ERP 4 OCD

Member/Contributor:

HELLO!

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Go to **www.justinkhughes.com/ocd** *now* to download this entire presentation with free forms referenced today.

Learning Objectives:

I. Be able to differentiate between **intrusive thoughts** in the average population and in OCD.
II. To **define OCD** diagnostically and briefly describe the history of its treatment.
III. Grasp and reiterate the most **effective treatments** for OCD and barriers to implementation of the "gold standard" treatment.
IV. Understand "**ERP in Action**"- able to reiterate key steps in assessing, planning, and treating of OCD.

Seriously, you'll enjoy this talk more if you GO NOW to: www.justinkhughes.com/ocd and download it

Fancy disclaimers:

1) **This is not therapy.** Education can help you apply ideas and tools, but it never takes the place of a competent provider actually offering treatment.
2) **Mature content.** This presentation is designed for adults, though we will discuss OCD in children and teens. Heads up: topics of a serious nature are addressed.
3) **No financial conflict of interest.** All resources today are free. If you click on certain links on my webpage, I may make a small affiliate commission (such as through Amazon). You are under no obligation to do so.
4) For Q&A, remember to check **anonymous** on the box if you want to remain that way.

I. You, Me, & OCD

Normative *intrusive thoughts* vs. in OCD.

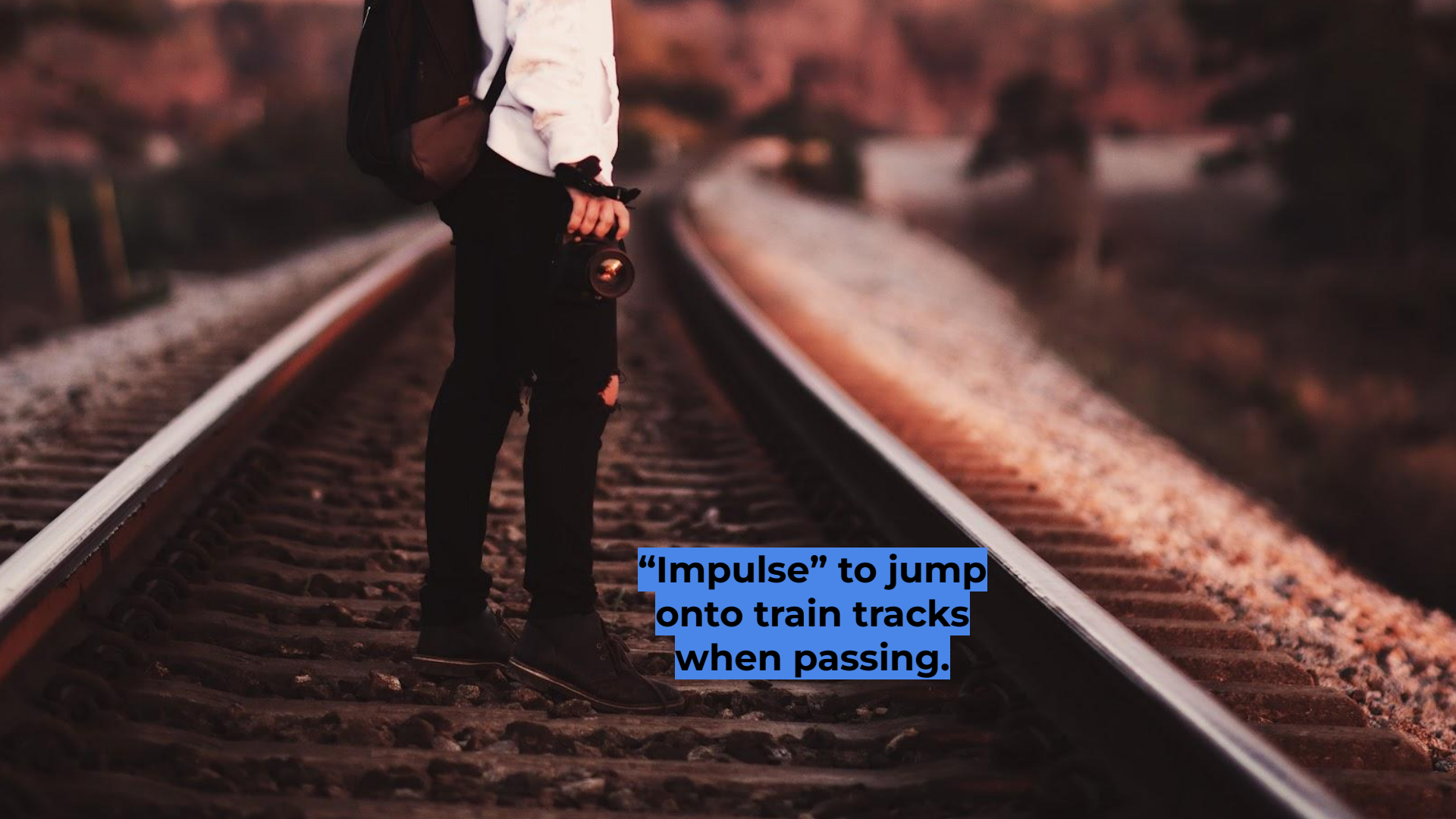
Clinical History of OCD Treatment.

Normative intrusive thoughts.

- Over 90% of people endorse having intrusive thoughts (Abramowitz, 2015)
- Like the following:


Jumping off a bridge onto the highway below.

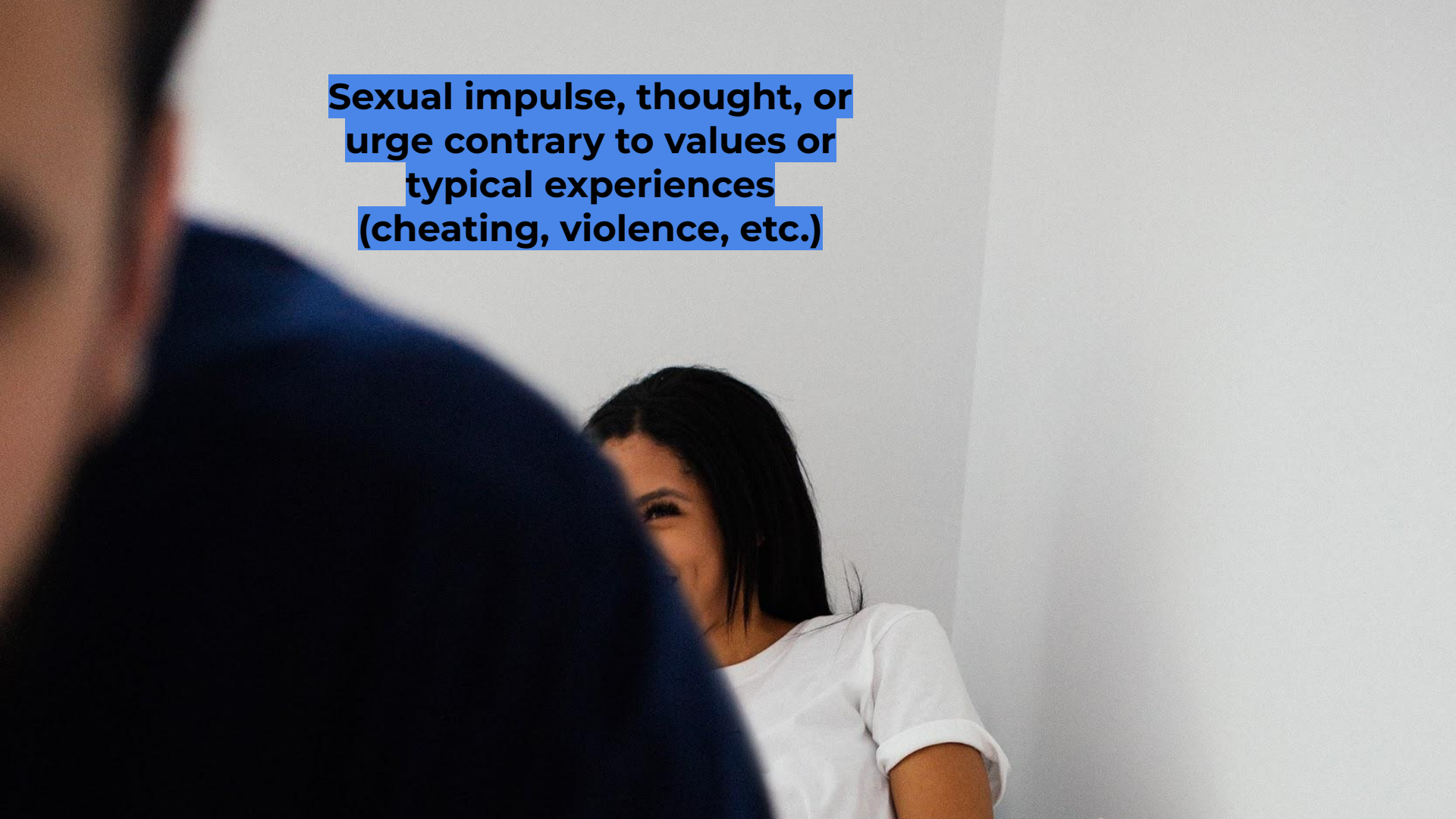

Thought of contracting a disease, catching HIV/AIDS, an STI, TB, after hearing a cough.


“Impulse” to jump
onto train tracks
when passing.

Thought of killing or hurting a loved one. Doubt as to why the thought occurred.


Leaving a door open or unlocked


Doubt of whether you abused or harmed a child


Sexual impulse, thought, or urge contrary to values or typical experiences (cheating, violence, etc.)

Intrusions in OCD

Difference between “normal” and OCD intrusions:

(1) *More distressing*
(2) *Resisted more strongly*
(3) *More repetitive*

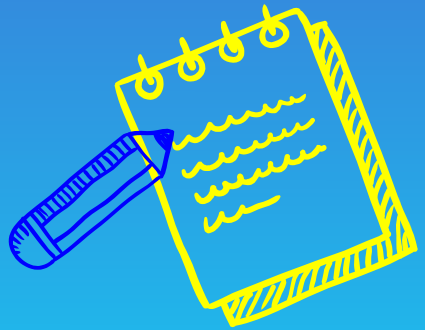
(Abramowitz, 2015)

Uh oh, hold on….

What if someone says:

- They're thinking about **jumping** off a bridge?
- Thinking of **harming** someone?
- Are sure they must be a **pedophile**?
- Must have contracted a **disease**.

Don't we have to report?
Warn?
Refer to a doctor?
Call 911?
What do we do????



Assessment!
Functional Assessment.

But First….

A Brief History

Clinical History of OCD Treatment

1) Freud & “Rat Man” (Thapaliya, 2017)
2) Psychoanalytic/dynamic lacked the framework to effectively treat OCD
3) Enter Behavioral Psychology
4) Later Behavioral techniques of Exposure (that worked for phobias) could be joined with the cognitive work of CBT
5) Now, ERP (Exposure and Response Prevention)

II. The Basics of OCD

What is OCD?

Prevalence and onset.

Examples of.

Etiology (Eat-a-what?).

Course and disability.

What is OCD?

Mental health disorder characterized in 3 parts:

1) Obsessions
2) Compulsions
3) Disruption

(APA, 2013)

Prevalence

Who has it and how prevalent is it?

- 1-2% (some estimates up to 3%)
  - In DFW area, the whole Dallas suburb of Richardson.
  - 6.6 MILLION in the U.S.
  - 156 Million people worldwide.
- Across socioeconomic, cultural, gender, religious, and other differences.

(Ruscio et al., 2008)

Onset

Two time periods most common:

- Puberty
- Early adulthood

(Lomax et al., 2009)

Examples (Sub-types)

Obsessions (can often overlap):

- **Contamination**
- **Doubt**
- **"Just right"** (also symmetry, order, incompleteness)
- **Harm** and responsibility, loss of control, including
- **Unacceptable Thoughts**
- Somatic (body and health) concerns
- Sexual or violent thoughts, including POCD, ROCD, H (or SO) OCD
- Religious/scrupulous/existential thoughts

Compulsions:

- Washing/cleaning
- Checking
- Repeating
- Reassurance
- Ordering
- Various Mental rituals (praying, counting, reviewing)
- Avoidance (including distraction, suppression)
- Asking/Confessing

Occurrence of Obsessional Themes		
THEME	**Patient %** **Study A** (Rasmussen & Eisen, 1992)	**Study B** (Foa and Kozak, 1995)
Contamination	**50**	**38**
Pathologic Doubt	**42**	
Somatic	**33**	**7**
Symmetry	**32**	**10**
Aggressive	**31**	**24**
Sexual	**24**	**6**
Multiple	**72**	
Religious		**6**
Hoarding		**5**
Unacceptable urges		**4**

Frequency of Compulsive Behaviors		
THEME	**Patient %** **Study A** (Rasmussen & Eisen, 1992)	**Study B** (Foa and Kozak, 1995)
Checking	**61**	**28**
Cleaning-Washing	**50**	**27**
Counting	**36**	**2**
Need to ask/confess	**34**	
Symmetry/exactness	**28**	
Multiple	**58**	
Ordering		**6**
Hoarding	**18**	**4**
Repeating		**11**
Mental Rituals		**11**

Etiology (cause)

Exact cause is unknown.

- Genetics
  - 27-65%, higher link to genetics if onset is in childhood (Nestadt et al., 2010; IOCDF, 2019).
- Neurobiological abnormalities (Nichols, 2018)
- Still being researched:
  - Strep in childhood (Nichols, 2018)
  - TBI (Grados et al., 2008; NY Times, 1988)
  - Pregnancy (ADAA, 2019)
  - Stress (OCD UK, 2019)
  - And more

Course & Disability

The World Health Organization (WHO) lists OCD with anxiety disorders as the

> "**sixth largest contributor to non-fatal health loss (disability)**." (WHO, 2017)

2 out of 3 individuals report:

- *severe impairment* in domains of life such as work, relationships, school, etc. (Gillihan et al., 2012)

III. Treatment

CBT with ERP.

SRI's.

Adjuncts and Alternatives.

ERP In Action

Treatments

Two Treatments of choice

1. *CBT, specifically utilizing* ***Exposure and Response Prevention (ERP)***

2. ***SRI's***
    - All are SSRI's except for clomipramine, which is a TCA

(Reddy et al., 2017)

Exposure & Response Prevention

The efficacy of ERP is high.

- 80% of participating patients respond well to a trial of ERP
- **Average symptom reduction of**
  - **60 - 70 %**!!!

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


60-70%!!

Exposure & Response Prevention

NOT Cognitive Therapy (C.T.) without "Behavioral Experiments"

ERP is the "gold standard" of care.

- Edna Foa: *"Exposure-based treatments have the largest evidence base to support their use for OCD."*

(Foa, 2010; Psychiatry Online, 2019; Abramowitz, 1997; Ponniah et al., 2013; Psychology Today, 2019)

GAP between evidence & practice

- **26% of advanced level clinicians (Ph.D) seldom or never use exposure for <u>OCD!</u>**
  - ~80% of patients never receive exposure when indicated (Sars et al., 2015)
  - Children rarely receive exposure therapy (Whiteside et al., 2016)
- **20% of patients receive exposure therapy for ANY anxiety disorder**

(Sars et al., 2015; Goisman, et al., 1993)

GAP between evidence & practice

Therapists are afraid! Clients are afraid!

- Research into views by clinicians (!) on exposure:
    a) "Insensitive"
    b) "Rigid"
    c) "Ineffective"
    d) "Potentially iatrogenic"
    e) "Not...real world"
    f) "Unethical"

(Sars et al., 2015)

GAP between evidence & practice

Why the gap? We *know* ERP is "gold standard." It's clear in the research.

- Finance and insurance coverage
- Access
- Lack of trained professionals
- Stigma by clients AND professionals
- Lack of awareness of the research

GAP between evidence & practice

Personal thoughts:

- ERP is still “new-ish”
- CBT and Psychodynamic are the most common orientations in psychotherapy,BUT
  - CBT can be weighted to be more CT heavy w/o behavioral experiments
  - “Underlying issues”, “root problems,” and beliefs about trauma still dominate the therapeutic mindset as to causation of psychiatric problems
- Exhibit A- me

Treatment: SRI's

SRI's are *often* beneficial.

- 40-60% of patients responding with an average of 20 - 40% symptom reduction.

(Steketee, 2012.)

Treatment: Adjunctive & Refractory

For additional complexity and/or treatment refractory patients, the following may be used:

- Augmentative use of antipsychotics
- Transcranial Magnetic Stimulation (TMS)
- Deep Brain Stimulation (DBS)
- Gamma Knife
- Brain Surgery

(IOCDF, 2019)

IV. ERP In ACTION
10 Key Domains

ERP In ACTION- 10 Steps

1) Assessment, Assessment, Assessment.
2) Track and Monitor.
3) “Roadmap” Planning.
4) Exposure practice.
5) Support.
6) Cognitive Work.
7) Additional Tools (like mindfulness).
8) Values development.
9) Problem Solving.
10) Relapse Prevention.

ERP In ACTION
#1: Assessment

- Identify your clinical goal(s).
- Get educated from reputable, trustworthy sources.
- Consider comorbidities or things that could get in the way of your progress with OCD treatment.

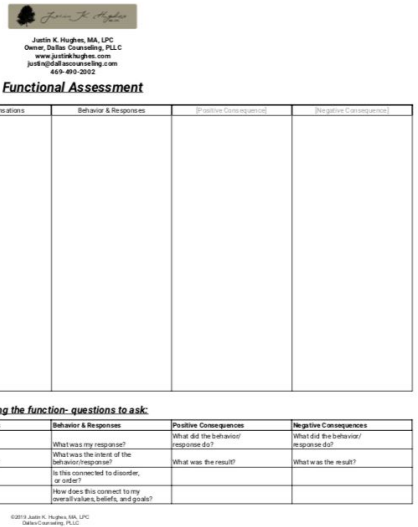
ERP In ACTION
#1: Assessment

Common assessments:

- Self-Monitoring
- Y-BOCS or CY-BOCS
- Subtype Checklists
- Cognitive Distortions in OCD
- **Functional Assessment**
- FAS, DOCS, OBQ-44, ASIS
- Non-OCD specific:
    - DASS-21, PHQ-9, IUS, etc.

ERP In ACTION
#1: Assessment

Functional Assessment!



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Functional Assessment

Triggers (Antecedents)	Thoughts & Beliefs	Feelings & Sensations	Behavior & Responses	[Positive Consequences]	[Negative Consequences]

Determining the function- questions to ask:

Triggers (Antecedents)	Thoughts & Beliefs	Feelings & Sensations	Behavior & Responses	Positive Consequences	Negative Consequences
Are there connections/ precedents to this?	Where did this thought/ belief come from?	What did I notice?	What was my response?	What did the behavior/ response do?	What did the behavior/ response do?
	What is the evidence?	How did my body feel?	What was the intent of the behavior/response?	What was the result?	What was the result?
	Is this connected to disorder, or order?		Is this connected to disorder, or order?		
	How does this connect to my overall values, beliefs, and goals?		How does this connect to my overall values, beliefs, and goals?		

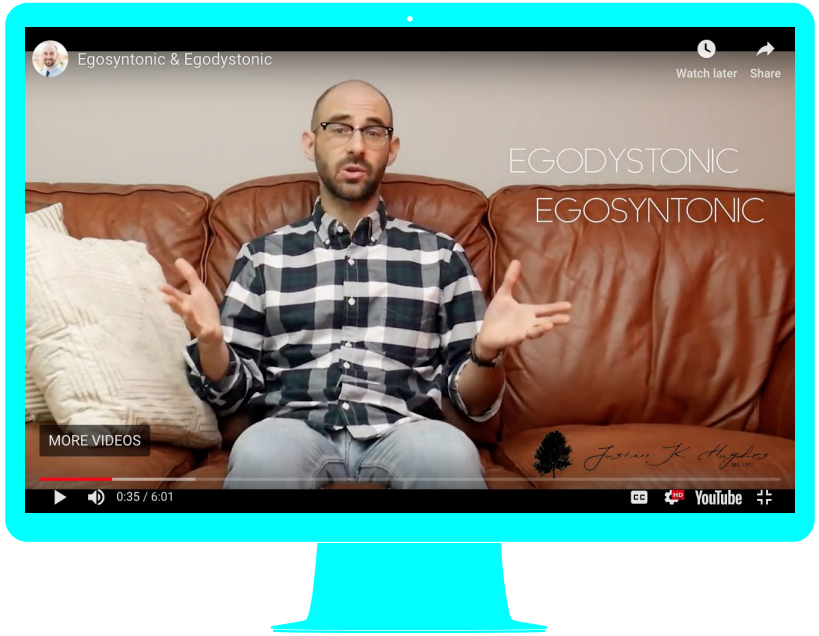
ERP In ACTION
#1: Assessment

Egosyntonic vs. Egodystonic

- Distinguish between intrusion and desire.

Core Fear Conceptualization

- Treat the core concern (this DOESN'T mean you have to dig into "subconscious" topics).
  - "Downward arrow technique"

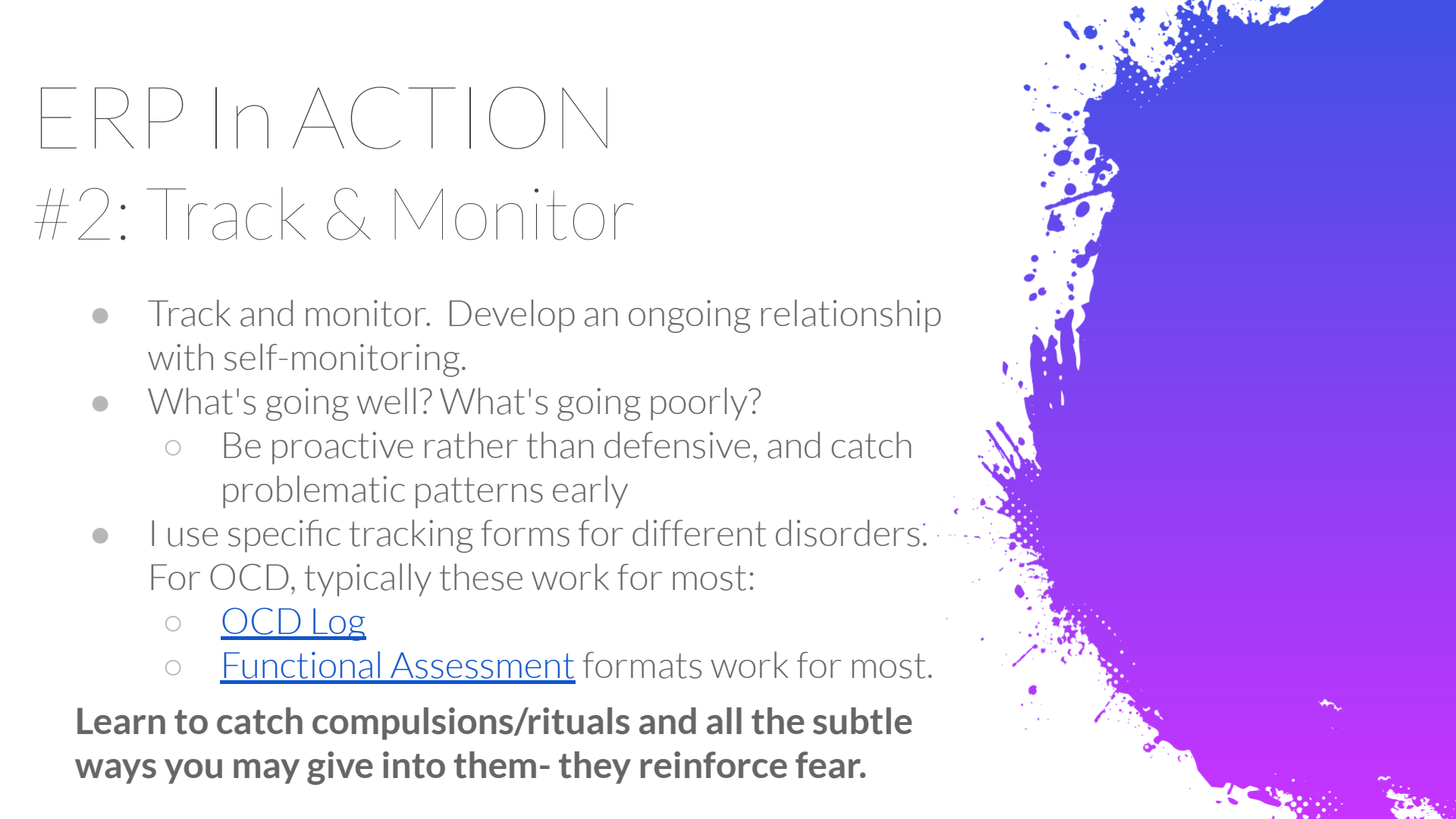


www.justinkhughes.com/egosyntonic-egodystonic

ERP In ACTION
#2: Track & Monitor

- Track and monitor. Develop an ongoing relationship with self-monitoring.
- What's going well? What's going poorly?
  - Be proactive rather than defensive, and catch problematic patterns early
- I use specific tracking forms for different disorders. For OCD, typically these work for most:
  - OCD Log
  - Functional Assessment formats work for most.

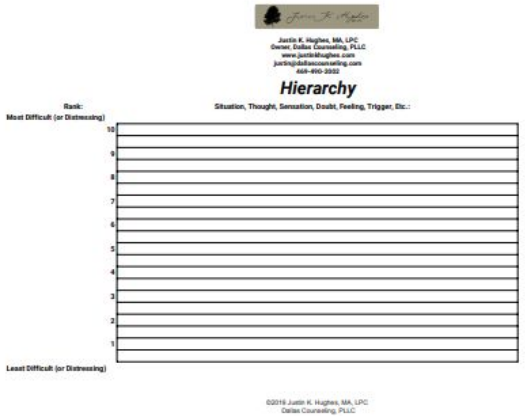
Learn to catch compulsions/rituals and all the subtle ways you may give into them- they reinforce fear.



ERP In ACTION
#3: “Roadmap” Planning

Identify and make a “roadmap” of what you need to face. The simplest form of this is a Hierarchy.

- Clients get a high-powered mutually shared electronic hierarchy, but this gives the gist

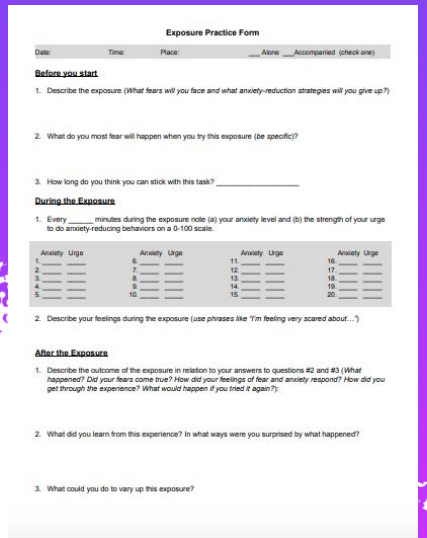


ERP In ACTION
#4: Exposure

Exposure: Practice, practice, practice. The heart of CBT for OCD is Exposure Therapy.

Systematically facing fearful/avoided stimuli while reducing fearful responses.

Dr. Jonathan Abramowitz's "Exposure Practice Form" is my favorite form/guide. Based on his work, find my ERP Tips for OCD.



Exposure Practice Form

Date: Time: Place: ___ Alone ___Accompanied (check one)

Before you start

1. Describe the exposure (*What fears will you face and what anxiety-reduction strategies will you give up?*)

2. What do you most fear will happen when you try this exposure (*be specific*)?

3. How long do you think you can stick with this task? _____

During the Exposure

1. Every _____ minutes during the exposure note (a) your anxiety level and (b) the strength of your urge to do anxiety-reducing behaviors on a 0-100 scale.

Anxiety	Urge	Anxiety	Urge	Anxiety	Urge	Anxiety	Urge
1. ____	____	6. ____	____	11. ____	____	16. ____	____
2. ____	____	7. ____	____	12. ____	____	17. ____	____
3. ____	____	8. ____	____	13. ____	____	18. ____	____
4. ____	____	9. ____	____	14. ____	____	19. ____	____
5. ____	____	10. ____	____	15. ____	____	20. ____	____

2. Describe your feelings during the exposure (*use phrases like 'I'm feeling very scared about…'*)

After the Exposure

1. Describe the outcome of the exposure in relation to your answers to questions #2 and #3 (*What happened? Did your fears come true? How did your feelings of fear and anxiety respond? How did you get through the experience? What would happen if you tried it again?*):

2. What did you learn from this experience? In what ways were you surprised by what happened?

3. What could you do to vary up this exposure?

ERP In ACTION
#4: Exposure

Exposure Types:

- In-Vivo Exposure
- Imaginal Exposure
- Interoceptive Exposure
- Virtual Reality

https://www.youtube.com/watch?v=zBzAttvMXY8

ERP In ACTION
#4: Exposure

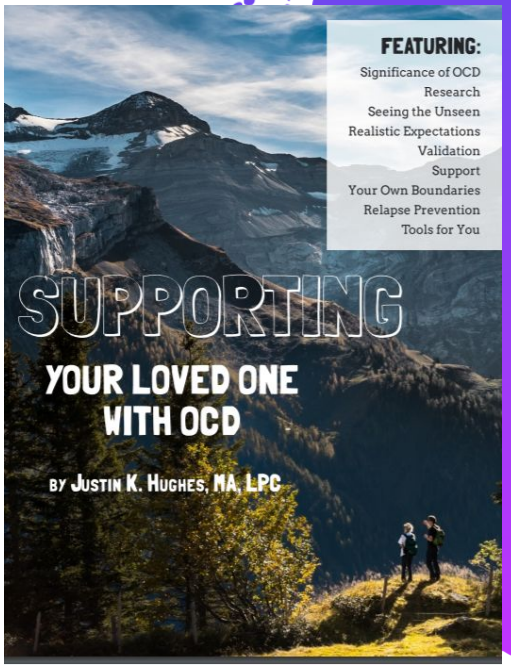
Exposure and Response Prevention requires adjustments and edits!

- Make sure you're not compulsing or you're decreasing the compulsion
- Match the type of exposure to the content
- Address core fears
- No purpose in exposure for exposure's sake.
- Learning to "work smarter, not harder"

ERP In ACTION
#5: Support & Family

Nearly ever case of OCD involves family and support in some way. Gaining support and addressing accommodation are key for long-term success.

Here's the full guide, FREE: "Supporting Your Loved One With OCD."



ERP In ACTION
#6: Cognitive Work

- By and large, **NOT "replacing negative/intrusive thoughts;"** this is a common error that leads to more engagement (ritual) with obsessions
  - OCD 'spits up' a high occurrence of intrusive, irrational thoughts.
- The cognitive portion examines and changes the relationship between faulty beliefs and the maintenance of problematic responses and reactions.
- Some obsessions differ in the cognitive work they need- sexual and religious obsessions for example often have more belief in their accuracy) (Van Schalkwyk et al., 2016)

ERP In ACTION
#7: Add'l tools

- Mindfulness, acceptance, etc. are often helpful, if not near essential.
- They are not the treatment in and of themselves, but without personalizing treatment to the individual, it can "miss the mark"
- Therapists may use additional tools found in ACT, MI, DBT, support groups, etc.
- Check out my Exposure-Friendly Mindfulness guide with accompanying video

ERP In ACTION
#8: Value Development

- Being able to identify the “bigger picture”- what you want to accomplish, what your goal is outside of feeling better, is *very* important. Some clients are ready to go. Others need help developing out their “why.”
- ACT (Acceptance and Commitment Theory) is a transtheoretical approach to stay present, engage with identified values and commitments, stay flexible, and make adjustments where necessary.

ERP In ACTION
#9: Problem Solving

- There will always be “problems.” But going to a trained clinician will help to be prepared for them.
- Having a good team around you will assist in growth rather than defeat (See Step 1 & 5- Identify the Problem/Getting Educated & Support).

ERP In ACTION
#9: Problem Solving

- This is one of the big differences a therapist and/or a specialist can make.
- Common **detours to treatment** are:
  - comorbid diagnoses like substance abuse and depression
  - any pattern of getting off track from the heart of exposure
  - Life events

ERP In ACTION
#10: Relapse Prevention

- How is it going? What am I learning? Steps 2 and 5 above (Tracking & Support) will help sustain a strong structure for accountability and growth- for the short term or long-haul.
- Planning for the long-haul leads to better outcomes (Gillihan et al., 2012)
- Shala Nicely wrote a great handout on Relapse Prevention.
- McLean OCD Institute Houston also has a great handout.

ERP In ACTION
#10: Relapse Prevention

Getting compulsions to relative ZERO.

- Relapse is *much more* likely when treatment is ended before a client can resist most all compulsions consistently.
  - (Abramowitz & Jacoby, 2015; Gillihan et. al, 2012)

Chronic and/or episodic nature of OCD

- Requires education, future "level-setting," and ownership of working with a chronic health condition.

ERP In ACTION
#10: Relapse Prevention

Case Example: Contamination

Case Example: Harm

<u>What's your purpose?</u>
Get your life back?
Do that thing you've wanted and couldn't?
Or improve relationships?
Not be so overwhelmed?

Or….

Fill in YOUR Blank_____

Ready for more? Lots of good starting points:

- Treatment (I treat TX & PA Residents)- Make appointment NOW on my website!
- LOTS More FREE Education

Resources

International OCD Foundation

OCD gamechangers

OCD TEXAS

- www.justinkhughes.com/ocd
- IOCDF.org
- ocdtexas.org
- facebook.com/ocdgamechangers/

THANKS for Joining!

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As a thank you,
Those on my OCD List are the 1st to receive the brand new guide tonight.
"***When & Why ERP Isn't Working***"
Click on the image if you aren't on my list or go to www.justinkhughes.com

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