

The Use and Misuse of Exposure Therapy for Obsessive-Compulsive and Related Disorders

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Abstract: In this article we define and describe the use of exposure-based therapy for OCD. This approach involves confrontation with feared stimulus with the aim of facilitating fear extinction. Exposure, however, is not applicable for a number of psychological conditions now listed as related to OCD in the DSM-5. We explain when it is appropriate to use exposure and when it is not, and raise cautions for clinicians to consider when working with patients with problems putatively related to OCD.

Keywords: Body dysmorphic disorder, exposure therapy, hair pulling, hoarding, obsessive-compulsive disorder, skin picking.

INTRODUCTION

A reclassification of obsessive-compulsive disorder (OCD) out of the Anxiety Disorders category and into a new diagnostic category of Obsessive-Compulsive and Related Disorders (OCDs) has occurred in the Diagnostic and Statistical Manual - Fifth Edition (DSM-5). The proposed OCDs include body dysmorphic disorder (BDD), hoarding disorder, hair-pulling disorder (currently known as trichotillomania [TTM]), and skin picking disorder. Although the empirical and intuitive bases for this re-alignment have received considerable criticism [1, 2], proponents argue that the new model is essentially etiological in that it defines OCD and putatively similar disorders based on endophenotypes and apparent overlaps in etiological factors such as heritability, brain circuitry, neurotransmitter abnormalities, and phenotypic similarities with other disorders [3].

Proponents of the OCD category also suggest that removing OCD from the anxiety disorders and into the new diagnostic OCD category is justified given that the putative OCDs share similar response profiles to so-called “anti-obsessional behavioral therapies” [3-6]. The present article focuses on this claim, which as we will show, reveals a fundamental misunderstanding of the behavior therapy techniques used in the treatment of OCD; i.e., exposure and response prevention. In this essay we argue that exposure-based therapy is inappropriate for the treatment of several proposed OCDs.

Behavior therapy is a collection of experimentally established procedures based on principles of learning, and these procedures are used to weaken (or eliminate) inappropriate or maladaptive responses (e.g., anxiety,

avoidance, hair pulling, etc.) to particular circumstances or stimuli [7, 8]. The planning of an effective behavior therapy regimen for someone with OCD or any other behavioral problem relies on precise information about the antecedents and consequences of the responses to be eliminated. The collection of this information (functional [behavioral] analysis) [7, 8] is critical to the success of behavior therapy because it influences the choice of therapeutic procedures. As we will explain, functional analyses (and research findings) reveal that in OCD, obsessional stimuli (e.g., contact with the floor) are associated with *increases* in anxiety, and compulsive rituals (e.g., hand washing), with *reductions* in anxiety. Rituals thereby ostensibly provide an escape from anxiety, yet in doing so are negatively reinforced leading to repetitive use in similar situations (e.g., contact with floors, shoes, money, etc.). Moreover, the immediate reduction in anxiety that is engendered by performing rituals prevents the natural extinction of the anxiety response and urge to perform rituals that would have otherwise occurred. In other words, rituals keep the individual from getting over his or her obsessional fear. Effective behavior therapy for reducing OCD symptoms must therefore weaken the associations between (a) obsessional stimuli and excessive anxiety, and (b) compulsive rituals and relief from anxiety. The most effective behavioral techniques for accomplishing these goals are *exposure* and *response prevention*. We next turn to a discussion of these techniques before explaining why they are not necessarily well suited for use with all of the OCDs.

EXPOSURE THERAPY AND ITS CONCEPTUAL BASIS

Exposure therapy is a set of behavior therapy (often referred to as “cognitive-behavior therapy”) techniques commonly used to reduce pathological fear responses in OCD and in other anxiety problems such as phobias, panic attacks, and posttraumatic stress disorder [9]. Exposure

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involves the patient intentionally confronting feared, but objectively safe, objects, situations, thoughts, and bodily sensations with the goal of reducing fear and other negative reactions (e.g., avoidance) to the same or similar cues. Three types of exposure can be used to help the patient face his or her feared stimuli: *situational* (i.e., real life or *in vivo*) exposure is used for confrontation with external stimuli (e.g., floors, toilets) and *imaginal* exposure is useful in confronting unwanted obsessional thoughts and doubts that are not easily accessible to real life situations (e.g., violent images, doubts about responsibility for harm). Less commonly used with OCD, *interoceptive* exposure might be employed to help patients confront feared (but objectively harmless) body sensations that sometimes accompany anxiety and fear (e.g., racing heart, breathlessness). The choice of exposure type is determined by features of the patient's individual fears; and it is often the case that different types of exposure are used together in the treatment of a given individual [9].

The use of exposure therapy for OCD is derived from Mowrer's two-stage learning theory of anxiety disorders [10]. This model proposes that fear is *acquired* through classical conditioning, and that the conditioned fear response (and resulting avoidance and compulsive rituals) is *maintained via* operant conditioning. For example, a patient might acquire a fear of "toilet germs" following an anxiety- or disgust-provoking experience in which urine was encountered on a toilet seat (classical conditioning). She might then avoid toilets when possible, or use a special hand washing ritual to remove all of the germs when she inevitably cannot avoid. The avoidant and ritualistic behavior might result in an immediate (and transient) reduction in fear, thus negatively reinforcing these behaviors (operant conditioning) leading to their becoming "compulsive." Moreover, the avoidance and rituals prevent the natural extinction of anxiety and learning that the conditioned stimulus (i.e., toilets, urine) is usually safe. The implication of Mowrer's two-factor model is that the treatment of OCD must foster extinction of the conditioned anxiety response. Systematic exposure and response prevention are procedures that promote fear extinction *via* repeated confrontation with conditioned fear cues while resisting urges to avoid and perform compulsive rituals that would impede extinction learning. Mowrer's model remains the basis of exposure therapy because it satisfactorily explains the *maintenance* of obsessional fear and rituals through operant conditioning. Cognitive theories (e.g., Rachman, 1998), however, have proven to provide a more empirically supported account than classical conditioning to explain the *development* of obsessions.

Foa and Kozak [11] proposed emotional processing theory (EPT) and adopted Lang's [12] concept of the fear structure to create a model for understanding the mechanisms involved in exposure therapy for anxiety disorders such as OCD. They asserted that exposure achieves its effects *via* "emotional processing," a process by which the pathological threat associations (e.g., "toilets are very dangerous") which form part of the fear structure are modified by the incorporation of corrective information (e.g., one does not become sick following exposure to a toilet). Craske *et al.* [13] noted inconsistencies in EPT and specified that during exposure new non-threat associations

(e.g., "toilets are safe") are formed that compete with existing threat associations. Long-term fear extinction (and the success of exposure therapy) therefore hinges on *inhibitory learning* [14]; that is, the non-danger associations successfully impeding access to and retrieval of the threat associations. The degree to which threat-based *versus* non-threat based associations are expressed after finishing exposure therapy depends on the strength of inhibitory learning across time and context - rather than, as espoused by EPT, the habituation of anxiety within and between exposure sessions [12].

EXPOSURE THERAPY FOR OCD

Situational and imaginal exposure are typically applied together in the treatment of OCD because OCD involves fear-provoking obsessional thoughts that are usually triggered by tangible environmental cues. For example, an individual who fears knives because they evoke unwanted violent obsessions would practice using knives (situational exposure) and imagining stabbing loved ones (imaginal exposure). As alluded to previously, abstaining from rituals (i.e., response prevention) is also an important component of exposure treatment for OCD. Rituals are performed in response to obsessive intrusions and are intended either to reduce the likelihood of harm from the feared situation, or just to reduce obsessional distress. Exposure and response prevention (ERP) treatment requires that the individual resist the urge to perform rituals in response to obsessions. During exposure therapy, repeated confrontation with feared situations and thoughts provokes fear or anxiety. The patient confronts the fear cues and the resultant anxiety, without attempting to reduce it by withdrawing from the situation or by performing compulsive rituals, in varying contexts to learn that (a) anxiety, uncertainty, and obsessional thoughts are manageable, (b) these experiences usually decline over time even in the absence of rituals, and (c) fear cues are not as dangerous as was predicted.

The delivery of ERP for OCD can vary widely. One format found to be very effective is a few hours of assessment and treatment planning, followed by between twelve and twenty twice-weekly exposure sessions, lasting 60 to 90 minutes each. Generally, the exposure sessions are supervised by a therapist, and self-exposure practice is prescribed as homework between sessions. The exposure exercises typically begin with moderately distressing situations or thoughts, although the use of a hierarchy is not a requirement. In fact, randomness in exposures appears to enhance extinction [14]. What is important is that the most distressing situations are confronted at some point during treatment. At the end of each treatment session, the therapist instructs the patient to practice for several hours the same exposure tasks that were completed in the session, but without the therapist and in different contexts.

Until the 1960's, OCD was considered unresponsive to psychotherapy, which at the time typically included psychoanalytic and supportive approaches [15]. However, with the introduction of ERP in the 1960s [16], the prognosis for this problem improved substantially. Numerous studies conducted in various centers around the world have established ERP as a highly efficacious therapy for OCD

[17]. Abramowitz [18] conducted a meta-analysis of 24 exposure treatment studies for OCD conducted between 1975 and 1995 encompassing over 800 patients. He found that this treatment produced large pre-post treatment ESs for outcome assessed by patient self-report ($ES = 1.16$) and by an interviewer ($ES = 1.31$). In addition, these large ESs remained at follow-up, suggesting that the improvements persisted even after the treatment had been ended.

The specific effects of the ERP techniques, as opposed to nonspecific effects common to all therapeutic interventions (i.e., time, attention, therapeutic relationship, etc.) can be examined through studies comparing ERP to other interventions. A second meta-analysis by Abramowitz [19] included only RCTs in which two treatments were compared; this ES was calculated as the standardized comparison between two interventions at post-treatment. Comparisons between ERP and a relaxation control yielded a large effect size in favor of ERP, ($ES = 1.18$). Similarly, in the largest meta-analysis conducted (86 studies), Van Balkom and colleagues [20] were able to examine treatments that were described as behavioral, as opposed to cognitive or a combination. Their results supported the effectiveness of standalone exposure techniques with an ES of 1.46 for self-reported OCD symptoms and 1.47 for assessor-rated symptoms. Taken as a whole, these studies provide strong support for the effectiveness of exposure alone or in combination with cognitive techniques for OCD. Advances in ERP are discussed in several excellent reviews [21, 22].

APPLYING EXPOSURE THERAPY FOR OTHER OCRDs

As we have discussed, the use of exposure-based therapy for OCD is derived from the unique relationship between obsessional fear and compulsive behavior. Specifically, obsessional fear is triggered by feared situations and thoughts that are not objectively dangerous. Compulsive rituals and other neutralizing behavior in OCD are performed deliberately with the purpose of reducing obsessional anxiety, yet in doing so, also maintain the anxiety. Rituals are redundant since the anxiety and fear would decrease naturally even if no ritual was performed. Yet the individual with OCD performs such behaviors compulsively (“neurotically”) as a way of ensuring anxiety reduction. The purpose of ERP is to teach the patient that obsessive fears are excessive, compulsive behaviors are unnecessary to maintain safety and that anxiety and obsessional thoughts are safe and tolerable. In the remainder of this article, we discuss how well this treatment model applies to the other disorders characterized in the DSM-5 as OCRDs.

BODY DYSMORPHIC DISORDER

Formerly classified as a somatoform disorder in DSM-IV-TR [23], BDD involves imagined or exaggerated concerns about physical defects such as preoccupations about the shape or size of one’s facial features. These appearance concerns trigger anxiety or distress. In response to their appearance-related anxiety and fears, individuals with BDD engage in frequent social avoidance and other behaviors designed to conceal, correct, check, or seek reassurance

about the imagined defects. A number of authors have suggested that BDD might be conceptualized as an OCRD [24-27]. Indeed, the appearance-related preoccupation observed in BDD is topographically similar to obsessions in OCD in that both are persistent, recurrent, and anxiety provoking; as well as subjectively resisted. In addition, as observed in OCD, there is some variation in the degree of insight into the senselessness of these intrusions. Appearance-related thoughts can range from mild obsessive preoccupations to overvalued ideation to severe delusion-like beliefs [28]. A number of studies suggest that individuals with BDD have poorer insight (greater overvalued ideation) than do those with OCD [29].

As with OCD, individuals with BDD appear to have “compulsions”, or at least tend to engage in ritualized behaviors designed to reduce anxiety. More specifically, these behaviors are performed with the intention of examining, hiding, correcting, or looking for reassurance about one’s appearance-related concerns. For instance, some individuals with BDD check their appearance for prolonged periods of time by gazing in mirrors, windows, and so on. Others focus their energies on avoiding all reflective surfaces so that they don’t experience unwanted intrusions—much like individuals with OCD avoid obsessional triggers. Other “compulsive” behaviors include dieting, comparing oneself to others, measuring the “flawed” body part, and seeking a cure (e.g., dental, dermatological, cosmetic, etc.) for the perceived defect [30].

BASIS FOR EXPOSURE THERAPY

Neziroglu, Roberts and Yaryura-Tobias [31] (2004) offer a cognitive-behavioral model of BDD that is derived from Mowrer’s two-factor theory [10], and which provides a basis for the use of exposure therapy. According to this conceptualization, classical conditioning then occurs when, perhaps around the time of puberty (when numerous body changes occur) an individual is teased or otherwise socially traumatized in some way related to his or her body [31, 32]. The shame, disgust, or other emotions associated with these events become classically associated with particular body parts [33]. Veale [34] offered an alternative explanation for how BDD is maintained from a cognitive perspective, proposing that the chain of events begins with an “external representation” of the individual’s appearance, such as seeing one’s reflection, which triggers a defective mental image. Through selective attention, the individual experiences heightened awareness of specific characteristics within the image, which then offer him or her information on how he or she appears to others. Next, the individual engages in negative appraisal of his or her appearance, turning towards his or her existing values and assumptions about the importance of physical appearance (e.g., “If I am unattractive, then life is not worth living”).

The person then engages in various “safety behaviors,” such as avoidance or compulsive-like rituals (e.g., checking) with the aim of preventing feared outcomes and reducing distress. Although these safety-behaviors might temporarily alleviate distress (and are thereby negatively reinforced), in the long run they increase self-consciousness, preoccupation

with the imagined defect, and negative appraisals of oneself. Moreover, they prevent the unlearning of the initial emotional reaction, thereby strengthening the avoidance and compulsive behavior. This model has clear implications for treatment and generally leads to the use of exposure-based interventions.

IMPLEMENTATION

Exposure therapy is implemented for BDD in much the same way that it is used in OCD [25]. In BDD, exposure helps the patient to learn that (a) the fear that others will notice and respond negatively to the imagined physical defect are excessive and unrealistic, and (b) that anxiety and feelings of embarrassment are temporary and tolerable. The following sorts of exercises might be incorporated into exposure for BDD: going out in public without makeup, enhancing an imagined defect using makeup, and wearing pants that reveal or accentuate certain parts of the body [35]. Gorbis [36] has reported success exposing patients to distorted images of themselves (i.e., using a curved mirror) while having them resist using a normal mirror to check on their body shape. Other strategies include using computer programs to manipulate pictures the person [37]). Response prevention incorporates abstinence from behaviors such as prolonged mirror-gazing and self-inspection, wearing clothing (e.g., hats) to conceal the hair or face, and seeking assurances from others (e.g., embarrassment) [31, 34].

EFFICACY

Although research on the treatment of BDD has increased in recent years, the number of studies evaluating the effects of exposure-based CBT for BDD is small relative to those on the effects of CBT for OCD. In a review of the literature through 2003 Williams *et al.* [38] identified 9 studies of exposure-based CBT for BDD. The mean effect size across studies in which treatment involved only ERP was 1.21, and that for studies of CBT which involved ERP was 1.78. These effect sizes are large and comparable to the effects observed with the use of ERP for OCD. More recently, Khemlani-Patel, Neziroglu, and Mancusi [39] found that adding cognitive therapy to ERP did not significantly enhance the effects of ERP alone. The small sample size of this recent study notwithstanding, findings from the treatment literature suggest that ERP is efficacious in the treatment of BDD.

TRICHOTILLOMANIA AND SKIN PICKING

The DSM-IV-TR defines TTM as an impulse control disorder involving: (a) recurrent pulling out of one's hair resulting in noticeable hair loss; (b) an increasing sense of tension immediately before pulling or when attempting to resist the behavior; (c) and pleasure, gratification or relief when pulling. It cannot be better accounted for by another mental disorder or due to a general medical condition such as dermatological problem. Moreover, a diagnosis of TTM requires clinically significant distress or impairment in social, occupational, or other important areas of functioning. Christenson, Mackenzie, and Mitchell [40] reported that

among a sample of 60 adults with hair pulling problems, 5% did not endorse feelings of tension prior to pulling, and 12% did not endorse gratification or release of tension following pulling episodes. About 75% of adults with TTM indicate that much of their hair-pulling behavior occurs outside of awareness (i.e., "automatically"), whereas 25% describe focusing on their hair-pulling [41]. This difference between "focused" and "unfocused" pulling, however, is confounded by the fact that many individuals report both types of pulling behavior [42]. In comparison to those with unfocused pulling, individuals who primarily engage in focused pulling more often pull hair from the pubic region and describe greater shame associated with hair pulling [43].

The DSM-5 has defined Skin Picking Disorder as an OCD involving recurrent skin picking that (a) results in skin lesions, and (b) causes clinically significant distress or impairment in one or more important areas of functioning. A growing literature indicates that the prevalence of skin picking in clinical and community samples ranges from 2 to 5.4% [44] and that many individuals with this problem also have mood and anxiety disorders. People with skin picking might spend substantial time engaging in this behavior, often several hours per day, and the picking might cause tissue damage and infection that necessitates antibiotic treatment or even surgery [44]. Although skin picking may be present at any age, it typically onset at adolescence and often in the context of a dermatological condition, such as acne [44]. The head and face are the most common areas for skin picking, and whereas the majority of patients use their fingernails, use of tweezers and other "tools" is common. Cues that trigger urges to pick include negative mood states as well as feeling irregularities in the skin [44]. Not surprisingly, shame and embarrassment are often associated with skin picking.

CONCEPTUALIZATION AND TREATMENT

Whether TTM and skin picking disorder should be conceptualized as impulse control disorders or as OCDs is a matter of disagreement. Many have associated TTM and skin picking with OCD on the basis of seeming topographical similarities between the recurring and perceived irrepressible nature of hair pulling and skin picking, and that of compulsions in OCD. Some studies have also reported higher rates of OCD among individuals with TTM [41]. Swedo and Leonard [45, 46] suggested that both OCD and TTM patients view their behaviors as unreasonable, and describe an overwhelming urge that causes them to perform the behaviors.

When one considers the *function* of the repetitive behavior in OCD, and in TTM and skin picking, however, it seems clear that the two latter conditions are distinct from OCD [47]. In contrast to the intrusive and repetitive nature of obsessions in OCD, TTM and skin picking do not involve distressing intrusive (obsessional) thoughts. That is, hair pulling and skin picking often occur outside of the person's awareness, as opposed to being provoked by obsessive fear. In addition, people with OCD usually describe their compulsive rituals as unpleasant yet necessary to reduce anxiety, whereas most with TTM and skin picking describe these behaviors as pleasurable or satisfying. This is

consistent with the notion of OCD as maintained by *negative reinforcement* (decrease in anxiety; compulsions rarely elicit positive affect), whereas TTM and skin picking are maintained (at least in some sense) by *positive reinforcement* (increase in pleasurable experience).

This difference in conceptualizations between OCD on the one hand, and TTM and skin picking on the other, has important implications for the use of exposure therapy. As we have seen, exposure is a procedure for helping patients with excessive fears (e.g., obsessions) to repeatedly confront anxiety-provoking stimuli and to promote habituation and changes (i.e., corrections) in expectations of feared consequences (e.g., “If I were to touch the floor, I would get sick;” “If I go to school without wearing a hat, people will laugh at my hair.”). Yet this approach does not apply to TTM and skin picking where there are no obsession-like fears of disastrous consequences.

We have observed that some clinicians attempt to use exposure for TTM and skin picking. For example, they might instruct patients with TTM to expose themselves to situations in which hair pulling occurs, such as standing with tweezers by a mirror, and resisting the urge to pull. This, however, represents a misunderstanding of the principles of exposure therapy. Exposure is a treatment for fear-based avoidance and compulsive behavior, not for *any* type of compulsive behavior. Unfortunately, lumping TTM and skin picking disorder with OCD in the new OCD diagnostic category is likely to lead to further confusion and the improper use of exposure. That is, clinicians might think that because ERP is effective for OCD itself, this intervention should be effective for all of the OCDs. Yet as we have touched on, urges to pull hair and pick skin are *impulsive*, and these behaviors are maintained by positive reinforcement because there is a pleasurable element. This is different than compulsive rituals in OCD, which are maintained by negative reinforcement. That is, on a functional level, OCD rituals are escape (safety) behaviors. TTM and skin picking are not fear-based, and therefore will not respond to exposure-based techniques.

Rather, individuals with TTM and skin picking are best served by implementing techniques that alter the antecedents (i.e., cues) of the target behaviors. For example, avoiding high-risk situations (the very *opposite* of what would be prescribed in exposure therapy) and using competing response strategies. In order to reduce urges to pull, TTM patients need to learn not to pursue positive reinforcement from pulling; *habit reversal*, which principally involves learning to engage in an alternative action that is not compatible with pulling, is derived from this conceptualization. This approach is described in manual format by Grant, Donahue, and Orlaug, [48].

HOARDING

Although not considered its own disorder in DSM-IV, hoarding has been defined as the acquisition of and failure to discard a large number of possessions that are of little or no value [49]. In the proposed DSM-5 definition, hoarding behavior must result in extreme clutter that prevents the use of living spaces, as well as significant distress and functional

impairment. Individuals with hoarding problems assign greater instrumental, sentimental, and intrinsic value to possessions; feel greater responsibility and need to control possessions; and have deficits in information processing and memory [49, 50]. Despite the proposed inclusion of hoarding in the OCD category in DSM-5, hoarding behavior is present across a wide range of psychological conditions such as obsessive-compulsive personality disorder, schizophrenia, and dementia; researchers have also proposed similarities between hoarding and impulse control disorders [51]. Although not mentioned in the DSM-IV description of OCD, hoarding has come to be considered a symptom of OCD [52], and yet hoarding symptoms tend to emerge as a distinct subgroup in factor and cluster analyses of OCD symptoms [53]. Researchers have recently proposed that hoarding should be a disorder distinct from OCD [54,55].

CONCEPTUALIZATION AND TREATMENT

Unlike obsessions and compulsions in OCD, Mowrer's two-stage learning theory of anxiety disorders [10] does not apply to compulsive hoarding. As with TTM and skin picking, there is no specific obsessional fear that serves as a trigger for acquiring behaviors in the way that obsessions provoke compulsive rituals in OCD (although patients with hoarding might report subjective anxiety in general). Thus, an intervention such as ERP that facilitates the extinction of a conditioned fear response would not apply to the treatment of hoarding. Indeed, hoarding symptoms predict poor treatment outcome for ERP [51, 56-58], further suggesting the two problems involve separate psychological mechanisms and demand distinct cognitive-behavioral treatments.

People with hoarding most likely respond poorly to ERP for several reasons. First, as mentioned above, there is no specific target for ERP—that is, there is no pathological fear or fear-induced ritualistic behavior. Second, individuals with hoarding often do not subjectively resist their urges to collect objects (i.e., these urges are ego-syntonic) [51]. Instead, patients may consider their possessions to be an extension of themselves, to have human-like qualities, and to provide comfort and security [49]. This is in stark contrast with unwanted, intrusive obsessional thoughts and rituals, which are typically resisted in OCD and considered to be ego-dystonic. Third, and relatedly, individuals who hoard have especially poor insight into the senselessness of their symptoms [51], and as a result are often resistant to efforts by others to curtail their hoarding behavior, and frequently refuse or drop out of treatment [57, 59-61]. Fourth, individuals with hoarding problems also demonstrate excessive emotional attachment to possessions, and these distorted ideas about discarding similarly interfere with the success of exposure treatments [62]. Fifth, patients with hoarding problems often have associated information processing deficits that maintain their hoarding, such as poor categorization/organizational skills, deficits in decision-making, difficulties with memory (i.e., reduced confidence in memory) and over-importance assigned to remembering information), and trouble with attention [50, 51]. These difficulties are not addressed with ERP, and instead require other types of interventions. Finally, relative to patients with OCD, those with primary hoarding symptoms tend to have

higher rates of dependent and schizotypal personality disorder traits, which are likely to interfere with treatment [60].

Instead of using exposure, current cognitive-behavioral treatment programs for hoarding [63] emphasize principles of motivational interviewing. As previously mentioned, patients with hoarding problems often have strong ambivalence about treatment and change, and motivational techniques strive to help them resolve this ambivalence and begin recognizing that the hoarding behavior is unreasonable and impairing. Treatment for hoarding also involves the development of attention, organization, decision-making, and problem solving skills [63], none of which are components of ERP. The actual process of helping the patient organize and discard acquired materials is also conducted in a manner that is quite distinct from exposure. The sorting of possessions involves developing an understanding of *why* the patient saves possessions and is considered to be a process of discovery [50], in contrast to the emphasis on distress ratings and anxiety habituation in ERP. Behavioral experiments are sometimes used in the treatment for compulsive hoarding, which are perhaps similar to response prevention techniques in ERP: patients are asked to visit locations in which acquisition is a particular problem in order to increase tolerance of urges to acquire possessions without giving into them. Yet these exercises are more focused on learning to tolerate strong emotions (including, but not limited to anxiety) [63].

CONCLUSION

In this article we have detailed the basis for the use of exposure therapy for OCD. Yet as we have seen, this treatment is not applicable for most of the conditions proposed to be diagnostically related to OCD and included as OCRDs in the forthcoming DSM-5. This is because exposure is derived from a specific psychological mechanism involving excessive fear that is maintained by avoidance and ritualistic behavior. This pattern is present in OCD and BDD, but not in TTM, compulsive skin picking, or hoarding. We believe that treatment response should be a litmus test of sorts for whether to include disorders as OCRDs, as it is ultimately successful treatment that we seek by dealing with matters of phenomenology and etiology. Accordingly, we have concerns about whether the present OCRD proposal might lead people with OCRDs *away from* the best treatments for their individual conditions. Individuals who present themselves at OCD treatment programs convinced that their hoarding, skin picking, or TTM complaints are forms of OCD, and should be treated as such, will invoke the OCRD concept in support of their convictions. We, for example, routinely receive referrals from health care providers who cite OCRD (or "OCD spectrum") concepts when referring a wide variety of problems for the treatment of "OCD". An unfortunate perception among many consumers and treatment providers is that the data supporting the efficacy of exposure therapy for OCD are similarly applicable to the proposed OCSDs. Yet, as we have seen in this article, this is not the case. In order to avoid the misuse of exposure therapy in the era of the OCRD diagnostic category, it will be important for clinicians to understand the conceptual basis for exposure, as well as the psychological mechanisms involved in the various conditions classified as OCRDs.

CONFLICT OF INTEREST

The author(s) confirm that this article content has no conflict of interest.

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