Obsessive-Compulsive Disorder Treatment Options: Considerations for Embracing an Integrative Approach

Tyler J. Schamehorn

Master of Counselling, City University in Canada

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Dr. Karin Coles

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Abstract

Obsessive-compulsive disorder (OCD) is a condition that lowers the quality of life for those afflicted by causing compulsions to carry out behaviours that can interfere with everyday functioning. This disorder is lifelong for many people and common treatments only typically help manage their behaviours and anxieties. Counselling interventions commonly include cognitive behavioural therapy (CBT) techniques, primarily exposure and response prevention. However, this treatment does not always lead clients into remission and their overall quality of life may still be poor. This paper provides a review of alternative treatments for OCD in the literature and discusses their efficacy. There are other modalities such as psychodynamic therapy, narrative therapy, and acceptance and commitment therapy that have research to back up their effectiveness for OCD, though the common theme from these modalities is that they work well in an integrative model with CBT. The implications of the literature review, in addition to an interview with a clinician that currently practices therapy with OCD clients in an integrative manner, suggest that exposure and response therapy should be involved in treatment, while including other interventions that are advised by the clinician's case conceptualization while building the relationship with the client. If a client's needs are attended to in an intentional manner while working to eliminate compulsive behaviours through exposure and response prevention, better treatment outcomes can be achieved and quality of life can improve.

Keywords: obsessive-compulsive disorder, integrative therapy, exposure and response prevention, case conceptualization

Obsessive-Compulsive Disorder Treatment Options: Considerations for Embracing an Integrative Approach

Obsessive-compulsive disorder (OCD) is a rare, but well-known and often misunderstood mental health disorder that causes many psychological difficulties for those afflicted. The American Psychiatric Association's (2013) *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM 5) defines the disorder as the presence of obsessions or compulsions in the form of thoughts, urges, or repetitive behaviours that are time-consuming, and are not better explained by another mental health disorder or psychological state. The prevalence of this disorder is thought to be in the range of 1.1%–1.8% according to the American Psychiatric Association (2013). In children and adolescents this has been estimated to be between 1%–3% (Walitza et al., 2011) and 1.2% in adults (Tomikawa, n.d.). However, society can often portray it as higher due to many people misusing the term OCD to refer to any behaviour that describes a person's particularity about something (Rapoport, 1989). More recent literature also explains that using the term OCD as a catchphrase to explain tendencies for organizational or perfectionist behaviour can lead to misconceptions for the general public to understand what OCD really is (Rogers Behavioral Health, 2018). This is cause for concern as it diminishes the collective perception of severity of the disorder for those that have legitimate cases.

The explanation for how OCD develops in individuals is not unanimously agreed upon, though most theories seem to point toward either biological or genetic factors such as family mental illness or comorbid diagnoses, or having psychological origins, namely from a cognitive behavioural perspective such as faulty beliefs (OCD-UK, n.d.; Rapoport, 1989). There is also evidence that the onset of OCD in individuals can be triggered by traumatic or stressful events that relate to the focus of an individual's symptoms, such as critical parenting messages causing the need for perfection with those afflicted, or a significant experience with abuse causing an adverse reaction to uncleanliness (Hofer et al., 2020). In these cases, there seems to be some environmental factors that can determine onset as well, such as

the role that the caregivers take in providing emotional support for the child around the traumatic event (Hofer et al., 2020). Another significant consideration around the development of OCD is the presence of fear or guilt that motivates the individual to act upon their compulsions.

Greenburg and Witztum (2001) offer a compelling argument that having a strong conviction towards a religious faith can lend itself to tendencies of OCD. They discuss this in context of an ultra-orthodox Jewish individual who sees the need to follow the laws of the religion perfectly. Not following through with a ritual or accidentally doing something "wrong" can cause anxiety, and this may start out of the fear of what may happen if the law is not adhered to. More recently, Kumar et al. (2021) ran a larger study to examine the role of religiosity and guilt within an OCD population in India, a very religiously diverse country. They found that religiosity and guilt had positive correlation with OCD at the start of their study when using scales to measure these various factors, and after a 6-month follow-up, OCD severity was negatively correlated with religiosity, but still positively correlated with guilt. The teachings within various religions may portray deviation from laws and commandments as having an unfavourable or permanent consequence, which can understandably cause stress even without OCD tendencies. Beyond this example, various other scenarios of religious significance come to mind such as premarital sex in most Western religions, food restrictions, or prayer schedules.

There are elements of culture and more generally, guilt that are at play here, but this of course can be applied to other cases, even outside of a religious context. Recently, literature around OCD points toward guilt being a major emotional factor in OCD symptoms. Melli et al. (2017) developed a guilt sensitivity scale to assess level of guilt sensitivity in participants that exhibit OCD symptoms and found that this trait was correlated with those that exhibited checking-related symptoms (making sure a stove is off repeatedly, checking for locked doors more than once). Research also seems to specify between altruistic guilt and deontological guilt. Deontological guilt, according to Ottaviani et al. (2019), can be differentiated by the context of having violated a set of moral norms valued by the person. In

their study, Ottaviani et al. had participants set up with a cleaning task to see if their perception of disgust regarding their environment provoked such a type of guilt. There was evidence to confirm this hypothesis, and the behaviours exhibited by participants seemed to be OCD-like in nature as they repaired their environment. It can perhaps be explained that if their environment could cause others to become sick or dirty, they would be held responsible for that outcome due to their lack of action. To wrap up the idea of guilt as a factor in OCD, Basile et al. (2014) observed through fMRI results that patients with OCD seem to process deontological guilt differently than those without OCD as there is reduced activation in the anterior cingulate, the insula, and the precuneus when exposed to this form of guilt comparative to what was expected.

What would determine the diagnosis of OCD as opposed to someone diligently following their religion or acting upon guilty feelings is whether these behaviours are only in the context of reacting to their religious commitments or guilty feelings. Someone that truly has OCD would experience obsessive and/or compulsive behaviours consistently and while they may focus towards particular stimuli, they affect several areas of their life and lower the quality of life due to time spent on these obsessions or repercussions from them. Considering that there are various explanations and theories to explain the development of the disorder, an all-encompassing explanation for the onset of OCD is that it differs from individual to individual but can be attributed to some combination of genetic and biological predisposition and psychologically triggering significant event. Rather than synthesizing the body of OCD research to determine an answer, it may need to be explored on an individual level to determine how a person developed the disorder.

While the cause of OCD may not always be clear, the treatment of the disorder seems to have more consensus. In most cases, serotonin reuptake inhibitor medication is prescribed to assist in reducing some of the symptoms of anxiety that are experienced, but this alone rarely provides a full respite from the disorder and psychotherapy is usually recommended (Milona et al., 2017). Most

research points to cognitive behavioural therapy (CBT) being the most used theoretical orientation when addressing OCD with research within other modalities being limited. The overall opinion of most professionals seems to be that cognitive and behavioural interventions are the gold standard of evidence-based treatment for this disorder (Kafes, 2021; Milona et al., 2017) and any other treatments that do not have a strong evidence base to support them could potentially be harmful (McKay et al., 2021). The idea of harm in this context would mostly suggest that due to the lack of research in other areas, it is hard to know if other interventions would have any benefit, thus making it a poor use of time in therapy. This includes any poorly applied CBT techniques and psychodynamic approaches. It seems to be a theme that practitioners will seek out the most reputable evidence-based treatment for a particular diagnosis and stop there in terms of considering the whole case conceptualization. While evidence-based practices should certainly be used, it is also important to consider every aspect of the client's needs.

CBT began as a way to help treat depression in the 1960s, primarily led by Aaron T. Beck (Beck, 2021). It is influenced by elements of behavioural therapy that preceded CBT development, though has a stronger focus on the beliefs that a person has that drive behaviour. Psychological dysfunction is conceptualized as having problematic ways of thinking that cause negative emotion or problematic behaviours, often referred to as cognitive distortions. For treatment, maladaptive elements are identified in a person's thought patterns and these are addressed through various interventions depending on the context.

Under the umbrella of CBT, the most referred to intervention for OCD is exposure and response prevention. This intervention is based on the principles of classical and operant conditioning and consists of the practitioner skillfully exposing the client to the stimulus that provokes their anxiety and helping them manage their response to it, in theory changing the negative conditioning they may have with it (Ferrando & Selai, 2021; Law & Boisseau, 2019). Ferrando and Selai (2021) provide an optimistic

take on exposure and response prevention in that it is the most effective treatment for the condition, pointing out that some research is needed in how to tailor it to the individual. Law and Boisseau's (2019) meta-analysis of current literature on the intervention shows that it is more effective than medication in most cases and generally has positive outcomes for those who engage in the therapy. However, they also concluded that it is not effective for everyone. There seems to be better outcomes with patients who have less severe symptoms and fewer comorbid diagnoses such as depression. This treatment has also been considered with children and yields similar results as long as the procedures of the intervention are closely adhered to (Kuckertz et al., 2020). The largest gap in the literature regarding its efficacy seems to be the long-term outcomes it can ensure. Whittal et al. (2008) presented a study that seemed to provide results that patients were able to maintain their outcomes at least 2 years after treatment but commented that a meta-analysis on long-term outcomes was lacking. Most other research seems to confirm that even effective treatment does not completely mitigate most symptoms of OCD, which prompts further inquiry into how this can be addressed in a more holistic manner.

Based on the current knowledge and practice on the subject, the purpose of this research project is to attempt to answer the three following questions: What are non-CBT options for treating OCD, what is the efficacy of non-CBT interventions on the disorder, and can practitioners address the problem in another way? To address these topics, this paper will start by declaring my self position on the topic, followed by a review of current literature focussed upon the identified research purpose. Following the review of literature, I will discuss the implications the findings have on counselling, what further research is needed, and what the best recommendations for practice are before offering an afterword on my self-statement and concluding the manuscript.

Self-Positioning Statement

As I explore the research on the topic of OCD treatment, it is important that I acknowledge my motivation for pursuing this topic and my current thoughts and biases around it. To help establish my

position on the matter I will be using the framework outlined by Holmes (2020) to explain my personal investment and influence into the research being done. In his essay, Holmes encourages that the researcher discusses several dimensions of their worldview, their opinions on the subject, how they are affected by the research personally, and how they will themselves affect the research by conducting it.

Considering my worldview in relation to how I perceive OCD is important, as it certainly is part of the catalyst for why I am pursuing research on this topic. As a White male from a comfortable socioeconomic background, mental health disorders were rarely discussed in my environment and if they were, it was with negative connotations. This can be attributed to the conservative attitudes that were present within my environment that if someone was suffering from a mental illness, it meant that they were inferior. Within my family and peer group, there was a degree of stigma and misunderstanding surrounding many mental health disorders and OCD was no exception. My idea of the term growing up was just someone who was quite picky about organization and germs, and I did not consider that anyone who claimed to have this disorder experienced a crippling amount of anxiety when certain boundaries were crossed around the things they were concerned about.

The first time I met someone with a diagnosed case of OCD was in my undergraduate program in university. In line with my beliefs at the time, I did not take it seriously when he said that he had OCD and thought he was maybe just particular about neatness and germs. One day when we were at the campus pub together with our friend group, I thought it might be funny if I took a small bite out of his dessert that he had ordered while he was in the restroom. When he came back, he noticed this immediately and was quite put off by this and went as far as to order a new dessert and have the old one taken away. This was an eye-opening experience for me and illustrated quite well how much this disorder could disrupt everyday functioning.

As I reflect back on this situation and my upbringing, I realize that my attitude toward the disorder and mental health in general have changed drastically over the years. These conditions are not

just phases that some people go through and “get over” or simply affect those that are not as “strong” as others. There may be some biological factors involved, but with the right setting conditions there is potential for anybody to develop disorders such as OCD. I now pursue an attitude of securing justice for those with hindered abilities and quality of life. This is part of what led me to choose counselling psychology as my career.

Currently as a prospective psychologist, I am exploring various theoretical frameworks for how to work with clients. While I am not someone to firmly stand by only one framework, I do have certain frameworks that I prefer and ground my personal theory on, including Bowenian theory, Adlerian and transactional analysis. I appreciate how these models have an emphasis on the root cause of disorders, such as experiences from earlier in life that may have caused an upset in their mental well-being, and the importance of family systems that have an impact on an individual’s functioning. Seeing as the most widely accepted treatment for this disorder is exposure and response prevention, which is a CBT intervention, I will admit that I am motivated to find reputable interventions that are more in line with the way I prefer to practice counselling. I am not saying that I do not agree with CBT, in fact, I have used CBT concepts myself and find them efficacious, but I do feel that there is potential for missing certain aspects of an individual by focusing solely on present feelings and concerns. Specifically, CBT tends to discourage looking into the past and places less value on how past experiences may have impacted a client’s current functioning. While managing present symptoms and creating positive outlook for the future is of course the end goal for any model of therapy, I do believe that if the foundation of a person’s mental health is not addressed, then any effort to manage current symptoms or behaviours might only be patchwork in addressing a larger problem.

To better explain my position, I will share another story of a client that I have worked with who has severe OCD that has been impeding his general functioning for many years. When I started seeing this client, he was under much duress due to the ongoing COVID-19 pandemic and was quite afraid to

engage in society for fear of contracting the virus and spreading it to other people. He has had several other compulsions throughout his life that have also affected his daily functioning, though this was the most significant in the moment. When exploring what he has done in the past to address his symptoms, he disclosed that he had been a part of a few group therapy sessions for OCD and that exposure and response prevention was the main intervention being used. While it helped him for some of his specific problems for the time being, it did not have a lasting outcome and he would fall back into some of his same patterns of behaviour afterwards. When exploring the timing of the onset of his symptoms started and what continues to drive them, he shared that when he was younger, he had a negative religious experience that instilled fear into him because of his actions. Though many of the things that continue to drive his OCD symptoms are not related to this initial event, there is an underlying feeling of guilt that seems to cause him to stive for perfection and assurance in many aspects of his life. I was motivated to pursue his feelings of guilt instead of repeating interventions he was already familiar with and had tried.

While this story that I shared can be seen as a major bias in how I approach this project, it is important to acknowledge how it has also inspired me in a positive way to pursue solutions for those that may not respond as well to the status quo intervention. Jardine (1992) comments on this idea from a philosophical point of view, saying that while there is a degree of bias in allowing personal experience of an individual case to inform the pursuit of knowledge, its potential for increasing self-understanding can lead to the sharing of knowledge that will overall be beneficial for anyone willing to learn. In this case, my experience with this client has alerted me of a need for further knowledge in a field that is thought by many to be already adequately explored. Being too cautious of bias and deciding not to pursue the topic would be a lost opportunity that may have had the potential to spark a revival in how treatment for various mental health disorders is considered.

Additionally, I believe this project can serve as an avenue for me to explore my own professional development, as well as advocate for how other clinicians can improve their practice. Some of the

interventions that will be discussed in this paper are likely to be unfamiliar to me and many other people that may only have one or two frameworks that they are competent in. Not only is this beneficial for any practitioner, it is also ethical practice for practitioners to be continually seeking to improve upon their professional competency. It is important that practitioners use evidence-based practice, which here would include exposure and response prevention, though if there are ways to enrich the treatment for clients, then ethically speaking, this must also be pursued.

What I am hoping to accomplish through this research project is to start a dialogue on what may be considered as reputable treatment beyond the current options prevalent in the literature for OCD. Again, I am not looking to scrutinize CBT or exposure and response prevention. I understand they are efficacious forms of treatment, as the research shows, and support their continued therapeutic use. However, it seems there may be certain circumstances where a client may need more than exposure and response prevention as a sole intervention for a better outcome. Approaching the consideration for inclusion of other, perhaps additional, forms of treatment should be made known to practitioners so they can work to address all aspects of the disorder with their clients.

Review of Literature

Treatment options for OCD will be explored by the various categories of theoretical orientations toward counselling. Due to the limited research in the areas outside of CBT, some categories may be underrepresented here. Article searches in the City University of Seattle and Google Scholar databases were conducted using search terms (OCD) in combination with AND (psychodynamic), (attachment), (narrative), (ACT), (psychopharm*), (medication), (EMDR) and other search terms that did not yield relevant results such as (Adlerian), (family systems), and (solution-focused therapy). The major categories that will be reviewed are psychodynamic, including general psychodynamic approaches and attachment theory, postmodern including narrative therapy and acceptance and commitment therapy, and psychopharmaceutical treatments. As research in these other areas was limited, the review to

follow contains summative information only in areas where multiple articles were found in relation to the topic.

Psychodynamic

Within the umbrella of psychodynamic theories, psychoanalysis and attachment theory are the most represented frameworks in OCD research. Limited research has been done in how these theories can be helpful in the treatment of OCD as they are typically regarded as inferior to dealing with this disorder compared to CBT (Mulhall et al., 2019). However, as is documented, there are some helpful insights from these theories that may help an individual cope with OCD beyond only managing the observable symptoms that CBT is predominantly utilized to treat.

Psychoanalysis is a theory that bases its conceptualization of human behaviour and dysfunction upon the influence of the unconscious mind (Sibi, 2020). Famously pioneered by Sigmund Freud, this is one of the earliest theories of counselling and paved the road for the many theories to follow. It is thought that while people consciously make an effort to dictate the behaviour they believe is appropriate (ego), they are constantly driven by unconscious thoughts, such as basic drives (id) or a set of laws or strong convictions that they might believe in (superego; Freud, 1920). Modern psychoanalysts will often explore the early memories of their clients to identify themes that might have had a profound effect on their psyches and be playing a factor in their current situation. Uncovering what are referred to as repressed memories can help the client manage these experiences in their conscious mind so they can have less hinderance on their overall functioning.

A psychoanalytic conceptualization of OCD would likely point to the client's superego being overactive, meaning there are certain strong beliefs coming from experiences that may be repressed from childhood and never addressed. A client's anxiety around germs for instance may have roots in a negative childhood experience with being sick or dirty that unconsciously motivates them to avoid

unclean situations to the present day. This even fits well with the research that suggests that the majority of OCD onset takes place in early childhood to adolescence.

Qualitative research into the early development of OCD have shown some evidence that early experiences with parental turmoil, as well as criticism and forbidden expression from the parents can have some impact on forming OCD behaviours. Mulhall et al. (2019) interviewed six adults of various age ranges about their childhood experiences and living with OCD. These three previously mentioned themes were prominent with the participants and some links can be drawn between these experiences and the onset of their symptoms. For the participants that experienced parental turmoil, they primarily experienced one of the parental figures struggling mentally or emotionally, while the other parent was unsupportive or emotionally absent. This in turn gave these participants a sense that when they were struggling with their own emotions, they would not be able to confide in their parental figures for their own emotions, leaving the onset of their OCD symptoms and related feelings unattended to.

The theme of criticism was also relevant in that the participants that expressed these experiences would often be criticized for incidents that they had no fault in causing and may have only been a bystander. Throughout their life, they would come to believe that any disaster may be their fault, causing them to engage in excessive behaviours that may prevent such occurrences (such as repeatedly checking to make sure the stove is off, or the doors are locked). The participant might realize that their guilt is irrational but has difficulty separating themselves from this thought process after it has been set in their beliefs through these critical messages they have received.

Forbidden expression came into play for several participants as well when talking about emotions with negative connotations such as anger. They described being restricted by parental figures for showing such emotions which would then cause them to internalize them. This led to various symptoms such as intrusive thoughts that are linked with OCD, and not expressing these emotions for

extended periods of time created strong patterns of internalizing behaviours that eventually developed into how they experience OCD.

Overall, this study featured a small sample size that only captures a handful of experiences with the development of the disorder and cannot be assumed to apply to the entire population. However, the themes addressed can provide some insight for clinicians as to what significant factors play into the development of OCD and the authors suggested exploring such in conjunction with more common treatments of the disorder.

In further implementing psychodynamic approaches to psychotherapy, there has been some evidence that shows that it is often useful in an integrative approach with CBT to treat OCD. An integrative approach entails purposefully using two or more modalities in a client's treatment based on their presenting concerns and what may be the most beneficial for them (Corey, 2019). While also administering more traditional CBT interventions, Dembo (2014) explored various other frameworks in working with a case of a 12-year-old client with pediatric OCD. Among these was a psychodynamic lens that encompassed the significant feelings that the client had that contributed to some of her symptoms. It often seemed to be linked to her idea that she was not a good enough person and had to compensate for this by engaging in repetitive behaviours to ensure she was not continuing to be a bad person. Also present in the client's case was unresolved anger towards her father, which is congruent with some early Freudian ideas that OCD compulsions are born out of these feelings. It is hard to say if her anger in this situation was related to her symptoms at all, as her anger was mostly due to her father's emotional unavailability towards her mother. Existential, metaphor, and narrative therapy were also utilized in this case, which will be examined more in depth in those sections of this literature review.

Woon et al. (2017) also support the use of an integrative approach to OCD treatment using a psychodynamic therapy alongside exposure and response prevention. The article in question utilizes a case study to examine how a client responded to using exposure and response prevention on its own

compared to how doing this intervention in an integrative model with psychodynamic therapy to address some of the initial feelings that may have caused the onset of the disorder. The client in the case study engaged in exposure and response therapy for the first few sessions, though was reluctant to engage in homework outside of sessions and eventually stopped making gains from the treatment. The client was then administered psychodynamic therapy focused on helping identify unresolved conflicts within the client's past that created turmoil. This was found to be helpful as it allowed the client to express his feelings beyond just the observable symptoms he was exhibiting. It also revealed some feelings of anger towards his parents, particularly for his father's critical parenting style which caused him to create defence mechanisms that came in the form of intrusive thoughts which he then started to counteract in the form of his OCD behaviours and compulsions.

There is also some research on the implications of attachment on the development of OCD. Attachment theory falls within the umbrella of psychodynamic theories for its focus on how early relationships (mostly with caregivers) can have a significant impact on how people form relationships with others throughout their lifespan (Johnson, 2019). John Bowlby developed the theory in the 60s and was inspired by how the functionality of relationships can have implications for a person's overall well-being. He proposed that people fall somewhere within the spectrum of attachment styles which are secure, anxious, avoidant, and disorganized (Bowlby, 1969). Secure attachment is thought of as the healthiest form of attachment while the dimensions of anxious and avoidant attachment styles move people away from attachment security, with both dimensions to their extreme combine to form disorganized attachment. Attachment theory on its own does not have a framework for counselling, though emotionally focused therapy uses the philosophy of attachment theory to facilitate change in clients (Johnson, 2019). OCD may be conceptualized in attachment theory as a result of highly anxious attachment. The association of guilt can point to early experiences of anxiety within their relationships if

they were to deviate from rules, perhaps scolding from parents or having a role in the misfortune of their caregiver.

Doran (2020) conducted a study to examine the relationship between attachment insecurity, fear of self, and OCD symptoms. Doran used a series of questionnaires to have participants rate their perception of their fear of self, obsessive-compulsive behaviours, experiences in close relationships and experiences with depression and anxiety. When analyzing the data, he drew some conclusions such as the fact that fear of self has a significant impact on the development of OCD which is often compounded when an insecure attachment is prominent. He also found that when a participant had a more secure attachment while having a significant fear of self, OCD tendencies were curbed. This helps to explain some causation of the disorder and also points to practical implications to help prevent it from happening in children.

Based on the literature of psychodynamic therapy to treat OCD, it seems that it can at the least be integrated with exposure and response therapy to help address some of the feelings and experiences that contribute to the disorder while continuing to practically address present behaviours via a CBT framework. There is currently not enough evidence to determine if this could function as a standalone treatment plan for OCD.

Postmodern

Several postmodern theories such as narrative therapy and acceptance and commitment therapy are becoming more prominent in the field of counselling and have been shown to be effective empirical models to help clients overcome various presenting problems. It appears that OCD is encompassed in this range of presenting problems as well, though based upon my review, the literature is currently sparse.

Narrative therapy was formulated throughout the 80s by Michael White and turned away from many of the other theories at the time by having a focus on the self (Madigan, 2019). The therapy

process is carried out by listening to the client's story and how they describe the world around them. The therapist can highlight some of these things to the client and utilize them as tools to help the client learn from their own life and choose how to reach their goals. A major concept within narrative therapy is externalizing. This is often done with the object of the client's presenting concern where the therapist will frame their problem in a way that it takes on its own character in their narrative instead of just being a part of the client. This helps the client to realize they can have control over their problems instead of just assuming they have flaws (Madigan, 2019). This can be valuable for OCD treatment so that the client can externalize their obsessions and compulsions as something beyond themselves that they can negotiate with in different ways. This can have the potential to help the client change the relationship they have with the objects of their compulsions and improve their everyday functioning.

One of the more significant examples of narrative therapy employed with an OCD pediatric client is Dembo's (2014) case study that integrated traditional CBT and exposure and response prevention with some psychodynamic therapy, existential therapy, and narrative therapy. This study includes modalities beyond narrative, but still serves as a good example of how using an integrative approach that includes narrative therapy and CBT interventions can be successful in providing therapeutic gains to clients. The study explained that while only employing CBT interventions, the client's symptoms improved, though did not get to a point that would be considered remission. Using the other forms of therapy added value to the client's treatment that they referred to as the most beneficial part of their counselling experience. Using these therapies helped the client to gain a more well-rounded understanding of their condition and make peace with the triggers that caused the onset of their disorder.

There is also some specific research done on how the externalizing technique found within narrative therapy can help increase therapeutic gains when integrated with CBT. Banting and Lloyd (2017) implemented this treatment with a 10-year-old client in a single case study and found that the

client was able to make significantly positive changes and met goals for therapy. After following up for 1 month, it was deemed that these gains were being maintained longer-term as well. In this case, narrative therapy appeared to enhance the therapeutic value for the client alongside CBT.

The research discussed here shows much promise for pediatric clients, though similar studies for narrative therapy with adult OCD could not be found. This suggests that early intervention is important with this disorder, though it is worth further research into the adult population to see if similar interventions can continue to be effective throughout the lifespan, particularly after the behaviours of the disorder have had several years to settle in.

Acceptance and commitment therapy (ACT) is another form of psychotherapy that has gained popularity in recent years. It has its roots in CBT, though focuses more on the idea of accepting one's condition rather than attempting to change their behaviour (Wilson et al., 2011). It was developed in the 1980s by Steven Hayes, influenced by the behaviourism school known as functional contextualism (Harris & Hayes, 2019). The process of the therapy is aimed at improving the client's psychological flexibility through mindfulness-based work to help them get the most out of their life. It is particularly useful for clients who are presenting with a problem that is hard to solve in a traditional manner and the most realistic outcome is that they will have to live with it. Instead of getting stuck on the negative aspects of their problem, clients are encouraged to reframe their situation in positive ways and act upon what will make the most change for themselves. This could be seen as helpful when considering that OCD is often a chronic condition. Instead of becoming defeated by their disorder, they can acknowledge that they may live with it for the rest of their life, but perhaps embrace the few positive aspects it brings and commit to working on their self-worth and pursuing what they can in life.

Philip and Cherian (2021) provide a meta-analysis on ACT for OCD and found enough studies to warrant the approach as effective and worth doing more research into. Several case studies found that after failure for symptoms to decrease using only psychopharmaceutical aid, the administration of 8

weeks of psychotherapy using ACT was found to decrease symptoms by 50% (Philip & Cherian, 2021). A few case series studies reported even more impressive results, with each study's series of cases seeing average improvements in symptom reduction of around 70% and some reporting even higher rates after follow-up periods (Philip & Cherian, 2021).

Several randomized control trials were also examined that compared the use of ACT with other treatment methods for OCD. In comparing with CBT and exposure response therapy, it was found that ACT could have similar results in symptom reduction to CBT methods. However, there was no significant change when using it in an integrative model with exposure and response therapy (Philip & Cherian, 2021). Another study used progressive relaxation training as a control intervention as it has also been a successful treatment method for OCD. The results showed that ACT yielded slightly better results and was also found to have lower drop-out rates, only 10% which is even lower than exposure and response therapy which has been found to have up to 25% drop-out rates (Philip & Cherian, 2021). A study looking at the use of ACT in tandem and compared to psychopharmaceutical treatment found that participants receiving only ACT or a combination of ACT and SSRI medication yielded better therapeutic outcomes than those receiving only SSRI medication (Philip & Cherian, 2021). The study even claimed that some participants experienced a full remission of their symptoms when receiving both. Overall, this meta-analysis supports the use of ACT to treat OCD, though admits that more research should be done with better sample sizes (Philip & Cherian, 2021).

Mazza and Coyne (2020) published a book that promotes principles of ACT in overcoming OCD symptoms while also using exposure and response therapy to help manage reaction to particular stimuli. The book touches on several concepts of ACT such as the ideas of acceptance and mindfulness, though where it strongly aligns with treating OCD is introducing the idea of letting go. There are case examples in the book and from additional studies that show that those afflicted with OCD have high degrees of perfectionism and low tolerance for being able to accept failure or achieving at a level less than

considered standard. This model could support clinicians in helping clients relinquish some identified anxiety they have around these feelings so they can exemplify these traits in a healthier fashion.

There is also research to reflect how the ACT model works with a pediatric population. Barney et al. (2017) implemented an ACT treatment plan with three 10- and 11-year-old participants facilitated by a school psychologist. The sessions included the parents of the children to help teach them skills for use at home and be supports during the session. The results found that the three children all experienced a decrease in their symptoms, though not to the same extent as traditional CBT and exposure and response prevention. It is worth noting that in this study, ACT was used as a standalone intervention as opposed to being integrated with exposure and response prevention and this comparison is made between the two as standalone interventions.

Psychopharmaceutical Treatments

While the use of medication is already a well-known intervention for OCD, it is important to explore the specifics of pharmaceutical treatment as there are several options when it comes to treating OCD. The prescription and management of pharmaceutical medication is outside the scope of practice for counsellors and psychologists, though it is common for clinicians to work with referrals from physicians or psychiatrists who do manage medications or work with them as part of an interdisciplinary team. Thus, current literature will be examined to identify the best method of administration and some of the efficacy between medication options.

Del Casale et al. (2019) provide a meta-analysis on the literature for the use of different groups of medication including selective serotonin reuptake inhibitors (SSRI), clomipramine, and serotonin-norepinephrine reuptake inhibitors (SNRI). SSRIs have a solid body of empirical evidence to show that several types such as fluoxetine, citalopram, fluvoxamine, sertraline, and paroxetine all have reasonable efficacy to treat and reduce symptoms associated with OCD such as phobic symptoms, anxiety, depression, avoidance, obsessive symptoms, and repetitive behaviours.

Clomipramine also has acceptable efficacy for treating OCD and was one of the earlier pharmaceutical treatments for the disorder (Del Casale et al., 2019). It has been shown to particularly have success in reducing obsessive symptoms in OCD, and further studies show global improvements in symptoms as well. Where this medication seems to fall short is that side effects have been found to be more common across several studies. These were mainly physiological, including heart rate increase.

SNRIs such as venlafaxine have shown similar efficacy to clomipramine but seem to have less side effects. Venlafaxine was also compared to the SSRI medication paroxetine and found to have similar success, though paroxetine seems to have more consistent results and specifically does better with refractory patients (Del Casale et al., 2019). Other SNRI medications that have shown some promise are duloxetine and milnacipran, though both require further research to properly determine efficacy.

Other studies have been conducted that show that an SSRI in combination with clomipramine has also shown to have positive results, even more so than either medication on its own, though this requires careful monitoring from the prescribing professional (Del Casale et al., 2019). While all of the mentioned medications have some beneficial effect, it seems as though SSRI medications have the largest body of evidence supporting their efficacy and have the least amount of reported side effects.

Beyond some of these more common psychopharmaceutical remedies, some other substances that have been helpful in treating OCD are ketamine and glutamatergic agents. Dougherty et al. (2018) looked at these drugs in how they can be applicable to psychological disorders other than depression, which they are known for treating. When treating OCD, glutamate modulation is thought to help correct impairments in the glutamatergic system that may be a characteristic of the disorder. This treatment has been shown to have positive effects; however, ketamine shows better outcomes when looking at the rate of change. Ketamine was shown to reduce obsessive symptoms by 50%. Other substances that have been tested are lamotrigine, d-cycloserine, memantine, topiramate, and riluzole, though less research has been done on these and significant effects are not as conclusive.

Overall, all these substances, while having some therapeutic value, need to be studied further to consider them a viable alternative to traditional medications for OCD. It is important to keep in mind that these medications can have a range of side effects, with clomipramine causing several minor physical side effects and more serious side effects such as suicidal ideation, hypersensitivity, and serotonin syndrome (Cunha, 2021). The side effects of SSRIs and SNRIs are quite similar but can also include hallucinations (Medical News Today, 2021; NHS, 2021). Ketamine can, on rare occasion, cause side effects as well, with a long list of physical and psychiatric symptoms (Rosenbaum et al., 2022), and glutamate can cause a similar array of physical ailments (Drugs.com, 2022).

Synthesis of Literature

While research into treatment options outside of CBT and pharmaceuticals is not extensive, it is clear that there are other acceptable options that can improve the quality of life more than standalone CBT. Psychodynamic, narrative therapy, and ACT all have evidence showing that they are effective in treating OCD, though the common factor with most research into these alternative forms of treatment is that they are the most beneficial when used in tandem with the proven method of exposure and response therapy and SSRI medication. Based on the literature reviewed, a conclusive decision on which framework is best integrated with CBT cannot be made (ACT may be a good candidate considering its connection to cognitive therapies), though it seems that adding another framework to the CBT model at worst does not change the outcomes and at best provides better outcomes.

The determining factor for choosing what method to employ with a client is likely the client's individual experience. Being able to determine what the client's specific needs are and carefully choosing a treatment option that is most beneficial for them is likely to have the best outcomes. This will be explained in the following sections as integrative psychotherapy and implications for therapy are further explained.

Integrative Model

As the evidence points toward how using an integrative model can be useful in treating OCD, it is worth expanding upon what this is and how it is used in therapy. Corey (2019) defines an integrative approach to counselling as "being rooted in a theory or theories, with techniques systematically borrowed from other approaches and tailored to a client's unique needs" (p. 4). This implies that utilizing an integrative therapy model is more than blending two therapies together but having a repertoire of ideas from various theories to utilize based on a carefully executed case conceptualization. The clinician may have a preferred framework for themselves but does not let this prevent them from using interventions and techniques from other frameworks if they may be better suited to their client.

The idea of integrative therapy is often referred to as eclecticism in literature and practice, though this is referring to one particular type of integration (Norcross et al., 2016). The concept of blending therapeutic approaches is something that has ample evidence to recommend its use when needed and can be done in several ways. There are four common ways that integration is achieved, the common factors approach, technical eclecticism, theoretical integration, and assimilative integration.

Common Factors

The common factors approach to psychotherapy integration focuses on comparing the proposed frameworks for integration and using the commonalities between them to build the individual approach (Norcross et al., 2016). It is thought here that what makes an effective treatment are the commonalities that it has with other reputable treatments more so than what makes it unique. This approach suggests a different method of integration than what is referred to within most of the literature on OCD but could have its benefits in specific cases. An example of this could be between Adlerian therapy and solution-focused therapy. Both frameworks are goal-centered, focus on encouraging clients to use their strengths, and make use of the "miracle question." A practitioner integrating these two modalities would lean into these commonalities but forego other components

that are not shared such as family constellation work in Adlerian therapy or scaling questions in solution-focused therapy.

Technical Eclecticism

Technical eclecticism has more of a "pick and choose" approach where the therapist may be subscribed to one primary theory, but they often utilize techniques from a wide range of theories without committing to the overarching philosophy (Norcross et al., 2016). This is thought to be a convenient way to meet the needs of the client without having to commit to a completely different structure of therapy. While this can certainly be helpful, it does carry some contention among some professionals as it comes across that the therapist is not grounded in a specific theory. This can be a feasible way for a clinician that does not practice CBT to utilize exposure and response prevention but continue to structure therapy around their primary framework. Even if a practitioner is rooted primarily in a theory that has little application for treating OCD, Bowenian therapy for example, they could still research theories and interventions that do have good application for OCD and utilize them as appropriate. Other aspects of the client's case conceptualization may still be treated by their primary modality.

Theoretical Integration

Theoretical integration involves blending two or more frameworks together so that the whole is greater than the sum of its parts (Norcross et al., 2016). This differs from common factors integration because it also incorporates the unique elements of each framework. This style of integration does not allow as much liberty to incorporate any intervention into practice that the therapist sees fit but does allow for more grounding within the chosen theories. This could be helpful for treating OCD if a therapist were to use CBT and another proven theory to provide a more holistic treatment for them, though the varying needs of clients with OCD may not all fit under only a couple of theories.

Assimilative Integration

Assimilative integration is similar to technical eclecticism, though goes a step further by claiming chosen techniques and interventions into the therapist's overall framework (Norcross et al., 2016). This can be seen as a way to account for being grounded in one theory while still being able to exercise the benefits of techniques from other frameworks. Clients with OCD can benefit here similarly to technical eclecticism by having evidence-based interventions applied to their treatment while still having other needs met through the therapist's main modality. For example, if a practitioner is rooted in narrative therapy and has a client with OCD present to them, they might assimilate exposure and response prevention into their overall framework, but still structure their treatment along the lines of narrative therapy. They may even implement exposure and response prevention in a style akin to narrative therapy (personifying the stimulus they are being exposed to, etc.)

The research from previous sections that mentions an integrative approach primarily refers to it in the style of technical eclecticism and this is likely the best option to integrate exposure and response prevention with another modality. While research does confirm that CBT is an efficacious framework for treating OCD, exposure and response prevention is overwhelmingly at the forefront of said treatment. It is theoretically feasible to use exposure and response prevention in an eclectic manner or assimilate it into the therapist's practice so that it can be used to manage overt behaviours associated with OCD.

Implications for Counselling Psychology

After reviewing the literature on current OCD treatment options outside of CBT, it prompts the discussion of what this means for the field of counselling, where to focus research next, and what practitioners can do to enhance their work. As will be discussed, this subject has a lot of potential to push the boundaries of how clinicians can treat clients for OCD, and even inspire one to build upon their approach to psychotherapy to treat other presenting concerns.

This research provides several implications for the field of psychology and even has implications beyond the treatment of OCD. The most convincing message that these findings give is that there are ways to address OCD and mental health in legitimate ways beyond cognitive-behavioural methods. As is shown in much of the research that was summarized, OCD can be effectively treated with interventions within psychodynamic (Dembo, 2014; Mulhall et al., 2019; Woon et al., 2017), narrative (Banting & Lloyd, 2017; Dembo, 2014), and ACT (Barney et al., 2017; Mazza & Coyne, 2020; Philip & Cherian, 2021) along with psychopharmaceutical treatments (Del Casale et al., 2019; Dougherty et al., 2018).

Another point that all this evidence makes is the effectiveness of an integrative approach. While all the frameworks mentioned are helpful in treatment, one cannot deny the empiricism of the current standards for treating OCD. In fact, Woon et al. (2017) talk about the value in taking an integrative approach to the disorder. It should be reiterated that the purpose of this research is not to forego CBT interventions in OCD treatment, but rather to find additional methods of treatment that can enhance the therapeutic outcomes. While exposure and response prevention can help manage individual behaviours for a client, further addressing the disorder through longer-term therapy may help to maintain some of the gains that they make in treatment. The potential that these other frameworks have over exposure and response prevention is that they can help to address some of the underlying feelings and emotions that drive the behaviours of OCD. Combined, a more holistic treatment towards OCD is theoretically possible.

Having various options for theoretical frameworks provides increased access for practitioners to be able to work with this population. Instead of having to refer to another clinician who specializes in a particular theory or learn how to incorporate a new framework in their practice, they can utilize the framework that is most comfortable to them and learn how to use exposure and response prevention as an intervention. This also provides some options for the client to decide on what framework suits them best when looking beyond the exposure and response prevention portion of their treatment. In some of

the previous research, it was revealed that many clients afflicted with OCD may be treatment resistant to exposure and response therapy, and they could potentially explore treatment options that may be more compatible with their situation.

Beyond the scope of OCD, it would be interesting to see how similar integrative approaches could be used to treat other disorders that are commonly only treated with CBT. There has been research to show that disorders such as schizophrenia (Lysaker & Roe, 2016), bipolar disorder (Valls et al., 2021), and eating disorders and substance use disorders (Lui, 2017) may respond well to treatment from an integrative approach. This tells practitioners that an integrative approach is not only advised for certain cases but can be fully immersed in your practice to deal with a gamut of presenting concerns. It allows the clinician to be more versatile in both their scope of what they can work with and the depth of treatment they can offer.

Ethical and Cultural Considerations

Beyond the practical implications of this research, the ethical and cultural implications are also significant. In Canada specifically, psychologists and counsellors are expected to adhere to any provincial governing college they may be part of, as well as the Canadian Psychological Association's (CPA, 2017) *Canadian Code of Ethics for Psychologists*. The CPA code of ethics is a document that was created to help regulate the actions of psychologists and counsellors in Canada and hold them accountable to practicing to a high standard. According to the code of ethics, psychologists are expected to maximize the benefit for those seeking services. This includes selecting interventions for those receiving the service based on their needs and what might fit well with their treatment according to code II.18 (CPA, 2017). They are also expected to maintain competency by keeping up to date with relevant knowledge for their practice according to code II.9 (CPA, 2017).

This is relevant in this discussion because there appears to be multiple interventions that can be used to treat OCD, though exposure and response prevention is used the majority of the time when

looking at the volume of research supporting it. It is good that clinicians are referring to evidence-based practices to work with a presenting problem as this is a way to maximize benefit according to code II.18 (CPA, 2017), though it seems as though most clinicians stop here. It is important to consider the whole case and what is contributing to the client's presenting problem when formulating a treatment plan. While exposure and response prevention will almost always help maximize the benefit of treatment, this can be fully realized when using it in an integrative model with another modality that might be beneficial for the client's case, as was seen in research on various frameworks to treat OCD (Dembo, 2014; Woon et al., 2017). Furthermore, a clinician that is not willing to consider other interventions by researching them can be seen as failing to maintain competency, and thus, acting unethically according to code II.9 (CPA, 2017).

Culture is another theme that appears throughout the CPA's (2017) code of ethics and is even a main component of code I.1, referring to general respect. When practicing psychology, culture must always be considered in every context as this helps to define a person and can be a determining factor in how treatment is received by the client. Much of psychological practice, especially what is taught in North America, is from a Westernized point of view or presented through a Western lens. Clients from other cultures may respond better or worse to various frameworks of counselling depending on the values they have, and it is a responsibility of the psychologist to honour this by how they interact with and treat these clients, again maximizing benefit according to the code of ethics.

OCD can be very intriguing to analyze through the lenses of various cultures. As mentioned earlier in this paper, religion can be a factor in carrying out compulsive behaviours (Greenburg & Witztum, 2001). A good example of where culture can become a highlight of a client's case conceptualization is if their religion values thorough commitment to fulfilling deeds and abiding by rules, though this can be detrimental to their everyday functioning. From the view of the psychologist, these behaviours might be seen as a problem, though the client may value their commitment to their faith,

and this is a way of showing that commitment. If exposure and response prevention is the only intervention used, the client may be asked to expose themselves to something that is contradictory to their faith which could be quite distressing. This is where bringing in other interventions may be more appropriate, perhaps using exposure and response prevention only in culturally sensitive scenarios. Considering the ethics and cultural factors of any case, whether OCD-related or not, is not only a legal responsibility but also part of what can determine successful treatment.

Considering those from more marginalized cultures, there are also implications for BIPOC individuals and those from lower socioeconomic status with OCD. While the prevalence of the disorder is similar across culture and ethnicity, the lived experience of the disorder can present quite differently (Wu & Wyman, 2016). Wu and Wyman (2016) conducted a study amongst White, Black, Asian, and Hispanic students to assess their experiences with OCD, measuring the extent of their symptoms, beliefs, and distress associated with the disorder. The results from their study revealed that Black and Asian students tend to score significantly higher on most of these measures compared to White students. It was partially explained that Black students may have stronger convictions towards their obsessions because of negative stereotypes construed about them, which can cause more intense symptoms. They can also display more contamination-like symptoms due to this discrimination (Wilson & Thayer, 2020). Asian students reportedly are less likely to access mental health resources and often underreport their symptoms, causing more distress.

Williams and Jahn (2017) elaborate on the specific challenges of the African American population that has been identified with OCD. Generally, this population is undertreated for OCD which causes more intense symptoms as it is not managed and thus will persist through life without going into remission. This is largely due to the many systematic barriers that African Americans face in terms of accessing adequate resources for mental health. Some of this is due to affordability amongst lower socioeconomic status families (which due to many systemic factors often include those of more

marginalized cultures), while also due to racist exclusion or dismissal of this population in funding for their communities. In general, lower socioeconomic status seems to correlate with a higher risk for developing OCD for similar reasons (Moreso et al., 2013).

When working with those with OCD, it is important to acknowledge that those from less privileged backgrounds are likely to experience more severe symptoms, but also different symptoms based on their unique context. It is important to advocate for those impacted by marginalization to have better access to resources to treat OCD as the disorder itself can often be more debilitating for members of minoritized or racialized cultures, and such individuals may not be receiving any treatment at all. What is maybe the most troubling is that many of these systemic barriers are created by those that hold more power to make a meaningful change. Therefore, as practitioners in a place of privilege, we should be mindful not to contribute to this and make concentrated efforts to remove such barriers to access, treatment, and funding.

Fundamental Next Steps for Research

The aim of this essay lends itself to encouraging further research in alternate treatment for OCD. As has been discussed, there is a plethora of research to show the efficacy of exposure and response prevention and CBT in treating OCD, though most of the other frameworks are limited in their literature, and what is represented in the literature review accounts for most of what there is for those frameworks. Further research into each of the frameworks discussed in this essay would be beneficial, and specifics will be outlined in the following.

It is known that the psychodynamic model has been useful in addressing the emotions that drive the disorder (Dembo, 2014; Mulhall et al., 2019; Woon et al., 2017), though the research that shows this is based primarily on the case studies of a few participants. Case studies are a more intimate method of getting to explore the experiences of those affected with OCD, though it would be helpful to have this

on a wider scale. A quantitative study with a large sample would complement the results from these studies as well.

Narrative therapy follows a similar theme in context of treating OCD. There are case studies that show that narrative therapy can be useful in further addressing some of the evocative triggers that fuel the disorder in tandem with addressing the overt behaviours with exposure and response prevention (Banting & Lloyd, 2017; Dembo, 2014). However, the extent of research is small and appears limited to these specific case studies. It would be helpful to see more studies that look at different aspects of narrative therapy to treat OCD, and possibly even some quantitative studies that can capture a larger sample size and report the outcomes of its use. Another major gap in this research is that these studies only explored the experiences of children with OCD and did not address the adult population. It is important to know if this intervention can be utilized with any other demographics so that appropriate recommendations can be made for treatment.

ACT appears to be the most researched framework apart from CBT in working with OCD. Amongst the literature in this essay, there seems to be a larger volume of research encompassing adult and pediatric populations (Barney et al., 2017) as well as both case studies and quantitative studies that look more specifically at how it can be used in conjunction with CBT, pharmaceuticals, or both (Mazza & Coyne, 2020; Philip & Cherian, 2021). Philip and Cherian (2021) did comment however that several of these studies would have been more reliable had they used larger sample sizes in their trials, so more work can be done here in terms of continuing to add to what is already a promising body of research.

There appears to be a small body of research comparing eye movement desensitization and reprocessing (EMDR) to CBT in treating OCD that has been primarily put forth by Zoe Marsden (Marsden, 2016; Marsden, Lovell et al., 2018; Marsden, Teahan et al., 2018). Both the case studies and the quantitative research show that EMDR is successful in providing symptom relief for OCD, though has no drastic benefits over CBT interventions. The lack of further research in recent years suggests that this

topic is currently not an area for priority research, though before recommending EMDR as a treatment for OCD, a larger body of research would be preferred.

Beyond expanding on the efficacy of the included frameworks to treat OCD, it would be worth investigating how other counselling theories can address OCD. Upon searching library databases, there are no significant results that are found when looking for articles that include obsessive-compulsive disorder and terms such as family systems, Adlerian, or existential. Those three examples may not be well geared to deal with the disorder, though it is worth being thorough to investigate any other potentially beneficial treatments. Having more varying options to treat a disorder can be helpful when a client is treatment resistant with certain interventions.

Clinical Reflections

In my limited experience working with OCD as an intern at a counselling agency, I can relate to many of the findings in this paper about going beyond exposure and response prevention to treat individuals identified with the disorder. As mentioned in my self-positioning statement, I was inspired to research OCD based on an experience I had working with a client with OCD. As I developed a relationship with my client, I came to know the intricacies of his experience with the disorder and began to form my own treatment plan for his presenting concerns. As a disclaimer, I was quite inexperienced at this point and did not have the knowledge that I do now regarding OCD together with forming an effective case conceptualization.

My client disclosed early on that he had engaged with exposure and response prevention on a few occasions as part of group therapy. While it did help him overcome anxieties he had around the behaviours he targeted, he still experienced the effects of the disorder generally throughout his life and would have to face new challenges as his circumstances changed. I decided that if he had already engaged in this on several occasions to only minimal success, I would not repeat the treatment and instead find something that addressed the root of his dysfunction. While I addressed my clients through

modalities that my supervisor would coach me through, I took a technical eclecticism approach to working with this client. I encouraged him to do exposure and response prevention as homework throughout the week (partly because I was doing teletherapy with him), but in session, I would address his OCD through narrative therapy.

In my case conceptualization, I noticed a strong theme of guilt in my client, originating from the onset of his disorder but perpetuating throughout his life as he navigated relationships and broader society. He was a very polite and caring person who wanted to please everyone and do the right thing. He had very little room for error in his self-concept and coming up short in anything he cared about was devastating for him. While these traits can be positive, his OCD tendencies made them maladaptive, and they became detrimental to his quality of life. He would often speak about his disorder as a roadblock that prevented him from realizing his full life potential, so I took that and externalized it with him. He would often talk about OCD as a bully-like character in his narrative that he had to build up the courage to stand up to. As we continued through therapy, he described progress in his courage to stand up to his OCD, and it also seemed to translate to how he would navigate his interpersonal relationships in life beyond just his OCD.

Having more wisdom now, I may have changed some aspects of my treatment plan and implemented other modalities. In particular, I think ACT would have been beneficial in his case as I think it would have done well to address his intense guilt. Regardless, I believe this experience helps to validate that OCD is more dynamic than a collection of phobias and compulsions. In this client's case, it seemed to be interlinked with his personality and required more attention than merely correcting maladaptive behaviours.

Recommendations for Practice

The current research, while relatively limited, still provides many practical ways for clinicians to improve their treatment of OCD. There are many frameworks that a clinician can choose to work with to

enhance outcomes in therapy, though it is conclusive that using these interventions in an integrative model along with exposure and response prevention and psychopharmaceutical treatment is the best plan for addressing OCD. ACT does have the most research support, so, if possible, this would be the top recommended framework to use in an integrative model. Though if a therapist does not have training in ACT, psychodynamic or narrative approaches also have some empirical evidence behind them when considering how best to work with an individual to treat OCD.

Interview With a Practitioner

To help provide more depth to these recommendations, I was able to have a discussion with a practitioner that frequently works with clients with OCD and often gets referrals from other clinicians who may not have success treating this population. Kara Irwin, MSc, R. Psych., uses an integrative approach to work with clients with OCD and has several useful guidelines for working with those with the disorder. She identified the following as being crucial to treating those with OCD, which also has implications for practice with other clients.

The first and most important step in treating OCD with a client is building a relationship and getting to know them. This is what Kara Irwin identifies as the key to being able to determine the best intervention for your client. Getting to know the client's needs will help the clinician build a better case conceptualization for their client, which will make for better treatment outcomes. Kara stated that this is often an overlooked part of the treatment plan and clinicians tend to only base their treatment from the client's diagnosis. She has identified this as treatment bias (K. Irwin, personal communication, July 29, 2022).

When conceptualizing the case, she has noted various themes that will come up as clients describe the fuel for their compulsions. Some of these themes are perfectionism, control, negative early experiences, ideas of a dangerous world, and anxiety around illness. The themes that a client identifies are what the clinician should be considering for their treatment plan, as certain interventions are better

equipped to deal with specific presenting problems. Examining these themes will also provide context for the content of their obsessions and compulsions, which is also important in formulating their treatment. The specific behaviours typically serve some sort of purpose and fill an emotional need. This is where the clinician decides what intervention would be most beneficial to the client (K. Irwin, personal communication, July 29, 2022).

Kara did not have specific recommendations for what interventions to use with certain themes, though she did acknowledge that exposure and response prevention is almost always part of the treatment plan. One aspect of treatment that she mentioned that has the potential to be overlooked is how the client's treatment is structured. The literature on integrative OCD treatment did not comment on this to much extent, but it was something that she found valuable to consider. Again, this is something that should be tailored to the individual client depending on their situation and needs. If the severity of the client's compulsions is debilitating enough that they would not be able to engage well in the therapeutic process of exploring their emotions or they are unable to function in society, then exposure and response prevention should come first. However, as was mentioned earlier, the compulsive behaviours often serve a purpose such as managing their anxiety around their obsessions. If they work to make a behaviour extinct, they may not have another avenue to cope with these things, thus their emotional needs should be attended to before exposure and response prevention (K. Irwin, personal communication, July 29, 2022).

Kara then shared that she has used various interventions to treat OCD, some of which are detailed in the literature review, but finds that taking a trauma approach for some clients has been very helpful. Some of her most successful cases have been when she has used EMDR to treat clients that had an experience that could be compared to trauma that caused the onset of their OCD. Regardless of what is being used, she stressed that the most important component of treatment is that the intervention fits the client's needs. She concluded by saying that "any practitioner that intends to treat OCD with only

exposure and response prevention in their toolbelt is acting unethically" (K. Irwin, personal communication, July 29, 2022).

Reflexive Self-Statement

After considering all the research that was previously analyzed, I am both enlightened by what I found and validated in my concerns of working with the OCD population. Before I started accumulating the research for this project, it seemed as though treating OCD was a closed book and that exposure and response therapy was the only recognized treatment with any legitimacy. While that does have truth behind it if you were to ask the average practitioner without a specialized knowledge of the subject, it seems that I may not have been the only one to consider the limitations of having only one option to treat OCD.

While I was able to find several significant frameworks that are successful in treating OCD such as psychodynamic theory, narrative therapy, and ACT, I was humbled by the fact that they are best used in an integrative approach with CBT, particularly exposure and response prevention. Again, I am not against using CBT at all, and have used it many times in my own practice, though I generally seek interventions that specifically address the feelings that are associated with a person's experience rather than primarily focus on behaviour. I was not able to find a way to reinvent the wheel with OCD treatment, nor was this my intention, but I feel that what I was able to find adds value to treating the disorder.

At the same time, I am pleased with how much literature I found that supports using an integrative approach. I personally have a difficult time sticking to one framework or theory in my own counselling philosophy and practice, and I have heard that this can sometimes be looked down upon. Of course, I believe it is important to be rooted in theory to properly practice counselling psychology, but by not exploring the array of ideas that are available within the field, this can be considered a form of disservice to clients that deserve the best treatment. Most of the research showed that an integrative

approach had better long-term outcomes for clients and could even help to overcome when clients became treatment resistant to exposure and response prevention. I would be cautious however, if there is a line that can be crossed as to when there is too much integration in an approach. Most of the research shows that having CBT with one other approach is sufficient to provide increased positive outcomes, but I would think that at some point, adding too many ideas into the approach would simply confuse the client and take away from the therapeutic value of the treatment. This encourages me to be more mindful in my own treatment planning so that every point of integration is intentional and beneficial to the client.

Another realization that I had during this project is how hard it can be to push forward new ideas once a status quo has already been established. In this case, it is my understanding that clinicians treating OCD are basically expected to use exposure and response prevention to treat the disorder, and extensive research seems to support this. The lack of research on other areas of OCD treatment shows that it seems to be the case that CBT is the status quo in this example. It is possible that there may be more research that has been done on other areas of OCD treatment, though it could have a hard time being published if there is publisher bias towards using what has already been empirically proven to work. This urges me to advocate more for what I have been exploring in this essay, which is to implement more integrative approaches in therapy and pursue better approaches that will benefit clients in treatment.

Conclusion

OCD continues to be a difficult problem to treat in therapy and often those afflicted with the disorder will have to live with it for most of their life. Engaging in exposure and response prevention is the best proven way to help reduce symptoms experienced from target stimuli, but as has been discussed, adding in other forms of psychotherapy, especially psychodynamic, narrative, and ACT, is a good way to maintain the outcomes from therapy. This shows that implementing a holistic integrative

approach can add significant value to an individual's treatment and should be considered for implementation. ACT appears to have the most current research to back up its efficacy, though any of the frameworks discussed in this essay can be beneficial if they are more accessible to the practitioner.

Most importantly, the frameworks and interventions used must be a proper match for the client's presenting concerns. Not all cases of OCD are the same and thus, may need to be treated differently. A thorough case conceptualization will determine what may be the best course of action to supplement exposure and response prevention, including how to structure when these interventions will be utilized.

My recommendation for practitioners looking to work with clients afflicted with OCD would be to implement exposure and response prevention along with a framework that suits their unique situation and addresses their specific needs, along with referral to a psychiatrist to establish a medication plan which includes SSRI medications. While this may not cure an individual's symptoms, it is currently the best-known treatment plan to aid them in a situation that they will likely have to work with for years to come.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Banting, R., & Lloyd, S. (2017). A case study integrating CBT with narrative therapy externalizing techniques with a child with OCD: How to flush away the Silly Gremlin. A single-case experimental design. *Journal of Child and Adolescent Psychiatric Nursing, 30*(2), 80–89. https://doi.org/10.1111/jcap.12173

Barney, J. Y., Field, C. E., Morrison, K. L., & Twohig, M. P. (2017). Treatment of pediatric obsessive compulsive disorder utilizing parent-facilitated acceptance and commitment therapy. *Psychology in the Schools, 54*(1), 88–100. https://doi.org/10.1002/pits.21984

Basile, B., Mancini, F., Macaluso, E., Caltagirone, C., & Bozzali, M. (2014). Abnormal processing of deontological guilt in obsessive-compulsive disorder. *Brain Structure and Function, 219*(4), 1321–1331. https://doi.org/10.1007/s00429-013-0570-2

Beck, J. S. (2021). *Cognitive behaviour therapy: Basics and beyond* (3rd ed.). The Guilford Press.

Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. Basic Books.

Canadian Psychological Association [CPA]. (2017). *Canadian code of ethics for psychologists* (4th ed.).

Corey, G. (2019). *The art of integrative counselling* (4th ed.). American Counselling Association.

Cunha, J. P. (2021, January 29). *Side effects of Anafranil (clomipramine).* MedicineNet. https://www.medicinenet.com/side_effects_of_clomipramine-oral/side-effects.htm#does_anafranil_clomipramine_cause_side_effects

Del Casale, A., Sorice, S., Padovano, A., Simmaco, M., Ferracuti, S., Lamis, D. A., Rapinesi, C., Sani, G., Girardi, P., Kotzalidis, G. D., & Pompili, M. (2019). Psychopharmacological treatment of obsessive-compulsive disorder (OCD). *Current Neuropharmacology, 17*(8), 710–736. https://doi.org/10.2174/2F1570159X16666180813155017

Dembo, J. S. (2014). "The ickiness factor:" Case study of an unconventional psychotherapeutic approach to pediatric OCD. *American Journal of Psychiatry, 68*(1), 57–79. https://doi.org/10.1176/appi.psychotherapy.2014.68.1.57

Doran, G. (2020). Self-vulnerabilities, attachment and obsessive compulsive disorder (OCD) symptoms: Examining the moderating role of attachment security on fear of self. *Journal of Obsessive-compulsive and Related Disorders, 27,* Article 100575. https://doi.org/10.1016/j.jocrd.2020.100575

Dougherty, J. W., Ettensohn, M. F., & Levine, S. P. (2018). Beyond depression: Ketamine and glutamatergic agents for PTSD, OCD, and other potential applications. *Psychiatric Annals, 48*(4), 184–188. https://doi.org/10.3928/00485713-20180312-03

Drugs.com. (2022, June 8). *Glutamine side effects*. https://www.drugs.com/sfx/glutamine-side-effects.html

Ferrando, C., & Selai, C. (2021). A systematic review and meta-analysis on the effectiveness of exposure and response prevention therapy in the treatment of obsessive-compulsive disorder. *Journal of Obsessive-Compulsive and Related Disorders, 31,* Article 100684. https://doi.org/10.1016/j.jocrd.2021.100684

Freud, S. (1920). *A general introduction to psychoanalysis*. Horace Liveright.

Greenburg, D., & Witztum, E. (2001). *Sanity and sanctity: Mental health work among the ultra-orthodox in Jerusalem.* Yale University Press.

Harris, R., & Hayes, S. C. (2019). *ACT made simple: An easy-to-read primer on acceptance and commitment therapy*. New Harbinger Publications.

Hofer, P. D., Wahl, K., Meyer, A. H., Miche, M., Beesdo-Baum, K., & Lieb, R. (2020). Parental emotional warmth interacts with traumatic life events in predicting the onset of obsessive-compulsive

disorder. *Journal of Obsessive-Compulsive and Related Disorders, 26,* Article 100531. https://doi.org/10.1016/j.jocrd.2020.100531

Holmes, A. G. D. (2020). Researcher positionality – A consideration of its influence and place in qualitative research – A new researcher guide. *Shanlax International Journal of Education, 8*(4), 1–10. https://doi.org/10.34293/education.v8i4.3232

Jardine, D. W. (1992). The fecundity of the individual case: Considerations of the pedagogic heart of interpretive work. *Journal of Philosophy of Education, 26*(1), 51–61. https://doi.org/10.1111/j.1467-9752.1992.tb00264.x

Johnson, S. M. (2019). *Attachment theory in practice: Emotionally focused therapy (EFT) with individuals, couples, and families*. The Guilford Press.

Kafes, A. Y. (2021). Behavioral intervention techniques used in the treatment of obsessive compulsive disorder: Systematic review. *Current Approaches in Psychiatry, 13*(3), 726–738. https://doi.org/10.18863/pgy.875418

Kuckertz, J. M., Piacentini, J., & Amir, N. (2020). Towards a clinically valid mechanistic assessment of exposure and response prevention: Preliminary utility of an exposure learning tool for children with OCD. *Journal of Obsessive-Compulsive and Related Disorders, 25,* Article 100528. https://doi.org/10.1016/j.jocrd.2020.100528

Kumar, R., Sharma, A., Bansal, P. D., Bahetra, M., Saini, B., Moria, K., Kaur, N., Gupta, S., Bansal, P., Kumar, A., Kaur, H., & Kaur, J. (2021). The role of religiosity and guilt in symptomatology and outcome of obsessive compulsive disorder. *Psychopharmacology Bulletin, 51*(3), 38–49.

Law, C., & Boisseau, C. L. (2019). Exposure and response prevention in the treatment of obsessive-compulsive disorder: Current perspectives. *Psychology Research and Behavior Management, 12*, 1167–1174. https://doi.org/10.2147/PRBM.S211117

Lui, P. P. (2017). Incorporating meta-emotions in integrative cognitive-affective therapy to treat comorbid bulimia nervosa and substance use disorders in a Latina American. *Clinical Case Studies, 16*(4), 328–345. https://doi.org/10.1177/1534650117698038

Lysaker, P. H., & Roe, D. (2016). Integrative psychotherapy for schizophrenia: Its potential for a central role in recovery oriented treatment. *Journal of Clinical Psychology 72*(2), 117–122. https://doi.org/10.1002/jclp.22246

Madigan, S. (2019). *Narrative therapy* (2nd ed.). American Psychological Association. https://doi.org/10.1037/0000131-001

Marsden, Z. (2016). EMDR treatment of obsessive-compulsive disorder: Three cases. *Journal of EMDR Practice and Research, 10*(2), 91–103. https://doi.org/10.1891/1933-3196.10.2.91

Marsden, Z., Lovell, K., Blore, D., Ali, S., & Delgadillo, J. (2018). A randomized controlled trial comparing EMDR and CBT for obsessive-compulsive disorder. *Clinical Psychology & Psychotherapy, 25*, 10–18. https://doi.org/10.1002/cpp.2120

Marsden, Z., Teahan, A., Lovell, K., Blore, D., & Delgadillo, J. (2018). Patients' experiences of cognitive behavioural therapy and eye movement desensitisation and reprocessing as treatments for obsessive-compulsive disorder. *Counselling and Psychotherapy Research, 18*(3), 251–261. https://doi.org/10.1002/capr.12159

Mazza, M. T., & Coyne, L. W. (2020). *The ACT workbook for OCD: Mindfulness, acceptance, and exposure skills to live well with obsessive-compulsive disorder.* New Harbinger Publications.

McKay, D., Abramowitz, J. S., & Storch, E. A. (2021). Mechanisms of harmful treatments for obsessive-compulsive disorder. *Clinical Psychology, 28*(1), 52–59. https://doi.org/10.1111/cpsp.12337

Medical News Today. (2021, May 18). *What to know about serotonin-norepinephrine reuptake inhibitor (SNRI) drugs*. https://www.medicalnewstoday.com/articles/snri

Melli, G., Carraresi, C., Poli, A., Marazziti, D., & Pinto, A. (2017). The role of guilt sensitivity in OCD symptom dimensions. *Clinical Psychology & Psychotherapy, 24*(5), 1079–1089. https://doi.org/10.1002/cpp.2071

Milona, S., Andrea-Apostolidou, S., Panayiotou, G., & Koukia, E. (2017). Cognitive behavioural therapy for obsessive compulsive disorder. *International Journal of Caring Sciences, 10*(1), 614–621.

Moreso, N. V., Hernandez-Martinez, C., Val, V. A., & Sans, J. C. (2013). Socio-demographic and psychopathological risk factors in obsessive-compulsive disorder: Epidemiologic study of school population. *International Journal of Clinical and Health Psychology, 13*(2), 118–126. https://doi.org/10.1016/S1697-2600(13)70015-2

Mulhall, K., O'Connor, J., & Timulakova, K. (2019). Managing the monster in the mind: A psychoanalytically informed qualitative study exploring the experiences of people diagnosed with obsessive-compulsive disorder. *Psychoanalytic Psychotherapy, 33*(2), 117–132. https://doi.org/10.1080/02668734.2019.1614087

Murayama, K., Nakao, T., Ohno, A., Tsuruta, S., Tomiyama, H., Hasuzawa, S., Mizobe, T., Kato, K., & Kanba, S. (2020). Impacts of stressful life events and traumatic experiences on onset of obsessive-compulsive disorder. *Frontiers in Psychiatry, 11*. https://doi.org/10.3389/fpsyt.2020.561266

NHS. (2021, December 8). *Side effects – selective serotonin reuptake inhibitors (SSRIs).* https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/medicines-and-psychiatry/ssri-antidepressants/side-effects/

Norcross, J. C., Goldfried, M. R., & Arigo, D. (2016). Integrative theories. In J. C. Norcross, G. R. VandenBos, D. K. Freedheim, & B. O. Olatunji (Eds.), *APA handbook of clinical psychology: Theory and research* (Vol. 2, pp. 303–332). American Psychological Association. https://doi.org/10.1037/14773-011

OCD-UK. (n.d.). *What causes OCD.* https://www.ocduk.org/ocd/what-causes-ocd/

Ottaviani, C., Collazzoni, A., D'Olimpio, F., Moretta, T., & Mancini, F. (2019). I obsessively clean because deontological guilt makes me feel physiologically disgusted! *Journal of Obsessive-Compulsive and Related Disorders, 20*, 21–29. https://doi.org/10.1016/j.jocrd.2018.01.004

Philip, J., & Cherian, V. (2021). Acceptance and commitment therapy in the treatment of obsessive-compulsive disorder: A systematic review. *Journal of Obsessive-Compulsive and Related Disorders, 28,* Article 100603. https://doi.org/10.1016/j.jocrd.2020.100603

Rapoport, J. L. (1989). *The boy who couldn't stop washing: The experience and treatment of obsessive-compulsive disorder.* Signet.

Rogers Behavioral Health. (2018, February 18). *"I'm so OCD…"*. https://rogersbh.org/about-us/newsroom/blog/im-so-ocd

Rosenbaum, S. B., Gupta, V., & Palacios, J. L. (2022, June 7). *Ketamine*. National Library of Medicine. https://www.ncbi.nlm.nih.gov/books/NBK470357/

Sibi, K. J. (2020). Sigmund Freud and psychoanalytic theory. *Langlit, 5*(61), 75–79.

Tomikawa, Y. (n.d.). OCD prevalence: How many people have OCD? *Zencare*. https://blog.zencare.co/ocd-prevalence/

Twohig, M. P., Abramowitz, J. S., Bluett, E. J., Fabricant, L. E., Jacoby, R. J., Morrison, K. L., Reuman, L., & Smith, B. M. (2015). Exposure therapy for OCD from an acceptance and commitment therapy (ACT) framework. *Journal of Obsessive-Compulsive and related Disorders, 6,* 167–173. https://doi.org/10.1016/j.jocrd.2014.12.007

Valls, È., Bonnín, C. M., Torres, I., Brat, M., Prime-Tous, M., Morilla, I., Segú, X., Solé, B., Torrent, C., Vieta, E., Martínez-Arán, A., Reinares, M., & Sánchez-Moreno, J. (2021). Efficacy of an integrative approach for bipolar disorder: Preliminary results from a randomized controlled trial. *Psychological Medicine*. https://doi.org/10.1017/S0033291721001057

Walitza, S., Melfsen, S., Jans, T., Zellmann, H., Wewetzer, C., & Warnke, A. (2011). Obsessive-compulsive disorder in children and adolescents. *Deutsches Arzteblatt International, 108*(11), 173–179. https://doi.org/10.3238%2Farztebl.2011.0173

Whittal, M. L., Robichaud, M., Thordarson, D. S., & McLean, P. D. (2008). Group and individual treatment of obsessive-compulsive disorder using cognitive therapy and exposure plus response prevention: A 2-year follow-up of two randomized trials. *Journal of Consulting and Clinical Psychology, 76*(6), 1003–1014. https://doi.org/10.1037/a0013076

Williams, M. T., & Jahn, M. E. (2017). Obsessive-compulsive disorder in African American children and adolescents: Risks, resiliency, and barriers to treatment. *American Journal of Orthopsychiatry, 87*(3), 291–303. https://doi.org/10.1037/ort0000188

Wilson, A., & Thayer, K. (2020). Cross-cultural differences in the presentation and expression of OCD in Black individuals: A systematic review. *Journal of Obsessive-Compulsive and Related Disorders, 27,* Article 100592. https://doi.org/10.1016/j.jocrd.2020.100592

Wilson, K. G., Bordieri, M. J., Flynn, M. K., Lucas, N. N., & Slater, R. M. (2011). Understanding acceptance and commitment therapy in context: A history of similarities and differences with other cognitive behaviour therapies. In J. Herbert & E. Forman (Eds.), *Acceptance and mindfulness in cognitive behaviour therapy* (pp. 233–263). Wiley.

Woon, L. S., Kanapathy, A., Zakaria, H., & Alfonso, C. A. (2017). An integrative approach to treatment-resistant obsessive-compulsive disorder. *Psychodynamic Psychiatry, 45*(5), 237–257. https://doi.org/101521pdps2017452237

Wu, K. D., & Wyman, S. V. (2016). Examination of racial differences in assessment of OCD symptoms and obsessive beliefs. *Journal of Obsessive-Compulsive and Related Disorders, 10*, 10–18. https://doi.org/10.1016/j.jocrd.2016.04.008