



# The Nature of OCD Senseless mental stimuli (and external triggers) are misinterpreted as significant and threatening Based on mistaken beliefs Leads to obsessional fear Avoidance and rituals performed to reduce obsessional fear Avoidance and rituals are reinforced by the reduction in distress they engender Avoidance and rituals maintain obsessional fears by preventing changes in mistaken beliefs

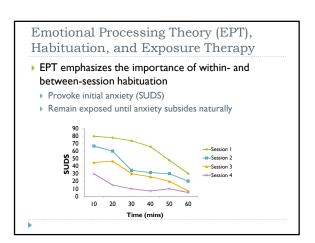
Treatment of OCD: ERP

OCD remits when patients come to believe their obsessions and fears are unfounded and act accordingly

Simply talking about probabilities is not as convincing as direct evidence from experience

Patients need to directly confront their fears (exposure) and drop their rituals (response prevention) to truly master them

Exposure & response prevention (ERP) is the most powerful intervention in the treatment of OCD



### Implications of EPT for OCD Patients

- It is assumed that patients improve if
- ▶ Self-reported anxiety (SUDS) decline during exposure trials
- Exposure to the same stimulus evokes less anxiety from one trial to the next

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## Is Performance During Exposure a Reliable Indicator of Learning?

- Although habituation usually occurs during exposure, it's not a good predictor of outcome
- Fear <u>expression</u> during learning is not the same thing as fear learning
- Decline in anxiety across similar exposures may predict, but is not necessary for, long-term improvement
  - Successful response to exposure can occur in the absence of habituation

Craske et al. (2008)

### Re-thinking Pathways to Long-term Success: An Inhibitory Learning (IL) Approach

- Research shows that fear associations remain intact during exposure while new safety learning is formed
  - > The old and new associations compete with one another
- Important to maximize the likelihood that safety learning will inhibit access and retrieval of fear associations
  - Violate negative expectancies
  - De-contextualize inhibitory associations

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## Consequences of Over-Relying on Habituation

- ▶ Can contribute to return of fear and relapse
  - ▶ Patients view anxiety/fear/arousal/obsessions as a problem
  - ▶ Exposure used to control anxiety
  - Sets up the expectation that lower-level anxiety is safer or easier than higher levels
  - ▶ Inevitable surges of anxiety and arousal viewed as a failure

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### Using Exposure to Foster Fear Tolerance

- ▶ If ERP can instill greater fear tolerance, inoculate patients against return of fear
  - Lapse vs. relapse
- ▶ How to set up exposures
- ▶ Opportunities to practice fear tolerance
  - OCD patients: "Make anxiety go down"
  - IL approach: "Learn that you can tolerate anxiety"
- "Bring it on" attitude!
- ▶ Be on the lookout...

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Techniques for Enhancing Inhibitory Learning during ERP

### 1. Frame ERP to Mismatch Expectancies

- Non-catastrophic exposure trials generate "non-threat" associations
- What are negative outcomes for OCD patients?
- ▶ Immediate
- ▶ Long-term
- Unknowable
- Intolerance of unpleasant internal experiences

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### Clinical Implications: Expectancy Tracking

- ▶ Set up exposure to violate expectancies, not SUDS
  - ▶ Strength of negative expectancy (90% sure X will happen...)
  - ▶ Level of distress tolerance
  - ▶ Length of time patient can resist ritual
- Consolidate learning by asking patients to summarize what they learned (i.e., the discrepancy between what was predicted and what occurred)

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	Time:			escription	OI task.					
1. Feared outcom	e of exposu	re ("wo	st case so	enario" h	ypothesis	to be test	ed):			
2. Safety behavio	rs to prever	ıt:								
3. How long do y	ou think yo	u can sti	ck with th	e task?;						
Every_ your ability to to	during the	exposur	e, rate the	(b) stren	gth of bel	ief in fear	ed outcom	ne, and (t	) confide	nce in
4. Anticipatory B	latings for (	a)		; (b)						
	Trial 1	2	3	4	5	6	7	8	9	10
(a) Belief										
(b) Confidence										
	11	12	13	14	15	16	17	18	19	20
(a) Belief										
(b) Confidence										
	21	22	23	24	25	26	27	28	29	30
(a) Belief						- 20				- 50
(b) Confidence										
5. What was the	outcome of	the expo	sure? Wh	at did you	i learn? (S	specificall	y address	#1 abov	:)	

### 2. Combine Fear Cues

- When an expected negative outcome fails to occur despite the presence of multiple fear cues, inhibitory learning is greater than when only a single fear cue is present
  - "Deepened extinction" (Rescorla, 2006)
- What are fear cues for OCD patients?
- External (contaminants, leaving the house, numbers, religion)
- Cognitive (obsessional thoughts, images, doubts)
- Physiological (arousal)

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### Clinical Implications: Multi-Media Exposure

- Include multiple fear cues and multiple media in exposures
- External fear cues along with imaginal exposure to the feared consequences of (or uncertainty about) doing so
  - $\,\,{}^{}^{}_{}^{}$  Ex:Touch public toilet and imagine getting AIDS one day
- External, cognitive, and physiological cues
  - ▶ Ex: Looking at teen bathing suit models, imagine engaging in sexual behavior, allow arousal to occur
- ▶ Consider interoceptive exposure to provoke arousal sensations

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### 3. Linguistic Processing

- Speaking about how one is feeling ("affect labeling") aids the development of non-threat associations
  - Different than cognitive therapy in which appraisals are changed

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### Clinical Implications: Put Feelings into Words

- Ask patients to label their feelings during exposure
  - "I'm feeling scared that reading about Jerry Sandusky's despicable behavior will cause me to become a pedophile"
  - "I am very afraid that when I touched the bathroom floor, I got urine and feces germs on my hands"
  - "I feel uncertain of whether God is angry at me for thinking curse words while sitting next to the bible"

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### 4. Maximize Exposure Variability

- Introducing variability into exposure makes shortterm learning more difficult, but enhances long-term retention and generalization of learning
- "Desirable difficulties"
- ▶ Challenges for therapists

(Bjork & Bjork, 2006)

### Clinical Implication:

- a) Variable Exposure Intensity
- Limitations of the traditional "gradual" exposure hierarchy
- ▶ Over-reliance on habituation
- Sets up the expectation that lower-level anxiety is safer or easier than higher levels
- ▶ Anticipation of high items reinforces fear of anxiety
- Alternative "variable" approach...

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### Clinical Implication:

- a) Variable Exposure Intensity
- Why vary exposure intensity?
- ▶ Tolerate exposure across a variety of emotional states
- More opportunities for "surprise"
- ▶ Preparation for real world settings
- In practice:
  - "To do list" as opposed to "hierarchy"
  - > Select at random (as much as possible)

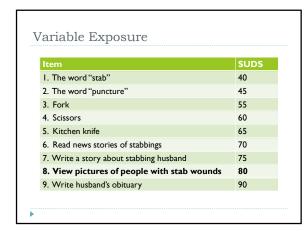
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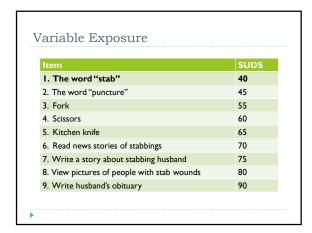
### Fear Hierarchy: Gradual Exposure

ltem	SUDS
I. The word "stab"	40
2. The word "puncture"	45
3. Fork	55
4. Scissors	60
5. Kitchen knife	65
6. Read news stories of stabbings	70
7. Write a story about stabbing husband	75
8. View pictures of people with stab wounds	80
9. Write husband's obituary	90

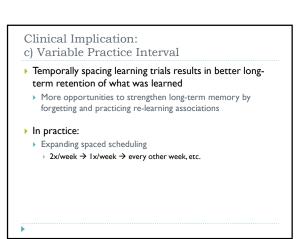
### Variable Exposure

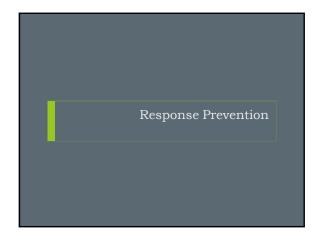
ltem	SUDS
1. The word "stab"	40
2. The word "puncture"	45
3. Fork	55
4. Scissors	60
5. Kitchen knife	65
6. Read news stories of stabbings	70
7. Write a story about stabbing husband	75
8. View pictures of people with stab wounds	80
9. Write husband's obituary	90

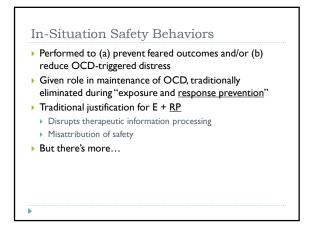




# Clinical Implication: b) Variable Exposure Contexts • Enhances accessibility and retrieval of new safety learning (e.g., cues) • In practice: • Patient practices exposure in as many contexts as possible • Situations and stimuli • Others present (therapist) • Other treatments (medication) • Time of day/week • Aim for practice in situations where symptoms are likely to be triggered







### Safety Behaviors Interfere with IL

Hypothesized to interfere with theoretical mechanisms of IL:

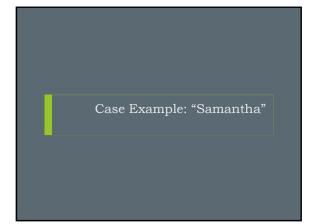
- Violate negative expectancies
- ▶ De-contextualize inhibitory associations
- ▶ Develop fear tolerance

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### Recommendations

- ▶ Continue response prevention
- At the patient's pace
- ▶ Consistent with "gradual" / "hierarchical" approaches
- ▶ Provide rationale for E + <u>RP</u>
- ▶ Tie in theoretical model of OCD
- ▶ Continued research will be helpful

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### "Samantha"

- > 30 yr old female (lives w/ husband)
- ▶ YBOCS = 27
- Obsessions: What if I "lose control" and murder loved ones, molest my nieces, or develop schizophrenia?
- Compulsions: Mental reassurance that personality isn't changing, mental phrases (e.g., "I'm ok"), reassurance from husband
- <u>Avoidance</u>: Potential weapons (e.g., knives), nieces, news stories about violence, information about mental illness
- Onset:Adolescence
- No history of abuse, violence, or other psychiatric diagnoses

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### Samantha's Exposure List

Item		SUDS
Read about schizophrenia		40
Write story about molesting nieces	85	
Hold knife next to cat		80
Rough-housing with young nieces		70
Write story about murdering husband		90
Read news stories about child molesters		60
Sleep next to husband with knives on nightstand		90
Read news stories about murderers		65

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### Samantha's Multi-Modal Exposures

Item

Read about schizophreni

Write story about molesting nieces while looking at pictures of nieces
Hold knife next to cat while listening to news story about psychotic break

Rough-housing with young nieces

Write story about murdering husband

Read news stories about child molesters after interoceptive exposure

Sleep next to husband with knives on nightstand

Read news stories about murderers

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## Samantha's Varied Context Exposures Item Read about schizophrenia before bed and while eating lunch Write story about molesting nieces Hold knife next to cat while anxiety sensation is high (e.g., after caffeine) Rough-housing with young nieces while mother is around and while alone Write story about murdering husband after argument or sad movie Read news stories about child molesters Sleep next to husband with knives on nightstand Read news stories about murderers

## Samantha's Response Prevention Goals Discontinuing "checks" and mental reviewing to test whether she is "normal" Fade out self-talk/phrases that assure she is "ok" Cutting back on asking husband questions

Discussion

How can we apply the techniques for enhancing inhibitory learning during ERP?

I. Expectancy tracking

2. Multi-media exposure

3. Linguistic processing

4. Variability in exposures

a) Order

b) Context

c) Practice intervals

