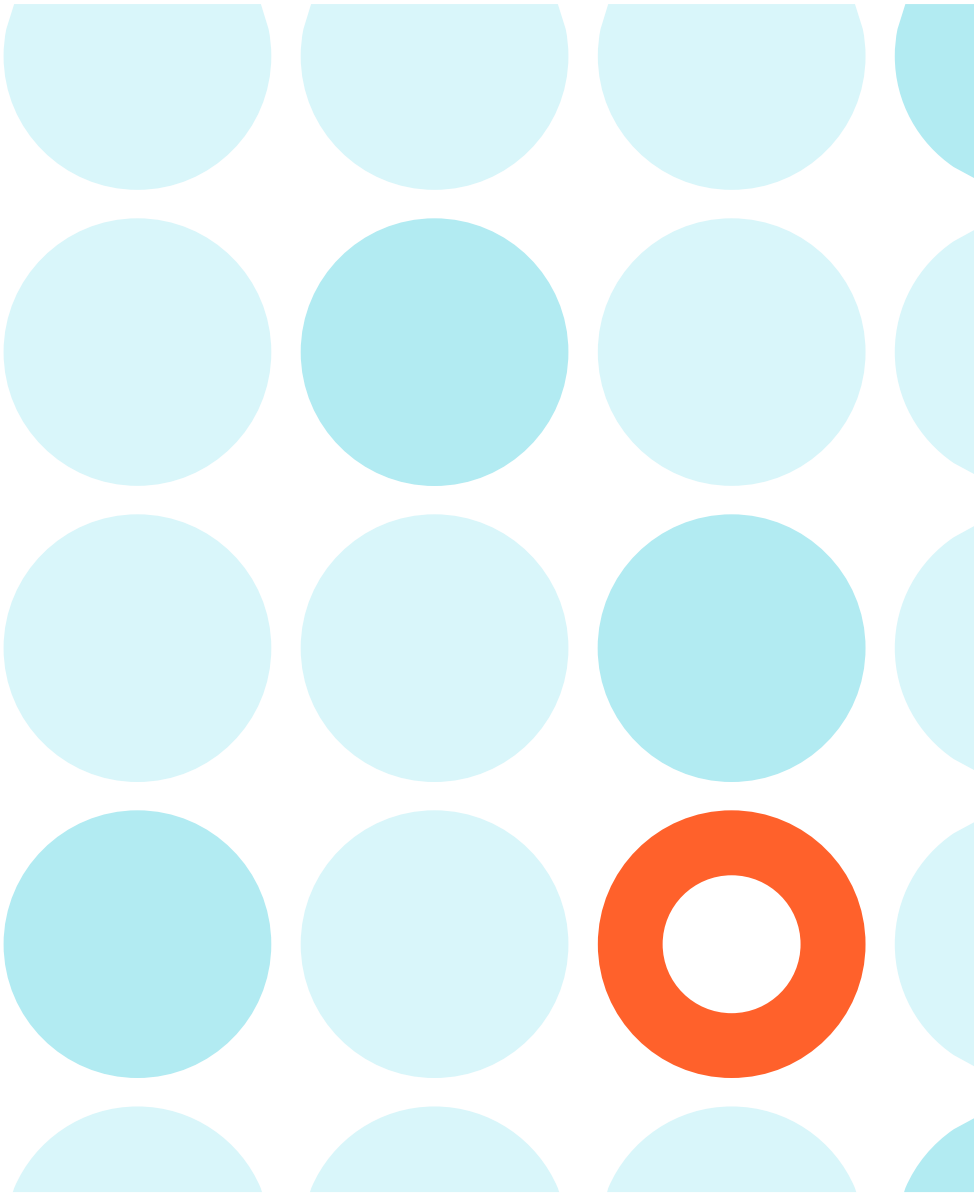
Assessment of OCD and Introduction to Exposure and Response Prevention

Presented by: Ida Moadab, Ph.D.



Disclosures of relevant financial relationships

In accordance with the Accreditation Council for Continuing Medical Education's (ACCME) Standards for Integrity and Independence in Accredited Continuing Education, Optum Health Education (OHE) requires all those in control of educational content to disclose their financial relationships with ineligible companies within the prior 24 months. Ineligible companies are defined by the ACCME as companies whose primary business is producing, marketing, selling, re-selling, or distributing health care products used by or on patients. Individuals must disclose all financial relationships, regardless of the amount, with ineligible companies and regardless of their view of the relevance of the relationship to the education. OHE ensures that the content is independent of commercial bias.

Activity presenters

Heidi Bausch-Ryan, PsyD, LP
Associate Director of Training
Optum Behavioral Care

Ida Moadab, Ph.D.
Clinic Subject Matter Expert
Optum Behavioral Care

The activity presenter has no financial relationships to disclose.

Activity planners

Regina Owens
•Learning and Development Director
•Optum Behavioral Care

Peggy Jones
•Instructional Design Manager
•Optum Behavioral Care

Elizabeth Albert, MD
•Clinical Activity Manager
•Optum Health Education

Heidi Bausch-Ryan, Psy.D., LP,
•Clinical Subject Matter Expert
•Optum Behavioral Care | Care Counseling

Miranda Murgasen, LGSW
•Senior Behavioral Health Clinician
•Optum Behavioral Care | Care Counseling

Katie Daron
•Instructional Designer
•Optum Behavioral Care

The activity planners have no financial relationships to disclose OR add anything noted on their forms.

Disclosures

- There are no potential conflicts of interest
- There are no relationships that can be construed as conflicts
- There is no commercial support for the program offered
- The speakers' views are their own and do not necessarily reflect those of Refresh Mental Health/Optum.

Learning Objectives

1. Describe the cognitive-behavioral model of the development and maintenance of obsessive compulsive and related disorders.
2. Detail the process of assessing for OCD, including how to identify themes in obsessions and compulsions.
3. Identify three components of a strong fear hierarchy.
4. Describe five components of effective exposure and response prevention.

Cultural considerations

- **More limited integration** of cultural factors
- **Essential** to assess **societal and cultural influences** on client distress, alongside OCD-specific tools.
- **Consider using DSM-5 Cultural Formulation Interview**
- Recognize **intergenerational, racial, and gender-based trauma** as contributing to Anxiety Disorders and OCD and in themes of disorder.

1

Learning Objective:

Describe the cognitive-behavioral model of the development and maintenance of obsessive compulsive and related disorders.

Eugene Center for Anxiety and Stress

Fear and Anxiety

Fear and anxiety are normal responses

Fear: Response to danger that is currently detected in immediate, present moment of time

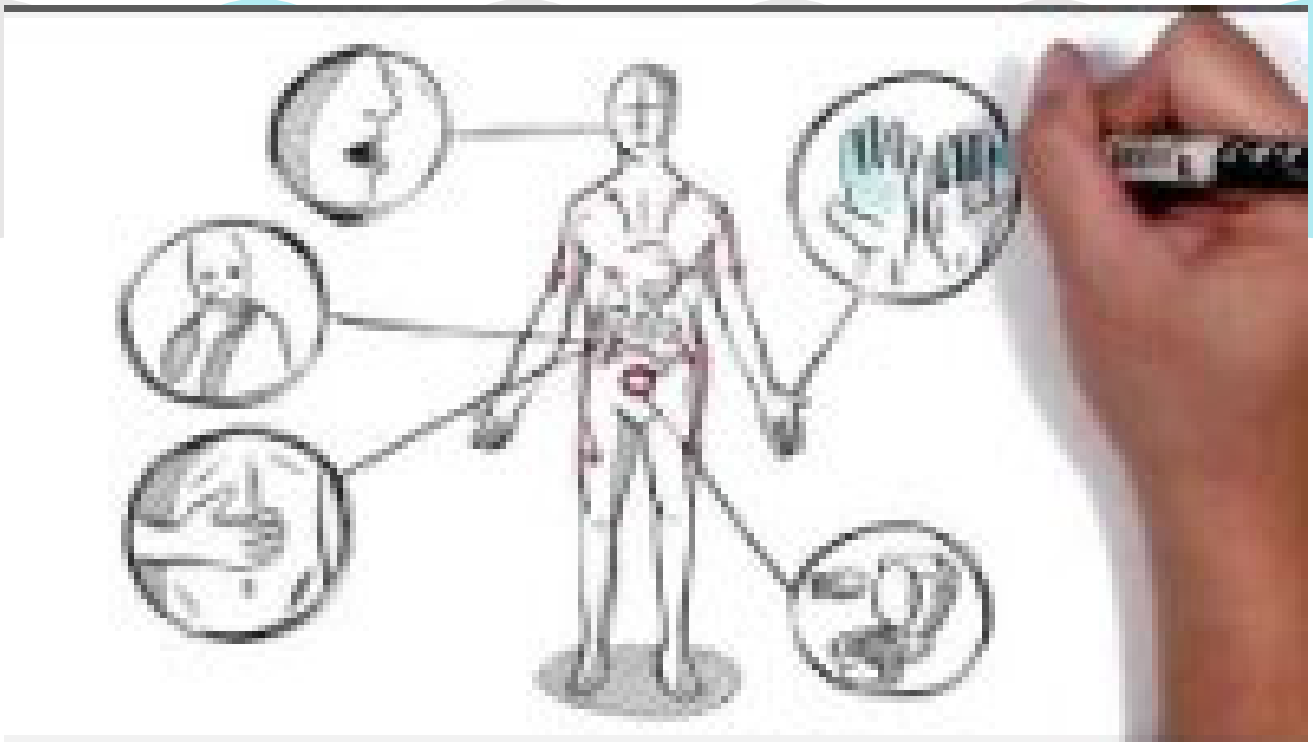
Anxiety: the *anticipation* of some potential threat that may, or may not, happen in the *future*.

Both are adaptive

- Help us escape immediate danger
- Help us avoid future threats

Physiological Response

- Both activate the Sympathetic Nervous System
- Trigger the **Fight, Flight, Freeze, or Fawn (FFFF)** response



FFF system is an important and necessary system; when exaggerated in response to neutral stimuli, can develop into an **Anxiety Disorder** (I'm including Fear, Anxiety, Obsessive-Compulsive, and Trauma-Related Disorders in that label for this presentation)

Eugene Center for Anxiety and Stress

Development of Anxiety Disorder

Genetic Vulnerability

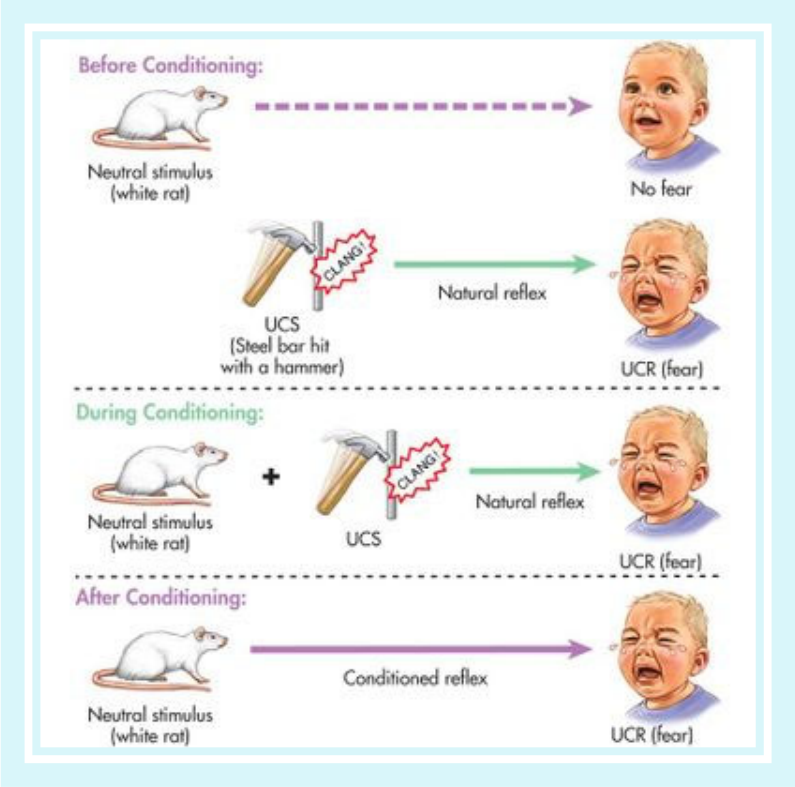
- Infant behavioral inhibition linked to development of social anxiety
- Higher prevalence of OCD within families

Conditioning

- Direct experience – principles of classical conditioning

(ASPPB, 2024; Keith-Spiegel, 2014; Pope & Vetter, 1992)

Principles of Fear Conditioning



Watson, 1920


WATSON'S
BEHAVIORISM

Development of Anxiety Disorder

Genetic Vulnerability

- Infant behavioral inhibition linked to development of (functional and dysfunctional) anxiety

Conditioning

- Direct experience
- Modeling
- Transmission of negative information

Maintenance of Anxiety Disorder Cognitive Factors

Overestimating Threat

Probability over-estimation
- How likely is it that the bad thing is going to happen

Cost over-estimation
- How bad will that consequence be?

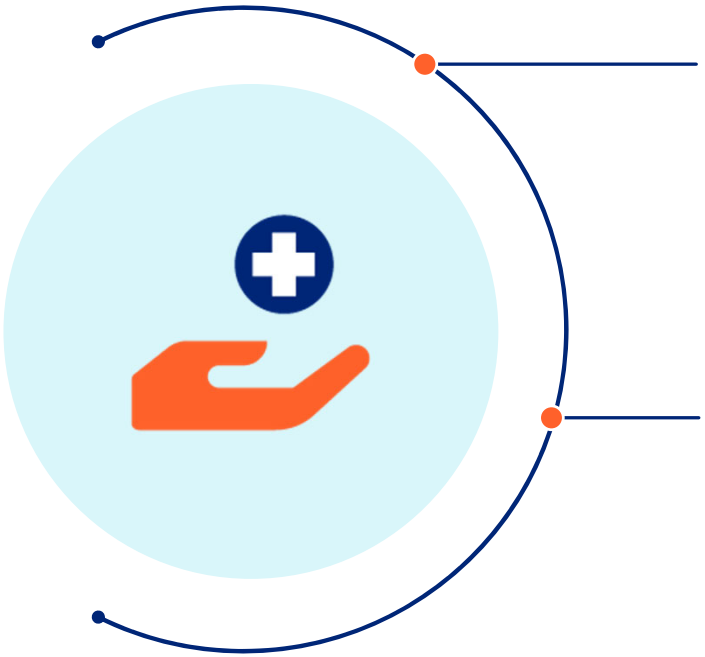
Underestimating Coping Resources

- I'll have a panic attack
- I'll die of embarrassment/go crazy
- I won't be able to tolerate the anxiety

Intolerance of Uncertainty

I need to know for sure that I will be okay today

Maintenance of Anxiety Disorder Information Biases



Selective Attention

- Over-attend to threatening information
  - Evidence from current conversation suggesting someone dislikes me
- Under-attend to safety signals
  - Evidence from current conversation someone likes or feels neutral about me

Selective Memory

- Selectively attend to memories consistent with fear-related beliefs
  - Replay conversation with focus on parts I messed up
- Feared consequence seem more likely
  - Consider all consequences of the person disliking me

Maintenance of Anxiety Disorder Safety Behaviors

Safety Behaviors:
actions that are geared to detect, avoid, or escape feared outcomes

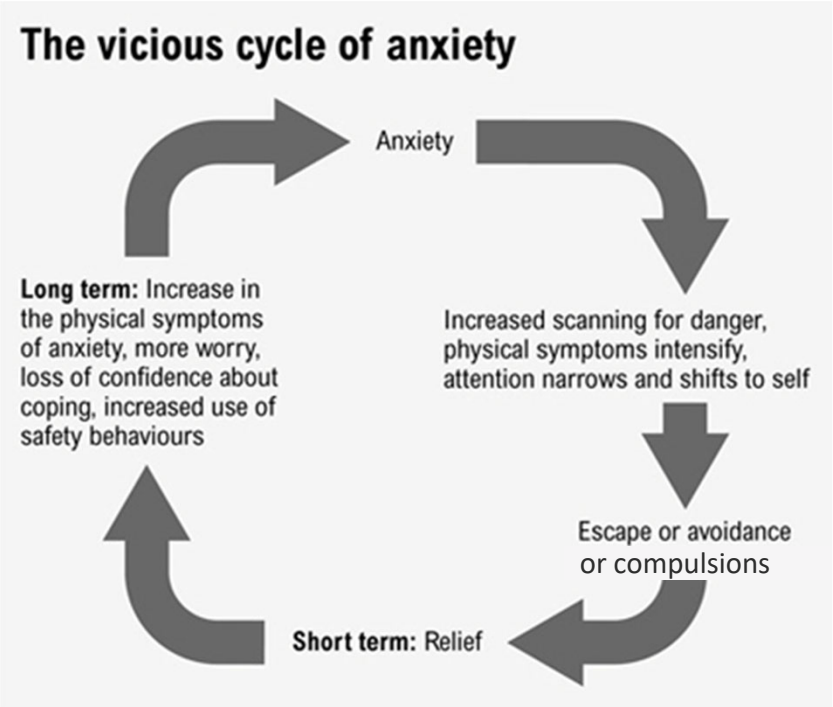
Anxiety complaint	Perceived threat	Safety behavior(s)
Fear of public speaking	Trembling in front of audience	– Gripping both sides of the podium – Ingest beta blocker before talk
Panic disorder	Losing control of one's vehicle while driving	– Avoid driving – Carrying rescue medication in one's pocket or purse
Post-traumatic stress disorder	Being attacked while walking down the street	– Avoid going out at night – Carrying a weapon in one's pocket or purse
Agoraphobia	Having a panic attack while in the grocery store	– Avoid grocery stores – Have a companion accompany one to the store
Obsessive–compulsive disorder	Slitting husband's throat while he is sleeping	– Locking up all knives and scissors before bed – Avoid arguments with husband
Relationship worry	Rejection from partner	– Reassurance seeking – Checking whereabouts of partner
Acrophobia	Plummet to one's death	– Avoid high places – Tightly grip railing while standing on balcony
Sitophobia	Choke while eating	– Avoid swallowing pills

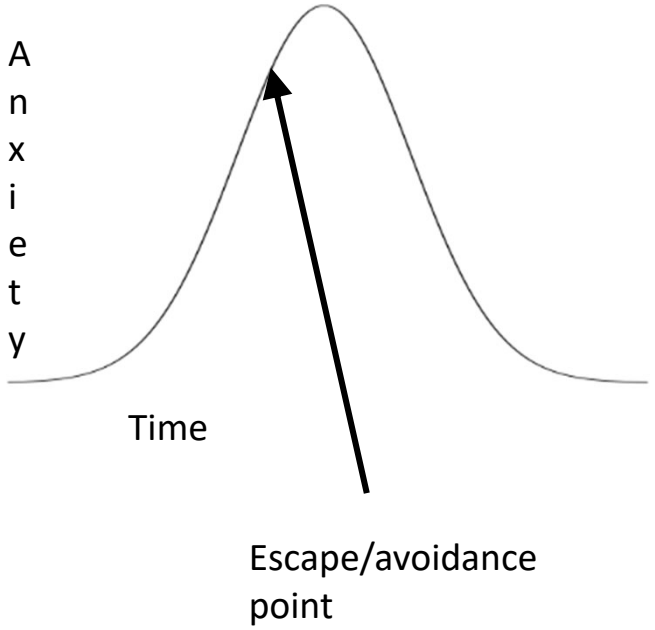
1 Examples of safety behaviors and their related threats across anxiety disorders

Telch & Lancaster, 2012

Maintenance of Anxiety Disorder Safety Behaviors

Maintenance of anxiety disorders Anxiety Cycle





- Recipe for avoidance or actions that ***feel like*** *they are decreasing risk, and actually* ***increase*** *anxiety over time*

Example: Simple Phobia of Yellow Jacket

Development (Vicarious learning)

Maintenance

- Overestimation of threat
- cost overestimation
- Intolerance of uncertainty
- Selective attention
- Selective memory
- Safety behaviors
  - Avoid eating outside
  - Running away/hiding
- Even though none of these behaviors kept me safe, because I didn't get stung, I believed they did (even though increased my fear over time)

Summary

Fear and anxiety are normal responses to threatening stimuli

Develop into disorder based on a combination of genetic contributions and environmental conditions

Are then maintained by a set of cognitive, behavioral, and attentional processes that when reinforced by safety behaviors worsen symptoms over time

Jason Adam Katzenstein

Eugene Center for Anxiety and Stress

Questions?

Eugene Center for Anxiety and Stress

Isn't OCD grouped separately from Anxiety Disorders?

- Grouped with anxiety disorders in DSM-IV (along with Trauma-related disorders).
- In DSM-5, grouped as "Obsessive-Compulsive and Related Disorders" along with
  - Hoarding Disorder
  - Body Dysmorphic Disorder
  - Body Focused Repetitive Behaviors
- New grouping makes some sense (brain mechanisms, family history, comorbidity across OCRDs)
- But also, doesn't (Illness Anxiety Disorder is basically OCD; high comorbidity; many compulsive behaviors in Anxiety and Trauma-related disorders)

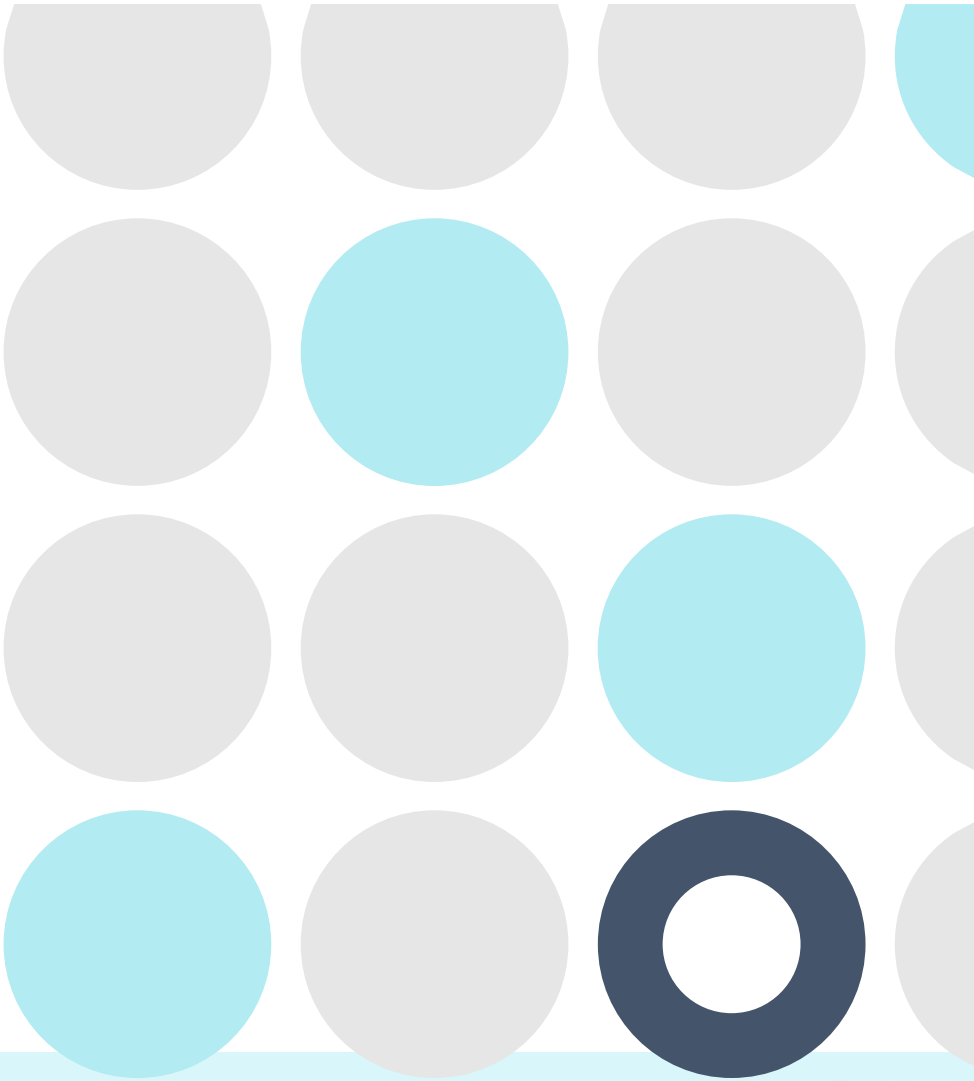
2

Learning Objective:

Detail the process of assessing for OCD, including how to identify themes in obsessions and compulsions.

Eugene Center for Anxiety and Stress

What is OCD?



Eugene Center for Anxiety and Stress

Obsessive Compulsive Disorder

*93.6% of participants across 13 countries on 6 continents, Radomsky et al 2014

In the past three months, have you had unwanted intrusive thoughts, images, or feelings where you suddenly felt like you BECAME CONTAMINATED, DIRTY OR ILL by something you touched?

For example, you may have been in a SLIGHTLY DIRTY PUBLIC WASHROOM, but you suddenly had the thought that you could catch some serious or dreadful disease?

Obsessive Compulsive Disorder

Without OCD, people are **not bothered** by these weird thoughts and can quickly dismiss them.

Just because you think something, doesn't mean it will happen, or you will act on it.

Example: Winning the lottery/getting hit by a bus

In individuals with OCD, intrusive thoughts are seen as dangerous because of the meaning that is made of having the thought.

Thought Action Fusion	Emotional Reasoning	Inability to Tolerate Doubt
If I think it, I might do it.	If I feel something is wrong, then something is wrong.	• How do I know for sure I wont act on it? • If I have a thought, I maybe left the stove on, how do I know for sure I didn't?

Because these thoughts are perceived as dangerous, the person acts to "fix" or neutralize them, through actions, other thoughts, or avoidance. By doing so, makes these thoughts occur more frequently (don't think of a white bear).

Obsessive Compulsive Disorder DSM-5 Criteria

Obsessions

- Recurrent and persistent thoughts, urges, or images
- Experienced as intrusive and cause marked anxiety and distress

Compulsions

- Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) performed in response to an obsession or according to rules that must be applied rigidly.
- The behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation.
- Behaviors or mental acts are not connected in a way that could realistically neutralize or prevent whatever they are meant to address, or are clearly excessive and time-consuming

Two parts to an Obsession

Trigger (stimulus)

- External (contaminated object, unlocked door)
- Internal (Intrusive thought/image about sex, violence, immorality)

Core fear (imagined consequence)

- Example: I will get sick and die; my family will be murdered; I will act on the horrible thought

Compulsions

Form of Compulsion

- **Behavioral compulsions** are viewable (hand washing, checking, reassurance seeking)
- **Cognitive/internal compulsions** are not (counting, thought replacement, mental checking, figuring-it-out); * no such thing as pure "O" OCD

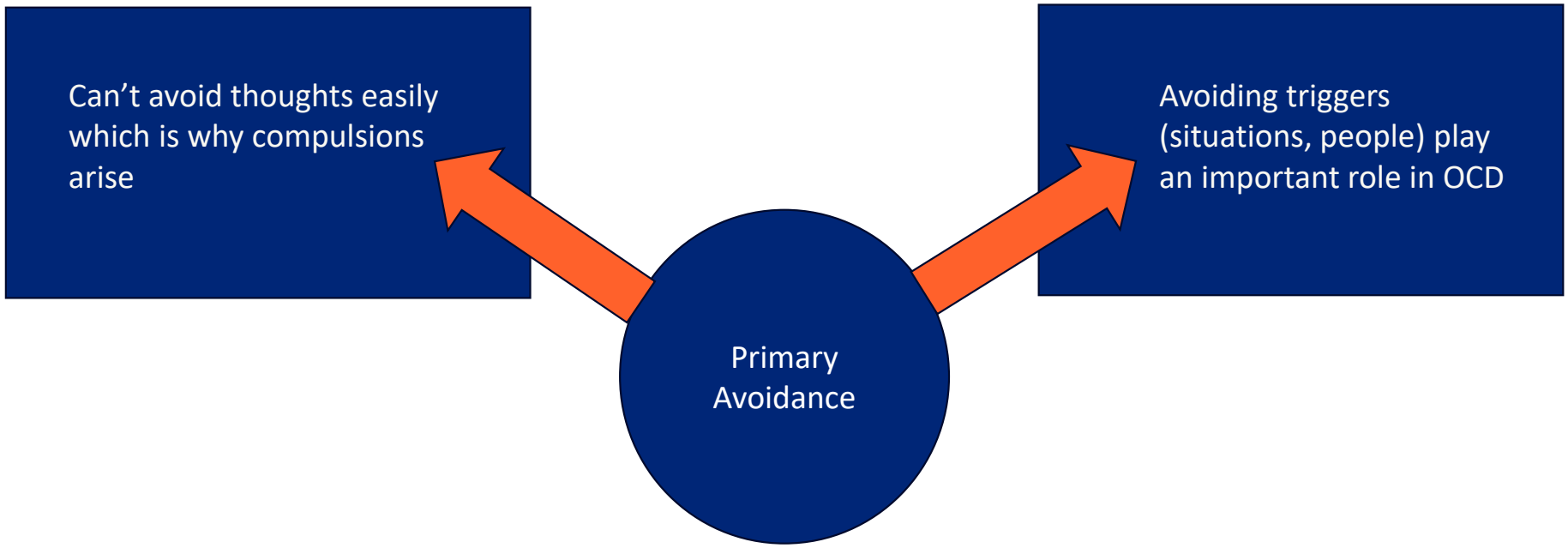
Intent of Compulsion

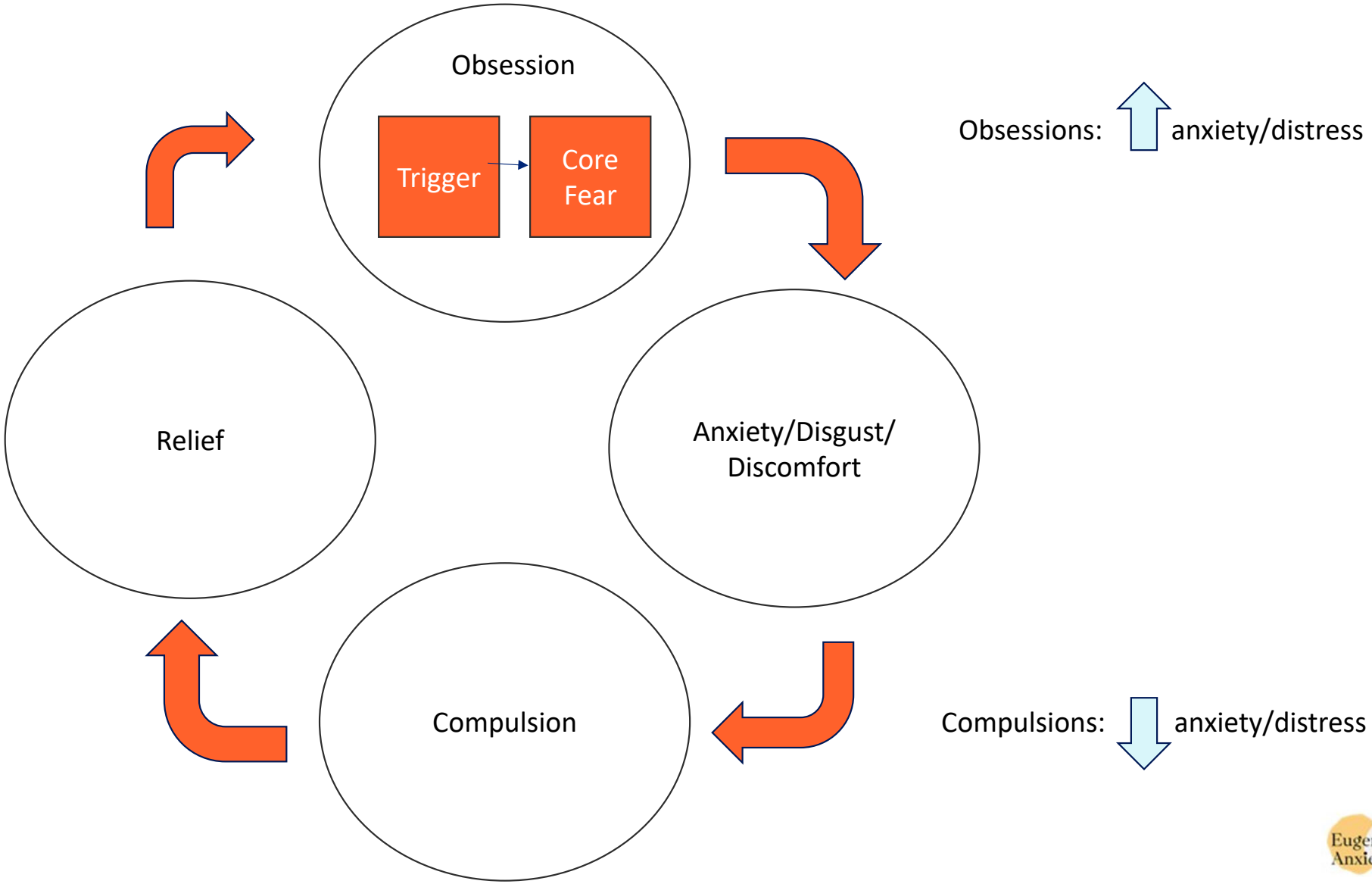
- **Prevention** (to make sure bad thing doesn't happen)
- **Reassurance Seeking** (to make sure I'm okay, that it didn't happen)

Relationship to Normal Functioning

- **Dysfunctional** (turning on and off light switch; rigid ordering rituals)
- **Functional** (washing, cleaning, praying)

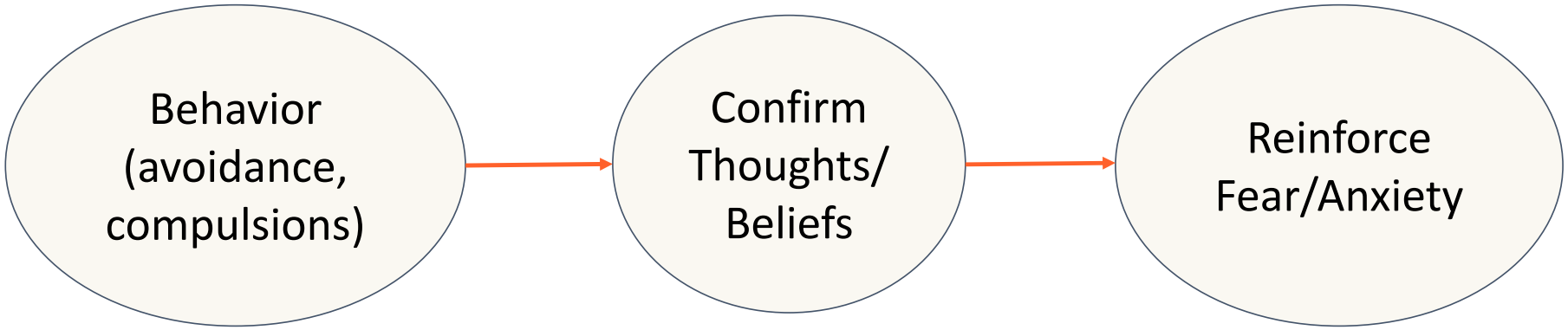
Primary Avoidance



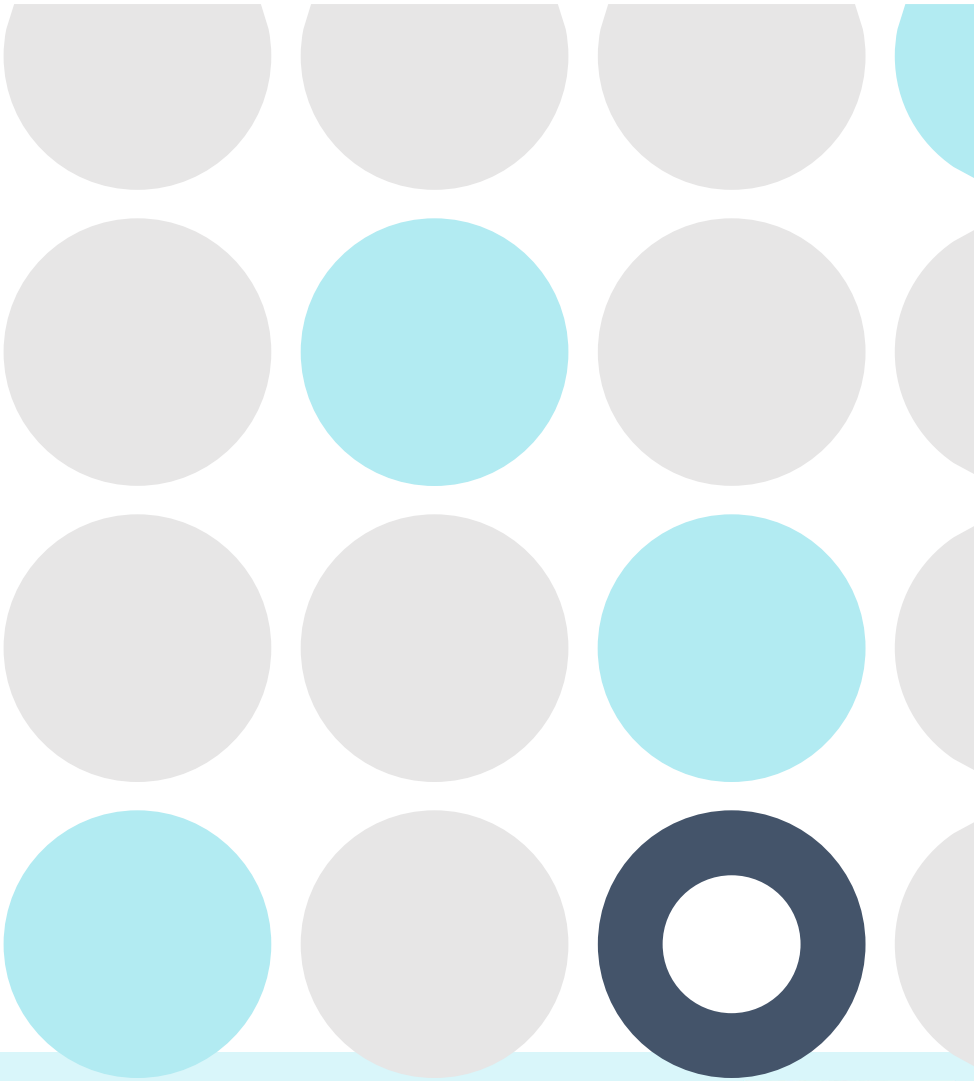


Eugene Center for Anxiety and Stress

If I had to act on it, it must have been dangerous

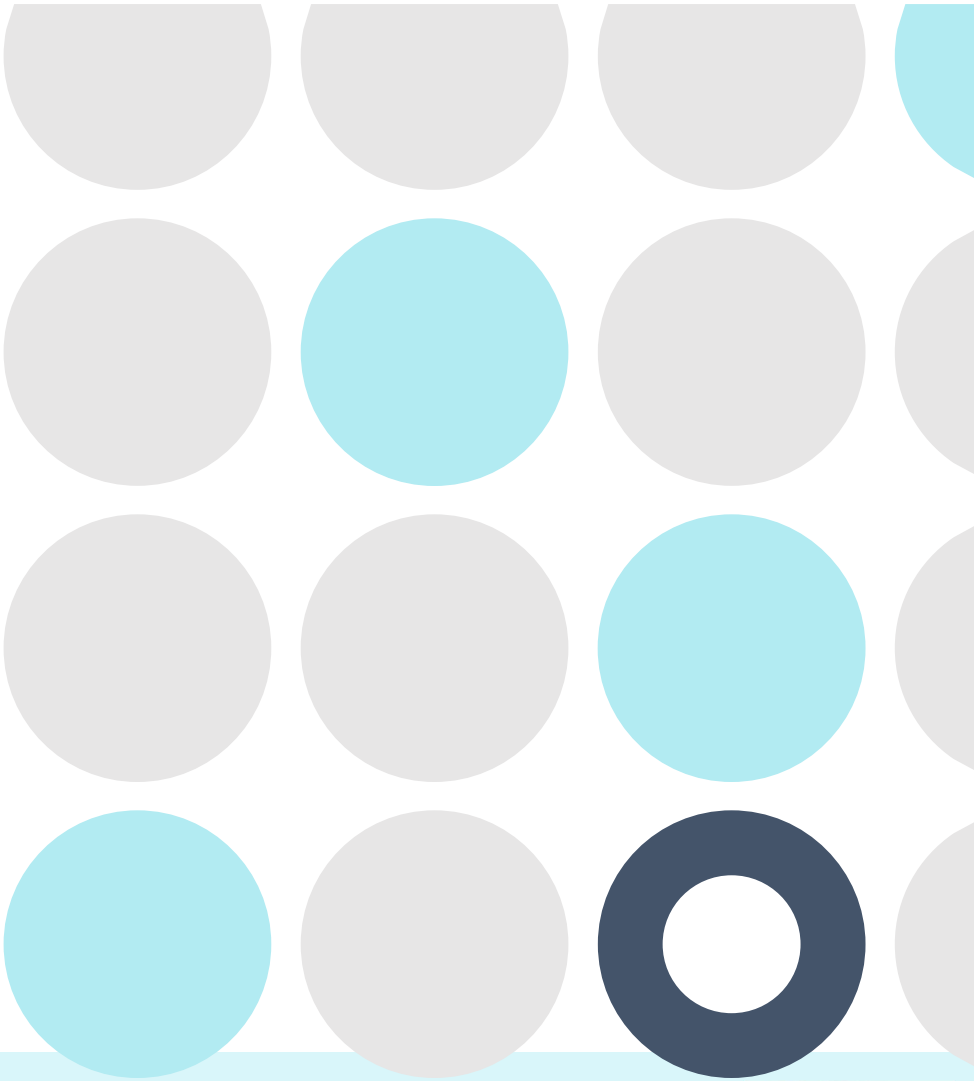


Questions about OCD/ OCD Cycle?



Eugene Center for Anxiety and Stress

Differentiation from other disorders



Eugene Center for Anxiety and Stress

Differentiating from other disorders

Screening questions:

Obsessions

Do you have unpleasant thoughts, urges, or images that repeatedly enter your mind?

Compulsions

Do you feel driven to perform certain behaviors or mental acts over and over again?

Saying yes to these questions does not mean someone has OCD

- Obsession vs worry or rumination
- Obsession vs traumatic re-experiencing symptoms
- Compulsions common in anxiety disorders (reassurance seeking or figuring it out)
- Compulsion vs addiction

Across disordered anxiety, different fear targets

Themes of Obsessive Thoughts in OCD

Not about just anything

Obsessions

- Aggressive
- Contamination
- Somatic/Health
- Sexual
- Hoarding/Saving
- Religious
- Need for symmetry/exactness
- Miscellaneous (luck, superstitious, memory)

What do these have in common?

- Person's values or cultural norms exaggerated

Content - Related to human values and morality

Morality

- Aggressive
- Sexual
- Religious
- Hoarding/Saving

Survival/Morality

- Contamination
- Somatic/Health

Right vs Wrong

- Need for symmetry/exactness
- Miscellaneous (luck, superstitious, memory)
- Sensorimotor

Importance and Control of Thoughts

Obsessive Beliefs Questionnaire (OBQ-44)

Assesses beliefs linked to anxiety and OCD, organized into three themes:

1. Perfectionism and intolerance of uncertainty
2. Importance of and control of thoughts
3. Inflated responsibility and perceived threat of harm

Importance and Control of Thoughts

- Obsessive Beliefs Questionnaire (OBQ-44)
- Assesses beliefs linked to anxiety and OCD, organized into three themes:

1. Perfectionism and intolerance of uncertainty
2. **Importance of and control of thoughts**
3. Inflated responsibility and perceived threat of harm

Myers, Fisher, & Wells, 2008

OBQ-44

ICT 27. Having a blasphemous thought is as sinful as committing a sacrilegious act.

7. For me, having bad urges is as bad as actually carrying them out.

ICT 13. If I have aggressive thoughts or impulses about my loved ones, this means I may secretly want to hurt them.

21. Having nasty thoughts means I am a terrible person.

24. I should not have bizarre or disgusting thoughts.

28. I should be able to rid my mind of unwanted thoughts.

30. Having bad thoughts means I am weird or abnormal.

32. Having an unwanted sexual thought or image means I really want to do it.

35. Having intrusive thoughts means I'm out of control.

ICT 38. Having violent thoughts means I will lose control and become violent.

Eugene Center for Anxiety and Stress

Role of doubt

- Inference-Based Therapy (IBT) puts **doubt** as the key mental process that leads to OCD
- Doubt also a factor in other anxiety disorders but most prominent in OCD
    - Can I even trust my memory? What if I remember wrong?
    - Did I do my ritual wrong? I better start all over again

Intolerance of feeling states

The discomfort that an obsession causes is seen as intolerable.

Often this is anxiety/fear,
but it can also be:

Disgust

Contamination, sensation

Right/Wrong

Symmetry, morality, superstition

Right/Wrong

Interoceptive perception

Centrality of compulsions

While other anxiety disorders also have compulsions, because the fear is thought, avoidance works less well (how do we avoid thinking?)

Because something has to be done to neutralize the intrusive thought, often develop strategies that have no real-life impact (making OCD more likely to lead to **magical thinking**)

- Cleaning my room will keep my parents safe from harm
- Walking 'right' will ensure my friends like me
- Showering correctly will keep me from getting sick

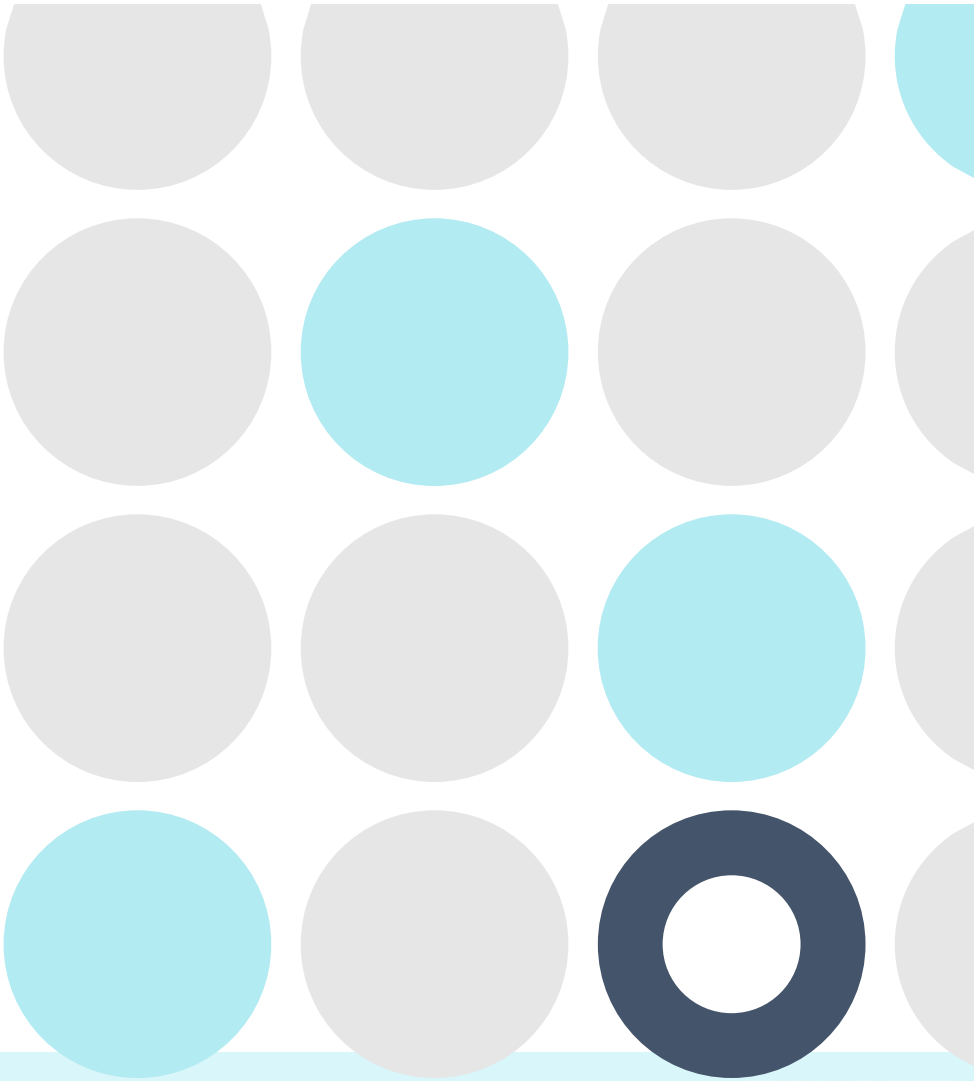
Summary of clinical differentiation

- Themes of obsessive thoughts
- Importance of control of thoughts
- Role of doubt
- Intolerance of feeling states
- Centrality of compulsions (including internal compulsions)

Questions/case examples?

Eugene Center for Anxiety and Stress

Assessment of OCD Themes



Eugene Center for Anxiety and Stress

Obsessions

Yale Brown Obsessive-Compulsive Scale Symptom Checklist *(Goodman, Rasmussen, et al.)*

AGGRESSIVE OBSESSIONS				
#	Past	Current		Examples
1			I fear I might harm myself	Fear of eating with a knife or fork, fear of handling sharp objects, fear of walking near glass windows
2			I fear I might harm other people	Fear of poisoning other people's food, fear of harming babies, fear of pushing someone in front of a train, fear of hurting someone's feelings, fear of being responsible by not providing assistance for some imagined catastrophe, fear of causing harm by giving bad advice
3			I have violent or horrific images in my mind	Images of murder, dismembered bodies, or other disgusting scenes
4			I fear I will blurt out obscenities	Fear of shouting obscenities in public situations like church or class, fear of writing obscenities
5			I fear doing something embarrassing	Fear of appearing foolish in social situations
6			I fear I will act on an unwanted impulse	Fear of driving a car into a tree, fear of running someone over, fear of stabbing a friend
7			I fear I will steal things	Fear of "cheating" a cashier, fear of shoplifting inexpensive items
8			I fear that I'll harm others because I'm not careful enough	Fear of causing an accident without being aware of it (such as a hit-and-run accident)
9			I fear I'll be responsible for something else terrible happening	Fear of causing a fire or burglary because of not being careful enough in checking the house before leaving

Obsessions

CONTAMINATION OBSESSIONS				
#	Past	Current		Examples
10			I am concerned or disgusted with bodily waste or secretions	Fear of contracting AIDS, cancer, or other diseases from public rest rooms; fear of your own saliva, urine, feces, semen, or vaginal secretions
11			I am concerned with dirt or germs	Fear of picking up germs from sitting in certain chairs, shaking hands, or touching door handles
12			I am excessively concerned with environmental contaminants	Fear of being contaminated by asbestos or radon, fear of radioactive substances, fear of things associated with towns containing toxic waste sites
13			I am excessively concerned with certain household cleansers	Fear of poisonous kitchen or bathroom cleansers, solvents, insect spray or turpentine
14			I am excessively concerned with animals	Fear of being contaminated by touching an insect, dog, cat, or other animal
15			I am bothered by sticky substances or residues	Fear of adhesive tape or other sticky substances that may trap contaminants
16			I am concerned that I will get ill because of contamination	Fear of getting ill as a direct result of being contaminated (beliefs vary about how long the disease will take to appear)
17			I am concerned that I will contaminate others	Fear of touching other people or preparing their food after you touch poisonous substances (like gasoline) or after you touch your own body

Obsessions

SEXUAL OBSESSIONS				
#	Past	Current		Examples
18			I have forbidden or perverse sexual thoughts, images, or impulses	Unwanted sexual thoughts about strangers, family, or friends
19			I have sexual obsessions that involve children or incest	Unwanted thoughts about sexually molesting either your own children or other children
20			I have obsessions about homosexuality	Worries like "Am I a homosexual?" or "What if I suddenly become gay?" when there is no basis for these thoughts
21			I have obsessions about aggressive sexual behavior toward other people	Unwanted images of violent sexual behavior toward adult strangers, friends, or family members

Obsessions

RELIGIOUS OBSESSIONS				
#	Past	Current		Examples
23			I am concerned with sacrilege and blasphemy	Worries about having blasphemous thoughts, saying blasphemous things, or being punished for such things
24			I am excessively concerned with morality	Worries about always doing "the right thing," having told a lie, or having cheated someone

Eugene Center for Anxiety and Stress

Obsessions

OBSESSION WITH NEED FOR SYMMETRY OR EXACTNESS				
#	Past	Current		Examples
25			I have obsessions about symmetry or exactness	Worries about papers and books being properly aligned, worries about calculations or handwriting being perfect

Eugene Center for Anxiety and Stress

Obsessions

SOMATIC OBSESSIONS				
#	Past	Current		Examples
36			I am concerned with illness or disease	Worries that you have an illness like cancer, heart disease or AIDS, despite reassurance from doctors that you do not
37			I am excessively concerned with a part of my body or an aspect of my appearance (dysmorphophobia)	Worries that your face, ears, nose, eyes, or another part of your body is hideous, ugly, despite reassurances to the contrary

Eugene Center for Anxiety and Stress

Obsessions

MISCELLANEOUS OBSESSIONS				
#	Past	Current		Examples
26			I feel that I need to know or remember certain things	Belief that you need to remember insignificant things like license plate numbers, the names of actors on television shows, old telephone numbers, bumper stickers or t-shirt slogans
27			I fear saying certain things	Fear of saying certain words (such as "thirteen") because of superstitions, fear of saying something that might be disrespectful to a dead person, fear of using words with an apostrophe (because this denotes possession)
28			I fear not saying just the right thing	Fear of having said the wrong thing, fear of not using the "perfect" word
29			I fear losing things	Worries about losing a wallet or other unimportant objects, like a scrap of note paper
30			I am bothered by intrusive (neutral) mental images	Random, unwanted images in your mind
31			I am bothered by intrusive mental nonsense sounds, words or music	Words, songs, or music in your mind that you can't stop
32			I am bothered by certain sounds or noises	Worries about the sounds of clocks ticking loudly or voices in another room that may interfere with sleeping
33			I have lucky and unlucky numbers	Worries about common numbers (like thirteen) that may cause you to perform activities a certain number of times or to postpone an action until a certain lucky hour of the day
34			Certain colors have special significance to me	Fear of using objects of certain colors (e.g. black may be associated with death, red with blood or injury)
35			I have superstitious fears	Fear of passing a cemetery, hearse, or black cat; fear of omens associated with death

Compulsions

CLEANING/WASHING COMPULSIONS				
#	Past	Current		Examples
38			I wash my hands excessively or in a ritualized way	Washing your hands many times a day or for long periods of time after touching, or thinking that you have touched, a contaminated object. This may include washing the entire length of your arms
39			I have excessive or ritualized showering, bathing, tooth brushing, grooming, or toilet routines	Taking showers or baths or performing other bathroom routines that may last for several hours. If the sequence is interrupted, the entire process may have to be restarted
40			I have compulsions that involve cleaning household items or other inanimate objects	Excessive cleaning of faucets, toilets, floors, kitchen counters, or kitchen utensils
41			I do other things to prevent or remove contact with contaminants	Asking family members to handle or remove insecticides, garbage, gasoline cans, raw meat, paints, varnish, drugs in the medicine cabinet, or kitty litter. If you can't avoid these things, you may wear gloves to handle them, such as when using a self-service gas pump

Compulsions

CHECKING COMPULSIONS				
#	Past	Current		Examples
42			I check that I did not harm others	Checking that you haven't hurt someone without knowing it. You may ask others for reassurance or call or text someone to make sure everything is all right
43			I check that I did not harm myself	Looking for injuries or bleeding after handling sharp or breakable objects. You may frequently go to doctors to ask for reassurance that you haven't hurt yourself
44			I check that nothing terrible happened	Searching the newspaper or listening to the radio or television for news about some catastrophe that you believe you caused. You may also ask people for reassurance that you didn't cause an accident
45			I check that I did not make a mistake	Repeated checking of door locks, stoves, electrical outlets, before leaving home; repeated checking while reading, writing, or doing simple calculations to make sure that you didn't make a mistake (you can't be certain that you didn't)
46			I check some aspect of my physical condition tied to my obsessions about my body	Seeking reassurance from friends or doctors that you aren't having a heart attack or getting cancer; repeatedly taking pulse, blood pressure, or temperature; checking your appearance in a mirror, looking for ugly features

Compulsions

REPEATING RITUALS				
#	Past	Current		Examples
47			I reread or rewrite things	Taking hours to read a few pages in a book or to write a short letter because you get caught in a cycle of reading and rereading; worrying that you didn't understand something you just read; searching for a "perfect" word or phrase; having obsessive thoughts about the shape of certain printed letters in a book
48			I need to repeat routine activities	Repeating activities like turning appliances on and off, combing your hair, going in and out of a doorway, or looking in a particular direction; not feeling comfortable unless you do these things the "right" way or the "right" number of times

Compulsions

COUNTING COMPULSIONS				
#	Past	Current		Examples
49			I have counting compulsions	Counting objects like ceiling or floor tiles, books in a bookcase, nails in a wall, or even grains of sand on a beach; counting when you repeat certain activities, like washing

ORDERING/ARRANGING COMPULSIONS				
#	Past	Current		Examples
50			I have ordering or arranging compulsions	Straightening paper and pens on a desktop or books in a bookcase, wasting hours arranging things in your house in "order" and then becoming very upset if this order is disturbed

Compulsions

MISCELLANEOUS COMPULSIONS				
#	Past	Current		Examples
52			I have mental rituals (other than checking/ counting)	Performing rituals in your head, like saying prayers or thinking a "good" thought to undo a "bad" thought. These are different from obsessions, because you perform these rituals intentionally to reduce anxiety or feel better
53			I need to tell, ask, or confess	Asking other people to reassure you, confessing to wrong behaviors you never even did, believing that you have to tell other people certain words to feel better
54			I need to touch, tap, or rub things	Giving in to the urge to touch rough surfaces, like wood, or hot surfaces, like a stove top; giving in to the urge to lightly touch other people; believing you need to touch an object like a telephone to prevent an illness in your family
55			I take measures (other than checking) to prevent harm or terrible consequences to myself or family	Staying away from sharp or breakable objects, such as knives, scissors, and fragile glass
56			I have ritualized eating behaviors	Arranging your food, knife, and fork in a particular order before being able to eat, eating according to a strict ritual, not being able to eat until the hands of a clock point exactly at a certain time
57			I have superstitious behaviors	Not taking a bus or train if its number contains an "unlucky" number (like thirteen), staying in your house on the thirteenth of the month, throwing away clothes you wore while passing a funeral home or cemetery
58			I pull my hair out (trichotillomania)	Pulling hair from your scalp, eyelids, eyelashes, or pubic areas, using your fingers or tweezers. You may produce bald spots that require you to wear a wig, or you may pluck your eyebrows or eyelids smooth

YBOCS PART 2: SEVERITY

OBSESSIVE THOUGHTS: Review the obsessions you checked on the Y-BOCS Symptom Checklist to help you answer the first five questions. Please think about the times when these symptoms were at their worst in the last 3-6 months (including today), and check one answer for each question.

1. TIME OCCUPIED BY OBSESSIVE THOUGHTS **How much of your time was occupied by obsessive thoughts? How frequently did these thoughts occur?**		
	0 =	None
	1 =	Less than 1 hour per day, or occasional intrusions (occur no more than 8 times a day)
	2 =	1-3 hours per day, or frequent intrusions (most hours of the day are free of obsessions)
	3 =	More than 3 hours and up to 8 hours per day, or very frequent intrusions
	4 =	More than 8 hours per day, or near-constant intrusions

2. INTERFERENCE DUE TO OBSESSIVE THOUGHTS: **How much did these thoughts interfere with your social or work functioning? Is there anything that you didn't do because of them?**		
	0 =	No interference
	1 =	Mild, slight interference with social or occupational performance, but still performance not impaired
	2 =	Moderate, definitive interference with social or occupational performance, but still manageable
	3 =	Severe interference, causes substantial impairment in social or occupational performance
	4 =	Extreme, incapacitating interference

3. DISTRESS ASSOCIATED WITH OBSESSIVE THOUGHTS **How much distress did your obsessive thoughts cause you?**		
	0 =	None
	1 =	Mild, infrequent, and not too disturbing distress
	2 =	Moderate, frequent, and disturbing distress, but still manageable
	3 =	Severe, very frequent, and very disturbing distress
	4 =	Extreme, near-constant, and disabling distress

Severity - Obsessions

4. RESISTANCE AGAINST OBSESSIONS How much effort did you make to resist the obsessive thoughts? How often did you try to disregard or turn your attention away from those thoughts as they entered your mind?		
	0 =	I made an effort to always resist (or the obsessions are so minimal that there is no need to actively resist them)
	1 =	I tried to resist most of the time (e.g. more than half the time I tried to resist)
	2 =	I made some effort to resist
	3 =	I allowed all obsessions to fill my mind without attempting to control them, but I did so with some reluctance
	4 =	I completely and willingly gave in to all obsessions

5. DEGREES OF CONTROL OVER OBSESSIVE THOUGHTS How much control did you have over your obsessive thoughts? How successful were you in stopping or diverting your obsessive thinking?		
	0 =	Complete control
	1 =	Much control; usually I could stop or divert obsessions with some effort and concentration
	2 =	Moderate control; sometimes I could stop or divert obsessions
	3 =	Little control; I was rarely successful in stopping obsessions and could only divert attention with great difficulty
	4 =	No control; I was rarely able to even momentarily ignore the obsessions

	OBSESSION SUBTOTAL (Add items 1-5)

Eugene Center for Anxiety and Stress

Severity - Obsessions

COMPULSIONS: Review the compulsions you checked on the Y-BOCS Symptom Checklist to help you answer these five questions. Please think about the times when these symptoms were at their worst in the last 3-6 months (including today), and check one answer for each question.

6. TIME SPENT PERFORMING COMPULSIVE BEHAVIORS How much time did you spend performing compulsive behaviors? How frequently did you perform compulsions?		
	0 =	None
	1 =	Less than 1 hour per day was spent performing compulsions, or occasional performance of compulsive behaviors (no more than 8 times per day)
	2 =	1-3 hours per day was spent performing compulsions, or frequent performance of compulsive behaviors (most hours were free of compulsions)
	3 =	More than 3 hours and up to 8 hours per day were spent performing compulsions, or very frequent performance of compulsive behaviors (during most hours of the day)
	4 =	More than 8 hours were spent performing compulsions, or near-constant performance of compulsive behaviors (hour rarely passes without several compulsions being performed)

7. INTERFERENCE DUE TO COMPULSIVE BEHAVIORS How much did your compulsive behaviors interfere with your social or work functioning?		
	0 =	No interference
	1 =	Mild, slight interference with social or occupational activities, but overall performance not impaired
	2 =	Moderate, definite interference with social or occupational performance, but still manageable
	3 =	Severe interference, substantial impairment in social or occupational performance
	4 =	Extreme, incapacitating interference

Eugene Center for Anxiety and Stress

Severity - Compulsions

8. DISTRESS ASSOCIATED WITH COMPULSIVE BEHAVIORS How would you have felt if prevented from performing your compulsions? How anxious would you have become?		
	0 =	Not at all anxious
	1 =	Only slightly anxious if compulsions prevented
	2 =	Anxiety would mount but remain manageable if compulsions prevented
	3 =	Prominent and very disturbing increase in anxiety if compulsions interrupted
	4 =	Extreme, incapacitating anxiety from any intervention aimed at reducing the compulsions

9. RESISTANCE How much effort did you make to resist the compulsions? Or how often did you try to stop the compulsions?		
	0 =	I made effort to always resist (or the symptoms were so minimal that there was no need to actively resist them)
	1 =	I tried to resist most of the time (e.g. more than half the time)
	2 =	I made some effort to resist
	3 =	I yielded to almost all compulsions without attempting to control them, but I did so with some reluctance
	4 =	I completely and willingly yielded to all compulsions

10. DEGREES OF CONTROL OVER COMPULSIVE BEHAVIORS How much control did you have over the compulsive behaviors? How successful were you in stopping the ritual(s)?		
	0 =	I had complete control
	1 =	Usually I could stop compulsions or rituals with some effort and willpower
	2 =	Sometimes I could stop compulsive behaviors, but only with difficulty
	3 =	I could only delay the compulsive behaviors, but eventually they had to be carried out to completion
	4 =	I was rarely able to even momentarily delay performing the compulsive behaviors

	COMPULSIVE SUBTOTAL (Add items 6-10)

Eugene Center for Anxiety and Stress

Severity - Compulsions

11. Do you think your obsessions or compulsions are reasonable or rational? Would there be anything besides anxiety to worry about if you resisted them? Do you think something would really happen?		
	0 =	I think my obsessions or compulsions are unreasonable or excessive
	1 =	I think my obsessions or compulsions are unreasonable or excessive, but I'm not completely convinced that they aren't necessary
	2 =	I think my obsessions or compulsions may be unreasonable or excessive
	3 =	I don't think my obsessions or compulsions are unreasonable or excessive
	4 =	I am sure my obsessions or compulsions are reasonable, no matter what anyone says

Eugene Center for Anxiety and Stress

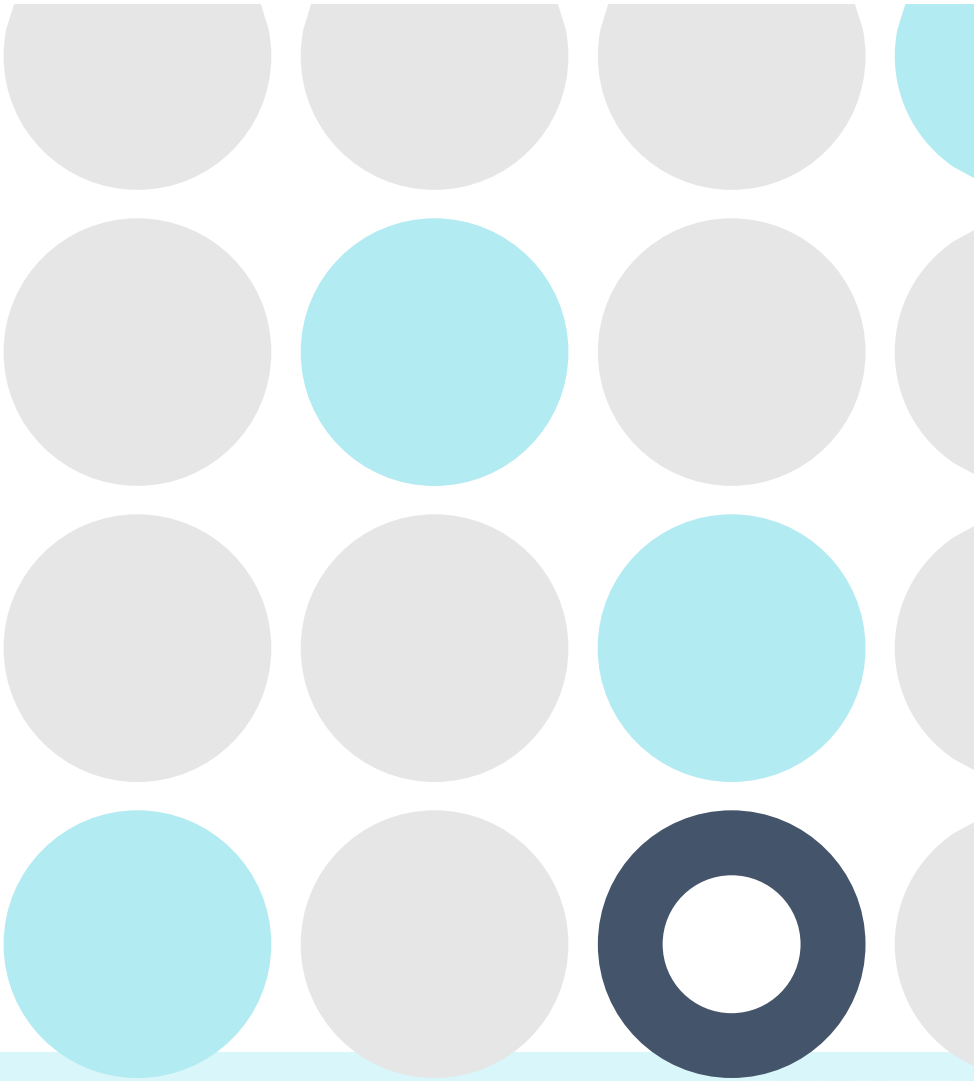
Themes summary

- Use YBOCS checklist/ask client about the types of obsessions and compulsions they experience, and group them into themes
- Goal is to group them in a cohesive, understandable way from which you and the client and make their OCD “make sense”
- Most clients have multiple themes to identify
- Once we identify the themes, we can understand the core fears that perpetuate the cycle

Cultural Considerations

- Because OCD often revolves around themes of right/wrong/morality, understanding the person's cultural context and norms essential
  - Norms around cleanliness, morality, religious faith and religious expression
- For scrupulosity OCD, may even bring in someone from the client's faith tradition for support
- Important to recognize OCD as separate from culture/faith → people from all cultural backgrounds find ways to balance doubt in a way that does not lead to undue distress and impairment.

Case Example



Eugene Center for Anxiety and Stress

Teresa Wood (Pseudonym)

30-year-old cisgender partnered Caucasian female

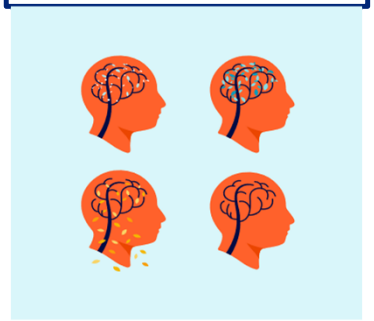
Seeking treatment for “anxiety, panic”

Thorough Assessment

Seeking treatment for panic attacks in the context of safety and health concerns that have become more severe in the last month.

Health Concerns

Harm Concerns



Social Situations

Driving

Thorough Assessment

Obsessions

- Aggressive
- Contamination
- Somatic/Health
- Sexual
- Hoarding/Saving
- Religious
- Need for symmetry/exactness

AGGRESSIVE OBSESSIONS

	Current	Past	Examples
1. Fear might harm self	☐	☐	Fear of eating with a knife or fork, fear of handling sharp objects, fear of walking near glass windows.
2. Fear might harm others	☐	☐	Fear of poisoning other people's food, fear of harming babies, fear of pushing someone in front of a train, fear of hurting someone's feelings, fear of being responsible by not providing assistance for some imagined catastrophe, fear of causing harm by bad advice.
3. Violent or horrific images	☐	☐	Images of murders, dismembered bodies, or other disgusting scenes.
4. Fear of blurting out obscenities or insults	☐	☐	Fear of shouting obscenities in public situations like church, fear of writing obscenities.
5. Fear of doing something else embarrassing *	☐	☐	Fear of appearing foolish in social situations
6. Fear will act on unwanted impulses	☐	☐	Fear of driving a car into a tree, fear of running someone over, fear of stabbing a friend.
7. Fear will steal things	☐	☐	Fear of "cheating" a cashier, fear of shoplifting inexpensive items.
8. Fear will harm others because not careful enough	☐	☐	Fear of causing an accident without being aware of it (such as a hit-and-run automobile accident).
9. Fear will be responsible for something else terrible happening	☐	☐	Fear of causing a fire or burglary because of not being careful enough in checking the house before leaving.
10. Other:_____	☐	☐	

Y-BOCS symptom checklist

SOMATIC OBSESSIONS

	Current	Past	Examples
55. Concern with illness or disease *	☐	☐	Worries that you have an illness like cancer, heart disease or AIDS, despite reassurance from doctors that you do not.
41. Excessive concern with body part or aspect of appearance (e.g. dysmorphophobia) *	☐	☐	Worries that your face, ears, nose, eyes, or another part of your body is hideous, ugly, despite reassurances to the contrary.
42. Other _____	☐	☐	

Obsessions

Obsessions

- **Aggressive**
- Contamination
- **Somatic/Health**
- Sexual
- Hoarding/Saving
- Religious
- Need for symmetry/exactness

Compulsions

Compulsions

- Cleaning/Washing
- Checking/Reassurance-Seeking
- Repeating
- Counting
- Ordering
- Hoarding/Collecting
- Rituals

Compulsions

Compulsions

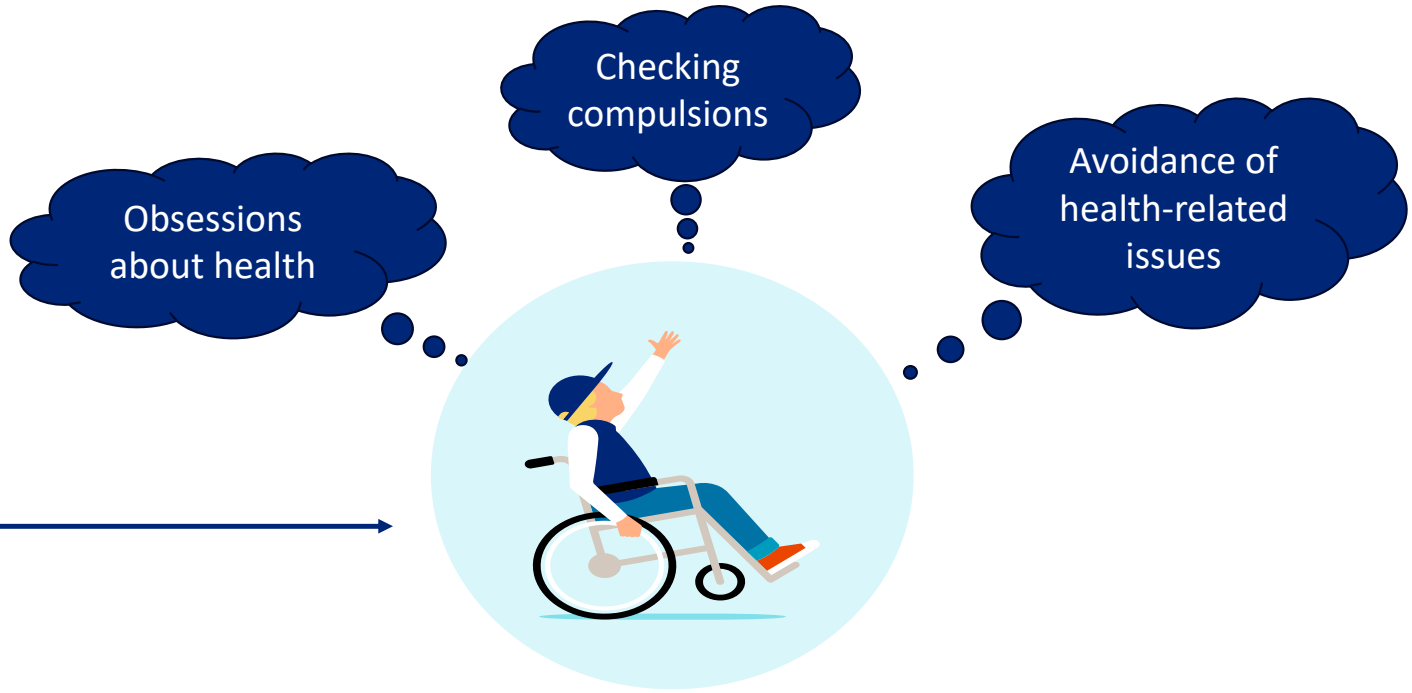
- Cleaning/Washing
- **Checking/Reassurance-Seeking**
- Repeating
- Counting
- Ordering
- Hoarding/Collecting
- **Rituals**

+ avoidance

OCD vs PTSD

Denied any history of trauma

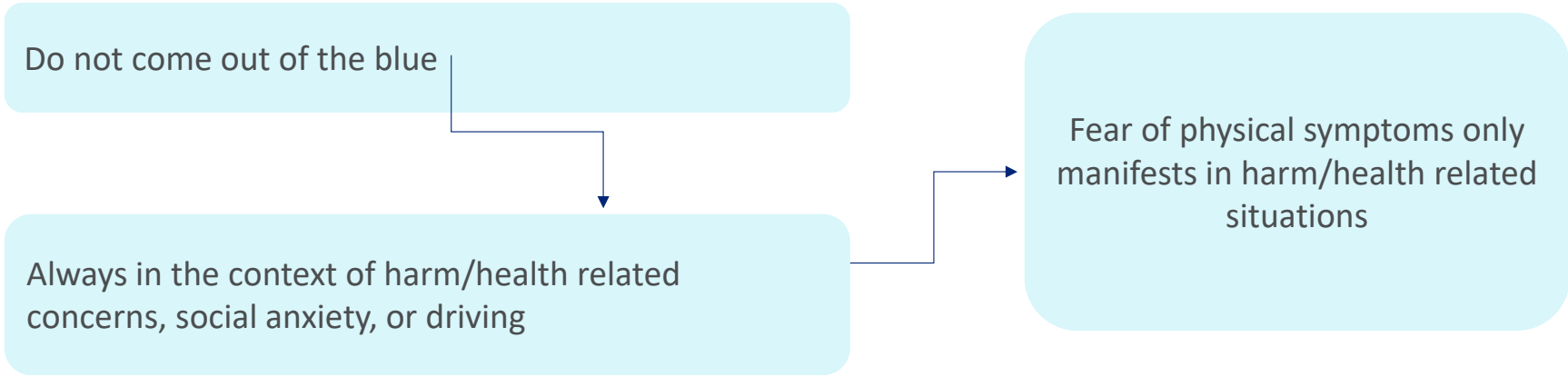
Brother's diagnosis of a chronic medical diagnosis is **triggering event** for OCD



**a trauma informed approach is important

Panic Attacks

In context of other disorders



The fear of having a panic attack then leads to avoidance and use of anti-anxiety medications

Diagnosis

Obsessive Compulsive Disorder, with panic attacks.

Themes of OCD

Somatic/Health

fear of developing an autoimmune disorder, fear of physical sensations as evidence of health concerns

Aggressive

fear of harming self/others while driving, fear of leaving doors unlocked, fear of doing something embarrassing in public, violent images she sees that she tries to prevent from happening

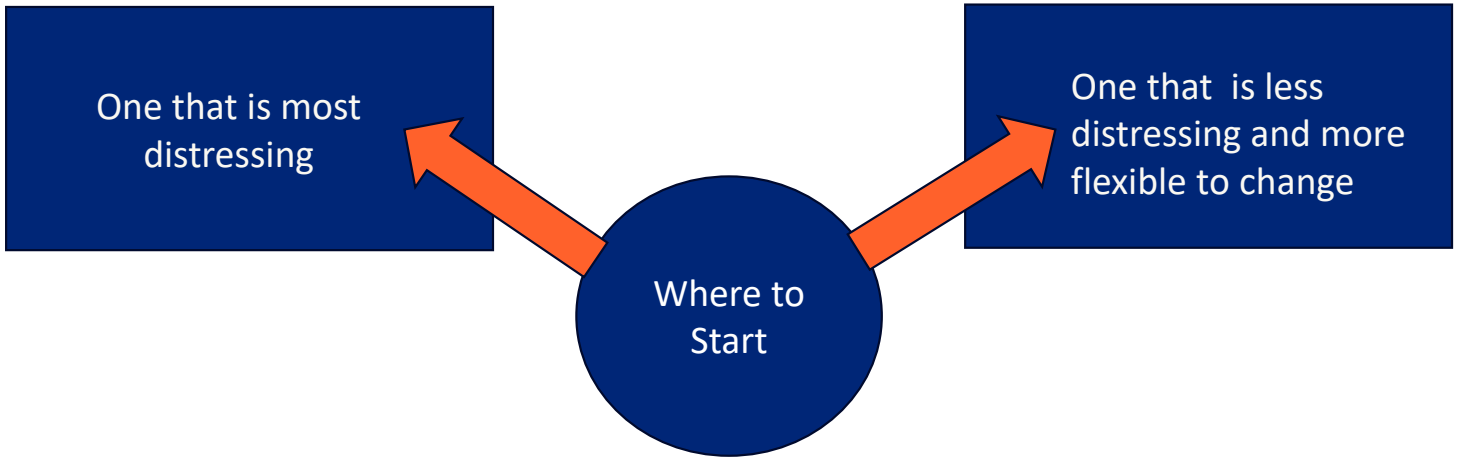
Why is an accurate diagnosis important?

Her previous therapist diagnosed her with PTSD and Panic Disorder, and used EMDR – was not successful in changing fear or behaviors

Diagnosed OCD, themes identified

When doing treatment, focus on one ‘theme’ at a time, with each hierarchy focused on a subtype.

Often clients have more than one theme and want to work on one core fear at a time.



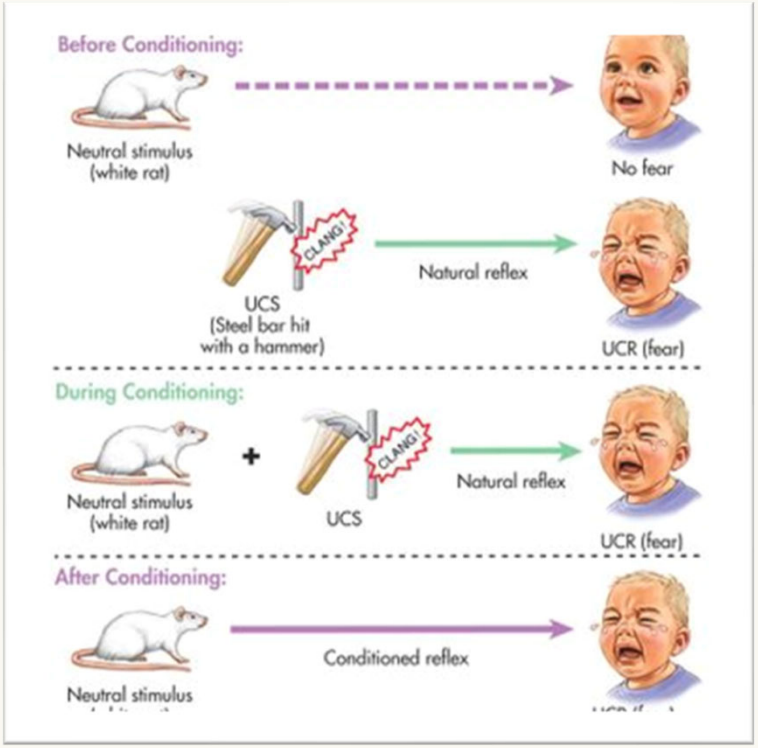
Questions?

Eugene Center for Anxiety and Stress

Exposure and Response Prevention

What is it and why does it work?

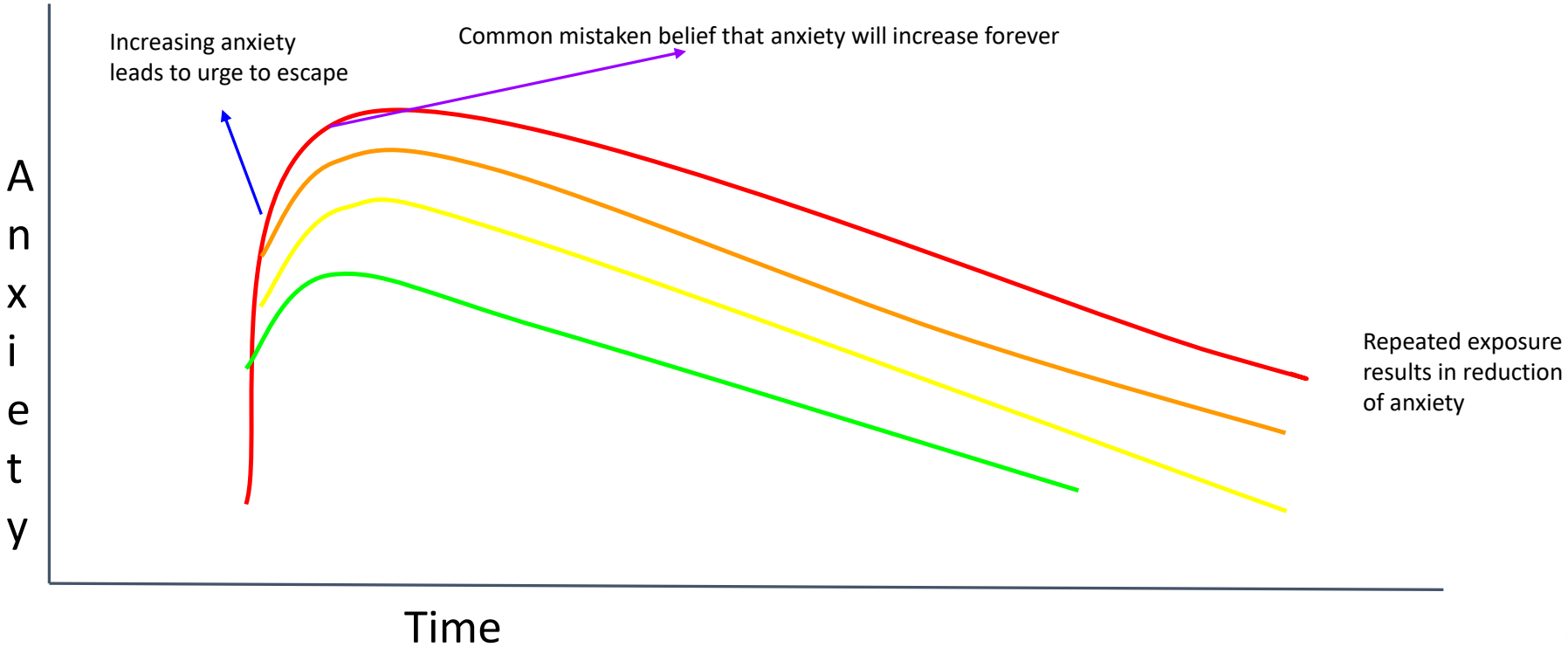
Eugene Center for Anxiety and Stress



PRINCIPLES OF FEAR CONDITIONING

Eugene Center for Anxiety and Stress

Habituation Model of Fear Extinction



Eugene Center for Anxiety and Stress

Habituation Model of Fear Extinction

Old School Approach

Habitation: a natural decrease in anxiety level to repeated conditioned/neutral stimulus

For optimal benefit from exposure

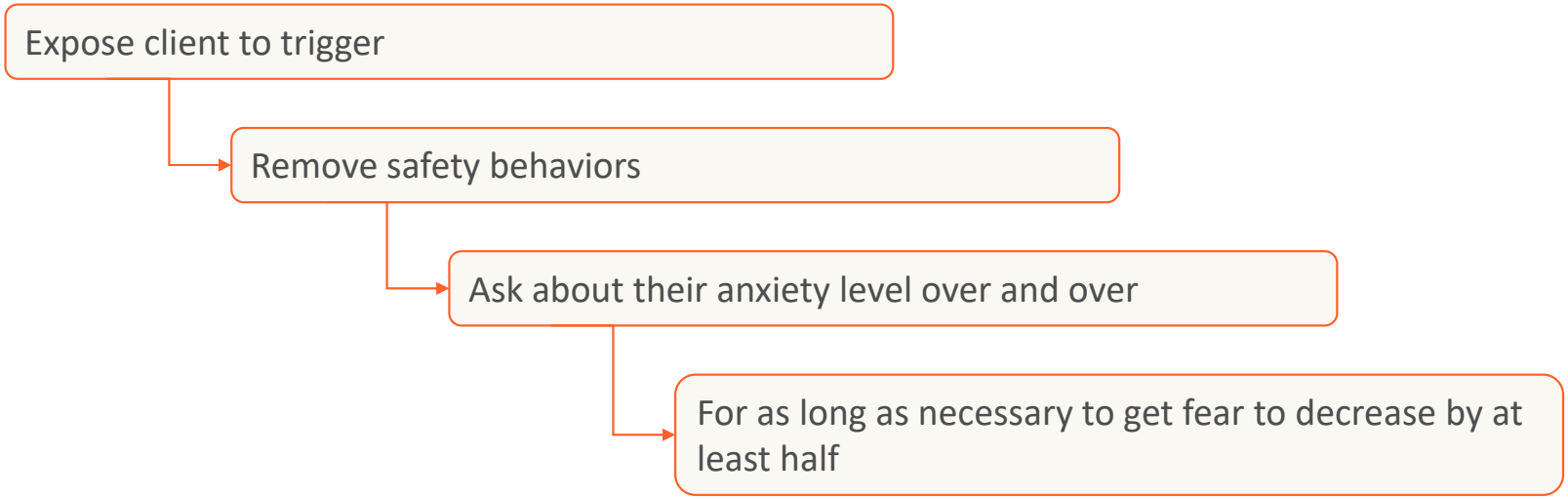
- fear activation
- minimization of anxiety-reducing behaviors
- Experience habituation

- The primary goal during exposures is anxiety reduction (to about half what it started as), which occurs through contact with a feared stimulus in the absence of avoidance, escape, and ritualizing.
- Passive, not active process
- Habituation suggests "breaking" association between stimulus and fear through exposure

Benito and Walther, 2015

Eugene Center for Anxiety and Stress

ERP using Habituation Model



Focus on decreasing anxiety; no active process needed

r.e. cognitive work, changing beliefs, actively altering narrative

Habituation Model of Fear Extinction

repeated  w/o    =

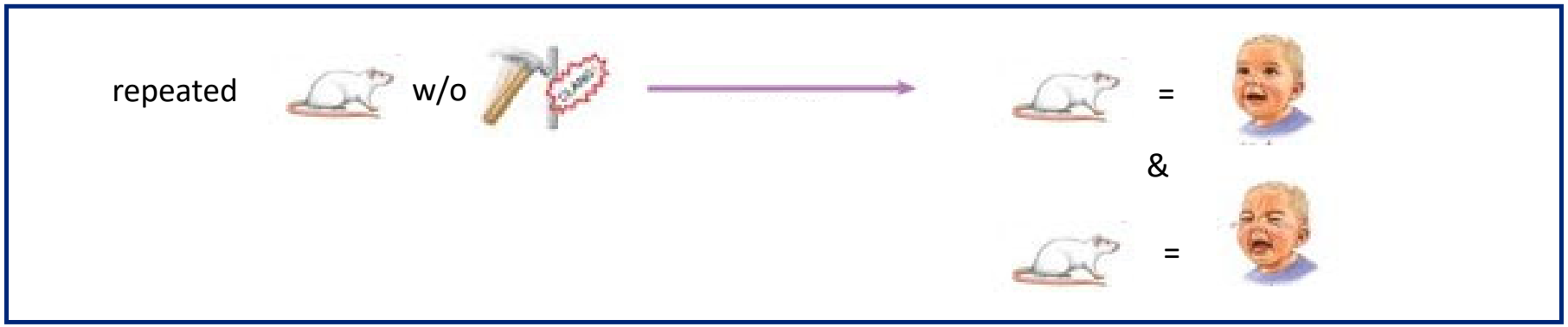
Removes association of loud noise from the rat

Problems With Habituation Model

- Emphasizes the importance of fear reduction as the goal
    - Implies that anxiety itself is inherently bad, and that treatment is only successful if one is anxiety-free.
- Decrease of anxiety to about half of start not always possible in a session or at all
- Habituation suggests "unlearning" of fear association – if there was true unlearning, there would not be relapse with fear/anxiety disorders, but there is
    - Evidence does not suggest that there is unlearning, but rather that a second type of learning/association (safety learning) has also been associated with the stimulus

Inhibitory Learning Model of Extinction

Suggests that repeated exposure of neutral stimulus without feared stimulus leads to **learning a new non-threatening association with stimulus that competes with the older threat associations** -- not breaking of connection -- **to inhibit fear-based learning**



Two associations with the rat (a **danger** association and a **safety** association)

Inhibitory Learning Model of Extinction

Given new understanding, there is less focus on decreasing anxiety (to "destroy" fear pathway) but rather to create an expectancy violation:

expect one thing and something else happens, so that new learning occurs

Goal is to create **safety learning**:

Confront and learn to tolerate anxiety and fear to triggers as non-threatening

Safety learning must be strong enough to inhibit danger learning

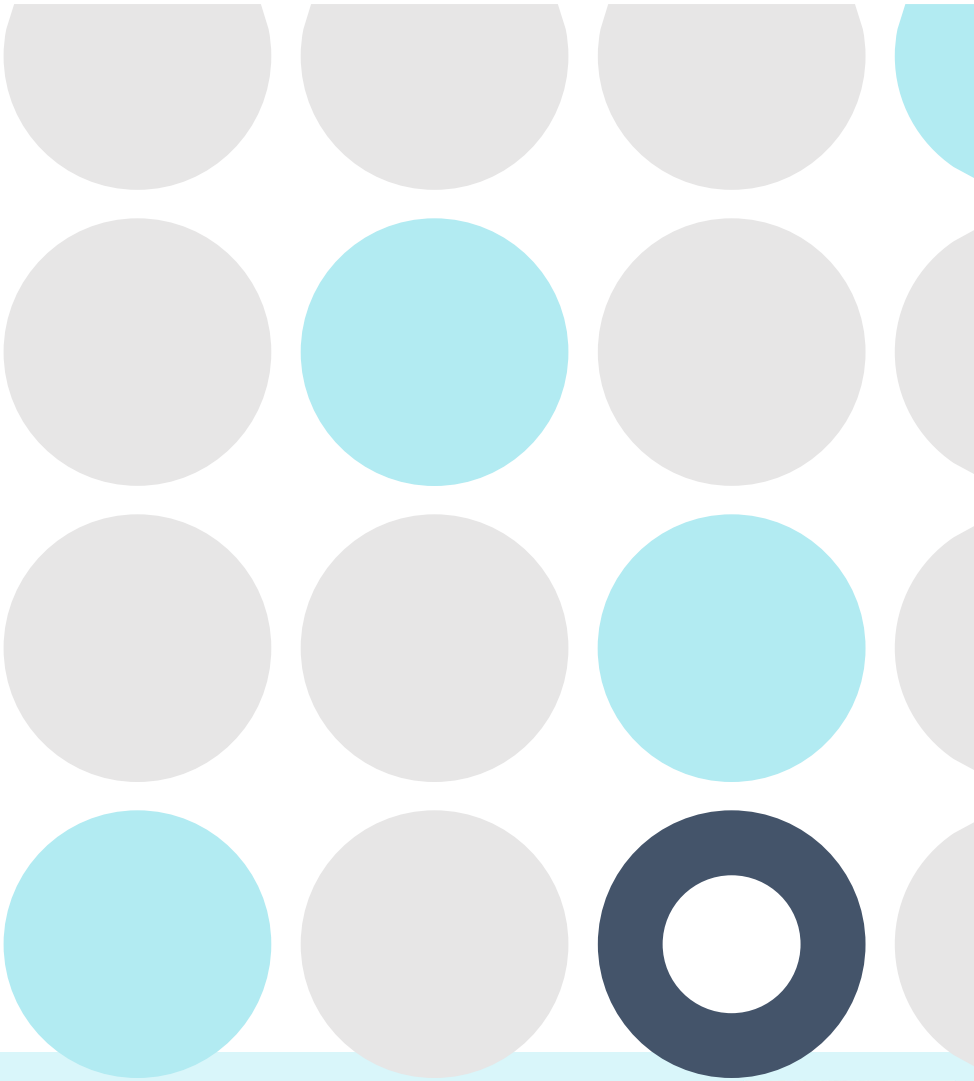
Inhibitory Learning Model of Extinction

- Recovery is NOT unlearning danger
- Recovery is **learning safety** → not necessarily because you feel less anxious, but because core fear did not occur (want to maximally violate client's expectancies about feared outcomes)
- To treat OCD, must create safety association that are strong enough to inhibit danger association, that also generalizes to variety of contexts
- **Safety association requires removal of safety behaviors/limit distractions**
- Relapse occurs when safety learning weakens and cannot inhibit danger associations

ERP using Inhibitory Control Model

- Expose clients to trigger without safety behaviors with the goal of having them experience something different than they predicted (have an expectancy violation)
- Much more cognitive (what is it you fear will happen? what actually happens?)
- Less focus on decreasing distress; more focus on tolerating distress in the service of learning something new
- Requires a clear understanding of the **client's core fear**

Questions?



Eugene Center for Anxiety and Stress

Assessment of Core Fear

- Given that decreasing anxiety is less of a goal than when habituation was central, more focus on how to “surprise” the client with the outcome
- Requires more focus on understanding client’s core fear– what is it they think will happen?

Eugene Center for Anxiety and Stress

Isn't the core fear obvious?

- Core fear for this client with fear of harming others impulsively with a knife – fear of harming others with a knife, right?
- Sort of! If it was about that, then a few times being around a knife and not harming someone should be enough to create safety learning. Why doesn't it?

What is the core fears generally about?

Specific, proximal catastrophic events (least likely)

- Spiders will attack my face immediately
- I'll have a panic disorder on a specific bridge on Tuesday at 5pm

What is the core fears generally about?

Specific, proximal catastrophic events (least likely)

- Spiders will attack my face immediately
- I'll have a panic disorder on a specific bridge on Tuesday at 5pm

Intolerable feeling of uncertainty (I can tell you my fear but not when it will happen)

- I will get cancer if exposed to X and eventually die
- What if someone thought what I said was stupid

What is the core fears generally about?

Specific, proximal catastrophic events (least likely)

- Spiders will attack my face immediately
- I'll have a panic disorder on a specific bridge on Tuesday at 5pm

Intolerable feeling of uncertainty (I can tell you my fear but not when it will happen)

- I will get cancer if exposed to X and eventually die
- What if thinking about the devil means I will go to hell

Intolerable feelings/ or right/wrong distinction

- Touching the doorknob will feel disgusting and intolerable
- The dishes are organized wrong and I can't stand how I feel when I see them

Formulation Statement	Treatment Implication	Component
If I am exposed to this trigger:	**E** {Tells you what the person should be exposed to}	*Obsessional trigger*
And I do not neutralize the threat by engaging in this behavior:	**RP** {Tells you what the person should not do during exposure}	*Compulsion*
Then this catastrophe will occur:	{Tells you the misappraisal to be evaluated in ERP}	*Core fear*

BTTI Pollard 2021

Eugene Center for Anxiety and Stress

Core fear identification

Then this catastrophe will occur:	{Tells you the misappraisal to be evaluated in ERP}	*Core fear*

By identifying core fear, can better build goals for "expectancy violation" in ERP

- "I won't be able to tolerate the feeling of uncertainty that I might be pedophile" – better than "it means I'm a pedophile"
- "I can't stand the feeling of disgust if I think something I touched might be sticky" – better than "something might be sticky"
- "I can't manage the feeling of wrongness if I don't put the dishes away in my normal way" – better than "the dishes will be put away wrong"
- "I can't stand the uncertainty that my parents might die if I don't do my prayer ritual" – better than "my parents might die"

Quiz

Scrupulosity OCD

Formulation Statement	Treatment Implication	Component
If I am exposed to this trigger:	Bad thoughts; images of Satan; the numbers 666	*Obsessional trigger*
And I do not neutralize the threat by engaging in this behavior:	pray for hours; read certain bible passages in a certain order perfectly	*Compulsion*
Then this catastrophe will occur:		*Core fear*

Quiz

Scrupulosity OCD

Formulation Statement	Treatment Implication	Component
If I am exposed to this trigger:	My "bad" thoughts; images of Satan; the numbers 666	*Obsessional trigger*
And I do not neutralize the threat by engaging in this behavior:	pray for hours; read certain bible passages in a certain order perfectly;	*Compulsion*
Then this catastrophe will occur:	I won't be able to stand the uncertainty that I might go to hell or that I'm not living in the light of God	*Core fear*

Quiz

Case Example:
Somatic OCD

Formulation Statement	Treatment Implication	Component
If I am exposed to this trigger:	Images of sickness; people in wheelchairs; tingling feelings on my skin	*Obsessional trigger*
And I do not neutralize the threat by engaging in this behavior:	Check for sensations; google symptoms; engage in cancelation actions	*Compulsion*
Then this catastrophe will occur:		*Core fear*

Quiz

Case Example:
Somatic OCD

Formulation Statement	Treatment Implication	Component
If I am exposed to this trigger:	Images of sickness; people in wheelchairs; tingling feelings on my skin	*Obsessional trigger*
And I do not neutralize the threat by engaging in this behavior:	Check for sensations; google symptoms; engage in cancelation actions	*Compulsion*
Then this catastrophe will occur:	I won't be able to handle the uncertainty that I could develop a lifelong chronic illness	*Core fear*

Quiz

Case Example:
Aggressive OCD

Formulation Statement	Treatment Implication	Component
If I am exposed to this trigger:	Leaving the house; seeing locked doors; feeling a bump when driving a car	*Obsessional trigger*
And I do not neutralize the threat by engaging in this behavior:	Checking that stove is off and door is locked; checking that I didn't hit anyone;	*Compulsion*
Then this catastrophe will occur:		*Core fear*

Quiz

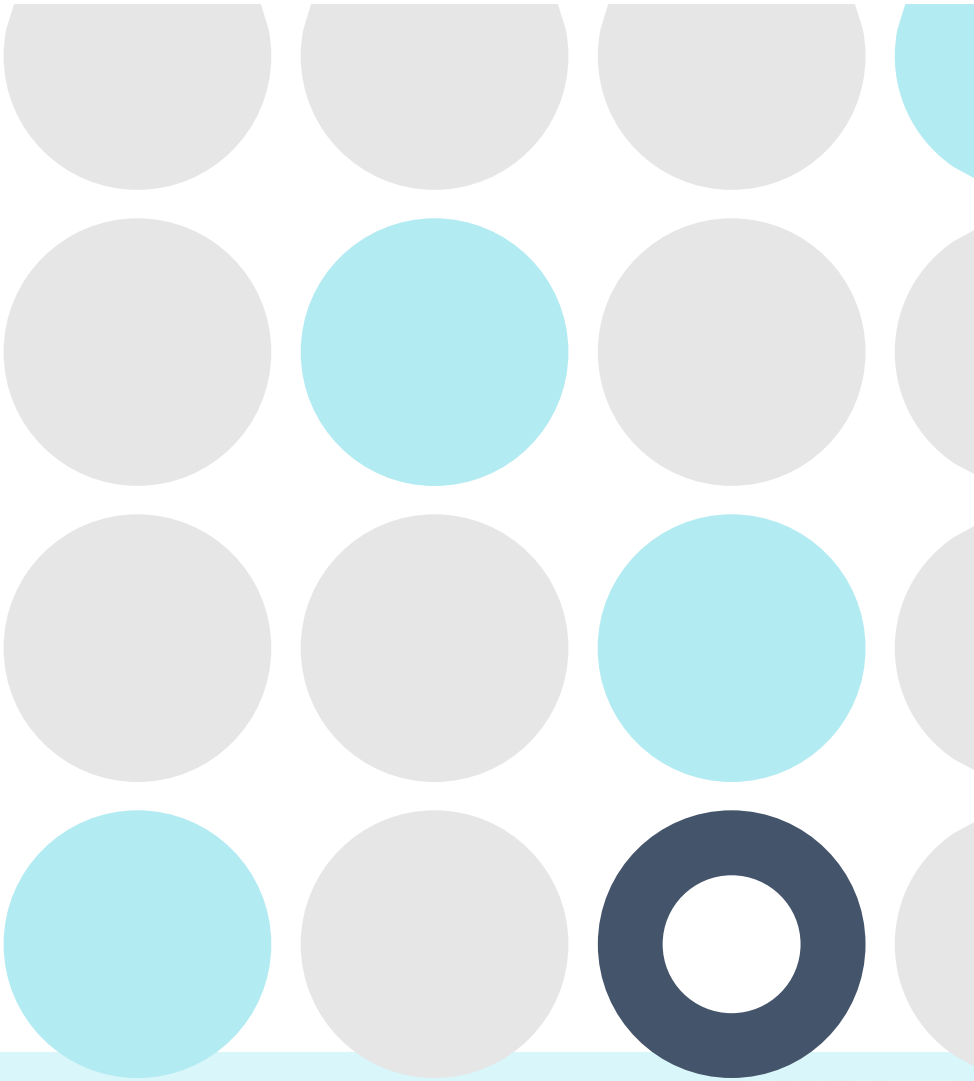
Case Example: Aggressive OCD

Formulation Statement	Treatment Implication	Component
If I am exposed to this trigger:	Leaving the house; seeing locked doors; feeling a bump when driving a car	*Obsessional trigger*
And I do not neutralize the threat by engaging in this behavior:	Checking that stove is off and door is locked; checking that I didn't hit anyone;	*Compulsion*
Then this catastrophe will occur:	I won't be able to tolerate the uncertainty that I might accidentally harm myself or others	*Core fear*

Summary

- Identification of core fear (that is tied to uncertainty or intolerance of distress) is important to help the client build distress tolerance and stop their search for perfect certainty and perfect comfort
- Identification of obsessions, compulsions, and core fear essential for development of hierarchy and ERP development

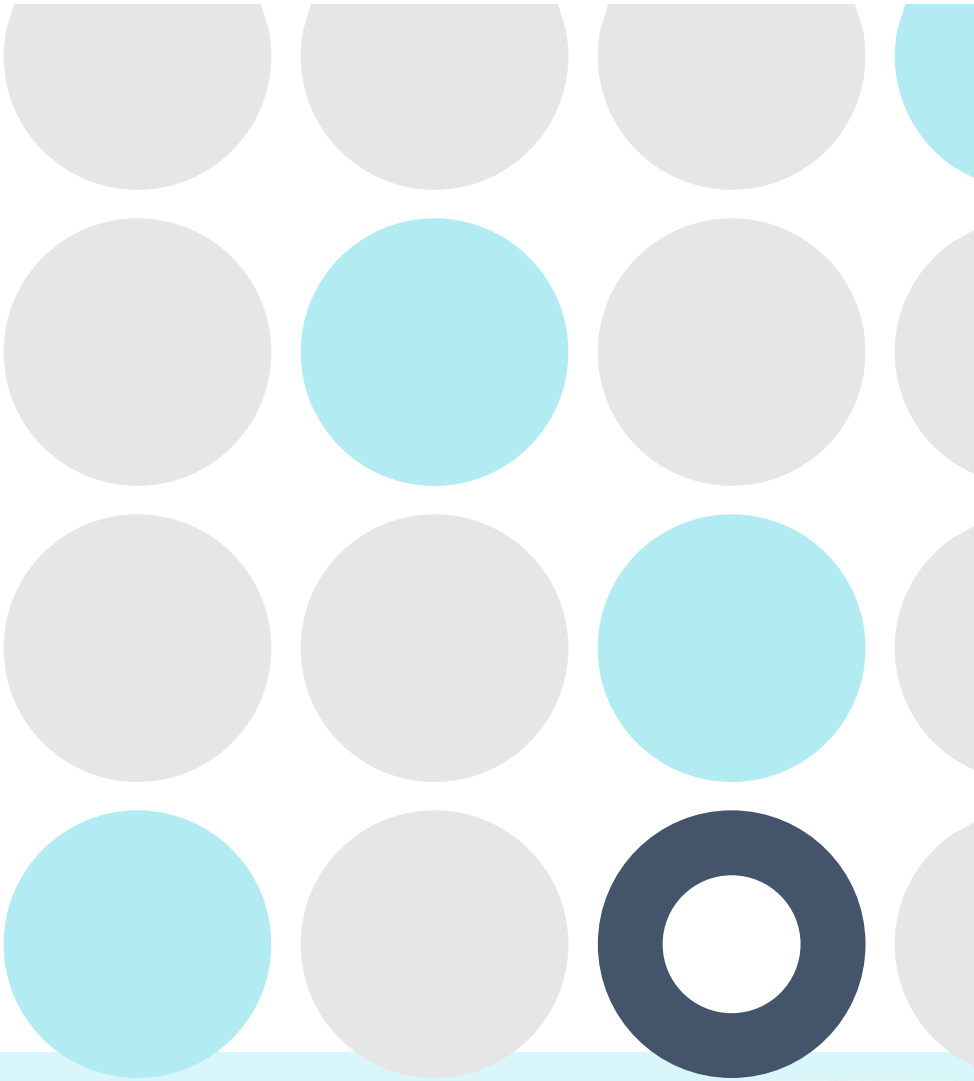
Questions?



Eugene Center for Anxiety and Stress

Formulation Statement	Treatment Implication	Component
If I am exposed to this trigger:	**E** {Tells you what the person should be exposed to}	*Obsessional trigger*
And I do not neutralize the threat by engaging in this behavior:	**RP** {Tells you what the person should not do during exposure}	*Compulsion*
Then this catastrophe will occur:	{Tells you the misappraisal to be evaluated in ERP}	*Core fear*

Preparation for ERP



Eugene Center for Anxiety and Stress

Prep phase 1: Education

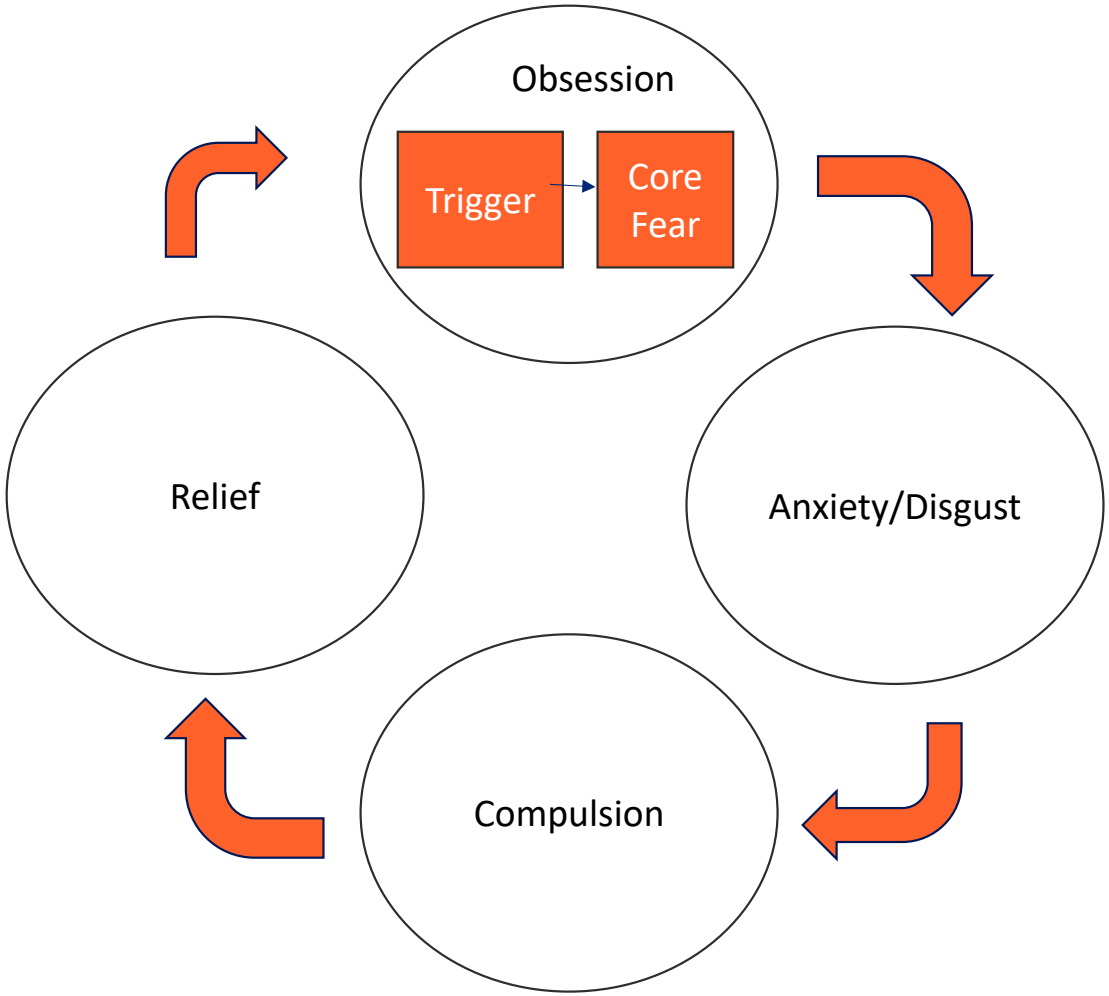
- Clarify client's goals and motivation for change
- Psychoeducation about OCD and CBT model
- Examples unrelated to their OCD
- Inquire about their learning and maintenance history
- Apply model to client's specific history and concerns

Clarify client goals and motivation for change

- “How do you want treatment to help you?”
- “How is OCD keeping you from living the life you want to live?”
- “How would your life be different if you were not spending so much time with your obsessions and compulsions?”

Psychoeducation

- Draw OCD cycle, and fill in details from an OCD cycle that is not that of the clients
    - Keeps them from getting caught in their own beliefs related to their own cycle



Obsessions: ↑ anxiety/distress

Compulsions: ↓ anxiety/distress

Inquire about their learning history

- What is their memories of how their OCD developed? Was there a single event? Was their modeling or vicarious learning?
- What did their safety behaviors and compulsions look like at first, and how did they change over time?
- Understand if there are cultural/religious aspects that you might need to understand better to help the client
- Recognize if any societal/oppression contributions to their presentation

Apply model to client's specific history and concerns

- Walk through model with the client's triggers and compulsions
- Help them understand that there is no end to how compulsions will ramp up over time
- Goal is to help client see that their cycle does not and cannot work
  - Not helping them be safer
  - No end to increasing compulsions
  - Does not help them be connected with the life they want for themselves
- Requires some insight on part of client

Prep phase 2

Collect Information/ Develop Self-awareness

- What are their triggers?
- What are their compulsions/avoidances?

III. OBSESSION TRIGGERS AND RELATED COMPULSIONS

EXTERNAL TRIGGERS?	RELATED COMPULSIONS
INTERNAL TRIGGERS?	**RELATED COMPULSIONS**

Prep phase 2.
Collect Information

Develop self-awareness

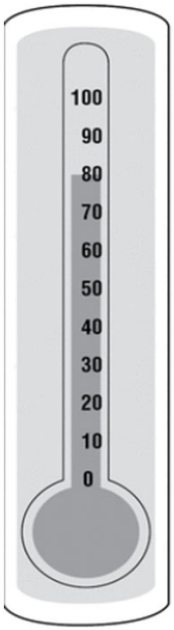
III. OBSESSION TRIGGERS AND RELATED COMPULSIONS

EXTERNAL TRIGGERS?	RELATED COMPULSIONS
• Hospitals • Wheelchairs • Calls from brother • Media images of sickness • Sounds of sickness	• Engaging in religious rituals • Avoiding phone • Avoiding the public • "canceling" actions (blinking, shaking head) when seeing perceived sick people/people with physical disabilities • Avoiding movies/news • Touching body to ensure 'health"
INTERNAL TRIGGERS?	**RELATED COMPULSIONS**
▪ Sensations on her body (tingling) • Images of sickness • Breathing	• Checking body for "bad" sensations • Touching parts of body repeatedly for 'rightness' • Contacting her doctor's office about symptoms • Checking memory about previous symptoms • Googling symptoms • "figuring out" how to stay healthy or respond to having an illness • Fixating on her breathing

Eugene Center for Anxiety and Stress

Understand distress on a spectrum

SUDS: The Subjective Units of Distress Scale



100 – Highest anxiety/distress that you have ever felt

90 – Extremely anxious/distressed

80 – Very anxious/distressed; can't concentrate. Physiological signs present.

70 – Quite anxious/distressed; interfering with functioning. Physiological signs may be present.

60 – Moderate-to-strong anxiety or distress

50 – Moderate anxiety/distress; uncomfortable, but can continue to function

40 – Mild-to-moderate anxiety or distress

30 – Mild anxiety/distress; no interference with functioning

20 – Minimal anxiety/distress

10 – Alert and awake; concentrating well

0 – No distress; totally relaxed

Identify Core fear

Formulation Statement	Treatment Implication	Component
If I am exposed to this trigger:	**E** {Tells you what the person should be exposed to}	*Obsessional trigger*
And I do not neutralize the threat by engaging in this behavior:	**RP** {Tells you what the person should not do during exposure}	*Compulsion*
Then this catastrophe will occur:	{Tells you the misappraisal to be evaluated in ERP}	*Core fear*

Identify Costs and Benefits

In the **identification process**, help client recognize:

- how compulsions/avoidance is 'working' (keeping them safe from fears)
- the cost of continuing

Mistakes of preparation phase

- Start ERP before the client has bought in
  - Roll with resistance
- Not identifying the core fears with the client
- Not helping the client see that the compulsions do not keep them safe
- Not helping the client see the costs of continuing
- Not identifying therapy interfering behaviors

3

Learning Objective:

Identify three components of a strong fear and avoidance hierarchy.

Eugene Center for Anxiety and Stress

What is a fear hierarchy?

- Ranked list of fears, with the least feared at the bottom of the hierarchy and the most feared at the top
- Goal is to organize ERP in a cohesive, stepwise fashion to increase client buy in and actions
- Should be:
  - Well-thought out
  - Collaborative
  - Flexible

Creating the hierarchy

- Explain concept of fear ladder and its purpose
- Ask client to brainstorm items in between sessions
- Use homework, self-monitoring, and assessments to identify a broad range of triggers and safety behaviors
- Develop list of concrete exposure exercises with SUDs scores for ordering

Guidelines for developing hierarchy

- Include a range of representative triggers but don't try to include everything
- Don't spend too much time on it (no more than 2 sessions)
- Keep core fear in mind
- Keep safety behaviors in mind – how would they feel about the trigger without compulsion/avoidance
- Include range of medium and high difficulty items

What about the hardest stuff?

- Include most feared trigger even if client doesn't feel like they can ever face it
  - They don't have to but is useful to have full scale
- Can include items that are not part of everyday behavior for non-sufferers (example: eating off of a toilet).
- Anything is fair game as long as it involves no more than an acceptable level of risk (not asking them to eat off a soiled toilet - many people don't wash hands after using the bathroom and then eat, likely gets the same level of risk)
- Anecdotally, more challenging items decrease risk of relapse

Hierarchy example

V. EXPOSURE HIERARCHY

LEVEL OF DIFFICULTY	TASK
Very High	
High	
Medium	
Low	

Examples – Contamination OCD

Very High	Picking up trash from the public floor (85)
	Touching garbage can in the lobby (80)
	Touching the Bottom of my shoes (80)
High	Touching office garbage can (75)
	Touching garbage can in my apartment (70)
Medium	Using a public restroom (50)
	Touching a strange dog (45)
Low	Touching money and then eating (40)
	Using the restroom at the office (35)
	Touching the handle of a suitcase (30)

Examples – Harm OCD

Very High	Using a knife in the kitchen when my husband is within 5 feet of me (100) Putting a knife close to my wrist (100) Imagining myself stabbing my husband with a knife (95) Driving a car on a busy road (95) Imagining jumping out of the car as a passenger (85)
High	Briefly taking my eyes off the road while driving (70) Being passenger in a car (65) Using a knife while cooking with no one near me (55)
Medium	Talking with my therapist while holding a sharp pencil (50) Driving a car in an empty parking lot (45) Using a butter knife while eating at a restaurant with husband (40)
Low	Imagining my therapist being hit by a bus (35)

Examples – Scrupulosity OCD

Very High	Imagining being possessed by a demon (100) Holding a satanic symbol (95) Watching ”The exorcist” (90)
High	Listening to satanic/dark metal music (90) Watching Rosemary’s baby (85)
Medium	Looking at pictures of satanic symbols (70) Watching tv shows about paranormal activities (60)
Low	Looking at or hearing ”bad” words (demon, devil, Satan, 666) (55) Thinking “bad” thoughts during prayers at church (50) Attending church (30)

Examples – Sexual Intrusions

Very High	Writing sexually explicit statements about children (100) Imagining myself doing something sexual with children (100) Making pedophile statements (100) Reading a story about pedophiles (90)
High	Looking at fully clothed images of young teens (80) Watching a TV show about a pedophile (75) Looking at clothed images of babies (50) Listening to children's music (40)
Medium	Saying "bad" words (like pedophile, rape) (40) Writing "bad" words (40)
Low	Sitting next to a child on a couch (35) Watching a TV show that has children in it (30)

TARGET: **FEAR OF HARMING SELF OR OTHERS DUE TO CARELESSNESS AND CHECKING RITUALS**

	Exposure Task	**SUDs** (0-100)
1.	Drive near an elementary school when children are present	100
2.	Drive around a busy shopping mall	95
3.	Drive on crowded roads	90
4.	Carry son over concrete	85
5.	Play with son near open stair gate	75
6.	Flush toilet with cover closed	70
7.	Open doors and windows in house	60
8.	Use stove and oven	50
9.	Use iron	40
10.	Go into attic and turn on lights	20

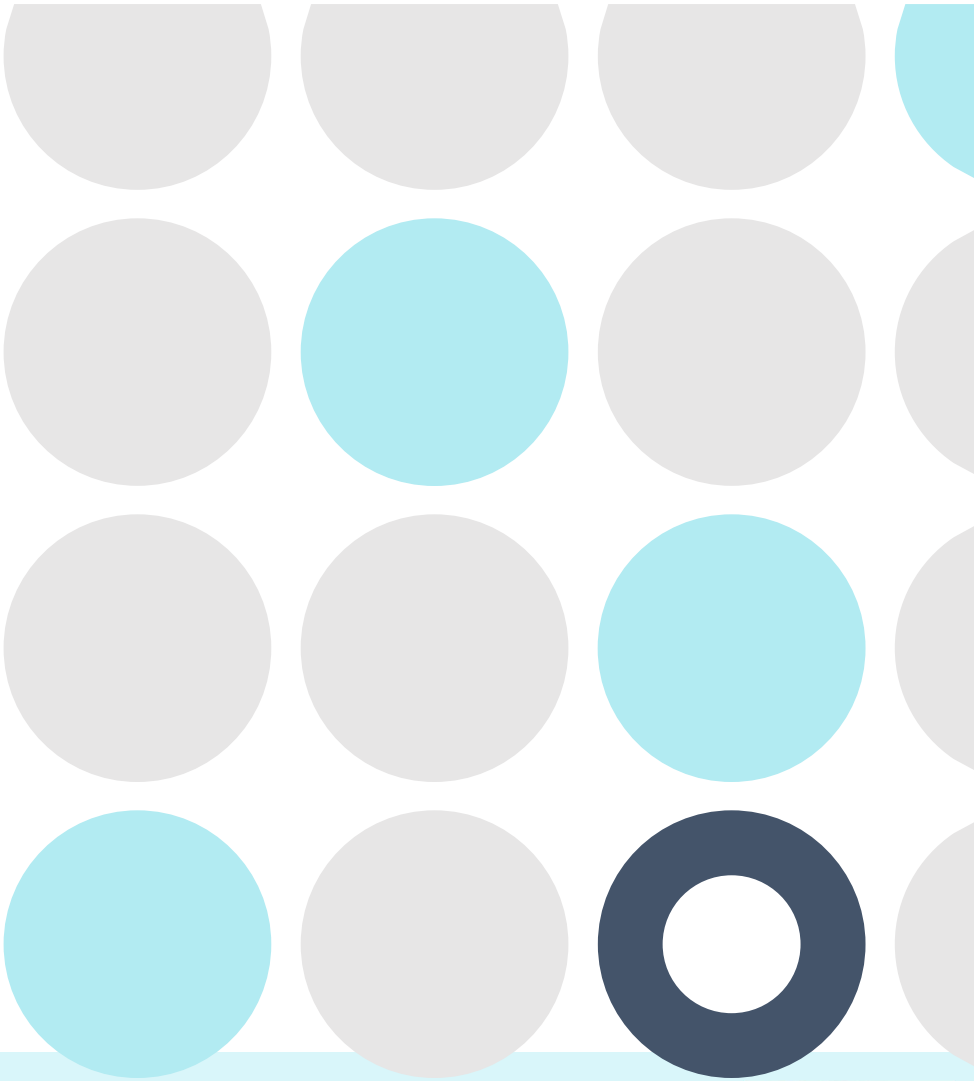
TARGET: **FEAR OF ASYMMETRY/IMPERFECTION**

	Exposure Task	**SUDs** (0-100)
1.	Write emails/letters to boss with intentional misspellings	100
2.	Write holiday cards with intentional misspellings	95
3.	Write emails to friends with intentional misspellings	90
4.	Pay bills with intentional misspellings	85
5.	Wear clothes in disorganized way (misalign buttons, shoelaces)	75
6.	Disorganize closet	70
7.	Disorganize desktop	60
8.	Put CDs and books out of alphabetical, color, size order	50
9.	Disorganize refrigerator contents	40
10.	Disorganize magazines on coffee table	20

Summary of Preparation Stage

- **Psychoeducation** – Help client understand avoidance/compulsion cycle, and how it is reinforcing fear and increasing distress
- Help client increase awareness to cycle and cost (lots of monitoring in between sessions)
- Teach client to see anxiety/distress on a spectrum and not all or none (SUDs scale)
- Learn that their fear is often not of the trigger itself but of the core fear
- Develop a comprehensive (and imperfect) hierarchy that will be the blueprint of the exposure work

Questions?



Eugene Center for Anxiety and Stress

Conducting ERP

Eugene Center for Anxiety and Stress

Therapists Beliefs about Exposure Scale (TBES)

1. Most clients have difficulty tolerating the distress exposure therapy evokes
2. Exposure therapy addresses the superficial symptoms of an anxiety disorder but does not target their root cause
3. Exposure therapy works poorly for complex cases, such as when the client has multiple diagnoses
4. Compared to other psychotherapies, exposure therapy has higher drop out rates
5. Conducting exposure therapy sessions outside the office increases the risk of unethical dual relationship with the client
6. Exposure therapy is difficult to tailor to the needs of individual clients
7. Compared to other psychotherapies, exposure therapy is associated with a less strong therapeutic relationship
8. Clients are at risk of decompensating during highly anxiety-provoking exposure therapy sessions
9. Most clients perceive exposure therapy to be unacceptably aversive

Deacon et al 2013. The Therapist Beliefs about Exposure Scale.

Therapists Beliefs about Exposure Scale (TBES)

Negative beliefs about exposure therapy were associated with therapist demographic characteristics, negative reactions to a series of exposure therapy case vignettes, and the cautious delivery of exposure therapy in the treatment of a hypothetical client with obsessive-compulsive disorder.

Therapists Beliefs about Exposure Scale (TBES)

1. Most clients have difficulty tolerating the distress exposure therapy evokes
2. Exposure therapy addresses the superficial symptoms of an anxiety disorder but does not target their root cause
3. Exposure therapy works poorly for complex cases, such as when the client has multiple diagnoses
4. Compared to other psychotherapies, exposure therapy has higher drop out rates
5. Conducting exposure therapy sessions outside the office increases the risk of unethical dual relationship with the client
6. Exposure therapy is difficult to tailor to the needs of individual clients
7. Compared to other psychotherapies, exposure therapy is associated with a less strong therapeutic relationship
8. Clients are at risk of decompensating during highly anxiety-provoking exposure therapy sessions
9. Most clients perceive exposure therapy to be unacceptably aversive

Deacon et al 2013. The Therapist Beliefs about Exposure Scale.

Therapeutic Stance

"Compassionate Expert" or "Open-minded cheerleader"

- Clearly demonstrate knowledge/skill and model the approach
  - Be aware of own fears and limitations
  - Be clear about difference between ethical and personal lines prior to taking on a case
- High use of validation and warmth about the difficult nature of anxiety treatment
- Lots of normalization about the use of safety behaviors
- BUT: do not rescue clients from their distress or collude with their anxiety
  - Be careful about subtle and explicit reassurance seeking or figuring it out from the client
- Appropriate use of humor throughout
- Take responsibility when things don't go as planned

4

Learning Objective:

Describe five components of an effective exposure and response prevention.

Eugene Center for Anxiety and Stress

Guidelines to Conducting Effective Exposure

1. **Exposure practices should be planned, structured, and predictable**
2. **Exposure practices should be repeated frequently and spaced close together**
3. **Exposure pace can be gradual** (use hierarchy, and be willing to adjust if numbers are not accurate)
4. **Expect client to feel uncomfortable. Help them choose not to fight the fear.**
5. **Notice and limit subtle avoidance strategies and compulsions/rituals during and after the exposure.**
6. **Use exposure practices to test negative predictions about the consequences of facing fears.**
7. **Help client notice change in distress/anxiety over time.**
8. **Plan exposure practices that are likely to lead to a reduction in anxiety initially.**
9. **Practices should take place in different settings to generalize learning.**

What exposure therapy is not

- Telling the client to go home and do the exposure without practicing together first
  - “Try not to wash your hands after you get home from work”
- Expecting client to change behavior just because they understand the OCD cycle
- Incorporating distraction into planned exercises
- Asking client to do something only once in between sessions
- Expecting gains from one exposure to generalize to other fears
- Providing reassurance about client’s safety about the exposure
  - Are you sure I won’t get sick if I touch this pen?

Set up in session in-vivo exposures

- The first new exposures should be as part of a session with the therapist's guidance
- **In-vivo**: directly facing a feared object, situation or activity in real life
- The first exposure is important for client buying into the model and having a different experience; choose carefully
- In vivo better than imaginal for first exposure
- Choose exposure in the 40-60 SUDs range that can be done together, and chosen collaboratively with the client
- If possible, do the exposure with them
  - Touching toilet/doorknob/shoe
  - Interoceptive exposure
  - Looking at or listening to images

Before you begin the exposure

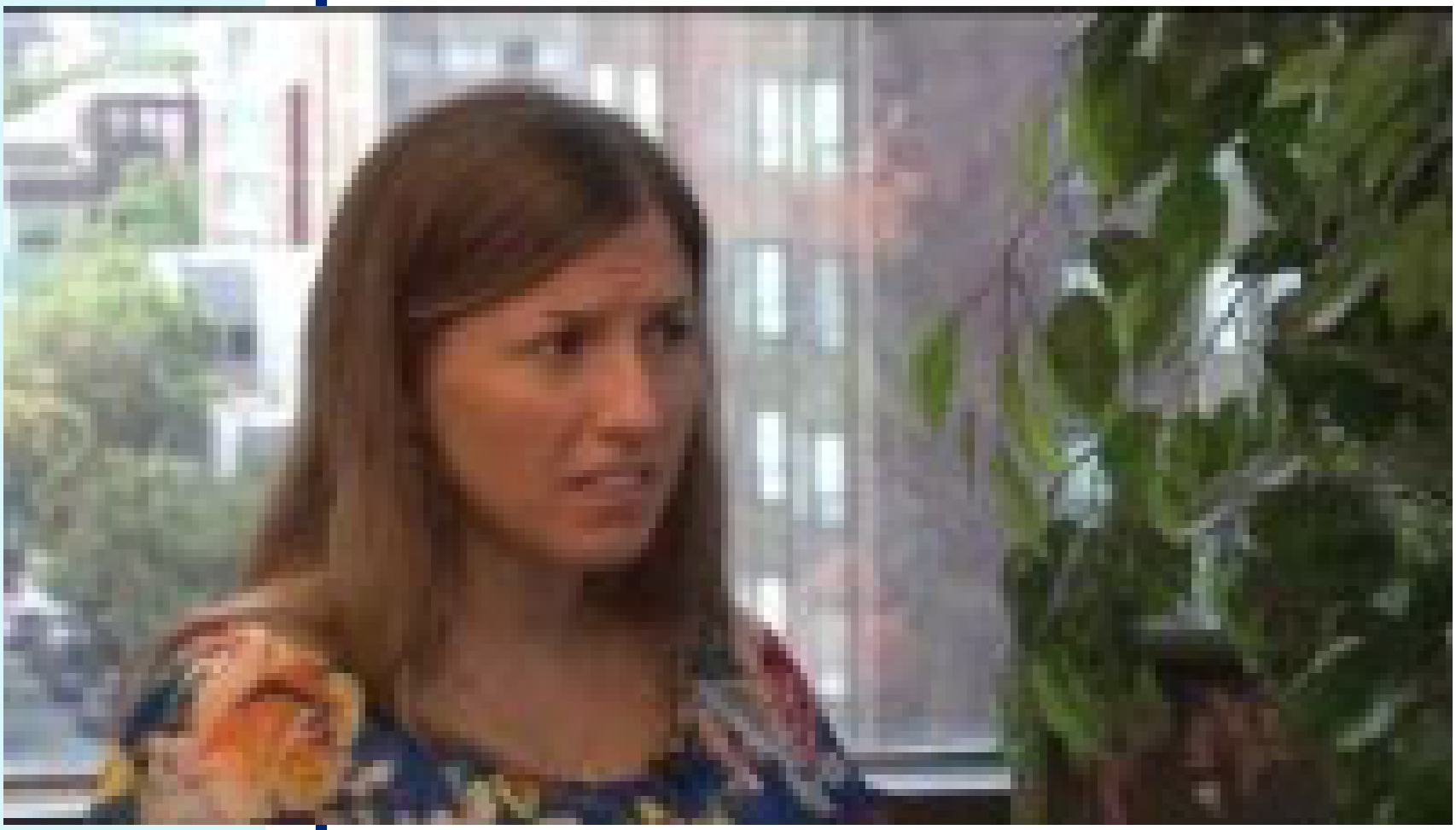
Be explicit about exactly what the exposure will be and why – Use an **Exposure Practice Worksheet**

Describe the exposure:

- What anxiety reduction strategies/safety behaviors will you give up?
- What feared outcome are you most worried about? **and/or** What are you worried you will not be able to tolerate?
- How will this exposure practice put your fear to the test?

What to do during exposure

- Ask for and draw out client's experiences (thoughts, emotions, sensations, safety behaviors)
- Can ask for distress level once or twice
- Set timer if helpful
- Validate difficulty and challenge without providing reassurance



Eugene Center for Anxiety and Stress

After the exposure (from worksheet)

What happened during the exposure – did your fears come true?
Were you able to tolerate the distress?
How did your SUDS change over time?

How was the outcome different from what you expected?
What surprised you about the outcome?

What did you learn from the experience?

Exposure homework set up

Make clear plan with client for exposure homework, with brainstorming obstacles to completion and safety behaviors to remove or decrease – remind them that consistency and repeatability is key

- *Touch the sponge at the sink, then contaminate yourself and objects around the house 5 times this week, without washing hands or showering outside of already established times*
- *Make a 'wrong' choice when choosing what to eat for lunch and dinner every day this week without engaging in perfectionistic thinking that arises*
- *Ask your husband to join you in the kitchen for at least 5 minutes every day while you are using a knife to cut things, with him 5 feet away, and when done leave the knife on the cutting board*

What can go wrong

Problem with exposure

- Exposure does not create enough anxiety
- Exposure causes too much anxiety (less likely than the first)
- Can't do it in the office

Client Factors

- Client convinced that danger is real (overvalued beliefs)
- Client has difficulty focusing on exposure (ask questions/distracts)
- Client uses safety behaviors

Therapist Factors

- Therapist talking too much
- Focusing too much on change in anxiety instead of learning
- Provides reassurance

Continue up the hierarchy

- Can do the same exposure again the following week or move up the hierarchy, depending on client's experience from the week
- Continue up the hierarchy through collaboration with the client until the client has sufficiently built safety learning about their feared theme

Summary of conducting ERP

- Use your hierarchy to choose an exposure exercise in the moderate range of difficulty that can be done together in the office to start
- Be clear about the plan, including what the client believes they will learn from the exercise and what safety behaviors they will not use
- Compassionately listen to and accept client's experiences during the exposure; validate ("I know this is so hard") without becoming a safety behavior
- Debrief afterwards, and set up a clear plan for repeated engagement in exposure for homework
- Continue up the hierarchy

Presentation Summary

- Learned about the CBT model of OCD
- Learned how to assess for OCD and differentiate from other disorders
- Learned how to prepare clients for exposure therapy, including how to make a hierarchy
- Learned how to engage in in-vivo exposure

Eugene Center for Anxiety and Stress

What's next?

- Integrating coping scripts into treatment process
- Using other types of exposures (imaginal, interoceptive, memory)
- International OCD Foundation Behavioral Therapy Training Institute (BTTI)
- Continue with ERP Interest Group (email me ida.Moadab@optum.com)

Eugene Center for Anxiety and Stress

Thank you!

References

- Watson, J.B. & Rayner, R. (1920). "Conditioned emotional reactions". *Journal of Experimental Psychology*. **3** (1): 1–14. doi:10.1037/h0069608Telch & Lancaster, 2012
- Adam S. Radomsky, et al, 2014. Part 1—You can run but you can't hide: Intrusive thoughts on six continents,
- Journal of Obsessive-Compulsive and Related Disorders, 3(3), 269-279.https://doi.org/10.1016/j.jocrd.2013.09.002.
- Pollard, A. (2021, 08). Behavioral Therapy Training Institute Three-day Intensive, Virtual.
- Myers, S. G., Fisher, P. L., & Wells, A. (2008). Belief domains of the Obsessive Beliefs Questionnaire-44 (OBQ-44) and their specific relationship with obsessive-compulsive symptoms. *Journal of Anxiety Disorders, 22*(3), 475–484. https://doi.org/10.1016/j.janxdis.2007.03.012
- Benito, K. G., & Walther, M. (2015). Therapeutic Process During Exposure: Habituation Model. *Journal of obsessive-compulsive and related disorders, 6*, 147–157. https://doi.org/10.1016/j.jocrd.2015.01.006
- Jacoby, R. J., & Abramowitz, J. S. (2016). Inhibitory learning approaches to exposure therapy: A critical review and translation to obsessive-compulsive disorder. *Clinical Psychology Review, 49,* 28–40. https://doi.org/10.1016/j.cpr.2016.07.001
- Deacon, B. J., Farrell, N. R., Kemp, J. J., Dixon, L. J., Sy, J. T., Zhang, A. R., & McGrath, P. B. (2013). Assessing therapist reservations about exposure therapy for anxiety disorders: the Therapist Beliefs about Exposure Scale. *Journal of anxiety disorders*, *27*(8), 772–780. https://doi.org/10.1016/j.janxdis.2013.04.006
- Abramowitz, B.J., Deacon, B.J., and Stephen, P.H. Whiteside. (2019). Exposure Therapy for Anxiety, Principles and Practice, Second Edition. Guilford Press.
- Goodman, W. K., Price, L. H., Rasmussen, S. A., Mazure, C., Fleischmann, R. L., Hill, C. L., Heninger, G. R., & Charney, D. S. (1989). The Yale-Brown Obsessive Compulsive Scale: I. Development, use, and reliability. *Archives of General Psychiatry, 46*(11), 1006–1011. https://doi.org/10.1001/archpsyc.1989.01810110048007