Community Education Series

The Recovery Village and Advanced Recovery Systems

ADVANCED RECOVERY SYSTEMS

an advanced approach to patient care

Presentation Topic:

Treating Obsessive-Compulsive Disorder with Exposure and Response Prevention Therapy: An Overview

Speaker:

Jordan A. Katz, MSW, LSW

About the Speaker:

Jordan A. Katz

MSW, LSW

- As a member of the Community Outreach team at The Recovery Village Cherry Hill at Cooper, Jordan is dedicated to helping clients, families, and organizations find quality treatment options. Before joining Advanced Recovery Systems in 2020, Jordan spent six years in public relations and marketing in New York City and nearly five years in behavioral health specializing in the treatment of OCD, anxiety disorders, and phobias in Houston and Philadelphia. Jordan holds a BA in public relations from Hofstra University and a Master of Social Work from Baylor University, where she graduated with top honors and was named Outstanding MSW Student of the Year. She is a Licensed Social Worker in NJ and PA. Jordan is a published researcher and maintains an active role in clinical research related to OCD, mental health stigma, and access to care. She is excited about the opportunity to engage with the community to raise awareness, provide education, and encourage hope in order to improve the lives of those living with substance use disorders and/or mental illnesses.

Obsessive-Compulsive Disorder: The Literature

- Chronic, debilitating disorder characterized by recurrent, intrusive thoughts, ideas, or images that are experienced as unwanted (obsessions), followed by repetitive acts or mental rituals performed to reduce resulting anxiety (compulsions) (American Psychiatric Association, 2000)
- Affects 2% of the global population (Bjorgvinsson, Hart, & Heffelfinger, 2007)
    - Fourth most common psychological disorder after depression, substance abuse, and phobias (Masellis, Rector, & Richter, 2003)
- May spend up to 10 years before seeking treatment (Rasmussen & Tsuang, 1984), due to fear of stigma (Simonds & Thorpe, 2003) or shame related to symptoms (Marques et al., 2010)
- Can take up to nine years for an individual to receive an accurate diagnosis, and up to 17 years to obtain effective treatment (Jenike, 2004)

ERP for OCD– The Evidence

- Specific form of CBT for OCD
- Most effective psychological treatment for OCD (Abramowitz, 1997; Lindsay, Crino, & Andrews, 1997; Mclean et al., 2001)
- Meta-analysis: 18 ERP conditions from 15 clinical trials found:
  - 68.8% of completers were improved (defined as between 30-50% improvement)
  - 38.2% of completed were recovered
  - Limitations: 30% don’t improve, 25% refuse treatment, and 20% drop out of treatment (Eddy, Dutra, Bradley, Westen, 2004)

Treatment Phases

- Phase 1 (Session 1+)
  - Assessment
  - Education
- Phase 2 (Session 2+)
  - Hierarchy and treatment planning
- Phase 3 (Sessions 3-15+)
  - Exposure and response prevention
- Phase 4 (Sessions 16-17+)
  - Relapse prevention and maintenance

Abramowitz, Deacon, & Whiteside, 2011

Assessment Skills

- Clinical interview
- Assessment tool examples
  - Y-BOCS
    - 10-item measure for obsessions and compulsions
  - DOCS
    - Measures for specific OCD categories (i.e., Scrupulosity)
- Cues, feared consequences, rituals (including mental rituals), avoidance (including passive avoidance)
- Behavioral observance
- Self-monitoring

Abramowitz, Deacon, & Whiteside, 2011

Assessment Questions

- Identifying cues
  - What intrusive thoughts, images, or urges do you have?
  - When you have these thoughts, images, and urges, do you feel anxious?
  - When do you have these intrusive thoughts, images, or urges?
- Identifying rituals
  - When you have these thoughts, images, or urges, what do you do to: a) decrease your anxiety, b) get rid of the thoughts, images, or urges, or c) minimize the likelihood of _____ (feared consequence)?
- Identifying feared consequences
  - If you had to _____ (act that causes anxiety) and couldn't _____ (ritual), what are you worried would happen?
- Identifying avoidance
  - Are there any situations that you avoid because you don't want to feel anxious or have intrusive thoughts, images, or urges?

Abramowitz, Deacon, & Whiteside, 2011

Examples of Cues, Feared Consequences, Rituals, and Avoidance

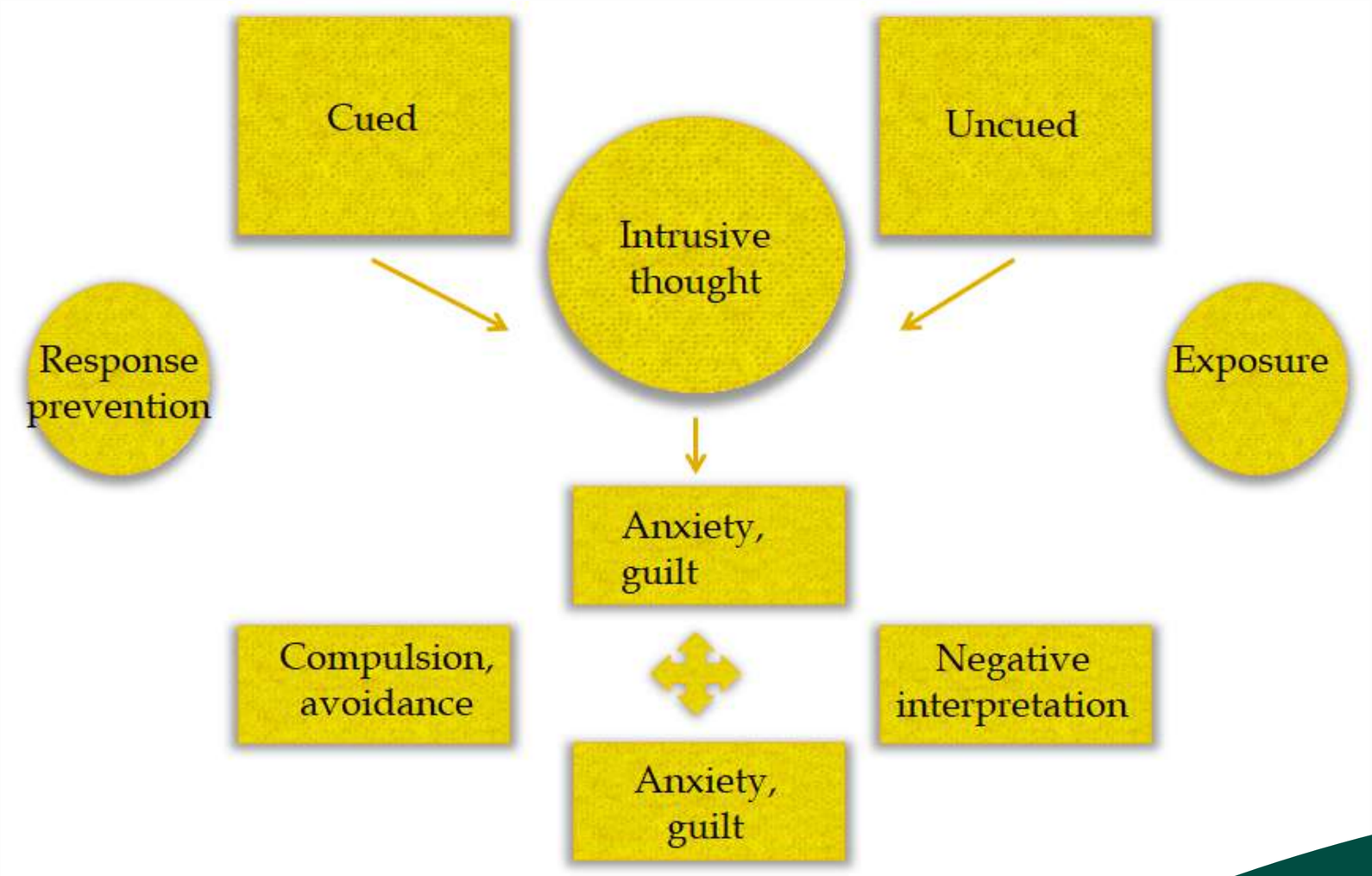
Situation	Feared consequence	Rituals	Avoidance
Touch faucet in public bathroom	Contract HIV and die	Wash hands excessively, use hand sanitizer	Avoid dirty public bathrooms, touch faucets with paper towel
Holding knife	Stab husband, kill him, and go to jail	Mental reviewing, checking husband's safety	Avoid using knifes when alone with husband

Abramowitz, Deacon, & Whiteside, 2011

Education About OCD

- Definitions: obsessions and compulsions
  - Obsessions: repeated and intrusive thoughts, images, or urges that increase anxiety
  - Compulsions: behaviors (mental or observable) used to decrease anxiety (American Psychiatric Association, 2000)

OCD Model



Abramowitz, Deacon, & Whiteside, 2011

Education About ERP

- OCD is treatable with ERP
- Helps to break the association between
  - Obsessions and anxiety
  - Compulsions and anxiety
- Challenges clients' automatic thoughts
  - Anxiety will not remain indefinitely, anxiety comes down
- Help clients understand that ERP is a form of CBT of OCD

Abramowitz, Deacon, & Whiteside, 2011

Phase 2 (Session 2)

Hierarchy and Treatment Planning

Subjective Units of Distress (SUDs Scale)

Personal scale of anxiety (1-10)

1 (none) 5 (mild) 10 (maximum)

Hierarchy Creation Skills

- Can be single or multiple hierarchies
- Include situations, thoughts, and images as described by the client
- Can consist of 10-20 items
- Include information from Y-BOCS, cues, obsessions, feared consequences, avoidance, and self-monitoring
- Ask clients to rate: “Assuming no ritualizing, how anxious would you feel if you _____ (act that causes anxiety) and didn’t _____ (ritual)?”

Abramowitz, Deacon, & Whiteside, 2011

Hierarchy Example

- A 25 y/o male has obsessions and compulsions around germs and disease. One of his fears is that he will contract HIV and die. He no longer touches doorknobs in public, uses public restrooms, and has a hard time going grocery shopping out of fear that his food will be contaminated by all of the people who touch the food boxes. His fear has become so intense that he avoids social activities in public and begins to find everyday tasks very difficult. Any time he is triggered by this fear of getting sick, he excessively washes his hands, body, and/or clothes depending on what was touched or came into contact with.
- Hierarchy Development
  - 1-3: Lower level exposures: Shaking hands, touching a doorknob, etc.
  - 4-7: Mid-level exposures: Using a public restroom, going to the grocery store and buying food, etc.
  - 8-10: High-level exposures: Using a restroom at a sporting event, visiting an HIV clinic, etc.

Phase 3 (Sessions 3-15)

Exposure and Response Prevention

In-Vivo Exposures Procedure Skills

- Elicit fear cue (thought, image, situation)
- Start with Subjective Unit of Distress Scale (SUDS) measures around 3-4
- Important to ask client to rate SUDS every five minutes
    - Encourages client to focus on their feelings associated with the exposure
- Exposure to feared situations, obsessions, and feared consequences (i.e., knife, contaminated item)
- Ensure that client is not ritualizing while engaging in exposure
- Ask client to focus on feared consequence
    - Helps client to work through thoughts and feelings about anxiety

Abramowitz, Deacon, & Whiteside, 2011

Post-Exposure Processing

- If client’s anxiety decreases
  - Discuss lessons learned about anxiety and feared consequences
- If client’s anxiety did not decrease
  - May need longer or more exposures
  - Repeated practice (i.e., between session exposures is more important than within session exposures)
  - Client might be ritualizing, cognitive rituals
  - Possible wrong cue, or cue too hard to begin with

Abramowitz, Deacon, & Whiteside, 2011

Imaginal Exposure

- Used when
  - Need to prepare for live exposures
    - A client may not be ready for in-vivo exposures
  - Specific consequences (i.e., stabbing someone and going to jail)
  - Consequences occur in distant future (i.e., dying from illness)
  - Combined with live exposures for better treatment outcomes

Abramowitz, Deacon, & Whiteside, 2011

Homework Assignments

- Assign similar or same exposures
- Ask client to spend approximately one hour conducting exposure outside of session
- Ask client to record pre-, peak, and post-anxiety level while engaging in exposure

Abramowitz, Deacon, & Whiteside, 2011

Phase 4 (Sessions 16-17+)

Relapse Prevention and Maintenance

Relapse Prevention and Maintenance Skills

- Review progress
  - Rate hierarchy again
  - Assessment measures (i.e., Y-BOCS, DOCS)
- Review important points
  - Anxiety decreases
  - Can cope with anxiety and not lose control
  - Feared consequence didn’t happen, but if it did client coped well
  - Will likely have obsessions, but client is aware of how to respond to them (i.e., ignore obsessions, work through anxiety)
- Preparing for the future
  - Present different scenarios and discuss how to respond
  - Design future exposures (higher hierarchy ratings)
  - Plan for relapse

Abramowitz, Deacon, & Whiteside, 2011

Specialized Training

- Attend workshops or trainings offered by the International OCD Foundation (IOCDF)
  - Behavior Therapy Training Institute
  - Annual OCD Conference
- Become members of
  - International OCD Foundation (IOCDF)
  - Association of Behavioral and Cognitive Therapists (ABCT)

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Questions?

THANK YOU