Emotional Schemas and Self-Help: Homework Compliance and Obsessive-Compulsive Disorder

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Many patients will either refuse to enter treatment or will drop out of treatment where exposure and response prevention (ERP) are employed. Patients may have a number of "good reasons" for noncompliance with ERP. For example, they may view their intrusions as conveying responsibility, reflecting higher threat, as personally relevant, and as requiring perfect and certain solutions. Inducing anxiety, from this perspective, only exacerbates the "problem." Moreover, patients may employ beliefs about emotion and anxiety that conflict with exposure—such as the belief that anxiety should always be avoided or decreased because it is assumed to rise indefinitely and cause psychological harm. Homework or between-session self-help necessarily involves exposure with increased anxiety and discomfort. In the current case study, both meta-cognitive and meta-emotional conceptualization and strategies were employed in the treatment of a previously treatment-resistant case of OCD, and homework compliance was improved through the use of an emotional schema approach.

COGNITIVE-BEHAVIORAL THERAPY for obsessive-compulsive disorder (OCD) has a high rate of efficacy, with many patients showing clinically significant improvement with the use of exposure and response prevention (Abramowitz, 1997; Abramowitz, Taylor, & McKay, 2005). However, a significant percent of OCD patients either refuse to enter CBT treatment, drop out prematurely, or do not comply with the requirements of exposure treatment (Whittal & McLean, 1999). Moreover, even among patients who show clinically significant improvement, a substantial percent of these patients (75%) are still affected by unwanted intrusions and difficulties in coping after "successful" treatment is completed (Fisher & Wells, 2005).

In recent years there has been an increase in attention to factors that might interfere with patient "compliance," "readiness," or "resistance" in CBT (Leahy, 2001, 2002a; Miller & Rollnick, 2002; Westra, 2004). This noncompliance is especially important because the CBT approach to the treatment of OCD and all anxiety disorders necessitates self-help homework between sessions. In particular, cognitive therapy approaches to OCD—involving examination of beliefs about the nature of one's intrusions and thought control strategies—have been proposed to address problems in compliance and to improve outcome (Clark, 2004; Wilhelm et al., 2005). Given the high rate at which potential or actual patients do not actually receive

adequate treatment for OCD, the application of techniques and strategies to increase adherence is an important issue. In regard to the treatment of OCD, effective treatment involves repeated exposure, with high rates of anxiety or emotional discomfort, and with abandonment of neutralization and safety behaviors (Foa & Kozak, 1985, 1986; Kozak & Foa, 1997). Although the psychoeducational component is a common initial intervention for treatment of OCD, it may not address the patient's beliefs about the nature and implications of anxious experience.

Converging theoretical approaches to the role of emotional experience may help elucidate important intervention strategies to address the problem of the patient's negative response to emotional experience. First, experiential models, such as those advanced by Hayes, Linehan, and colleagues from the mindfulness, dialectical behavioral, and acceptance approaches (Blackledge & Hayes, 2001; Hayes, Jacobson, & Follette, 1994; Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Hayes, Strosahl, & Wilson, 1999; Linehan, 1993), propose that individual change often involves willingness to experience unpleasant thoughts, emotions, and sensations for the purpose of personal growth and adjustment. Specifically, these "third wave" approaches stress the importance of addressing the patient's myths about emotions ("emotions are good/bad, overwhelming, or must be eliminated") and focus on the present moment, mindful detachment, observing emotion, and personification of emotion through the use of metaphor and other experiential and Gestalt techniques. The driving force here is that emotional experience cannot be avoided if change is to

be achieved. A second approach, which is consistent with the third-wave models, stresses the underlying emotional "beliefs" or "philosophies" that the patient holds. This model—*emotional schema therapy*—proposes that individuals differ as to their beliefs that painful emotions can be expressed, validated, accepted, and utilized for growth and that emotions are temporary, not dangerous, universal, comprehensible, complicated, and not shameful (Leahy, 2002a,b, 2003). This model, which draws on emotion-focused therapy (Greenberg, 2002) as well as Gottman's model of emotion coaching and emotional philosophies (Gottman, Katz, & Hooven, 1996), argues that individuals will resist exposure and unpleasant emotional experiences to the extent that they endorse negative emotional schemas (e.g., "Painful emotions are to be avoided" or "Painful emotions are dangerous and need to be controlled").

Moreover, the emotional schema model is a meta-emotional model, consistent with other meta-cognitive models of anxiety disorders (Wells, 2003, 2004). The cognitive model of OCD stresses the role of interpretations that the patient gives of intrusive thoughts (or urges). Thus, although intrusive thoughts are universal, the OCD patient believes that he or she must attend to and control the intrusive thoughts, that uncontrolled thoughts will lead to negative consequences either in action or dangerous outcomes, and that these thoughts are personally significant ("They say something about 'me'") (Purdon & Clark, 1994; Rachman, 1997; Salkovskis & Kirk, 1997; Wells, 2000). It appears that acceptance, mindfulness, emotional schema, and meta-cognitive approaches would agree that the patient's interpretations and strategies in handling unpleasant emotional and cognitive phenomena will have an impact on the course of anxiety disorders.

Cognitive models of thought suppression indicate that attempts to control, suppress, or eliminate unwanted intrusive thoughts may either increase the frequency or strength of these intrusions, exacerbate OCD symptomatology, and/or increase negative affect and appraisals (Clark, 2003; Purdon, 2004; Purdon, Rowa, & Antony, 2005; Salkovskis & Campbell, 1994). Thought control strategies may reaffirm for the patient that thoughts are out of control, and failures to "adequately suppress" may lead to demoralization and increased future failed attempts to suppress, thereby maintaining the vicious cycle of OCD obsession and neutralization.

These converging models were utilized in the treatment of a chronically obsessive-compulsive patient who had earlier dropped out of cognitive behavioral treatment with the author. Ten years prior to the current course of treatment, this patient had entered treatment with the author for her obsessional preoccupations. At that earlier time, the therapist attempted to employ traditional exposure with response prevention (ERP) for these obsessions. Although the patient reported a great deal of stress as a result of her OCD, she terminated treatment after only six sessions and, during the prior treatment, she completed almost no self-help homework. Thus, the current course of treatment, utilizing newer conceptualizations and strategies based on the previously discussed models, afforded a special opportunity for the therapist to compare his two treatments of the same patient. Specifically, how would the course of treatment differ if we included new meta-cognitive and meta-emotional conceptualizations and strategies?

Case Example

The patient reentering therapy was a 38-year-old single woman with a long history of obsessions about possible mistakes and leaving things undone. Her compulsions were primarily rechecking doors, windows, locks, and projects at work. She reported that her earlier experience in therapy with me had been useful in understanding OCD, but she felt she had not been "ready" for exposure, consequent anxiety, and risking any negative outcomes and regrets if she were to forego her neutralization. She had viewed self-help homework, involving ERP or delayed response, as risking intolerable levels of anxiety that would go out of control and overwhelm her. She indicated that she had hoped she could "do it on her own." She also felt some ambivalence about "needing someone for help."

Her OCD had spread to more areas of her life since her initial treatment. This contributed to a sense of demoralization as she reported feeling both depressed and helpless about her OCD and angry at herself (and her OCD). She reported shouting at herself to stop being so "irrational" and indicated that her hope in her new phase of therapy was to eliminate any of her urges or negative thoughts.

General Plan of Treatment

The new form of therapy was intended to utilize the advances in understanding of cognitive elements in OCD (Frost & Steketee, 2002) as well as new approaches to acceptance and emotional schemas. In particular, the initial goal in treatment was to educate her about the fact that individuals with OCD have specific dysfunctional interpretations of intrusions and utilize problematic thought-control strategies. In this psychoeducational phase she was told that people with OCD view intrusions as personally relevant, they think that they are responsible for these intrusions, that intrusions are viewed as dangerous, and that intrusions are viewed as pathological. She was presented with the following (see Table 1).

In reviewing these evaluations she could quickly see a number of things: first, she endorsed every one of these beliefs; second, she was obviously not alone; and third, we