



Common Pitfalls in ERP for OCD

©Justin K. Hughes, MA, LPC & Molly Martinez, PhD

**Thank you for being here sufferers,
support, family, professionals.**





Common Pitfalls in ERP for OCD

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HELLO!



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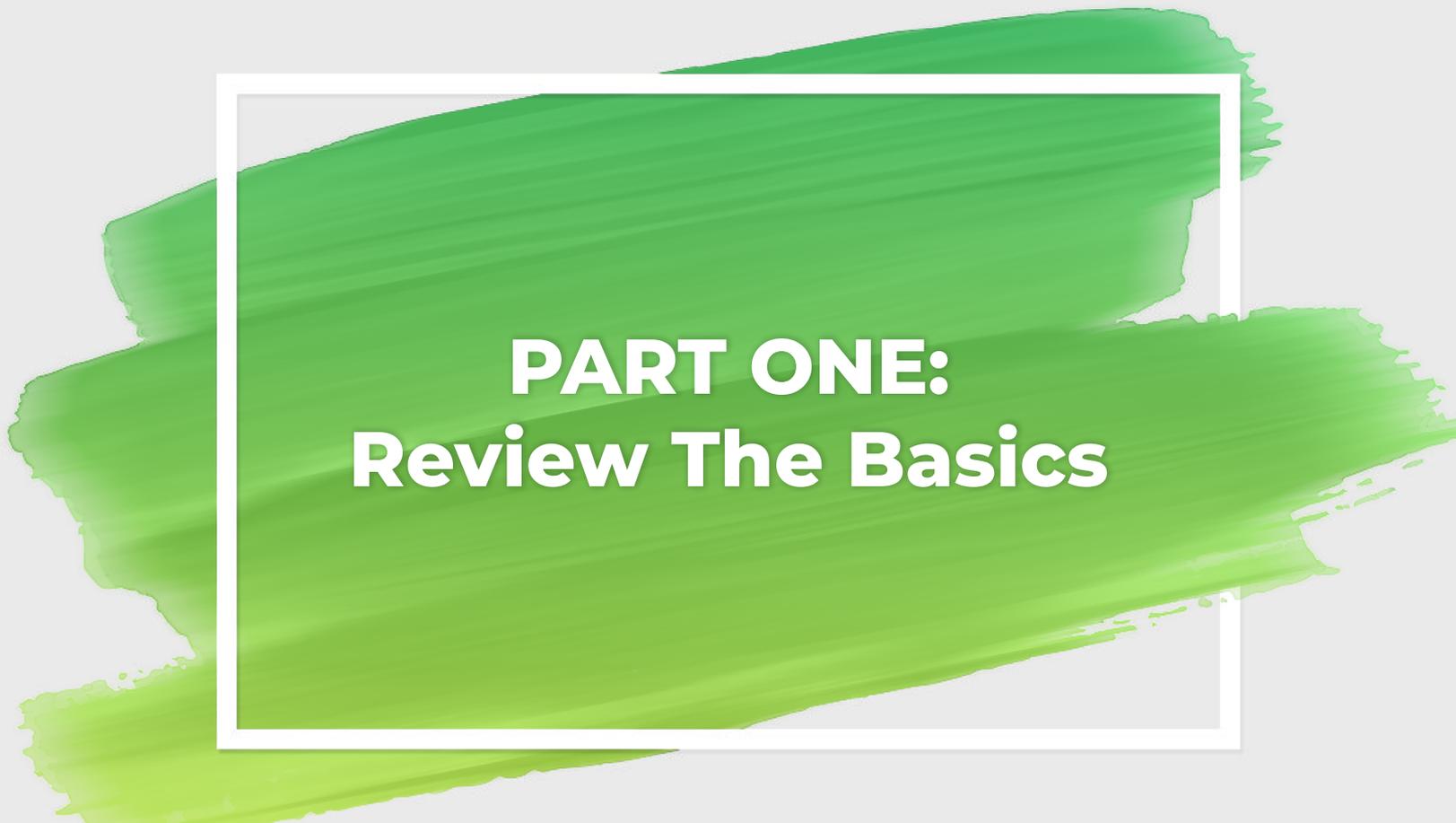
www.soartgether.net
Richardson, TX

Learning Objectives

- 1) Overview OCD and ERP
- 2) Identify roadblocks to effective ERP
- 3) Identify solutions to address these common pitfalls

Want these slides right now???

www.justinkhughes.com/ocd

The background features three horizontal brushstrokes in shades of green, ranging from a vibrant lime green to a slightly darker forest green. A white rectangular frame is superimposed over the middle stroke, containing the text.

PART ONE:
Review The Basics

A large, vibrant green brushstroke graphic that sweeps across the left side of the slide, partially overlapping a white rectangular frame.

**PART ONE:
Review the
Basics**

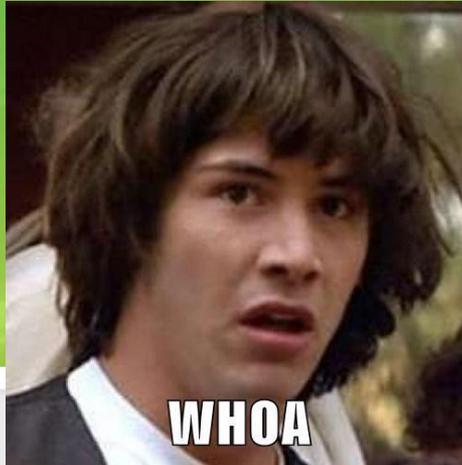
You Probably Know...

- What OCD is
- What ERP is
- That ERP is the gold-standard of evidence-based treatment for OCD

For a PRIZE...

**What is the average amount of
symptom reduction after a trial of ERP
for OCD?**

60-70%!!



(Abramowitz & Jacoby, 2015; Foa et al., 2010)



**PART ONE:
Review the
Basics**

You Might Know...

- Compulsions function by reducing distress via:
 - Reassurance
 - Avoidance
- ERP is hard
- ERP requires planning
- ERP requires adjustment
- ERP doesn't always work as expected



**PART TWO:
ERP Pitfalls &
Solutions**



PART TWO: ERP Pitfalls & Solutions

- Fear-Related Issues
 - Therapists' Fears
 - Not Addressing the Core Fear
 - Clients' Fear of Distress
- Covert Compulsive Behaviors
 - Reassurance
 - Mental Compulsions
 - Distraction
- Treatment Plan(ning) Problems
 - Treatment Compliance
 - Not Going Far Enough
 - Not Working with Family
 - Wrong Form of Exposure
 - Unrealistic Expectations (Extinction Burst) Medication Myths/Misconceptions
 - Detours & Comorbidities
 - Therapy "Dosing"
 - No Relapse Prevention Plan



Fear-Related Pitfalls & Solutions

For a PRIZE...

**Whose responsibility is it to
manage fear in ERP?**

Whose fear is being managed?

Answer Options:

a) Patient b) Therapist c) Both



**Pitfall:
Therapists'
Own Fears**

It's well documented: Exposure is Gold Standard for OCD and First Line for Anxiety Disorders. But...

- Exposure is underutilized (Sars et al. 2015), *especially in treating children* (Whiteside et al., 2016)
- Therapists sometimes struggle to implement exposures (Gillihan et. al, 2012)
 - a. Practicability in Outpatient
 - b. Therapist distress (Pittig et al., 2019)
 - c. Negative perspectives (Olatunji et al., 2019)



**Pitfall:
Therapists'
Own Fears**

Examples of therapists' negative views:

- a) “Insensitive”
- b) “Rigid”
- c) “Ineffective”
- d) “Potentially iatrogenic”
- e) “Not...real world”
- f) “Unethical” (Sars et. al 2015)

A close-up photograph of a woman with long dark hair, her face partially obscured by her hand as she covers her eyes. She has a pained or frustrated expression, with her mouth slightly downturned. The background is a plain, light-colored wall. The image is framed by a white border with purple decorative elements on the left and right sides.

**THERAPIST: ASKED MY CLIENT
TO RAMP UP THEIR EXPOSURE WORK**

THE CLIENT SAID I'M MEAN



**Solution:
Therapists'
Own Fears**

What can we do?

Advocate for good treatment!!

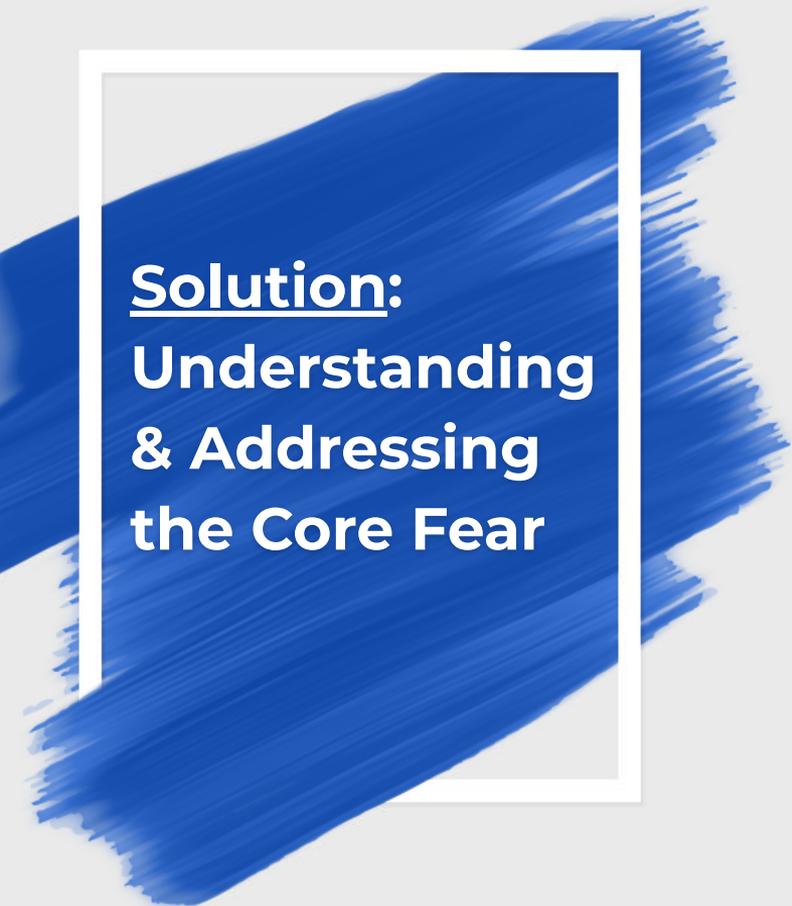
- Ask good questions up front, but also ask about your treatment plan and if you are going as far as you need to.
- The IOCDF has a wonderful article entitled “How to Find the Right Therapist”

Advocate for others- invite them to events like this, tell them of the help that exists.

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**Pitfall: Not
Understanding
& Addressing
the Core Fear**

- OCD is a shape-shifter
 - Obsessions & compulsions often change
- ERP can be a game of “Whack-A-Mole”
 - Chasing specific obsessions/compulsions
 - Get one thing conquered & another pops up
- Typically there are one or more themes that show up & which point to a Core Fear



Solution:
**Understanding
& Addressing
the Core Fear**

- UNCERTAINTY is the common thread
- FOCUS: Tolerating the distress associated with UNCERTAINTY
 - Am I a bad person?
 - Will I go to hell?
 - Will I/my loved one die/get sick?
 - Will I lose something important?
 - Will I never feel “right”
- Core Fears can change over time
- **Design ERP around the Core Fear**
- Downward arrow technique to find the Core Fear

Solution:
**Understanding
& Addressing
the Core Fear**

Downward Arrow Technique

Compulsion: Checking that the stove is off.

Obsession: I might have left the stove on.

[So what?]



My apartment might catch on fire
& I'll lose everything/others will get hurt.

[So what?]



That would be irresponsible/careless/imperfect

[So what?]



This is evidence that I'm a bad person;
I might go to jail/hell



**Pitfall:
Clients' Fear
of Distress**

Fear Reduction as a focus of treatment can be problematic.

- A fine ***long-term*** goal is to reduce anxiety
- Anything ***in-the-moment*** used to *make fear go away* is **just another compulsion!!!**
 - Reinforces you need to fear it!
 - Relaxation training is *not* a specific treatment for OCD.



Hard to
swallow
pills



**EXPOSURE &
RESPONSE PREVENTION**

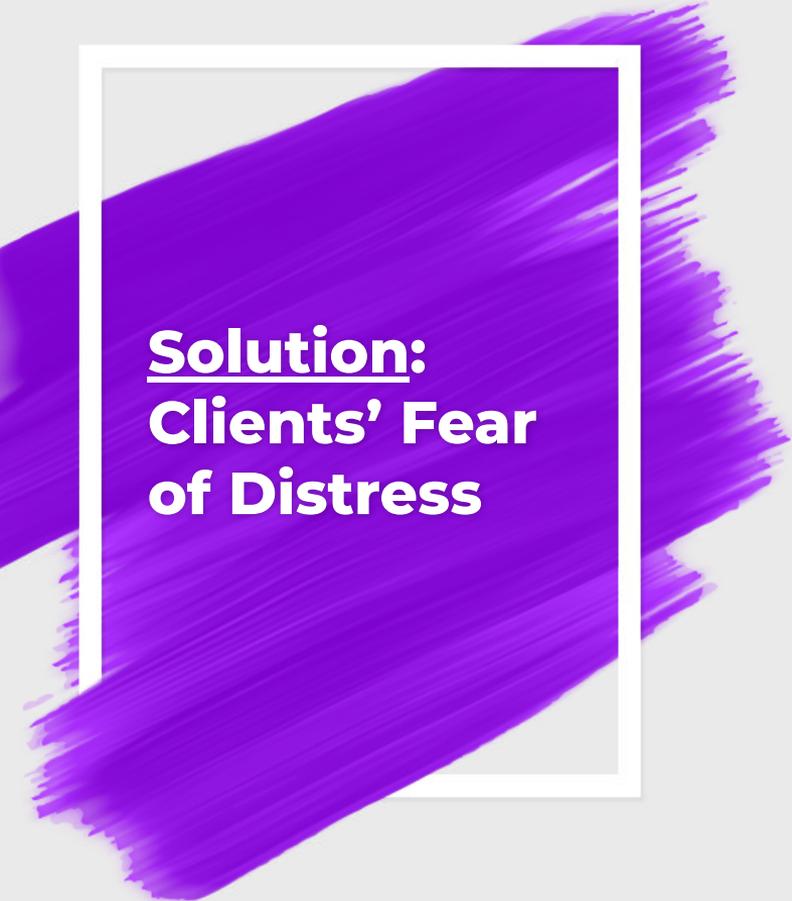


**Solution:
Clients' Fear
of Distress**

Helps:

- Psychoeducation:
 - Mechanisms of change:
 - Inhibitory learning
 - Fear habituation and extinction (Craske et al., 2014)
- Teaching skills to sit with distress:
 - Acceptance
 - Commitment
 - Distress Tolerance (Hezel et al., 2019)

We maintain fear when we avoid it.

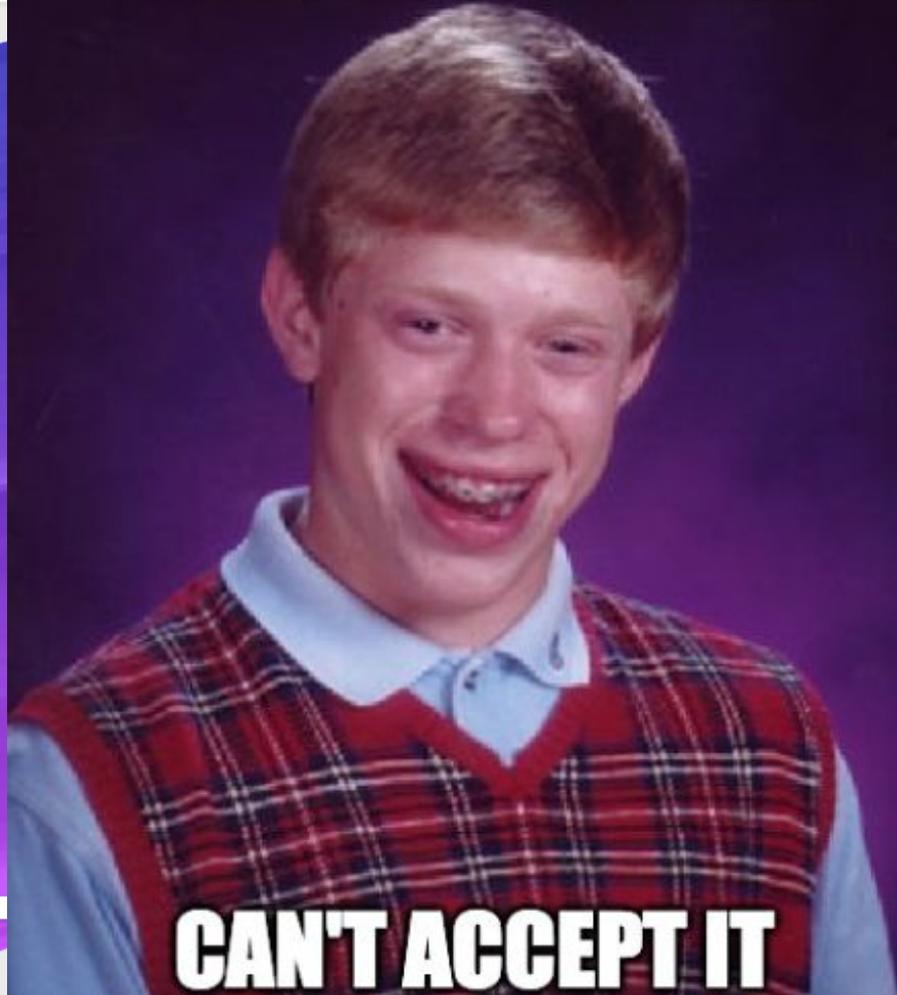


**Solution:
Clients' Fear
of Distress**

Adjuncts to bolster CBT / ERP (or when ERP cannot be tolerated / accessed):

- Cognitive Therapy for cognitive features (thought-action-fusion, intolerance of uncertainty)
- Acceptance and Commitment Therapy (ACT)
- Dialectical Behavior Therapy (DBT)
- Motivational Interviewing (MI)
- Family therapy work
- Cognitive Therapy with Behavioral experiments
- Support groups, reading, podcasts

TRIES ACCEPTANCE

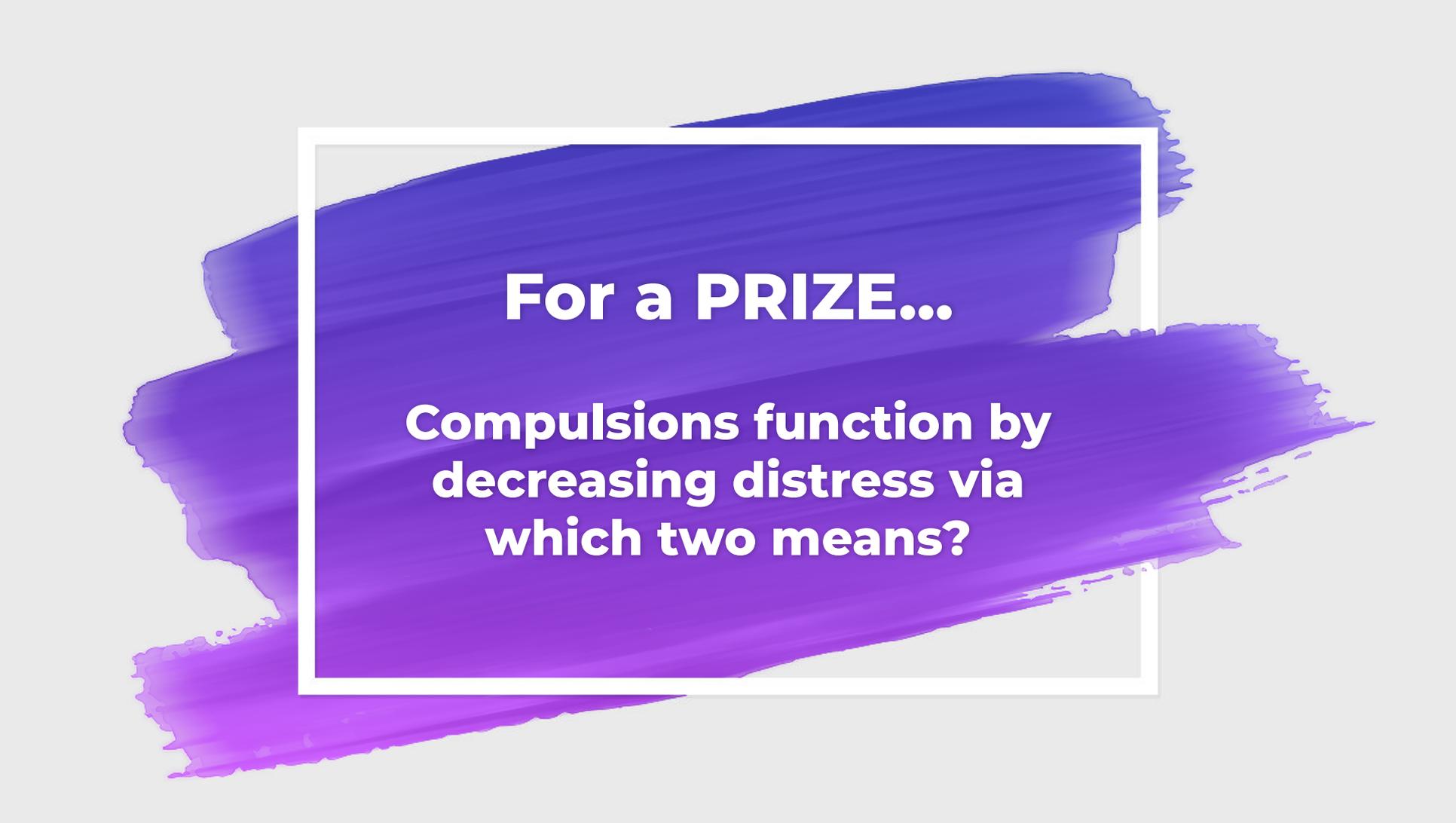


CAN'T ACCEPT IT



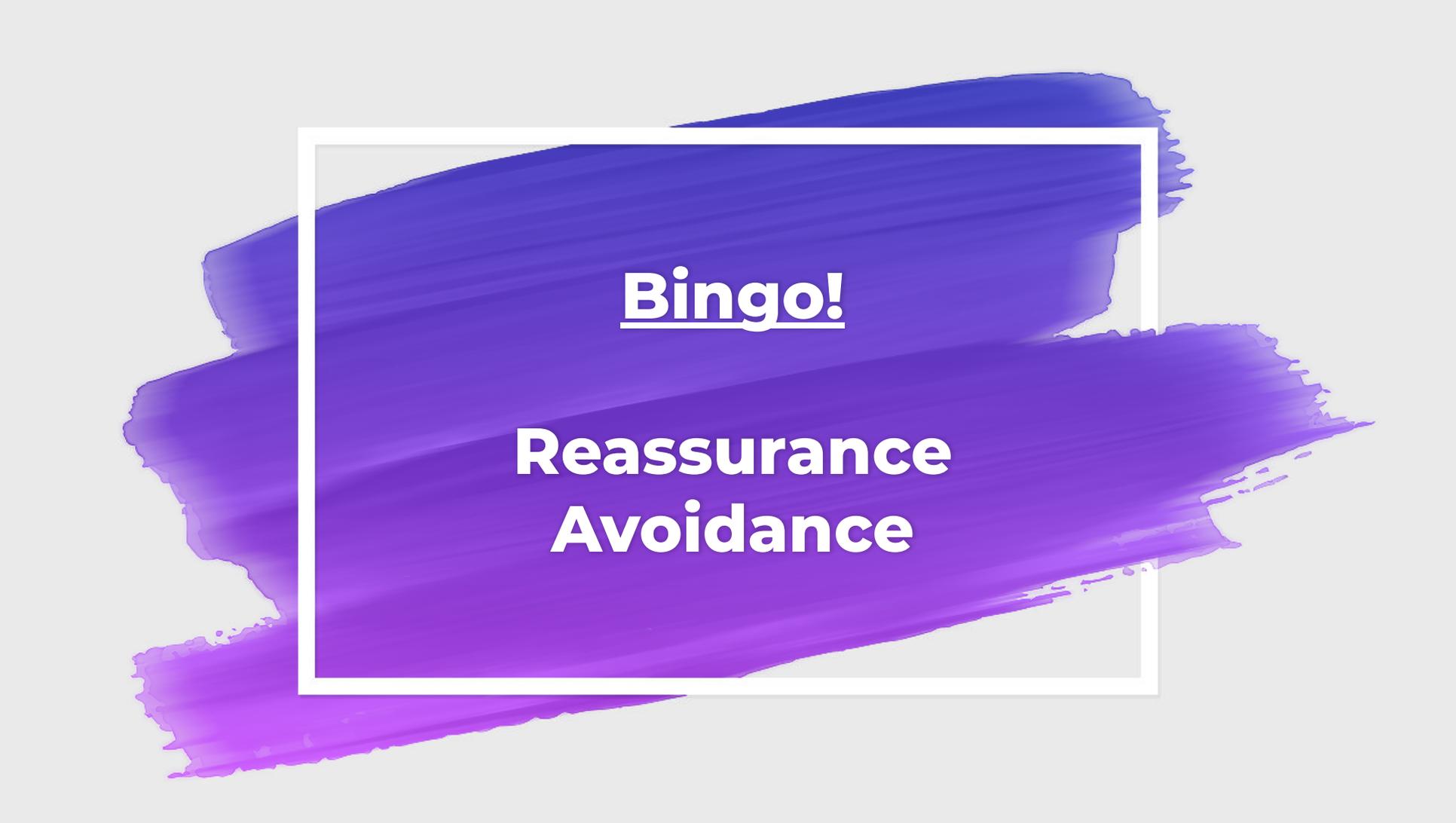
Covert Compulsions

(Keep the “RP” in ERP!)



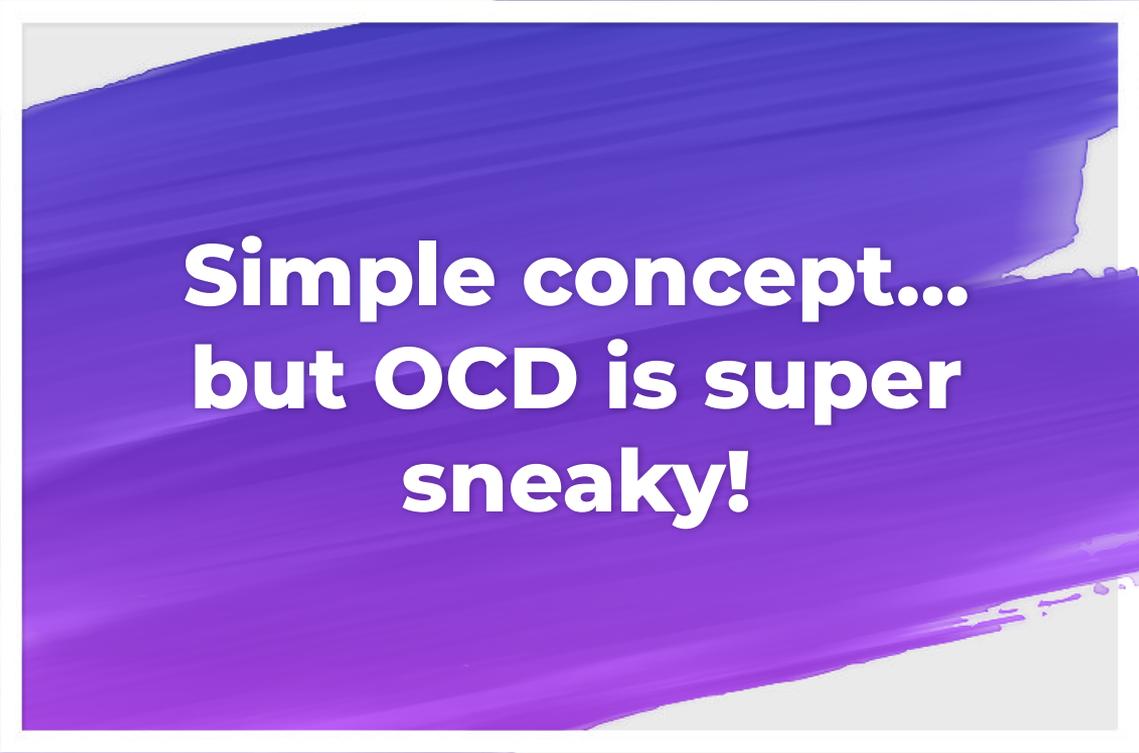
For a PRIZE...

**Compulsions function by
decreasing distress via
which two means?**



Bingo!

**Reassurance
Avoidance**

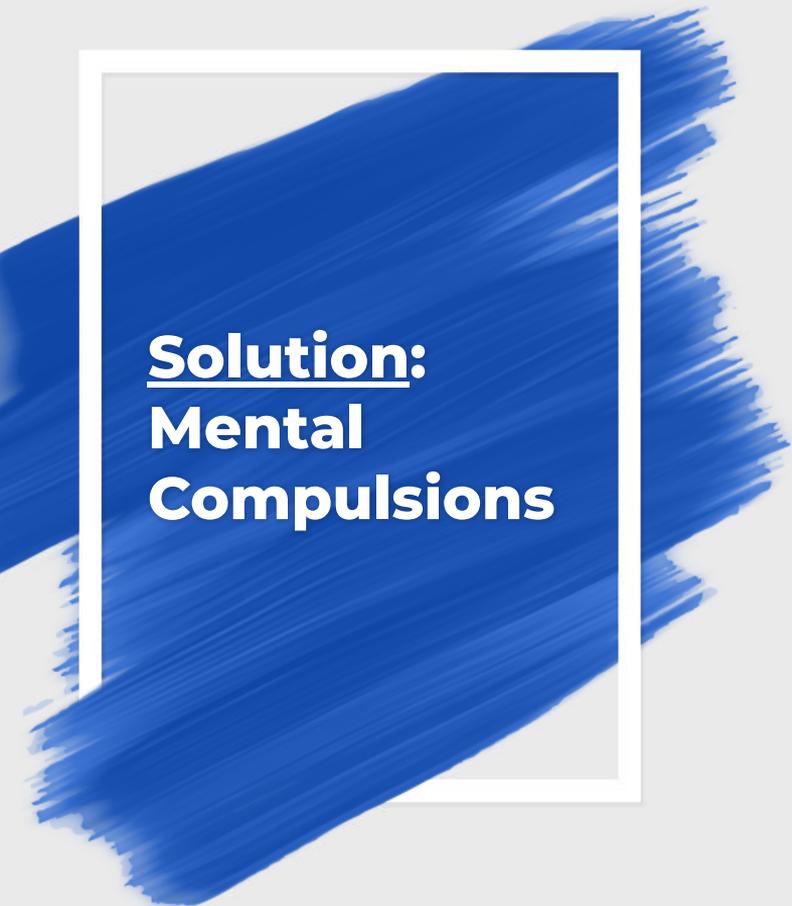


**Simple concept...
but OCD is super
sneaky!**

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**Pitfall:
Mental
Compulsions**

- Mental (or “internal”) compulsions may be undetectable by others & unrecognized by the sufferer
- Difficult to distinguish between obsessions & mental compulsions
- “Pure O”
- Review: Compulsions decrease distress via reassurance or avoidance
- Examples: praying, counting, analyzing, figuring out, neutralizing, mentally undoing, memorizing, checking/scanning body for sensations/emotions



**Solution:
Mental
Compulsions**

- Be open to the possibility that covert compulsions may be lurking
 - Stop and re-evaluate
 - Every new piece of info about your OCD is a victory!
 - ERP does not have to be perfect to be effective
- Utilize Competing Responses & Scripts
 - But mix it up! (Careful not to form new compulsions!)

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**Pitfall:
Providing
Reassurance**

Reassurance- an attempt to remove doubts or fears through comment or action (Oxford Dictionary)

- OCD reassurance goes beyond typical reassurance in day-to-day life

Persistent Reassurance-seeking is *common in OCD*

- Most patients involve others in reassurance; helps to manage uncertainty (Jacoby et al., 2013)
- Those with sexual & religious obsessions are most likely to seek reassurance (Williams et al., 2011)



**Pitfall:
Providing
Reassurance**

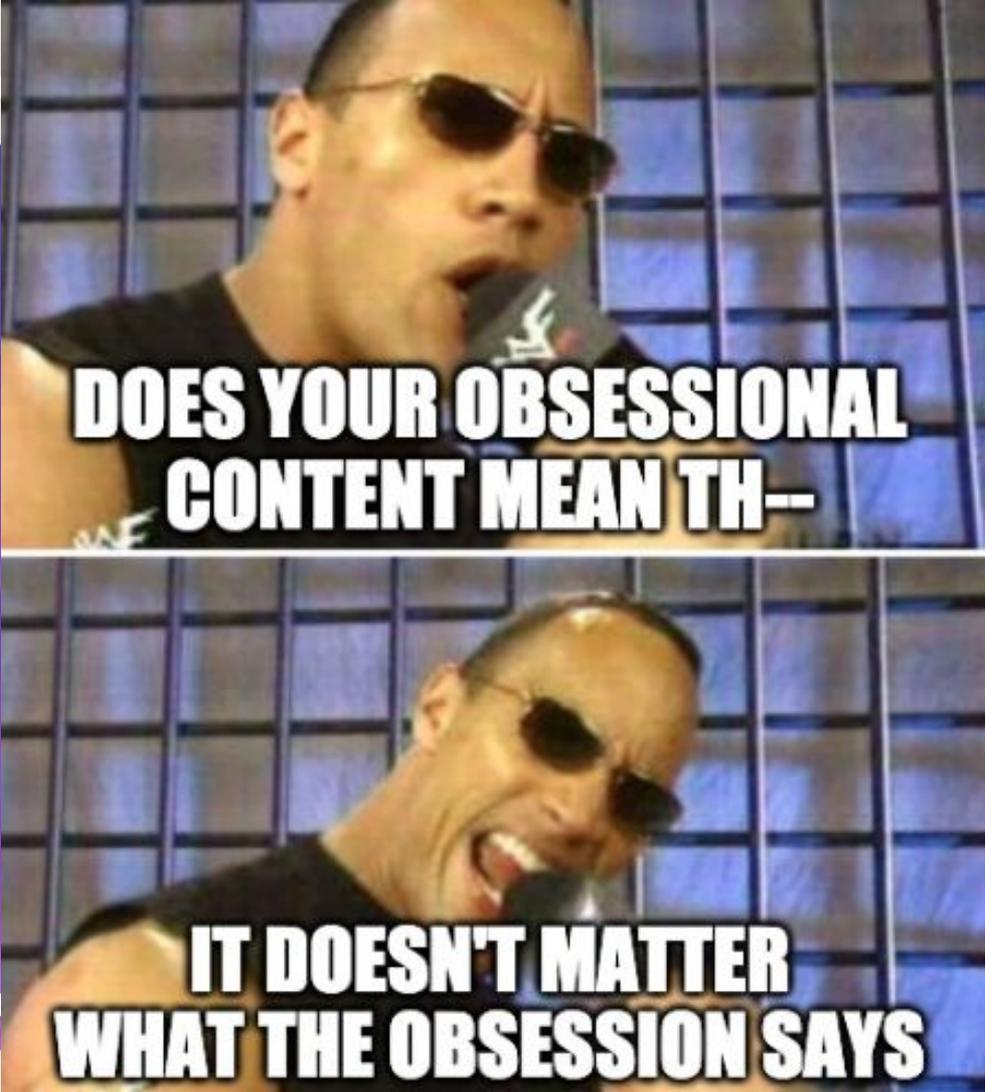
Client: “You’re sure this is OCD?”

Therapist: “Yes, because you are endorsing ego-dystonic.....wait a second....”

The Problem? *How Uncertainty and Doubt function in OCD.*

Solution:
Not
Providing
Reassurance

- First and Foremost- acknowledge It's COMPULSIVE
 - Anterior Cingulate Cortex (ACC) has problems “shifting” from emotional connections to executive reasoning
 - It FEELS like you're stuck in OCD.
 - The “Doubting disease” is exacerbated with more attempts to “feel” certain.
- We must lean into the discomfort of *not knowing* & not feeling reassured - **content doesn't matter** (Gruner et al. 2017)



**DOES YOUR OBSESSIONAL
CONTENT MEAN TH--**

**IT DOESN'T MATTER
WHAT THE OBSESSION SAYS**



**Solution:
Not
Providing
Reassurance**

Not giving reassurance is often counter-intuitive, especially in therapy!!!!

To be clear: Rituals (Compulsions including Reassurance) *must* be terminated to make long-term progress.

- This work often involves training family and loved ones to help not give reassurance (accommodation).
- We have to learn how to not give reassurance with structure/support.

**Distinguishing Information-Seeking
and Reassurance Seeking**

<i>An information-seeker:</i>	<i>A reassurance-seeker:</i>
Asks a question once	Repeatedly asks the same question
Asks questions to be informed	Asks questions to feel less anxious
Accepts the answer provided	Responds to an answer by challenging the answerer, arguing, or insisting the answer be repeated or rephrased
Asks people who are qualified to answer the question	Often asks people who are unqualified to answer the question
Asks questions that are answerable	Often asks questions that are unanswerable
Seeks the truth	Seeks a desired answer
Accepts relative, qualified, or uncertain answers when appropriate	Insists on absolute, definitive answers whether appropriate or not
Pursues only the information necessary to form a conclusion or make a decision	Indefinitely pursues information without ever forming a conclusion or making a decision

Developed at the Anxiety Disorders Center, Saint Louis Behavioral Medicine Institute

FREE Resource (Developed at the Center for OCD and Anxiety-Related Disorders, Saint Louis Behavioral Medicine Institute)

“[Distinguishing Information-Seeking and Reassurance Seeking](#),” find @ www.justinkhughes.com/ocd

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Pitfall:
Distraction
During
Exposures

Distraction during exposure may limit fear disconfirmation.

Don't. Do. It.
Stay PRESENT.

Examples:

- Thinking about other topics
- Emotional distancing or “blinking out”
- “White knuckling”
- Games with children that lead to forgetting the exposure.
- Any activity that demands too much attention other than the exposure



**Pitfall:
Distraction
During
Exposures**

Distraction can create:

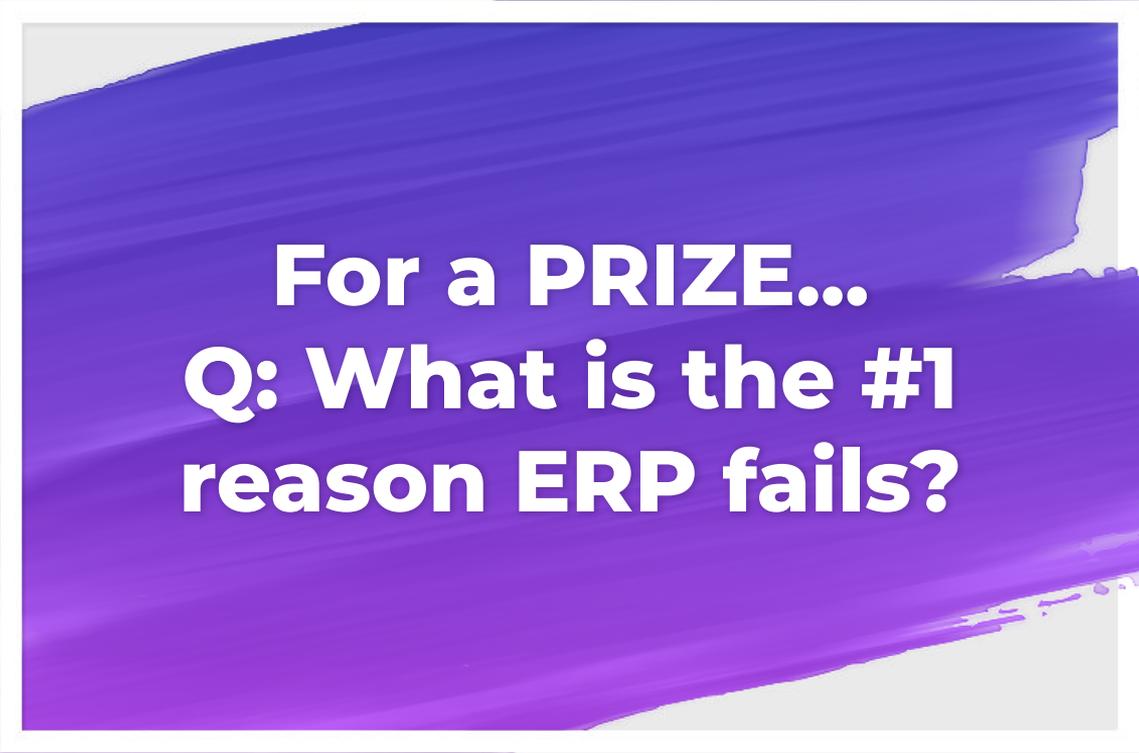
- Self-efficacy interference
- Mixed message - client cannot tolerate higher levels of anxiety or uncertainty (i.e., interferes with disconfirmation)
 - *We are going for expectancy violation- don't let distraction get in the way of this!!!!*

Solution:
Not
Distracting
During
Exposures

“The goal of exposure in EX/RP is to face the obsession-provoking stimuli head-on, without tricks or subtle forms of avoidance.... Exposure works better when patients focus their attention on the feared stimulus rather than distracting themselves during exposure” (Gillihan et al., 2012).



**Treatment
Plan(ning)
Pitfalls & Solutions**



For a PRIZE...
Q: What is the #1
reason ERP fails?



Bing-Bing-Bing!

**A: Treatment
Noncompliance**



**Pitfall:
Treatment
Noncompliance**

- **#1 reason therapy “fails”**
- Attending therapy is not enough - Practice is critical
- Barriers to practicing ERP
 - Too hard?
 - Too aversive?
 - Treatment ambivalence?
 - Lack of faith that it will work?
 - Time management?
 - Need a support person?
 - Do you understand rationale?

(Abramowitz & Jacoby, 2015)



**Solution:
Treatment
Compliance**

- Be honest with your provider
- Problem solve
- Review rationale & objectives
- Utilize supports
 - Adjust practice goals
 - Calendar/reminders
 - Apps (e.g., NOCD)
 - Recruit support
- Trial and error

“Never, never, **never** give up.”

- Winston Churchill



**Pitfall:
Not Going
Far Enough**

How Much OCD Do We Get Rid Of?

- First, we need to understand OCD's chronic and/or episodic course.
- To be most effective in the long-term, **ALL rituals/avoidance** must be addressed.

TERMINATE



COMPULSIONS

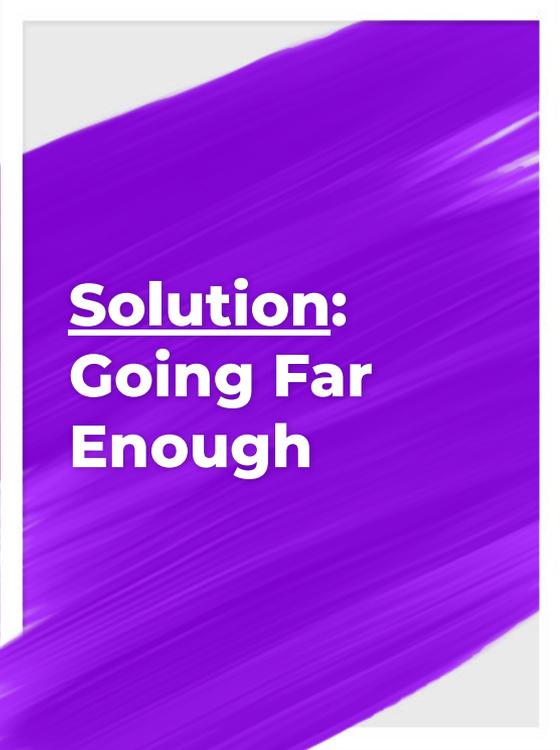


**Pitfall:
Not Going
Far Enough**

Realistically, all rituals are often not addressed in therapy.

- Why? The evidence is so clear!
 - Patients may not be educated or see the value
 - Clients may protest that “a person without OCD wouldn’t do that.”
 - Early termination
 - Feeling better
 - Therapists can be guilty of giving in to hesitation or difficulty seeing their patients distressed.
 - Other reasons unknown.

Don’t let the OCD ‘infection’ spread!!



**Solution:
Going Far
Enough**

Helps for therapists and family:

- Gentle confidence goes a long way
- Sometimes patients just can't/won't go further. A therapist or support can help identify something helpful that *can* be done.
- Utilize adjuncts (ACT, MI, etc.) to facilitate buy in. We all are motivated by something:
 - Goals, Values, Commitments
 - Consequences



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**Pitfall:
Not Working
With
Significant
Others &
Family**

- Recovery happens within a system; therapy must incorporate that system
- Most families provide at least some reassurance or modification of routines and activities.
- **Family Accommodation (FA):** “ways in which family members take part in the performance of rituals, avoidance of anxiety-provoking situations or modification of daily routines to assist a relative with OCD”
 - Strongly associated with symptom severity, especially for children
 - Impairs families’ quality of life

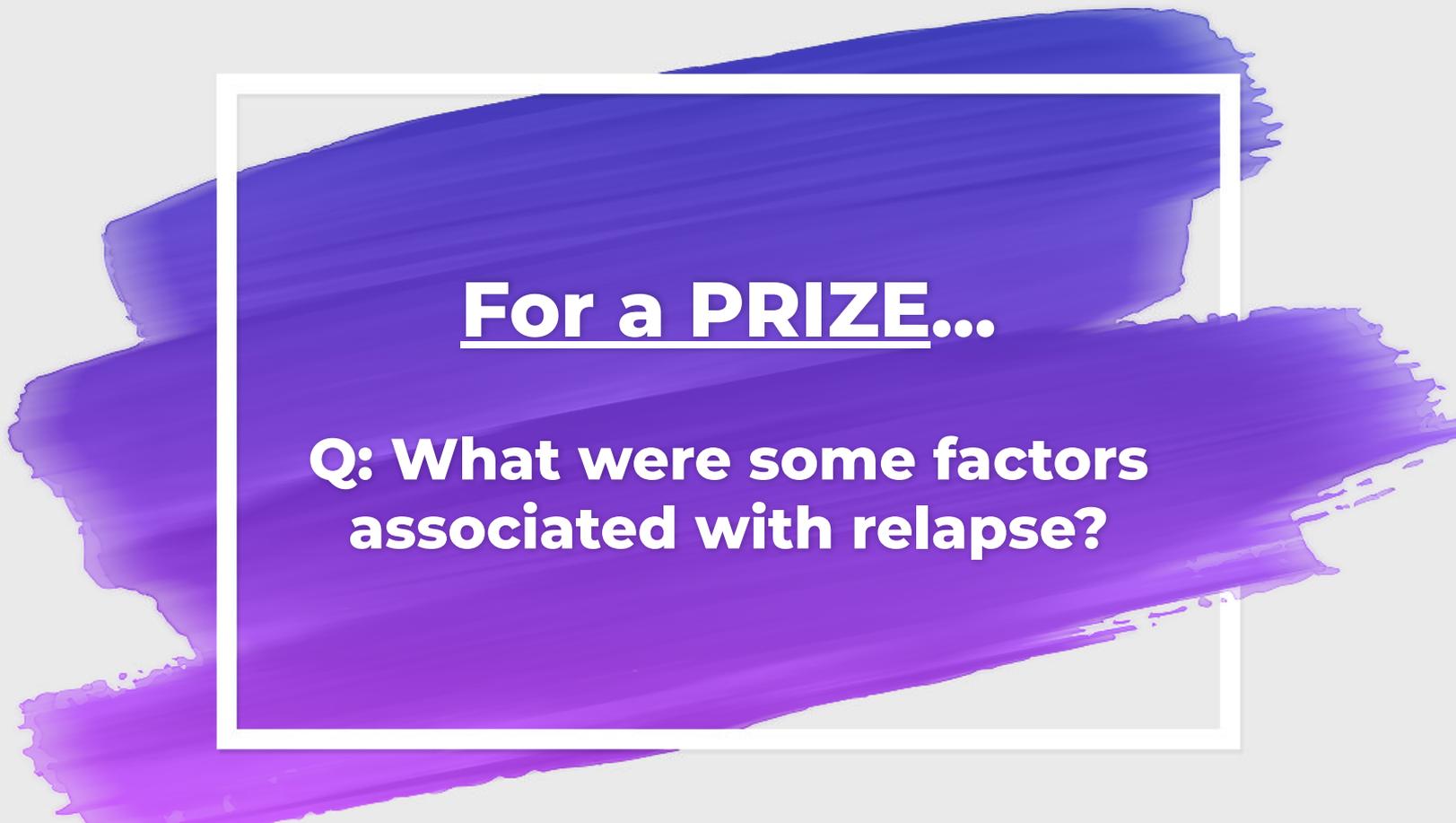
(Lebowitz, et al., 2012)

Case Example

**Pitfall:
Not Working
With
Significant
Others &
Family**

**Dog phobic 9 yo girl, successfully
treated in 16 sessions**

**Returned 1 year later with
symptoms as severe as initial
presentation. WHY?**



For a PRIZE...

Q: What were some factors associated with relapse?

You guessed it!

- **Family Accommodation**
- **Reassurance**
- **Avoidance/Escape**
- **Not incorporating mom into exposure therapy**



**Solution:
Working With
Significant
Others &
Family**

- Family psychoeducation helps get everyone on the same page/plan
 - Collaborate on a plan to reduce FA (gradually!)
 - Teach loved ones to support ERP
 - Avoid exacerbating OCD or aggression & negative reactivity (Lebowitz et al. 2012)
- **Supportive Parenting = Acceptance + Confidence**
(Lebowitz & Omer, 2013; SPACE)
 - Acceptance: “I understand this is really hard/you are very anxious”
 - Confidence: “I know you can do this”



**Pitfall:
Wrong Form
of Exposure**

Quick overview:

4 types of exposure:

1. In-Vivo
2. Imaginal
3. Interoceptive
4. Virtual Reality

(Watch: “The 4 Types of Exposure Therapy”
Video @ www.justinkhughes.com/ocd)

In-Vivo (Situational) and Imaginal Exposures
are most commonly used in OCD

- VR is very useful in Flying Phobia,
and Interoceptive exposure is
important with Panic Disorder



**Solution:
Right Form
Exposure**

Pair the right exposure for the obsession you are treating.

- Sickness related to touching items in the grocery store?
 - Typically In-vivo.
- Fear of “snapping” and killing someone?
 - Typically Imaginal.
- Fear running someone over with your car?
 - In-vivo and Imaginal sometimes simultaneously.
- Obsession you are a pedophile?
 - In-vivo for avoidances and Imaginal for thoughts.



**Solution:
Right Form
of Exposure**

Combining In-Vivo and Situational provides a powerful force and useful variation.

*When you can disconfirm fears in “real time” situationally, this is **ideal**.* However, there are typically core fears in every obsession that require imaginal exposure to access an anticipated event.



IN VIVO WHEN YOU NEED IMAGINAL

THESE AREN'T THE EXPOSURES YOU ARE LOOKING FOR



**Pitfall:
Unrealistic
Expectations
about ERP**

- “Want to” ≠ “Able to”
 - Moving too quickly
- Reluctance to progress
 - Moving too slowly
 - Not understanding the extinction burst
- Focusing on reducing distress (intensity & frequency)
 - Leads to “white-knuckling”
- Promising/expecting habituation

**SOMETIMES
FEELS LIKE**



**WAITING ON
HABITUATION**

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**Pitfalls:
Unrealistic
Expectations
about
Medication**

- Myths/Misconceptions about Medication
 - Refusing to consider medication
 - Expecting medication to work unrealistically fast
 - Only trying one medication
 - Expecting symptom remission from medication alone



**Solution:
Realistic
Expectations
about ERP**

- Pace ERP appropriately
 - Don't rush it or expect instant results; recovery takes practice & time
 - You might never feel “ready” for the hardest exposures - do them anyway!
- Goal #1 of ERP: Tolerate distress
 - Not eliminate distress
 - Building distress tolerance skills
- When we tolerate distress (& do not escape/avoid), we learn new safety associations
- GOAL: Change your relationship with discomfort; lean in & “bring it on”; NOT escape & avoid
- Inhibitory Learning Model (Craske, et al)



**Solution:
Realistic
Expectations
about ERP**

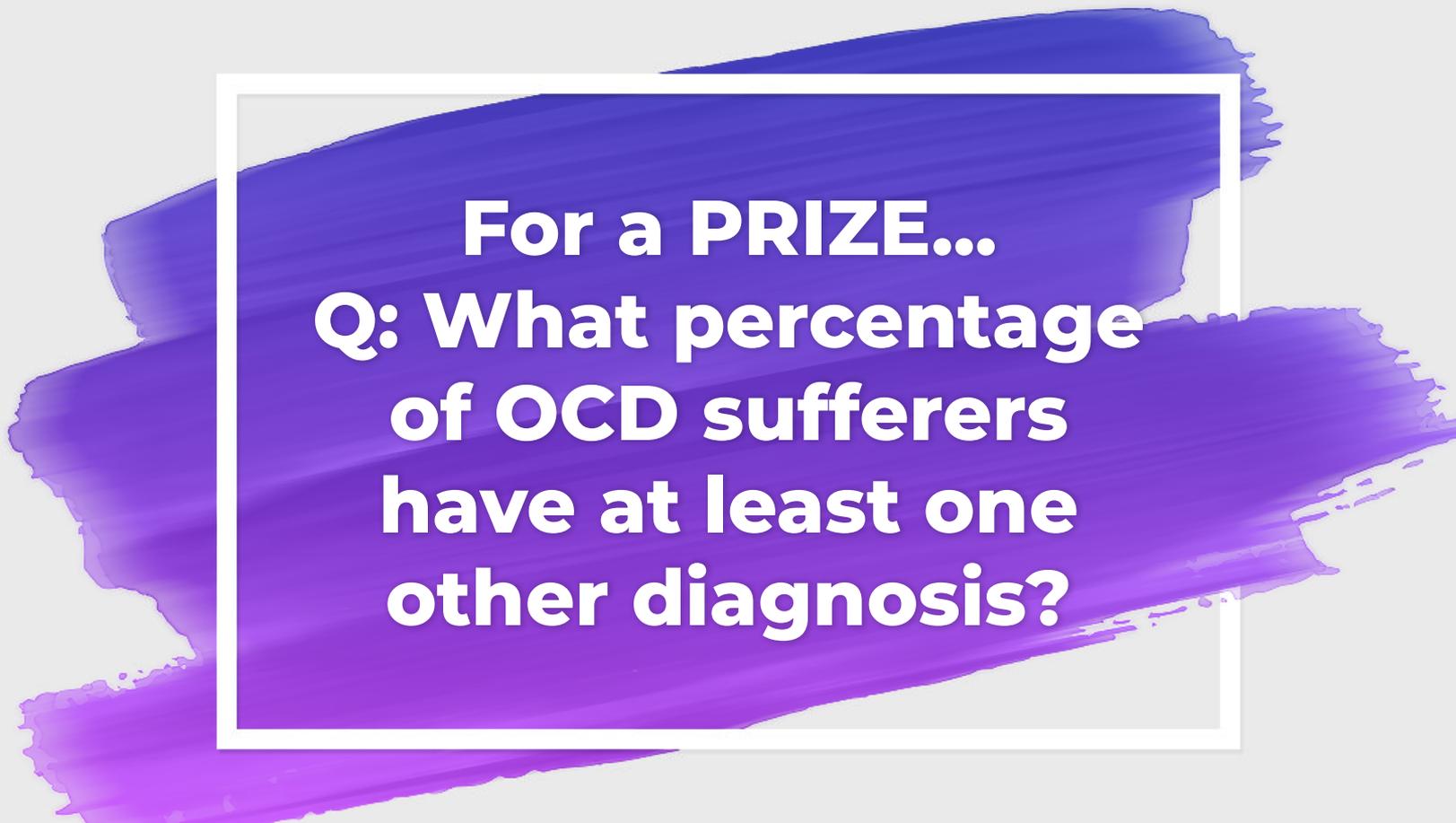
- Understand and Expect the Extinction Burst
 - Symptoms often get worse before they get better
 - OCD fights back
 - Don't stop when symptoms get worse!
- <https://www.youtube.com/watch?v=rKrh5uytRKY>

“If you're going through hell,
keep going”
- Winston Churchill

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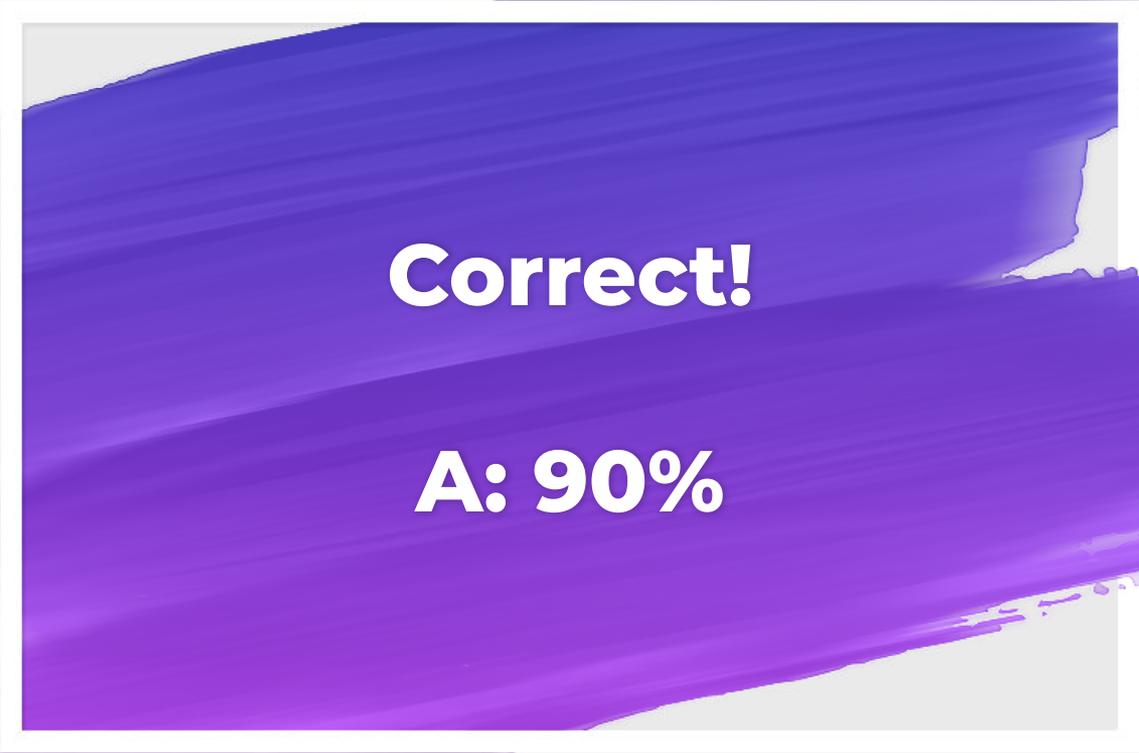
**Solution:
Realistic
Expectations
about
Medication**

- Combined (Rx + ERP) is recommended for severe OCD
- SSRIs are 1st-line medications for OCD
 - Often higher doses of SSRIs needed
 - 2-6 wks to see any effect; 10-12 for maximal effect
- Meds offer ~40% symptom reduction
 - Behavioral therapy is critical!
- May need >1 medication
- For additional complexity and/or treatment refractory patients, the following may be used:
 - Augmentative medication (e.g., tricyclics, antipsychotics)
 - Transcranial Magnetic Stimulation (TMS)
 - Deep Brain Stimulation (DBS)



For a PRIZE...

**Q: What percentage
of OCD sufferers
have at least one
other diagnosis?**



Correct!

A: 90%



**Pitfall:
Detours and
Comorbidity**

Comorbidity is COMMON!! **90% will have at least one other comorbid diagnosis** (Ruscio et al., 2010).

Comorbid conditions and other issues can create detours away from recovery in OCD. Examples:

- Substance Abuse/Need for Detox
- Emotional Regulation Problems (can be d/t dx or other), such as in Bipolar
- Psychosis
- Panic
- Unwillingness / lack of consent (significant among children)



Pitfall:
Detours and Comorbidity

What do clinicians treat first (First Order)?

- Assessing acuity (how severe and urgent something is), risk, and benefit help determine what to address first.
 - Active psychosis, mania, or need for substance detox become first order
- OCD is very commonly treated first, though



**Solution:
Detours and
Comorbidity**

Assess other conditions ongoing to re-determine if their impact or severity changes

- Eating disorders, trauma, depression, panic, substance use, family, financial and access problems, phobias, etc.

Upon identifying a “detour,” *they* must be addressed either first or co-occurring.

- Many ways to address depending on the detour.





**Pitfall:
Lack of
Proper
Dosing**

- Refusing to consider therapeutic doses of medication
- Lacking necessary “dosing” of therapy to accomplish symptom remission
 - 40 YBOCS ≠ weekly outpatient therapy (Reddy et al., 2017)
- Only doing ERP in short bursts (e.g., a few minutes or less)
- Moving too quickly to a high level hierarchy item
- Moving too slowly up the hierarchy



**Solution:
Proper
Dosing**

- Higher dose SSRIs may be needed
- Weekly outpatient treatment
 - Foa: 1.5-2hr sessions, 2x/week, for 8.5 weeks (17 sessions; ~34 hrs of therapy + PRACTICE)
- How long to spend in ERP?
 - Long enough for expectancy violation & learning
 - Sit with the discomfort & “lean in”
 - 20-90 min
- May need to consider a higher level of care:
 - Intensive outpatient programs
 - Partial Hospitalization
 - Inpatient/Residential

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**Pitfall:
Failing to
Understand
the
Extinction
Burst**

- “ERP makes my symptoms worse!”
- “ERP doesn’t work for me”
- “I tried ERP once and it’s not for me”



**Pitfall:
Not Planning
Relapse
Prevention**

Reminder: *Clients who don't address **all** their compulsions are much more likely to relapse* (Abramowitz and Jacoby, 2015)

Important: Relapse Prevention Planning (Claiborn, 2019).

- Can greatly improve outcomes (Hiss et al., 1994).
- It will benefit patients if they know this from Day 1: OCD is not cured, so having a good plan of attack long term is useful.



**Solution:
Planning
Relapse
Prevention**

Shala Nicely, LPC provides a wonderful handout on her website (also linked on my page):

<https://www.shalanicely.com/wp-content/uploads/2016/08/Relapse-Prevention.pdf>



**Solution:
Planning
Relapse
Prevention**

When ready to end treatment, clients manifest:

- 1) Ability to completely (or almost) refrain from compulsions.
- 2) Self-efficacy in designing and practicing exposure with no therapist input.
- 3) Minimal adverse impact of daily routine (Abramowitz & Jacoby, 2015).



**Intrusive
Thought**



**After
ERP**



Discussion and Questions?



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THANKS!

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