Understanding and Treating Adult Obsessive-Compulsive Disorder

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Disclosures/Conflicts of Interest

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Learning Objectives

1. Describe the conceptualization and assessment of adult OCD and explain how these inform treatment planning using exposure and response prevention (ERP).
2. Identify strategies to optimize exposure therapy through an inhibitory learning framework.
3. Identify common challenges that arise during ERP, such as family accommodation, and how to address them in therapy.

Workshop Outline

- What is OCD?
- Treatment Models of OCD
- Discussing the Treatment Rationale for ERP
- Beginning Treatment
- How does Exposure Therapy Work?
- Generating the ERP Hierarchy
- Using ACT in the Treatment of OCD
- Working with Couples and Families
- Advanced Considerations

A Poll for You

Q: How many patients with OCD have you treated with exposure and response prevention?

- 1-4
- 5-9
- 10-19
- 20-49
- 50-99
- ≥ 100

What is OCD?

Essential Features of OCD

Recurrent **obsessions** or **compulsions** that are severe enough to be time consuming (i.e., they take more than 1 hour a day) or cause marked distress or significant impairment in functioning.

Obsessions

Persistent thoughts, impulses, or images that are experienced as intrusive, inappropriate and distressing

Not simply excessive worries about real life problems

The person attempts to ignore or suppress the obsessions or neutralize them with other thought or action

The person recognizes that they are a product of his or her own mind

Common Obsessions

Contamination - dirt, germs, bodily waste, chemicals

Responsibility – harm, mistakes, accidents, locks, appliances, paperwork, hit-and-run

Unacceptable thoughts - violence, sexual, religious

Order - neatness, symmetry, numbers

Compulsions

Repetitive behaviors (e.g., handwashing) or mental acts (e.g., praying silently) that the person feels driven to perform in response to an obsession or according to rigid rules

The compulsions are aimed at reducing distress or preventing a dreaded situation: the compulsions are either unrealistic or clearly excessive

Common Compulsive Rituals

- De-contamination – hand washing, cleaning, shower/toilet routine
- Checking – locks, appliances, accidents, harm, paperwork, reassurance from others
- Ordering/arranging – “just right”
- Repeating – steps, doorways, light switches
- Counting – lucky numbers, while checking or washing
- Mental rituals - praying, self-reassurance, thought replacement

Avoidance in OCD

- Individuals seek to avoid anxiety-evoking (i.e., obsessional) situations and stimuli due to…
  - Fears of disastrous consequences
  - Inconvenience of having to ritualize

- Avoidance might be preferred to rituals
  - Ritual is used to restore a sense of safety if the situation/stimuli cannot be avoided in the first place

- Most pronounced with contamination fears

Relationship Between Obsessions and Compulsions

- Obsessional thoughts give rise to anxiety/distress
- Compulsions are performed to reduce this distress and/or to reduce the probability that disastrous consequences will occur
- *Neutralizing is a cardinal feature of OCD*

OCD With Poor Insight

- For most of the time during the current episode the person does not recognize that the obsessions and compulsions are excessive or unreasonable.

Treatment Models of OCD

Models and Treatments of OCD

- OCD once considered treatment-resistant
- Insight-oriented therapy rarely helped core symptoms
- Effective treatments have been derived from theoretical accounts of the problem:
  - Cognitive-behavioral theories → cognitive and behavioral treatment techniques
  - Biological theories → serotonergic medication

Cognitive-Behavioral Model: Obsessions

- Intrusive unpleasant thoughts are universal
  - *A thought about stabbing my child at dinner*
- "Obsessive beliefs" lead to misinterpretation of normal intrusions as anxiety-provoking
  - *"Only bad people have bad thoughts"*
  - *"I am a bad person for thinking about this"*

Rachman, 1997; Salkovskis, 1999

Cognitive-behavioral Model: Compulsions

- Rituals and avoidance reduce obsessional fear
  - Avoidance of child, keep knives locked up
  - Asking for reassurances, checking, repetitive praying
- Avoidance and rituals prevent the correction of obsessive beliefs and misinterpretations

Rachman, 1997; Salkovskis, 1999

Acceptance Model of OCD (ACT)

- It's not the thoughts themselves that are the problem, it's *how* we treat them
- Distress and impairment result from *experiential avoidance*
  - The tendency to try to push away or control unwanted internal experiences
  - *"If you don't want it, you've got it"*
- Three parts to OCD:
  1. Unwanted internal experiences (e.g., thoughts, uncertainty)
  2. Behavioral responses (rituals, avoidance) as attempts to control internal experiences
  3. Negative effects on quality of life

Treatment Implications of Psychological Models

- OCD symptoms lessen when patients come to believe their obsessional fears are unfounded, that they can manage short-term anxiety
- Simply talking about probabilities is not as convincing as direct evidence from experience
- Patients need to directly confront their fears to truly master them
  - **Exposure** – confront feared stimuli (external and internal) to learn they are not dangerous
  - **Response prevention** – end compulsive rituals that interfere with safety learning

Discussing the Treatment Rationale for ERP

Explaining Treatment

- Socializing the patient to the cognitive-behavioral model
  - Obsessional thoughts are normal
  - Misinterpretations of thoughts leads to anxiety
  - Trying to control obsessions and anxiety using avoidance and compulsive rituals maintain obsessional fears
    - Provide examples from the patient's own repertoire

Explaining Treatment

- Rationale for exposure therapy
  - *Exposure* and *response prevention* change how the person relates to unwanted thoughts and anxiety so that these internal experiences don't push the person around and keep them from valued activities in life
  - Define ERP
  - Give examples of ERP exercises
  - Explain the basic idea
    - Repeatedly confronting situations and thoughts that evoke anxiety will teach you that (a) you can manage anxiety, which does not remain forever, and (b) feared consequences are unlikely (and even if they occur you can handle them)

Explaining Treatment

- Explain how treatment is tailored to the patient's particular needs
  - Development of an exposure list/hierarchy
  - All treatment exercises will be planned and structured
  - Sometimes the patient will be asked to do thing that *most people wouldn't do*

Beginning Treatment

Functional Assessment of OCD

- Gathering information about specific cognitive and behavioral features to understand how they are linked
  - Uses the cognitive-behavioral model of OCD as a framework
- Critical for developing a successful case conceptualization and treatment plan
- Beginning at first session
  - Continue informally throughout treatment

Self-monitoring of Rituals

- Why?
  - Valuable information, but you can't follow the patient around
  - Outcome measure (hopefully ritual frequency/duration reduces over time)
  - Sometimes therapeutic in itself
- What to self-monitor
  - 2 prominent rituals
- When
  - Begin after functional assessment
- Make sure to review with the patient to reinforce its importance

ERP for OCD

- OCD symptoms lessen when patients come to believe their obsessional fears are unfounded, that they can manage short-term anxiety, *and act accordingly*
- Simply talking about probabilities is not as convincing as direct evidence from experience
  - Patients need to directly approach their fears to truly master them
- ERP is the most powerful intervention in the treatment of OCD

In Vivo (Situational) Exposure

- Approaching actual feared stimuli in the external environment
  - Stimuli perceived as dangerous, but that actually represent no more than everyday risk
- Examples:
  - Knives
  - Bad luck numbers (13)
  - Toilets
  - Driving in a crowded parking lot
  - Pornography
  - Books about beliefs you disagree with

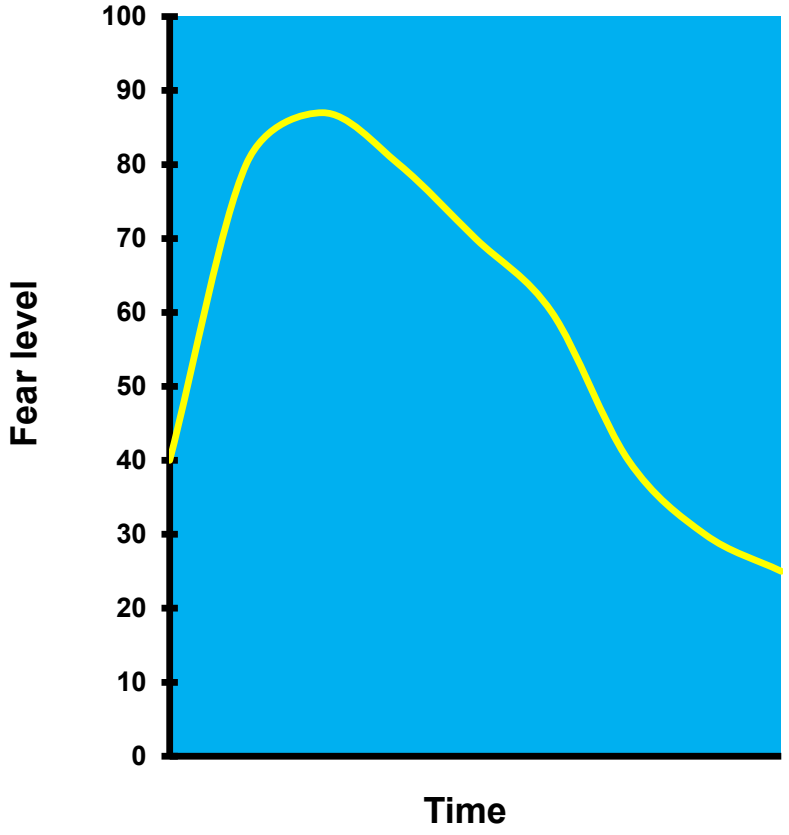
Imaginal Exposure

- Engaging with feared mental stimuli such as thoughts, doubts (uncertainty) images, impulses, worries, and memories
- Useful when feared stimuli are difficult or impossible to create in real life
- Useful when the feared consequences are “unknowable” or might not occur until the distant future

How Does Exposure Therapy Work?

Emotional Processing Theory

- Exposure to fear-eliciting stimuli or situations
- Prevention of avoidant behaviors
- Anxiety increases initially, followed by habituation



Optimizing Inhibitory Learning

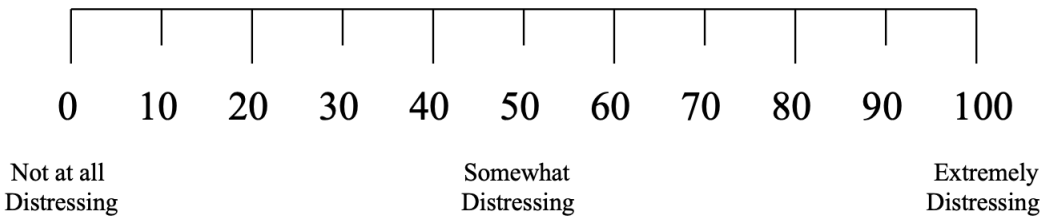
- During exposure/extinction, the "fear-based" association is not *erased*
  - A secondary "safety-based" association develops
- After exposure to "floor germs", a patient has two learned associations in memory:
  - Threat-based: floor → illness
  - Safety-based: floor → no illness
- The hope is that with repeated exposure, the safety-based learning inhibits (extinguishes) the threat-based learning (*inhibitory learning*)

Generating the ERP Hierarchy

Constructing the Exposure Hierarchy/List

- Generate list of triggers and avoided stimuli and situations that recreate the patient's fear (from functional assessment)
- Introduce **Subjective Units of Discomfort Scale (SUDS)**

The **SUBJECTIVE UNITS OF DISCOMFORT** Scale (SUDS)



- Patient rates SUDS for each item on the list

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Constructing the Exposure Hierarchy/List

- Make sure exposure items match with patient's idiosyncratic beliefs and fears
  - Realistically *safe enough*, but subjectively distressing
- Key is for the patient to lean into the possibility of feared consequences
- Generate list of safety behaviors / compulsions to eliminate
- Decide where on the hierarchy to start
  - Collaborative effort
  - SUDS, variability, values

Sample Hierarchy Items: Bathrooms

- Doorknobs
- Sink and faucet
- Trash can
- Toilet/urinal and flusher/seat
- Floor (eat snack on the floor)
- Touch paper towel to contaminated items and carry the towel in pocket or purse

Response Prevention for Washing Rituals

Goal: feel "contaminated" 24/7

- So that exposure never really ends

Limit washing of any body part

- Even after using the bathroom and before eating
- Exception: if contaminant can be seen/smelled *without close inspection*

Limit cleaning of objects and laundry

Limit use of barriers (gloves, sleeves, etc.)

Sample Hierarchy Items: Mistakes and Insults

- Write and send e-mails (no checking!)
- Send texts
- Post on social media
- Imagine insulting insertions
- Think of curse word
- Write curse word
- Send messages/posts immediately after writing curse words
- Send messages/posts while listening to curse words

Response Prevention for Checking

Goal: feel uncertain 24/7

- So that exposure never really ends

No checking

- Paperwork may be checked once (briefly)

No other re-assurance seeking behaviors

- Significant others must be on board
- Questions may be answered once only

No mental reviewing/analyzing

- Focus on being uncertain instead
- Perform rituals incompletely or incorrectly

Implementing ERP

Early Treatment Sessions

- Begin with moderately distressing stimuli and intrusions
- Coaching and encouragement in abstaining from rituals
- Troubleshooting and planning future exposure exercises together
- Process the experience

Moving Up the Hierarchy

- Build on past successes from earlier sessions
- Encourage patient to choose from among equivalent stimuli for exposures
- Note changes in impairment & decreased symptoms to highlight improvement

Confronting the Greatest Fears

- Encouragement and praise for efforts
- Modeling
- Discussion of acceptable *vs.* unacceptable risk
- Repeated and prolonged exposure
- Approach fears in multiple contexts

General Hints and Tips for Exposure Therapy

- Use everyday situations (eat snacks)
- Discuss negative outcomes as *unlikely*, but not *impossible*
- Consider gradual response prevention (e.g., urine fears)
- Look out for mental rituals
- Manage your own comfort level
- Don’t be afraid of self-disclosure
- Consider field trips

Optimizing Inhibitory Learning During Exposure Therapy

- Frame exposures to violate threat-based expectations
- Introduce variability wherever possible
- Combine multiple fear cues and exposure media
- Put feelings into words (affect labeling)
- Focusing attention

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Stylistic Considerations

Therapist as coach and cheerleader

Therapist and patient *vs.* OCD

- *Not* therapist *vs.* patient + OCD

Focus on "choosing to be anxious" and "increasing risk tolerance"

Discourage reassurance-seeking or analyzing

Use of humor

Providing treatment outside of the office

Homework Includes:

- Self exposure to feared situations
- Instructions to refrain from mental or behavioral rituals
- Daily monitoring of rituals

Using ACT in the Treatment of OCD

REMINDER: ACT Model of OCD

- It's not the thoughts themselves that are the problem, it's *how* we treat them
- Distress and impairment result from *experiential avoidance*
  - The tendency to try to push away or control unwanted internal experiences
  - *"If you don't want it, you've got it"*
- Three parts to OCD:
  1. Unwanted internal experiences (e.g., thoughts, uncertainty)
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ACT for OCD

- Basic techniques
  - Experiential metaphors to increase psychological flexibility
  - Learn to respond differently (live life) even if obsessions/anxiety are present
    - Acceptance
    - Defusion
    - Values

Implementation

- Metaphors to set up exposures and help patients focus on valued living despite intrusive thoughts and anxiety
  - "Jerk at the door"
  - Chessboard
  - Passengers on the bus
  - **Tug of war with a monster**

Working with Couples and Families

OCD in an Interpersonal Context

- Person with OCD acts to structure their environment to minimize obsessions and anxiety
- Partners often become part of “OCD World”
  - Partner helps person **avoid** anxiety
  - Partner **participates in compulsive rituals**
  - Partner provides ongoing **reassurance**
  - Partner may **argue** with their loved one

Elements of Couple-Based CBT for OCD

- Assessment
- Education about OCD in relationship context
- Communication training
- Partner assisted exposure and response prevention
- Alter couple's relationship relative to OCD
  - No accommodation
  - Healthy ways to show care and concern
  - Broaden couple behaviors as OCD improves
- Focus on general relationship distress *or* relationship enhancement

Advanced Considerations

Addressing Common Obstacles

- Arguing
- Nonadherence
- Continued asking for reassurance
- Therapist presence can invalidate exposures
- Be careful about giving subtle reassurance
- Make sure exposure doesn’t become a ritual

Justice-Based Treatment of OCD

- Doubts about sexual orientation or gender identity
  - "What if my relationship with my husband is a lie and I'm supposed to be with women?"
- Unwanted racist, homophobic, or transphobic intrusive thoughts
  - Ex: the urge to yell a racial slur in the middle of a meeting
- Ensure that exposures **do not cause harm** to the minoritized individuals who are identified in these obsessions
  - Eliminate exposures that contribute to **minority stress**
  - Exposures to neutral and positive stimuli and uncertainty, while still targeting core fears

Justice-Oriented Exposures

Traditional Hierarchy	Justice-Oriented Hierarchy
EX1: Write worry script about suddenly becoming gay/bi/trans.	Read/write a coming-out letter. Tolerate uncertainty about consequences of being gay/bi/trans (e.g., loss of relationships, being labeled a “liar”)
EX2: Shake hands with gay person and resist washing hands.	Hold pride flag. Sit next to individual who may or may not be LGBTQ+ and tolerate uncertainty of not knowing.
EX3: Look at photo or watch video of two queer people kissing and describe associated feelings (e.g., fear, disgust)	Watch LGBTQ+-themed movies made by LGBTQ+ writer/directors.
EX4: Read, write, say racial slur	Talk to coworkers of other races they have been avoiding and tolerating uncertainty that an unwanted word would somehow slip out.

Pinciotti, Smith, Singh, Wetterneck, & Williams, 2022

Implementing Treatment via Telehealth

- Virtual treatment can be as effective as in-person treatment
- When to use virtual vs. in person?
  - Virtual works well for moderate symptoms and for imaginal and home based exposures ; It promotes real world generalization
  - In person is recommended for more severe symptoms , when treatment requires extra coaching, and in specific settings (e.g., dog parks)
- Key considerations
  - Convenience, access, and flexible scheduling are key advantages
  - Stable Internet and comfort with digital tools
  - Building report can be more challenging
- Consider a hybrid model to optimize care

Thank You!

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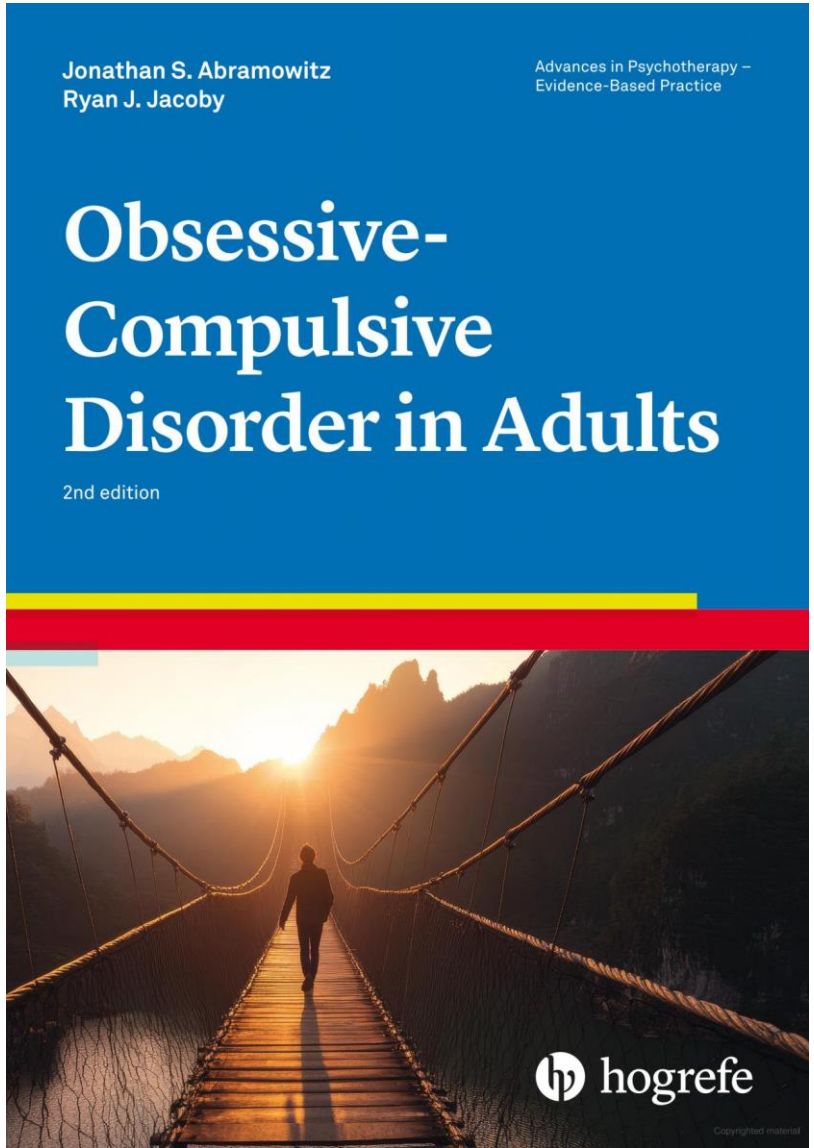
Clinical Resources



Free Handouts QR code

Book purchasing QR code

Exposure Practice Form

Date: _____ Time: _____

Check one: _____ Alone _____ Accompanied

Before you start

1. Describe the exposure (What fears will you approach and what distress-reduction strategies will you give up?)

2. What do you most fear will happen when you try this exposure (be specific)?

3. What are your goals? How long do you think you can stick with this task?

During the exposure

1. Every _____ minutes during the exposure note (a) your distress level and (b) the strength of your urge to do distress-reducing behaviors on a 0–100 scale.

Distress	Urge	Distress	Urge	Distress	Urge	Distress	Urge
1.		6.		11.		16.	
2.		7.		12.		17.	
3.		8.		13.		18.	
4.		9.		14.		19.	
5.		10.		15.		20.	

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Q&A

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