Interoceptive Exposure: An Underused Weapon in the Arsenal against OCD

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Outline

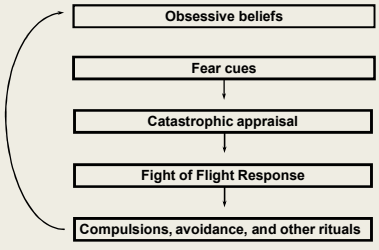
- Background
- Anxiety sensitivity and OCD treatment
- Utility of interoceptive exposure (IE)
  - *Assessment and case formulation*
  - *Integration into treatment plan*
- Case example
- Common clinician concerns
- Tips and troubleshooting

Background

Obsessive-Compulsive Disorder (OCD)

- Obsessions
- Compulsions, avoidance, rituals
- Common themes:
  - *Doubt/responsibility for harm*
  - *Symmetry/order*
  - *Unacceptable thoughts*
  - *Contamination*

Conceptual Model of OCD



Exposure Therapy for OCD

- Repeated, prolonged confrontation with feared stimuli without performing rituals
- General aims
  - *Test threat overestimates*
  - *Develop distress tolerance*
- Most effective treatment for OCD

What do you notice when

you become anxious or fearful?

What did you notice?

What is Anxiety?

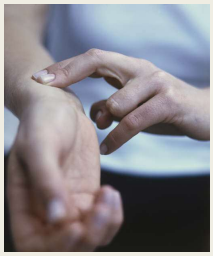
- The body's alarm reaction to perceived threat
  - *"Fight-or-flight" response*
- 3 Systems
  - *Cognitive, physical, behavioral*
- Normal and highly adaptive
  - *Helps us survive and do our best*

Anxiety Sensitivity (AS)

- Tendency to fear ambiguous or anxiety-related body sensations
  - *"Fear of fear"*
- Based on the belief that anxiety and anxious arousal is dangerous

Body vigilance

- Attentional bias toward somatic sensations
- Increased detection of sensations misperceived as dangerous
- Similar to other OCD checking behaviors



AS and OCD

- Under-studied area
- OCD patients > non-patients
  - *Panic disorder and social anxiety patients > OCD*
- AS and OCD symptom severity positively correlated in clinical and nonclinical samples

Somatic Concerns in OCD

- Body sensations = "losing control"
- Body sensations = intolerable
- Body sensations = "proof" of obsessional fears
  - *anxious arousal or sexual arousal?*
- Panic = sign of being "untreatable" or a "failure"

AS and OCD Treatment

AS and OCD Treatment

- Also under-studied
- Residential OCD Clinic:
  - *Pre-treatment AS predicted poorer OCD treatment outcome*
- Unclear how AS influences exposure outcomes
  - *Two possibilities…*

1: AS Reinforces Obsessive Beliefs

- Hypervigilance → increased threat perception
  - *Danger = seemingly everywhere*
  - *"Proof" that obsessions are true*
- AS-related safety behaviors perceived as necessary
  - *Misattribution of safety*

2: AS Threatens Adherence to Exposure Therapy

- AS amplifies exposure difficulty
  - *High-AS OCD patients face <u>two</u> exposure stimuli*
  - *Reluctance to do exposures or homework*
- AS creates prognostic pessimism
  - *Patient believes s/he is "too weak"*
  - *Patient believes exposure is "too hard"*

Interoceptive Exposure

Interoceptive Exposure (IE)

- Repeated, prolonged confrontation with somatic stimuli without performing rituals or other "safety behaviors"
- General aims
  - *Test threat overestimates*
  - *Develop distress tolerance*
- An underused therapeutic tool!

Utility of IE for OCD

- Literature and clinical experience points to the importance of body sensations in OCD
- High AS might contribute to relapse or poor treatment response
- Implications for assessment, treatment planning, and exposure hierarchy

Assessment and Case Formulation

Assessment of AS in OCD Patients

- Assessment method
  - *Self-report or clinician-rated*
- Assessed content
  - *Sensations and their (anticipated) consequences*
  - *Bodily secretions and their (perceived) meaning*
  - *Safety behaviors*

Self-Report Measures

- Anxiety Sensitivity Index-3 (ASI-3; Taylor et al., 2007)
  - *18 items load onto 3 subscales*
    - "It scares me when my heart beats rapidly"
    - "It scares me when I am unable to keep my mind on a task"
    - "When I tremble in the presence of others, I fear what people might think of me"
- Body Vigilance Scale (BVS; Schmidt et al., 1997)
  - *4 items measuring attention bias toward specific sensations*
    - Heart palpitations, dizziness, nausea, etc.

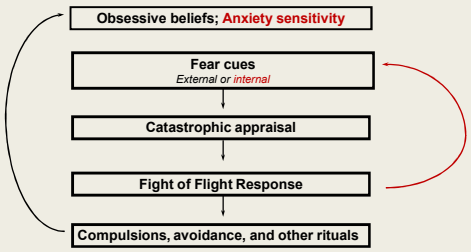
Clinician-Rated Assessment Questions: Sensations

- What sensations in your body trigger you to feel fearful?
- What goes through your mind if you notice these sensations?
- Do you ever feel like certain body sensations are proof that your OCD fears are true (or will come true)?

Clinician-Rated Assessment Questions: Rituals/Avoidance

- Do you have any checking rituals related to your OCD-related sensations?
- Do you frequently visit doctors about certain body sensations?
- Do you frequently research body sensations online?
- Do you ever do certain things (or avoid certain things) to prevent feeling certain body sensations in the first place?

A More Comprehensive Conceptual Model of OCD



Psychoeducation and Presenting a Treatment Rationale

Psychoeducation

- Nature of anxiety and the "Fight-or-Flight System"
- Normalize somatic sensations
  - *"Noisy bodies"*
- Normalize unwanted intrusive thoughts
- Explain how rituals/avoidance counterintuitively maintain OCD
  - *Draw conceptual model for patient*

Rationale for Exposure with IE

- Disconfirm mistaken beliefs about obsessions *and* OCD-related sensations
  - *Sensations aren't necessarily dangerous*
  - *Anxiety doesn't last forever or "spiral out of control"*

Developing an IE Fear Hierarchy

IE Assessment

- To identify exercises that tap into OCD-related fear
- After every exercise, assess:
  - *Physical sensations and their intensity*
  - *Psychological distress ("SUDS")*
- Allow sensations to subside between exercises
  - *Not recommended during actual exposure trials later on*
- Need: watch/timer, thin cocktail straws, swivel chair
  - *Appropriate clothing/shoes*

LET'S TRY IT!

Exercise	Sensations (Intensity, 0-10)	Intensity of Distress (0-10)
Shake head from side to side (30 seconds)		
Swallowing quickly (10 times)		
Straw breathing (60 seconds)		
Hyperventilate (60 seconds)		

Exercise	Sensations (Intensity, 0-10)	Intensity of Distress (0-10)
Shake head from side to side (30 seconds)	*Dizziness (7)* *Headache (2)*	*4*
Swallowing quickly (10 times)		
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Hyperventilate (60 seconds)		

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Swallowing quickly (10 times)	*Tight throat (6)* *Breathlessness (5)* *Dry mouth (6)*	*4*
Straw breathing (60 seconds)		
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Straw breathing (60 seconds)	*Chest tightness (7)* *Breathlessness (8)* *Hot flash (3)*	*7*
Hyperventilate (60 seconds)		

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Straw breathing (60 seconds)	*Chest tightness (7)* *Breathlessness (8)* *Hot flash (3)*	*7*
Hyperventilate (60 seconds)	*Derealization (8)* *Dizziness (7)* *Tingling appendages (6)*	*9*

Implementing Interoceptive (and other) Exposures

IE Hierarchy

- Only include IE exercises that are related to case conceptualization
  - *Patient-dependent*
- IE exercises may be rank-ordered and completed gradually
  - *Repeated and varied contexts*
- May be “stand-alone” exposures
- May be paired with imaginal or in-vivo exposures

Case Example: Maria

Maria's obsessional fears centered around the possibility that she might commit bestiality. She had no explicit desires for sexual contact with animals and reported becoming anxious and disgusted when these intrusive thoughts popped into her head. During the intake, Maria explained that these obsessions were triggered by certain physical sensations when around animals; namely, increased heart rate, feeling hot or flushed, and muscle tension. She was particularly concerned about an instance during which she thought she felt a "twinge" of sexual excitement when her roommate's dog was licking her arm. Maria interpreted this as a sign that she might commit bestiality at any moment. As a result, she became acutely aware of any physical sensations that occurred in the presence of animals and removed herself from the presence of animals when she had these sensations. She also spent an hour each day on the internet seeking assurance that it is normal to have these sorts of experiences. She thought that if only her sensations would go away, so would her OCD.

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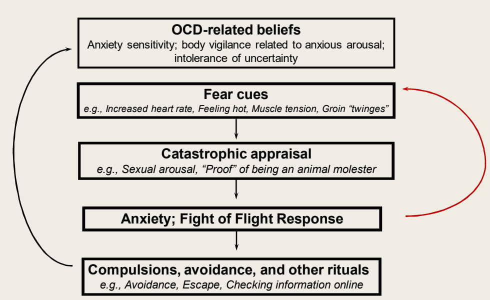
Case Conceptualization



Treatment Rationale and IE Assessment

- Psychoeducation (thoughts *and* "fight-or-flight response")
- Discussed how AS "confirmed" her obsessions
- Explained how resisting anxiety makes anxiety worse
- Provided rationale for exposure (including IE)
  - *Disconfirm incorrect beliefs about anxious arousal*
  - *Learn to accept unexpected body sensations when around animals without resisting or fighting them*

Integrated Treatment Plan

- Response prevention
  - *Stop avoiding or leaving situation*
  - *Stop seeking reassurance on the internet*
- Exposures
  - *IE to increased heart rate, feeling flushed*
  - *Imaginal exposure to feelings of uncertainty*
    - "You'll never know for sure if you will molest an animal…"
  - *Be near animals while experiencing sensations*
    - Take roommate's dog on walks unsupervised

Mistaken Clinician Concerns

Concern 1: IE is dangerous

- Anxiety is *natural* and *adaptive* (fight-or-flight)
- Meehl's (1973) Spun Glass Theory

Concern 2: IE is Intolerable

- Unpleasant vs. Intolerable
  - *Like going to the dentist…*
- Exposure (including IE) is tolerable and therapeutic
  - *Chance to develop greater distress tolerance*

Clinicians' Solution?

- Conduct IE tasks by yourself to examine *own* AS and distress tolerance
  - *Exposure therapy for the exposure therapist!*
- Seek supervision and/or consultation during first OCD cases incorporating IE

Tips and Troubleshooting

Tips to Optimize IE for OCD

- Prolonged and intense trials
  - *Minimize breaks*
- Don't provide reassurance
  - *Psychoeducation: Therapist provides <u>new</u> information*
  - *During exposure: "I don't want to be insensitive, but it sounds like you're looking for reassurance. We've already discussed this—you know the answer."*

Tips to Optimize IE for OCD (continued)

- Determine an appropriate "stopping point"
  - *Belief change*
  - *Distress tolerance*
- Show confidence in IE <u>and</u> patient
  - *Early modeling of IE tasks*
  - *"Bring it on!" attitude*

What if Your Patient Panics?

- Re-channel empathy
- Normalize without providing reassurance
- Demonstrate confidence in patient's ability to continue
- Still learning valuable information!

THANK YOU!

Questions?

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