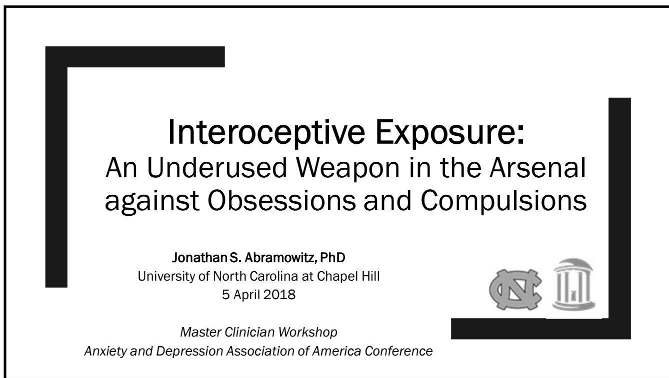
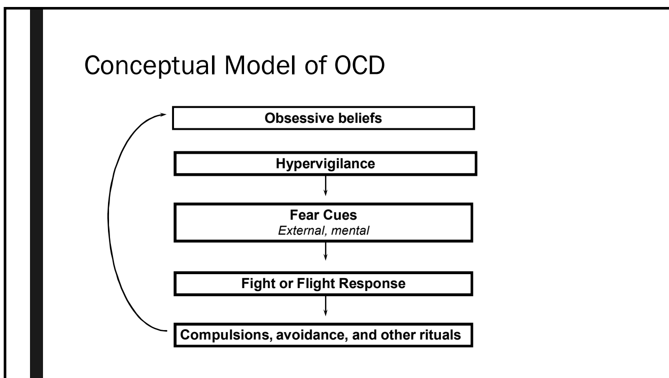


Obsessive-Compulsive Disorder (OCD)

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



Exposure Therapy for OCD

- Repeated, prolonged confrontation with feared stimuli without performing rituals
- General aims
  - *Learn that feared stimuli are safe*
  - *Develop distress tolerance*
- Most effective treatment for OCD

What is Anxiety?

- The body's alarm reaction to perceived threat
  - *"Fight-or-flight" response*
  - *Sensations are side effects*
- Normal and highly adaptive
  - *Helps us survive and do our best*
- Explanations for specific fight-flight sensations

Anxiety Sensitivity (AS)

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

Body vigilance

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

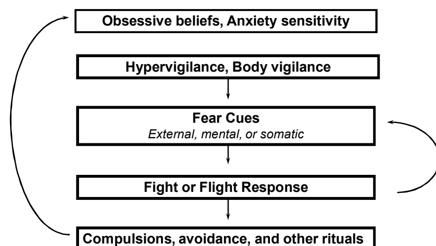
AS and OCD

- 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

- Arousal-related body sensations misinterpreted as
  - Intolerable
  - Sign of being “untreatable” or a “failure”
  - “Proof” of obsessional fears (anxious arousal or sexual arousal?)

A More Comprehensive Conceptual Model of *Some* Presentations of OCD



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 two exposure stimuli*
    - The obsessional situation AND the arousal-related sensations
  - *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 (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 point to the importance of body sensations in OCD
- High AS might contribute to relapse or poor treatment response
- Implications for assessment, treatment planning, and the exposure to-do list

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.

http://www.jabramowitz.com/resources-and-free-stuff.html

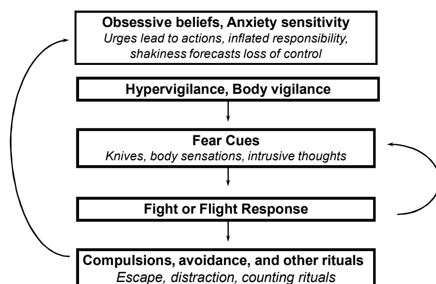
Interview Questions: Body Sensations

- What sensations in your body trigger you to become 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)?

Interview Questions: Rituals/Avoidance

- What checking rituals do you have that are related to your OCD-related body sensations?
- How frequently do you:
  - *visit doctors about the body sensations?*
  - *research body sensations online?*
  - *do things (or avoid certain things) to prevent the body sensations from showing up in the first place?*

Case Conceptualization: Jen



Psychoeducation

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

Rationale for Exposure <u>with</u> IE

- Violate threat-related beliefs and expectations about obsessions *and* OCD-related body sensations
  - *Sensations aren't necessarily dangerous*
  - *Anxiety (and sensations of arousal) is tolerable/manageable*
  - *Anxiety doesn't last forever or "spiral out of control"*

Determine IE Tasks

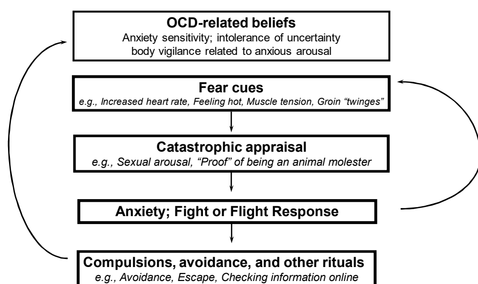
- Identify exercises that tap into OCD-related fear
- After every exercise, assess:
  - *Physical sensations and their intensity*
  - *Subjective distress ("SUDS")*
- Allow sensations to subside between exercises
  - *Not recommended during actual exposure trials later on*
- Need: watch/timer, thin cocktail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

Exercise	Sensations (Intensity, 0-10)	Distress (SUDS) (0-10)	Similarity to "real life" (0-10)
Shake head side to side (30 seconds)			
Place head between legs (30 seconds)			
Run in place (60 seconds)			
Hold breath (60 seconds)			
Spin (30 seconds)			
Breathe through straw (30 seconds)			
Hyperventilate (60 seconds)			

IE To-Do List

- Only include IE exercises that are related to case conceptualization
- IE exercises may be rank-ordered and completed gradually
  - *Or not*
- Repeated and varied contexts
- Might be "stand-alone" exposures
- Might be paired with imaginal or in-vivo exposures (deepened extinction)

Case Conceptualization: Mark



Treatment Rationale and IE Assessment

- Psychoeducation (thoughts *and* "fight-or-flight response")
- Discussed how AS "confirmed" his obsessions
- Explained how resisting anxiety makes anxiety worse
- Provided rationale for exposure (including IE)
  - *Correct mistaken 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 100% for sure what you'll do in the future"
  - *Be near animals while experiencing sensations*
    - Take girlfriend's dog on walks unsupervised

Concern 1: IE is dangerous

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

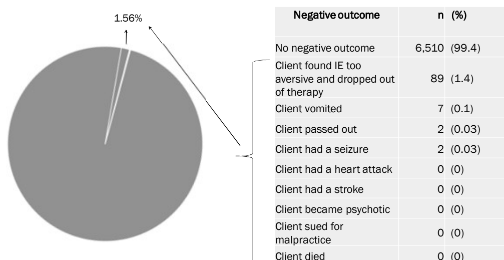
IE Therapist Survey (Deacon et al., 2011)

- "We'd like you to imagine what might happen if you asked a panic disorder client to complete a hyperventilation IE exercise in the following manner. Specifically, imagine that you asked your client to:
  - *Hyperventilate for 30 consecutive minute-long trials*
  - *Take only a 15-second rest period between each trial to provide a verbal SUDS rating*
  - *Refrain from using diaphragmatic breathing or other arousal reduction strategies during the exercise*
- Imagining you used IE in this manner, please rate the likelihood that the following possible negative outcomes would occur as a result…"

Clinicians' perceived likelihood of negative outcomes (N= 66 Clinicians)

- 54.9% - The client will prematurely stop exposure.
- 37.1% - The client would drop out of therapy.
- 22.2% - The client's anxiety would become so high that he or she would decompensate during the session.
- 17.9% - Following the IE exercise, the client's panic disorder symptoms would worsen.
- 17.3% - The client would pass out/lose consciousness.

Frequency of Negative Outcomes (N=6,545 Patients)



Negative outcome	n	(%)
No negative outcome	6,510	(99.4)
Client found IE too aversive and dropped out of therapy	89	(1.4)
Client vomited	7	(0.1)
Client passed out	2	(0.03)
Client had a seizure	2	(0.03)
Client had a heart attack	0	(0)
Client had a stroke	0	(0)
Client became psychotic	0	(0)
Client sued for malpractice	0	(0)
Client died	0	(0)

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*
  - *Learn that anxiety is safe and manageable*

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 to Optimize IE for OCD

- Prolonged and intense trials
  - *Minimize breaks*
- Don't provide reassurance
  - *Psychoeducation: Therapist provides new 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*
  - *NOT SUDS reduction*
- Show confidence in IE and patient
  - *Early modeling of IE tasks*
  - *"Bring it on!" attitude (lean in to it!)*
  - *I know you can do this!*

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