Cell Phone Exposure Therapy

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I have written before about how OCD often hits hardest at home (OCD Newsletter, Late Fall, 2003). The privacy, lack of social pressure to constrain ritualizing, and large blocks of free time at home all combine to create an atmosphere conducive to obsessing, worrying, and ritualizing. Creating OCD-free zones in different areas of the house, inviting friends over, and leading a productive, active life are some ways of minimizing at home ritualizing. (Avoid being a couch potato; start exercising and reading a lot more.) These strategies, although helpful, do not replace the need to do effective exposure response prevention (ERP) therapy. To work best, ERP must expose one to the actual situations/thoughts that trigger obsessions while refraining from doing any rituals. Good homework assignments often involve confronting such situations at home. Unfortunately, some patients find it difficult to follow through on these assignments. I tell my patients that discomfort is part of the cure. Still, the follow through can be spotty.

When possible, making a home visit is a good way to jump start the process. The therapist can walk the patient through the exposures in their natural context. Then the patient can do it more or less alone as the therapist fades out of the scene, perhaps by going into another room. Another advantage to home visits is that the therapist can more clearly understand exactly how the ritualizing proceeds. Frequent home visits, however, can be impractical, especially for patients who live far away. I have found that telephone therapy, especially with a cell phone, is an effective substitute for follow up home visits.

Being at home, the patient is better able to remember and see bothersome triggers. The comforting voice of the therapist then allows (cajoles, suggests, motivates — whatever) the patient into confronting these triggers. A wide array of troublesome situations can be dealt with in one session. A patient of mine concerned about AIDs recently challenged herself by doing ERP with a “dangerous” newspaper that had an article about blood/gay men, slime under a bath mat, and dirty laundry. She also “recontaminated” and used a nail clipper that had been sterilized because it came in contact with the newspaper. Making sure that she could touch and smell all these triggers repeatedly we then decided on home- work assignments to reinforce the initial exposures. She agreed to put the scary newspaper article on her pillow, sprinkle tissues soaked in red dye around the house, and use tampons without examining the wrapper for spots or breakages. (By the way, OCD loves scary and embarrassing/intimate triggers. Don’t hold back on discussing such items with your therapist. Blood, sex, and violence are common OCD themes.)

Cell phone therapy can be used in any environment — not just the home. Of course if used in the car, say for hit and run OCD, it should only be done when the vehicle is pulled over and parked. It should not be used while someone is actually driving. Finally, cell phone therapy can be helpful in that it allows for more frequent visits without major inconvenience. It gets people to con- front the real deal in the natural environment. And it gets them to do it “right now”. With all anxiety disorders, the anticipation of acting is worse than the actual deed. Fast action — without hesitation and contemplation — is by far the best way of confronting OCD triggers and most scary things in life.

Lastly, I think it’s important to remember that we have no panaceas for OCD. Even the best treatments can be incomplete and subject to some relapses. OCD is creative; it can change form and “mutate.” The good news is that effective, properly applied CBT, possibly combined with medication, can be of enormous benefit to many patients.

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