The impact of experiential avoidance and obsessive beliefs on obsessive-compulsive symptoms in a severe clinical sample

Rachel C. Manos [a,c,*], Shawn P. Cahill [a,1], Chad T. Wetterneck [b,2], Christine A. Conelea [a,c,3], Ashley R. Ross [c,4], Bradley C. Riemann [c,5]

[a] Department of Psychology, University of Wisconsin-Milwaukee, PO Box 413, Milwaukee, WI 53201, USA
[b] Department of Psychology, University of Houston – Clear Lake, 2700 Bay Area Blvd., Houston, TX 77058, USA
[c] Rogers Memorial Hospital, 37000 Valley Road, Oconomowoc, WI 53066, USA

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ABSTRACT

The present study sought to replicate and extend a study by Abramowitz et al. (2009), who examined how well experiential avoidance (EA) and obsessive beliefs predicted obsessive-compulsive (OC) symptoms in a non-clinical sample. The current study utilized a severe, clinical, treatment-seeking sample ($N = 108$), and examined how well EA and obsessive beliefs predicted changes in OC symptoms from pre- to post-treatment. Findings were generally consistent with Abramowitz et al. EA was generally not related to OC severity and did not add significantly to the prediction of OC symptom domains above and beyond depression or general anxiety, whereas obsessive beliefs did. Pre- to post-treatment change in one type of obsessive belief (perfectionism/certainty), but not change in EA, predicted global change in OC severity. Results suggest that EA as it is measured currently may not play a significant role in OC severity or changes in OC severity across treatment.

Experiential avoidance (EA) is defined as an unwillingness to experience or remain in contact with unpleasant private experiences (e.g., emotions, thoughts, images, etc.) through attempts to escape from or avoid these experiences (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). EA is a primary target of acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999) and has received considerable research attention due to the proliferation of ACT research in the past decade. EA is associated with higher levels of general psychopathology, depression, anxiety, trauma-related symptoms, and lower quality of life (Hayes et al., 2004). There is evidence that decreases in EA are associated with improvements in psychopathology and that focusing treatment on EA may lead to symptom improvements within an anxiety-disordered sample (Chawla & Ostafin, 2007).

It has recently been suggested that ACT interventions targeting EA may be a preferable alternative to exposure and response prevention (ERP), the traditional cognitive-behavioral treatment method utilized in the treatment of obsessive-compulsive disorder (OCD; Eifert & Forsyth, 2005; Twohig, Hayes, & Masuda, 2006). OCD is characterized by obsessions (i.e., intrusive, unreasonable thoughts, images, fear, or worry) and compulsions or rituals used to reduce the anxiety associated with the obsessions (American Psychiatric Association, 2000). Eifert and Forsyth (2005) have suggested that compulsions function as attempts at EA, in that individuals with OCD engage in compulsions in order to "...control or reduce their unwanted thoughts because they want to reduce the negative affect associated with them (p. 58)." In support of this view, an eight-session ACT intervention devoid of within-session exposure in a sample of four participants led to reductions in EA and reductions in OCD symptoms from pre- to post-treatment, but this relationship could not be explored in depth due to the nature of the study design (Twohig et al., 2006). Although treatment did not explicitly involve therapist aided exposure techniques, a component of treatment involved having patients make "behavioral commitments" to engage in values-guided behavior that seemed to have led to ERP-like activities in some instances. For example, Twohig et al. (2006) list examples of behavioral commitments,

* Corresponding author at: Department of Psychology, University of Wisconsin-Milwaukee, PO Box 413, Milwaukee, WI 53201, USA. Tel.: +1 414 229 5078; fax: +1 414 229 5219.
  E-mail addresses: rcmanos@uwm.edu (R.C. Manos), cahill@uwm.edu (S.P. Cahill), wetterneck@uhcl.edu (C.T. Wetterneck), cconelea@uwm.edu (C.A. Conelea), ARoss@rogershospital.org (A.R. Ross), BRiemann@rogershospital.org (B.C. Riemann).
  [1] Tel.: +1 414 229 5099.
  [2] Tel.: +1 281 283 3364.
  [3] Tel.: +1 414 229 6078.
  [4] Tel.: +1 262 646 1159.
  [5] Tel.: +1 262 646 1388.

including not engaging in rituals on campus, removing hoarded material from one's home or storage units, and spending time in public locations that provoked anxiety or were previously avoided. Thus, it seems possible that these behavioral commitments may have led to symptom reduction via ERP strategies.

Whereas ACT interventions aim to reduce EA and increase acceptance and willingness to experience unpleasant private experiences (Hayes et al., 1999), cognitive-behavioral interventions work to decrease and change maladaptive interpretations of those private experiences (e.g., Abramowitz, 1997; Rachman, 1997). This focus on changing cognitive distortions is beneficial when used in conjunction with ERP (Abramowitz, 1997), and may lead to a lower dropout rate than ERP without cognitive techniques (Whittal, Robichaud, Thordarson, & McLean, 2008). The Obsessive-Compulsive Cognitions Working Group (OCCWG; 2005) identified three domains of beliefs related to the maladaptive interpretation of thoughts by OCD sufferers, which are assessed by the Obsessive Beliefs Questionnaire-44 (OBQ44; OCCWG, 2005): responsibility/threat estimation, perfectionism/certainty, and importance/control of thoughts.

In an attempt to explore the relationship between EA and obsessive-compulsive (OC) symptoms, Abramowitz, Lackey, and Wheaton (2009) examined whether EA predicts OC symptoms in a non-clinical sample and compared this to how well obsessive beliefs (as measured by the OBQ44) predict OC symptoms. Abramowitz et al. (2009) found that EA and obsessive beliefs were not significantly related to one another, and that EA did not significantly add to the prediction of OC symptom dimensions above and beyond depressive symptoms and obsessive beliefs. Obsessive beliefs, however, contributed to prediction of OC checking and obsessing symptoms after controlling for EA and depression. They concluded that perhaps the construct of EA was too general to significantly add to the prediction of OC symptoms over more specific constructs such as obsessive beliefs. Self-identified limitations of this study include use of a non-clinical and non-treatment-seeking sample, measuring the variables of interest at a single time point, and use of a general measure of EA that may not discriminate between various avoidance strategies. Furthermore, Abramowitz et al. (2009) controlled for depressive symptoms in their analyses but did not control for general anxiety. Finally, we note that the Obsessive-Compulsive Inventory – Revised (OCI-R; Foa et al., 2002) was used to measure severity of OC symptoms, whereas the Yale – Brown Obsessive-Compulsive Scale (Y-BOCS; Goodman et al., 1989) is the most widely used measure of OC symptom severity (Björgvinsson & Hart, 2007).

The current paper attempts to replicate and extend results of Abramowitz et al. (2009) while addressing their identified limitations, with the exception of the measure of EA as more specific measures of EA have not yet been validated. Specifically, the present study examines the impact of EA and obsessive beliefs on OC symptoms in two ways. The first is by conducting analyses similar to those in the Abramowitz et al. (2009) study among EA, obsessive beliefs, and OC symptoms (including use of the self-report Yale-Brown Obsessive-Compulsive Scale [Y-BOCS-SR; Baer, Brown-Beasley, Sorce, & Henriques, 1993]) above and beyond depression and general anxiety in a severe, clinical, treatment-seeking sample. The second is by examining relationships among EA, obsessive beliefs, and OC symptoms with respect to changes occurring from admission to discharge. Based on the Abramowitz et al. (2009) findings, it is expected that EA will not significantly predict admission level OC symptoms over and above depression, anxiety or obsessive beliefs, whereas obsessive beliefs will predict OC symptoms over and above depression, anxiety, and EA. It is further predicted that change in obsessive beliefs will predict change in OC symptoms, whereas change in EA will not predict change in OC symptoms.

1. Method

1.1. Participants and procedures

Participants included 108 adults (59 females) with a primary diagnosis of OCD who were admitted to either a residential OCD treatment program (n = 88) or an intensive outpatient OCD treatment program (n = 20) at Rogers Memorial Hospital in Oconomowoc, WI. Before admission to one of the OCD treatment programs, all prospective patients undergo a 90-min phone assessment that includes the Y-BOCS and other anxiety measures. The information is then reviewed by Dr. Bradley Riemann, Clinical Director of the Obsessive-Compulsive Disorder Center and Cognitive-Behavioral Therapy Services, who determines whether the person is appropriate for one of the OCD treatment programs at Rogers Memorial Hospital, and, if so, recommends which program would be best for the patient. Then, each patient has an initial assessment with a psychiatrist experienced in the assessment and treatment of OCD and who made the official diagnosis and up to four comorbid psychiatric diagnoses. Most (54%) of the current sample had at least one additional diagnosis, with the most common comorbid diagnosis being an affective disorder. Of those with psychiatric comorbidity, 36% had a secondary diagnosis of an affective disorder. For the present sample, admissions dates ranged from May 2003 to August 2007. The average length of stay was 52 days (SD = 26.85; range = 6–143). Participants ranged in age from 18 to 65 (M = 32.10 years, SD = 12.44). Upon admission to the hospital, each participant completed an admissions packet consisting of various questionnaires. Measures of interest for the current study were grouped into three categories (measures of OCD severity, predictor variables, and control variables) and are described in Section 1.2.

Treatment consisted of intensive cognitive-behavioral therapy, with an emphasis on ERP with adjunctive cognitive restructuring and medication management. Weekday treatment programming on the residential unit included 30 min of a homework review group, 180 min of therapist aided and self-directed exposure, 60 min of therapist aided cognitive restructuring, 60 min of recreational therapy, 45 min of self-directed cognitive restructuring and 90 min of additional self-directed exposure. Residential participants were also offered 120 min of voluntary group therapy per week. Required weekend programming per day included 30 min of homework review, 120 min of self-directed exposures, and 90 min of cognitive restructuring. Intensive outpatient program patients attended treatment programming three hours per day Monday through Thursday. Programming included a 15-min homework review group at the beginning and end of each day, and 180 min of a combination of self-directed and therapist aided exposure and cognitive restructuring. Programming totaled 12 h per week with an additional required two hours of treatment-related homework every day. Patients in both programs received one-on-one time with behavioral therapists each treatment day.

1.2. Measures

1.2.1. OCD severity

Two measures were used to assess severity of OCD. The self-report version of the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS-SR; Baer et al., 1993) contains five items that rate severity of obsessions and five that rate severity of compulsions on a scale ranging from 0 to 4, for a total score ranging from 0 to 40 (0–7 = subclinical, 8–15 = mild, 16–23 = moderate, 24–31 = severe, and 32–40 = extreme). Although the Y-BOCS 10-item interview version is the most comprehensive assessment available for OCD, Baer et al. (1993) found that scores on the self-report version and the interview version were very highly correlated (r = .97). The