study provides important information for therapists who wish to provide ERP in a maximally effective manner.

There are some limitations to the present study that must be kept in mind. First, all interviewed participants completed the treatment programme, and it is likely that the experiences and specific and non-specific variables differ from patients who ceased or refused the same treatment programme. Second, as only eight participants took part in this study, and given the heterogeneity of OCD experience, it is possible that additional themes or categories could emerge if further research is conducted with more participants. It is also possible that participants may have recounted information to the researcher that they were told in therapy and believed that the researcher "wanted to hear," given that the participants for the research were drawn from the same clinic where treatment was undertaken.

The logical next step in addressing this issue is to conduct interviews with individuals who refuse ERP and individuals who drop out of the treatment prematurely. This study has provided insights into factors that maximise the acceptability and effectiveness of ERP. Studies with treatment refusers and those who drop out will provide the additional necessary information about how best to encourage and retain clients in ERP treatment. Combined with the results of this study, practitioners may be able to structure/refine more efficient and effective treatment plans for OCD clients.

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