

5day Intensive OCD Treatment

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	<p>Session 1 Assessment Psychoeducation: OCD and ERP Cognitive Strategies</p> <p><u>Home Practice:</u> Read about OCD and ERP</p>	<p>Session 3 Review Sx record Conduct exposure with patient alone Report to Parents</p> <p><u>Home Practice:</u> Repeat exposure Parents read coaching handout</p>	<p>Session 5 Therapist complete exposure, parent completes record</p> <p><u>Home Practice:</u> Exposure Response prevention</p>	<p>Session 7 Parent and therapist collaborate to conduct exposure</p> <p><u>Home Practice:</u> Exposure Response prevention</p>	<p>Session 9 Parent and patient conduct exposure with minimal assistance</p> <p><u>Home Practice:</u> Exposure Response prevention</p>
PM	<p>Session 2 Review CBT model Strategies for fighting OCD Create Hierarchy Mock Exposure</p> <p><u>Home Practice:</u> Daily Record- if needed Complete Hierarchy</p>	<p>Session 4 Review home exposure Therapist lead exposure, parent reviewing handout Meet with parents alone</p> <p><u>Home Practice:</u> Repeat exposure Response prevention</p>	<p>Session 6 Parent introduce and complete record, therapist completes exposure</p> <p><u>Home Practice:</u> Exposure Response prevention</p>	<p>Session 8 Parent lead exposure with therapist assistance</p> <p><u>Home Practice:</u> Exposure Response prevention</p>	<p>Session 10 Design home treatment schedule and follow-up Review success completing 3 goals</p> <p><u>Home Practice:</u> Follow treatment plan</p>

**LEARNING ABOUT MY OCD
DAILY RECORD**

Date	<p align="center">Obsession</p> <p align="center">Intrusive Thought or Idea that causes anxiety</p>	<p align="center">OCD's Lie that made the thought scary</p>	<p align="center">Compulsion</p> <p align="center">The Ritual you did to reduce your anxiety</p>	<p align="center">Frequency</p> <p align="center">Make a tally mark each time you have this symptom</p>
	<p>Example: Touching the floor will make me sick</p>	<p align="center">Overestimation of threat</p>	<p align="center">Washed my hands</p>	<p align="center"> </p>

Strategies for fighting OCD

1. Exposures - Face your fears
2. Response Prevention – Don't do what OCD tells you to do
3. Learn how OCD works
4. Reminder that OCD is the enemy
5. Teach Mom and Dad to be good teammates
6. Measure anxiety so it is easier to handle
7. Recognize the lies that OCD tells you
8. Be your own cheerleader, don't help OCD by getting down on yourself
9. Take it one step at a time. Set goals you can reach
10. Reward yourself because making changes is hard

The Lies that OCD Tells You

1. You shouldn't have bad thoughts: OCD tells you that “normal or good people don't think this way” and that you are bad for having your thoughts.

Example: Jon believes he is a bad person for thinking about hurting someone else.

Truth: Research shows that there are no differences between the thoughts that people with and without OCD have

2. Thoughts = actions: OCD tells you that just having a thought or urge to do something makes it more likely to happen.

Example: Betty thinks she is more likely to stab her Mom because she had a thought about it.

Truth: You can't control the world with your thoughts, try it.

3. You have to know for certain: OCD tells you that something bad will happen unless you have a 100% guarantee of that everything is safe.

Example: Billy thinks he has to check with his Mom one more time that everything is all right.

Truth: Most people think things are safe unless there are clear signs of danger. You do too when OCD is not lying to you; think of some examples.

4. You can't handle feeling upset: OCD tells you that anxiety or discomfort will last forever and that you can't handle it unless you do a ritual to make it go away.

Example: Suzy believes that she will be so upset if she doesn't wash her hands that she will fall apart.

Truth: Anxiety goes away and you can handle until it does, we can think of lots of examples from your life.

The Lies that OCD Tells You
Or
Cognitive Distortions in Obsessive-Compulsive Disorder
Page 2

5. You have to stop bad thoughts: OCD tells you that you should be able to control or stop yourself from having certain thoughts.
Example: Alex feels that he can and should stop his thoughts about hurting people
Truth: We are thought making machines; that's our best skill. We can't stop good, bad, or upsetting thoughts from coming into our heads. But we can change how we react to these thoughts.

6. Bad things are going to happen: OCD tells you that bad things are very likely to happen.
Example: OCD tells Jenny that she will get sick and die if she gets germs on her hand.
Truth: If you think about all the steps that are needed for the bad event to happen, you realize that the chances are too low to worry about.

7. You have to stop bad things from happening: OCD tells you that you can stop bad things from happening, and that you have to try and stop them.
Example: OCD tells Jose that he must count to a certain number or repeat things to prevent a car accident.
Truth: We know you can't control the world with your thoughts. If you aren't in control, then your thoughts can't make things happen or stop them from happening.

8. You have to do things "Just Right": OCD tells you that things must be "just right" or "evened out" for you to feel okay.
Example: If you touch the wall with your right hand, you feel you must touch it with your left had.
Truth: "Just right" is something OCD makes up and you will feel fine even if things are not "just right."

Coaching Instructions for Exposures

1. Be positive and supportive
2. You are going to find yourself saying the same things over and over, that's okay
3. Set-up the exposure:
 - “The next exposure we agreed to do is _____. Are you ready to start.”
 - ”Great, what are you afraid will happen when we do this exposure?” (Child answers)
 - “What are the chances of that happening?” (If child gives a high estimate review the *The Lies OCD Tells You*)
 - “What are the rituals that you will be tempted to do?” (Child answers)
 - “Are you going to stop yourself from doing your rituals?” (If child says no, review the model of OCD and how rituals keep the fear going in the long run.)
 - “Good, what's going to happen to your anxiety when we do the exposures?” (Child should respond that it will initially increase and then decrease over time. If child says they will stay anxious forever, review past exposure practice charts)
 - “Great lets get started, how nervous are you just before we begin the exposure?” (Write down SUDS rating)
4. During the exposure your goals are to help your child realize that their anxiety is decreasing without doing their rituals. Keep you eyes open for rituals or the development of new rituals
5. Approximately every 2 minutes ask you child for to rate his/her anxiety or distress and then plot it on the chart.
6. Responses during exposures
 - When your child's anxiety decreases:
 - “That's great. What brought down your anxiety?” (Try to get your child to say that they did not do anything other than sit there and their anxiety went down because there is nothing to be afraid of.)
 - “Did you do any rituals to bring down your anxiety?”
 - When your child's anxiety stays the same:
 - “That's okay, this takes time. I bet it will start to go down soon”
 - When your child's anxiety increases:
 - “Good, that means that we are doing the right thing and have found what makes you nervous. This will really help us beat OCD.”
7. Potentially difficult situations to handle
 - A. Your child slips up and does a ritual
 - “Thanks for telling me, now let's recontaminate/think the scary thoughts again/put things out of order. Next time try to not do your ritual/do the ritual wrong/mess the ritual up in some way.”
 - B. Your child's anxiety does not go down after 90 minutes
 - “You have worked really hard today and I am proud of you for not doing any rituals. Even though your anxiety did not come down yet, we learned that you can handle your anxiety and that your fears did come true. This hard work will make the next exposure easier.”

“It looks like we tried an exposure that was too hard, lets try an easier one next time.”

(Make sure your child was not doing rituals (including new rituals or other behaviors that interfered with desensitization.)

C. Your child refuses to start an exposure

“What do you need to get started?”

“I know it’s hard, but none of the exposures we have done were as bad as you thought they would be.”

“I know it’s hard, but doing exposures will help you feel better”

“Do we still need to work on the last exposure?”

“Can we make this exposure easier?”

“Let’s review the “*Strategies for fighting OCD.*”

“Remember, if you complete your exposure you can have (agreed upon rewards).”

(If this is a frequent problem set-up a system where your child’s privileges (e.g. wathcing TV, computer, etc.) are based on doing exposures)

D. Your child wants to stop in the middle of an exposure

“I know this is hard, you are doing a great job. Your anxiety will probably go down soon, just like the exposures we have already done. If we stop now it will make OCD stronger. If we stick with it you are going to beat OCD and feel better soon.”

E. Your child begins crying and saying that it is too hard.

(Make sure that you have selected an exposure that is at the appropriate level of difficulty. Focus on how hard the child is working, be very supportive, comforting and show them you are proud they are sticking with it. Try to ignore the crying and focus on their good effort.)

“Wow, this is a really tough one. You are doing great. OCD has no chance against you. You are going to have come a long way after this one.”

F. Your presence during and exposures is a ritual. (Have you child do exposures without you around.)

8. Notes from session observations

A. _____

B. _____

C. _____

D. _____

E. _____

Follow-up plan

Overview

Post-treatment is very important for continuing to decrease OCD symptoms and to prevent relapse of symptoms.

There will be 3 phases following the end of your time at the clinic: At home-treatment, Working on the fly, and Moving on.

At-home-treatment:

When you leave the clinic we expect that you will continue to have OCD symptoms. However, we also expect that you and your parents know how to continue treatment at home. During the “At home-treatment” phase you will continue doing treatment like you did at the clinic. That means you will do two planned exposures each day and prevent yourself from doing rituals.

Working on-the-fly:

During this phase you will focus more on fighting OCD when it happens during the day and spend less time doing planned exposures. Working on-the-fly means that when OCD fears pop-up in daily life you will expose yourself to those them. Also, when you have the opportunity you will challenge yourself to do things that you normally wouldn't do to prove how far you have come.

Moving on:

During this phase, you will begin to stop making plans to work on OCD or keeping records and spend more time doing the activities that you want to. However, it is important that you don't let OCD begin to cause trouble again. If you start to have OCD worries make sure that you do some exposure quickly including planned exposures.

Phone calls:

During each phase you will make phone calls to your therapist. These calls are just to check-in. You can leave a message stating that everything is going well and you are sticking with your plan. If there are problems we will talk through them.

Relapse:

It is important to remember that OCD symptoms tend to come and go over time. You will likely have a time when your OCD symptoms get worse again, probably during a time that you are under stress. That's okay because you now have the skills to handle it. Just sit down with your parents and plan some exposures and response prevention. Give your therapist a call if you need more help.

At Home Treatment Plan

Two exposures per day of approximately 45 minutes each. Check off when completed.

Day 1 At home-treatment (Sunday)

___ morning exposure: _____
___ evening exposures: _____

Day 2 At home-treatment (Monday)

___ afternoon exposure: _____
___ evening exposures: _____
___ Check-in phone call

Day 3 At home-treatment (Tuesday)

___ afternoon exposure: _____
___ evening exposure: _____

Day 4 At home-treatment (Wednesday)

___ afternoon exposure: _____
___ evening exposures: _____

Day 5 At home-treatment (Thursday)

___ afternoon exposure: _____
___ evening exposures: _____

Day 6 At home-treatment (Friday)

___ afternoon exposure: _____
___ evening exposures: _____
___ Check-in phone call

Day 7 At home-treatment (Saturday)

___ morning exposure: _____
___ afternoon exposures: _____

Day 8 At home-treatment

___ AM exposure: _____

___ PM exposures: _____

Day 9 At home-treatment

___ AM exposure: _____

___ PM exposures: _____

Day 10 At home-treatment

___ AM exposure: _____

___ PM exposures: _____

Day 11 At home-treatment

___ AM exposure: _____

___ PM exposures: _____

Day 12 At home-treatment

___ AM exposure: _____

___ PM exposures: _____

Day 13 At home-treatment

___ AM exposure: _____

___ PM exposures: _____

___ Check-in phone call

Day 14 At home-treatment

___ AM exposure: _____

___ PM exposures: _____

___ Complete Treatment Plan for next week

Working on the Fly

One planned exposures per day for as long as needed.
Keep track of at least two "Exposures on the fly" a day.
Check off when completed.

Day 1 Working on the Fly

Planned exposure: _____

Exposure on the fly #1: _____

Exposure on the fly #2: _____

Day 2 Working on the Fly

Planned exposure: _____

Exposure on the fly #1: _____

Exposure on the fly #2: _____

Day 3 Working on the Fly

Planned exposure: _____

Exposure on the fly #1: _____

Exposure on the fly #2: _____

Day 4 Working on the Fly

Planned exposure: _____

Exposure on the fly #1: _____

Exposure on the fly #2: _____

Day 5 Working on the Fly

Planned exposure: _____

Exposure on the fly #1: _____

Exposure on the fly #2: _____

Day 6 Working on the Fly

Planned exposure: _____

Exposure on the fly #1: _____

Exposure on the fly #2: _____

Check-in phone call

Day 7 Working on the Fly

Planned exposure: _____

Exposure on the fly #1: _____

Exposure on the fly #2: _____

Complete plan for next week

Moving on

Decrease frequency of planned exposures.

Keep track of "Exposures on the fly"

The schedule below is an general guide.

Check off when completed.

Day 1 Moving On

___ Exposure on the fly #2: _____

Day 2 Moving On

___ Planned exposure: _____

Day 3 Moving On

No planned practice

Day 4 Moving On

___ Exposure on the fly #1: _____

Day 5 Moving On

___ Planned exposure: _____

Day 6 Moving On

No planned practice

Day 7 Moving On

___ Exposure on the fly #1: _____

___ Check-in phone call

___ Complete plan for next week. Continue with structured plan as needed.

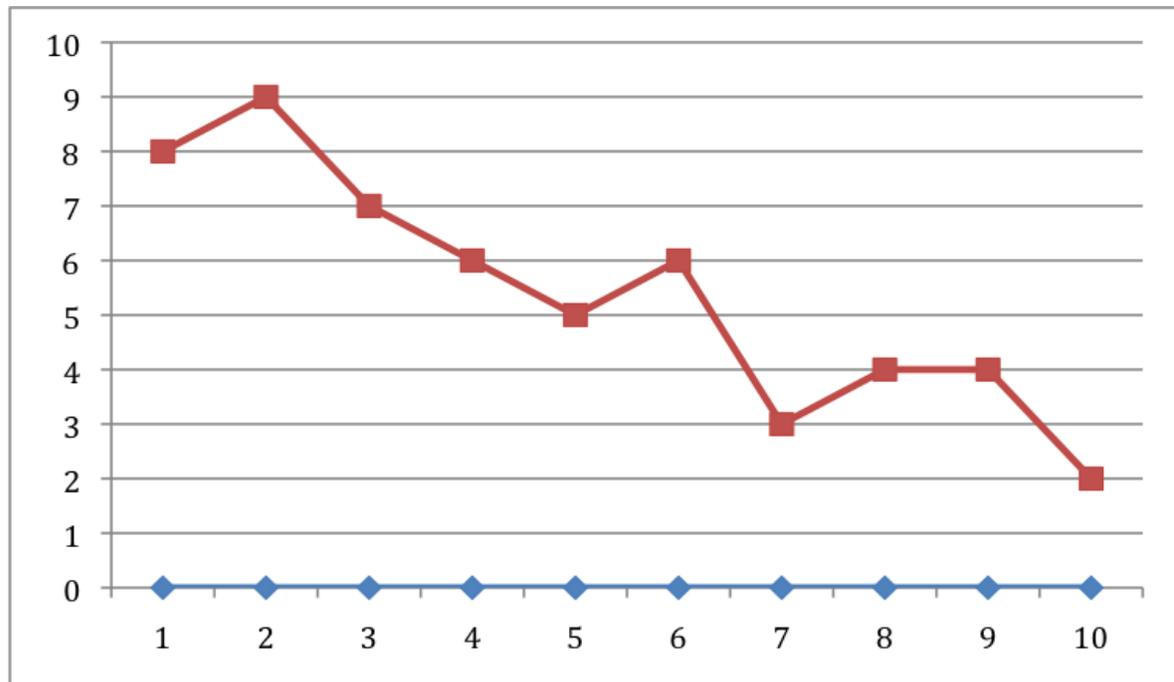
EXPOSURE PRACTICE FORM

Session Number:

Date:

- 1) The situation to practice:
- 2) What is OCD telling you will happen:
- 3) What is OCD telling you to do to make yourself feel better:

Anxiety ratings: (practice may take up to one hour)



- 1) What happened?

Comments or Difficulties:

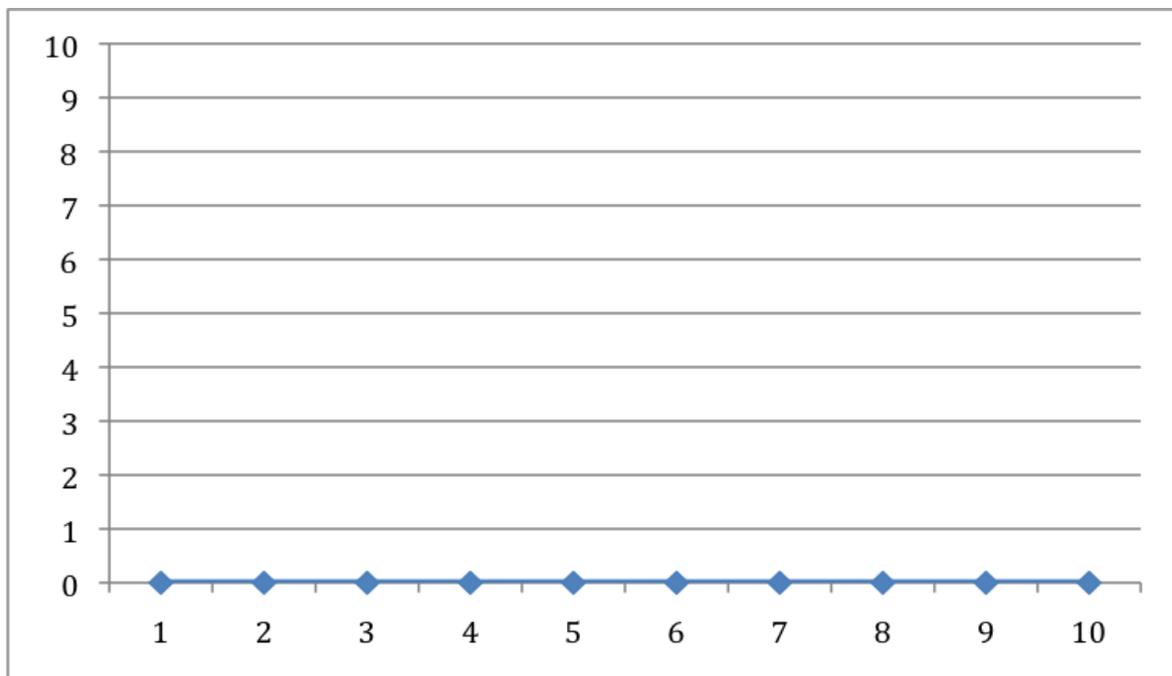
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- 1) What happened?

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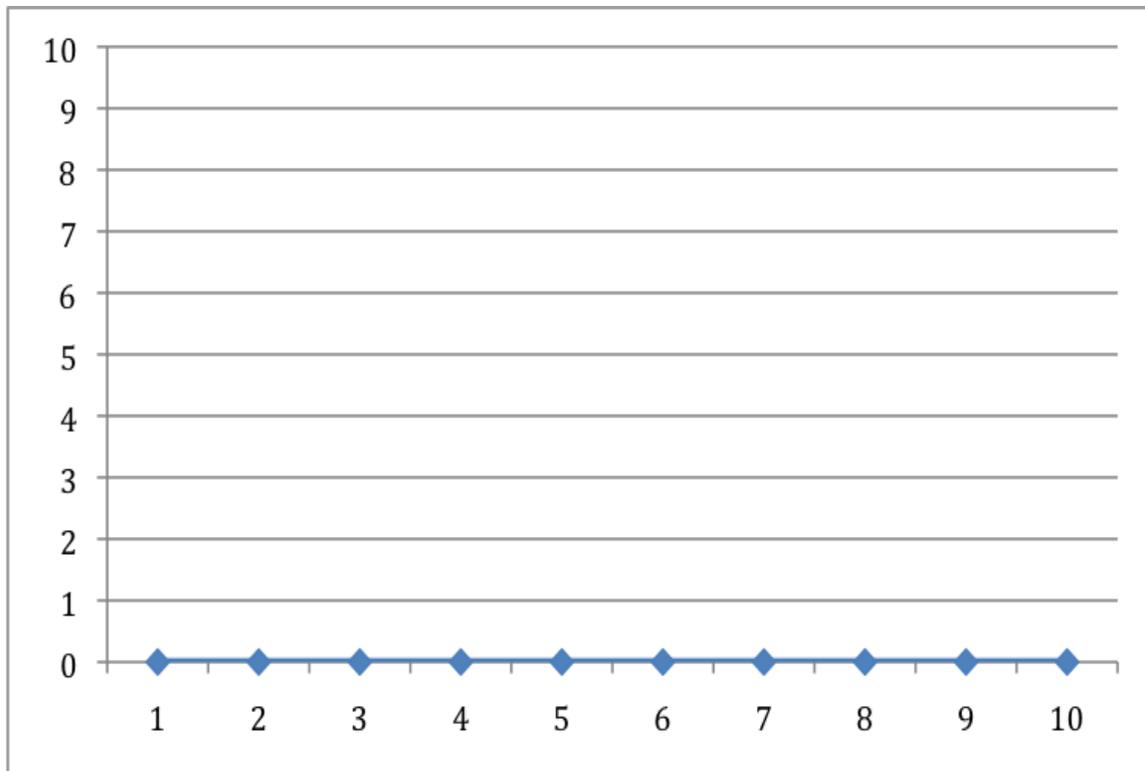
EXPOSURE PRACTICE FORM

Session Number:

Date:

- 1) The situation to practice:
- 2) What is OCD telling you will happen:
- 3) What is OCD telling you to do to make yourself feel better:

Anxiety ratings: (practice may take up to one hour)



- 2) What happened?

Comments or Difficulties:

UNDERSTANDING HOW OCD WORKS

Obsessive-compulsive disorder (OCD) is an anxiety disorder, meaning that it involves excessive, irrational, or unreasonable fear and anxiety. Anxiety is typically associated with the anticipation of future negative events; for example, “what if ____ happens?” Other anxiety disorders include phobias (e.g., fears of thunderstorms or heights); panic attacks, and generalized anxiety which is defined as uncontrollable worries concerning situations such as work, health, or finances. In OCD, people have unwanted or senseless thoughts (obsessions), and urges to perform special behavioral or mental rituals (compulsions).

Researchers have been interested in understanding the causes and symptoms of OCD, and thus have conducted numerous studies on this topic beginning in the middle of the 1960’s. This research has confirmed two important facts about OCD: 1) obsessions evoke anxiety and distress; and 2) compulsive rituals reduce anxiety and distress. This handout explains these important relationships in more detail. The explanations can be divided into two parts: 1) how obsessional fears develop, and 2) why obsessional fears continue.

OBSSESSIONS

Let’s first examine obsessions. Obsessions are unwanted intrusive thoughts, ideas, or images that evoke anxiety, worry, or discomfort. Their content is usually senseless or bizarre- and the person often recognizes this. People with OCD try to resist their obsessions- meaning that they try to stop the thoughts, often unsuccessfully. Broadly speaking, obsessions often concern the possibility of danger, harm, or responsibility for danger or harm. Their specific content may focus on aggressive actions, contamination, sex, religion, mistakes, physical appearance, diseases, need for symmetry or perfection, among other topics.

PART 1: HOW DO OBSSESSIONS DEVELOP?

You may be surprised to learn that intrusive, upsetting, unwanted thoughts that resemble obsessions are experienced by just about everyone in the world. That is, people without OCD experience the same kinds of unwanted and intrusive thoughts as do people with OCD. Indeed, human beings have many, many thoughts while awake and during sleep, and so it would be expected that our brains will, at times, focus on bizarre or senseless thoughts. To illustrate this, researchers have conducted studies in which people with OCD were asked to list some of their unpleasant unwanted thoughts, as were a group of people who did not have OCD. The researchers then gave the lists of thoughts to psychologists and psychiatrists and asked them to distinguish between the thoughts of people with and without OCD. Indeed, the professionals did a poor job of determining whether the thought was from an OCD or non-OCD person. Below are listed several intrusive thoughts reported by people without OCD:

- Impulse to harm someone
- Thoughts of accidents involving loved ones
- Thought of harm coming to one’s children
- Impulse to jump in front of an oncoming vehicle
- Impulse to shout rude or inappropriate things during a performance
- Thought about harm from asbestos
- Impulse to shout at someone or abuse them
- Thought about harm coming to husband/wife
- Doubts about having committed a sin
- Thought of being punished by God
- Impulse to curse in church
- Thoughts of accidents or mishaps
- Thoughts of children getting sick
- Thought of “unnatural” sex acts
- Thought about molesting children
- Images of germs festering on one’s skin
- Sense that something is not perfect
- Bad thoughts about God

These studies demonstrate that people with OCD do not have something terribly wrong with their brains that cause them to have terrible, senseless, or immoral thoughts. And, this is good news because it means that people with OCD are not in the least “abnormal”. Their thoughts are no different than people without OCD.

You might be wondering why these strange but completely normal negative intrusive thoughts exist in the first place? This is probably due to the fact that as humans, we have highly developed and creative brains. We are able to imagine all kinds of scenarios- some more pleasant than others. We have a “thought generator” in our brain that sometimes generates thoughts we would rather not think about. Sometimes, the generator produces thoughts about danger even though there may not be any real threat present.

DIFFERENCES BETWEEN PEOPLE WITH AND WITHOUT OCD

But, if intrusive distressing thoughts are a normal part of life for everyone, every day, why do some people develop OCD and others do not? It turns out that scientists have discovered differences in how people with and without OCD interpret their unwanted negative thoughts. Depending on their mood, people without OCD seem to simply dismiss their senseless thoughts as meaningless and not worthy of further attention. In response to such a thought, they might automatically say to themselves, “that’s a silly thought, I would never do that”, or “that thought doesn’t make sense, time to think about something else.” When this happens, the person doesn’t pay any more attention to the thought, and the thought soon passes.

For people with OCD, however, things go much differently. Studies have found that people with OCD misinterpret their intrusive thoughts as highly meaningful or significant in one way or another. In fact, many people with OCD view their intrusive thoughts as threatening. When this happens, it activates the body’s automatic danger detection system (the “fight-flight” system), which causes us to pay more attention to the perceived threat. Sometimes, however, the danger detection system overreacts by acting like there is a tiger lurking around the corner, when there is really only a kitten. Therefore, it is not surprising that people with OCD pay lots of attention to particular unwanted negative thoughts that they misperceive as being threatening. This occurs because attention to threat serves to protect us. If nature did not endow us with the reflex to pay attention to potential threats, we would not have survived as a species.

So, as you can see the main difference between people with and without OCD is in the importance that they attach to their intrusive thoughts- not the thoughts themselves. It is no coincidence that we typically see contamination obsessions among clean people, harming obsessions among gentle people, blasphemous or sexual obsessions among religious or moral people, and thoughts about mistakes among careful people. The more important something is, the worse it seems to have a bad thought about it.

MISINTERPRETATIONS OF INTRUSIVE THOUGHTS IN OCD

It turns out that most people with OCD make similar types of misinterpretations of their intrusive thoughts- misinterpretations that lead to feeling threatened. Below, we will explore some of these.

People with OCD often feel overly responsible for harm or danger associated with their obsessional thoughts. They may have a particular thought and immediately jump to the conclusion that they had better act to reduce the chances of something terrible happening. But they do not stop to evaluate the realistic probability of danger- which is usually extremely low. So, people with OCD often act on the blind assumption that their intrusive obsessional thoughts are true (which, as we have seen, is not the case). In addition, whereas people without OCD

typically assume a situation is safe if there is no recognizable sign of danger, people with OCD assume obsessional situations are dangerous and require excessive assurance that they are, in fact, safe. Thus people with OCD have an “intolerance of uncertainty”.

Another error that people with OCD sometimes make is to believe that it is somehow bad to have bad thoughts. This is simply not true. In fact, as human beings, we are fortunate to have the capacity to think about anything we want. We can plan ahead, remember, and create fantasies about both positive and negative events. Our thoughts are private occurrences and we can hide them from others if we choose. Further, we can decide whether or not to act on our thoughts. As we have seen, everyone at times has unpleasant thoughts about actions we would consider inappropriate or immoral. Whereas there might be consequences for acting on these thoughts, we are completely free to imagine such events without consequences. Indeed, most movies, shows, books, artwork, and science are the result of this wonderful ability to think creatively.

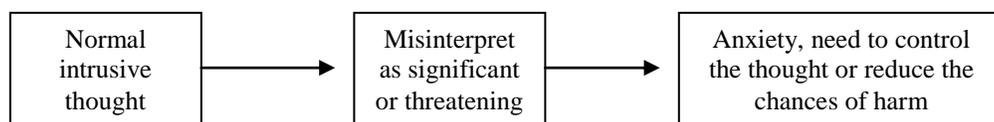
Some people with OCD fear they will automatically act on their obsessional thoughts without thinking. Thus having the thought is perceived as dangerous because it will lead to a terrible action. However, this is not true. Our thoughts are not the only determinant of our actions. Indeed, we have the free will to pick and choose which thoughts we will act on and which we will not. You might experiment by thinking about standing up out of your chair, but deciding not to actually stand. If you decide not to stand, all the thinking in the world will not cause you to stand. In fact, there is nothing that can make you stand if you consciously choose not to. So, thoughts about inappropriate or harmful actions that you don't want to act on can not actually cause you to act against your will.

Other mistakes include “magical thinking”- believing that if you have a thought about an event, it makes the event more likely to happen. But this is illogical as well. Just because we think of something does not make it more likely to occur. Think of how many times you think about something at it doesn't happen. The mistake here is the tendency for people with OCD to base their predictions on what they feel, rather than on what their experience, or other kinds of valid evidence, tells them.

Another common mistake is to believe that you can, and should, *control* your thoughts. Not true. In fact, human beings are notoriously poor at controlling their thoughts. You might know this first hand if you have ever tried to stop yourself from having a specific thought- this is called “thought suppression”. Most likely you found that attempts to suppress your unwanted thoughts resulted in the thought coming back. Researchers have studied thought suppression extensively finding that people can not stop their thoughts by simply telling themselves not to think them. So, using this strategy with obsessions is doomed to fail also. In fact, one of the ways obsessions can develop is by habitually trying to suppress thoughts. If you believe a thought is dangerous and try to suppress it, but can't, you will start to feel more and more anxious. However, if you believed 100% that your unwanted thoughts are not threatening, you would not have the need to control or suppress them, and the thoughts would actually occur less frequently.

A MODEL OF THE DEVELOPMENT OF OBSESSIONS

What we have described so far helps to explain how obsessional thoughts develop. A simple model of the development of obsessions would look like the following:



PART 2: WHY DO OBSESSIONAL FEARS CONTINUE?

This brings us to the second part of our explanation: how obsessions continue. Once a fear or obsession is established, people naturally seek to reduce their discomfort. As stated above, if a person feels threatened, they will act to remove the threat. In OCD there are two methods of removing threat evoked by obsessions. The first is to avoid threatening situations or thoughts in the first place. The second is to escape from unavoidable situations or thoughts. As we will see, both have the same eventual outcome—they actually strengthen obsessional fears. We will focus on avoidance first.

AVOIDANCE

People with OCD spend a lot of energy avoiding situations that provoke obsessional anxiety. This is understandable since no one wants to feel anxious or threatened. Avoidance may be subtle, such as turning the channel on the television or not touching a certain surface; or it may be overt, such as driving out of your way to avoid passing a certain landmark. Thus, avoidance tends to be one of the more devastating aspects of OCD because it can severely restrict people from their normal functioning. The purpose of avoidance in OCD is to dodge confrontation with feared situations featured in obsessional thoughts and reduce the likelihood of anxiety and harm. So, there is a relationship between obsessional thoughts and situations that are avoided. However, as we have seen above, obsessional fears are unrealistic and usually based on a person's thoughts as opposed to real threat. Thus, avoidance is an exaggerated response to situations that pose little if any real threat.

Not only is avoidance an excessive response to obsessions, it also strengthens obsessional fears in two ways. First, because it requires effort, avoidance calls greater attention to the obsessional thought. You start to believe "if I have to go to so much effort to avoid, it must be important." In addition, avoidance leads to being overly watchful, or "hyper-vigilant", for possible things you must avoid. With time, more and more situations become potentially threatening, further restricting your activity. Again, this results in increased significance of the obsessional fear. Second, avoidance prevents you from learning that your obsessional fear is not valid. That is, by avoiding, you never give yourself the opportunity to enter a feared situation and see that (a) harm is unlikely to occur, and (b) you can handle temporary anxiety and discomfort that eventually goes away. Thus, avoidance contributes to the continuance of obsessional fears.

COMPULSIVE RITUALS AND "ESCAPE BEHAVIOR"

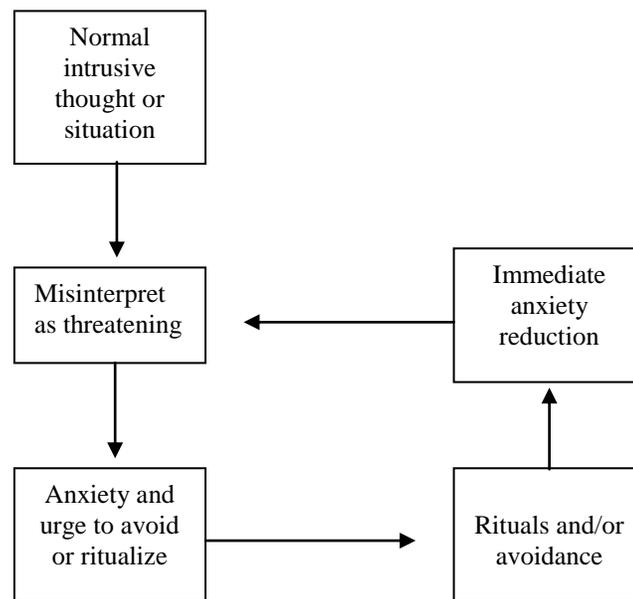
The second method of removing threat is by escaping from situations judged to be threatening. Indeed, it is perfectly natural to want to escape from potential harm-- people leave a burning building as quickly as they can. In OCD, escape involves intentionally performing a behavior or a mental act to reduce the likelihood of harm. We call these compulsive rituals, and they often take the form of repeated washing, checking, praying, arranging, mentally neutralizing, repeating, and asking for assurance. These are all forms of escape because they are performed to reduce (a) uncertainty, (b) anxiety/distress, and/or (c) the potential for danger. For example, a person with obsessional fears of contamination from floors might avoid touching floors and wash their hands if they came into contact with something they fear may have touched the floor. This washing serves to reduce the distress because, to the person with OCD, it has removed the possibility of contamination. Importantly, compulsive rituals represent excessive behaviors because you are actually not in any danger in the first place.

As with avoidance, compulsive rituals also serve to strengthen obsessional fears. First, you may have come to believe that "something worth ritualizing about must really be dangerous".

Second, if compulsive rituals serve as an escape from perceived danger, than by performing rituals you never give yourself the opportunity to see that the obsessional situations are not dangerous. In addition, people with OCD often come to believe that their rituals really prevent the disastrous consequences they fear. In the example above, the person might believe, "I did not get sick because I washed my hands a special way." This is a dangerous trap because not only is it a false belief, but it leads to strong feeling that the ritual is important in keeping safe. Thus, rituals also serve to reinforce obsessional fears.

A final point about compulsive rituals is that they seem to be effective for reducing anxiety in the short term. That is, after performing a ritual, you might feel a sense of relief or completion. When this occurs, it means you have tricked yourself into believing that you have just averted catastrophe. As we have seen, there was no threat to avoid in the first place, so this feeling is superstitious. However, the feeling of relief is important because it quickly leads to more urges to complete this ritual the next time you feel threatened. That is, because the ritual made you feel better, you learn to do it again to escape threat under similar circumstances in the future. Psychologists call this "negative reinforcement". This is how rituals become a strong habit. In the long term, however, rituals are wasteful because they teach you to use excessive, time consuming, and meaningless tactics to reduce fear and distress.

So, you can see how avoidance and compulsive rituals, by virtue of their ability to reduce fear and distress, help to strengthen OCD symptoms of obsessional fear. If we think of a model of OCD that incorporates rituals and avoidance, we have the following:



Misinterpretations of normal, harmless intrusive thoughts leads to increased fear and urges to reduce the fear by ritualizing or avoiding. Rituals reduce the fear in the short term, but reinforce the misinterpretation of obsessional fears and situations as dangerous. Thus, opportunities to learn that your fears are unfounded never occur. Obviously, then, once you believe that obsessional situations and thoughts do not represent a high risk of harm, you will feel fewer urges to avoid situations or perform compulsive rituals. Cognitive-behavior therapy (CBT) is a treatment based on this idea and will help you to (a) correct faulty beliefs about your thoughts, (b) weaken the associations between certain thoughts and feelings of uncertainty, anxiety, and distress, and (c) reduce the urges to avoid or perform compulsive rituals.

Understanding Exposure and Ritual Prevention

The treatment you are beginning is called Exposure and Ritual Prevention. It is designed to break two types of associations that are present in obsessive-compulsive disorder (OCD). The first one is the association between sensations of distress and the objects, situations, or thoughts that produce this distress. The second association you want to break is the one between carrying out ritualistic behavior and decreasing the distress. The treatment we offer will break the automatic bond between the feelings of discomfort/anxiety and your rituals. It will also train you to not ritualize when you are anxious. This treatment program includes three components which we call *actual exposure*, *imagery practice*, and *ritual prevention*.

The Treatment Procedures

Exposure: Staying, for longer periods in the presence of a feared object or situation that evokes anxiety and distress (e.g., actual contact with contaminants)

Imagery Practice (imaginal exposure): Mentally visualizing oneself in the feared situations or visualizing their consequences (e.g., driving on the road and hitting a pedestrian)

Ritual Prevention: Refraining from ritualistic behavior (e.g., leaving the kitchen without checking the stove, or touching the floor without washing one's hands)

What is Exposure?

Exposure means that you purposely confront objects or situations that prompt distress and anxiety, and that you stay in those situations for a period of time that lasts until the symptoms decrease by themselves. For example, a person who feels contaminated by public restrooms would visit a public restroom. If you feel contaminated by contact with the floor, you must sit on the floor for an extended period of time. You may believe that your discomfort or anxiety will last forever unless you avoided or escape such situations, or that you wouldn't be able to handle it. However, as you will find out, this is not so. It is true that at first, you can expect discomfort. However, after a little while of exposure, such situations will no longer make you feel as uncomfortable as they once did. This is called habituation.

If this is true, you might wonder why you haven't relieved your distress already, because you have had many encounters with situations that provoked obsessions. The reason is that simply provoking an obsession is not enough. It must be done for a long enough time for the distress to diminish on its own, and it must be done repeatedly to really help with OCD. Many people with OCD hold mistaken beliefs that something terrible will happen if they don't ritualize. Only prolonged exposure without ritualizing can put this mistaken belief to the test and disconfirm it. Therefore, in this treatment, you will also refrain from ritualizing.

If exposure to situations that trigger obsessional distress and urges to ritualize is necessary to relieve OCD, how can you improve without actually confronting your anticipated harm? You can confront the harm by visualizing it in your mind. In *imaginal exposure*, you create in your mind detailed pictures of the disaster that you fear will occur if you do not avoid or ritualize. As in actual exposure, the obsessional distress gradually decreases during imaginal exposure.

Imaginal exposure is also helpful for individuals in whom obsessions occur spontaneously and are not triggered by any identifiable situations. For example, a person might have a blasphemous thought at any time or place, which is the main source of obsessional distress. In this case, there is no particular situation for the person to confront, and therefore the person can't practice remaining in an exposure situation for a prolonged period of time. In using imaginal exposure, the person would purposely imagine the blasphemy repeatedly, without trying to eliminate or neutralize it with a prayer or other ritual.

Imaginal exposure may also be very helpful when a person is particularly distressed about disastrous consequences that he or she fears will occur. For example, if a person fears that their house will burn down, we would not actually burn her house for exposure practice! However, she *can*, for a prolonged period of time, imagine the house burning, until the distress associated with this image decreases. Similarly, someone who fears that they have run over a person who is now lying on the road would not purposely injure someone

in therapy. In imaginal exposure, you create a mental image of the disaster that you fear would occur if you don't ritualize. As with actual exposure, distress gradually decreases during this imagery.

Another reason for using imagery is to make subsequent exposure practices easier for you. If you are extremely distressed over the idea of confronting a situation or object that provokes your obsession, you might find it helpful to *imagine* confronting it. The decrease in your distress during imagery will carry over to the actual exposure.

What is Ritual prevention?

When people with OCD encounter their feared situations or have obsessional thoughts, they become anxious or distressed and feel compelled to perform the ritualistic behavior as a way to reduce their distress. Exposure practices can cause this same distress and the same urges to want to ritualize. Usually, performing rituals strengthens the associations between distress and rituals. Therefore, in treatment, *ritual prevention* is practiced to break the habit of ritualizing. Ritual prevention requires that you stop ritualizing, even though you are still having urges to do so. By facing your fears without resorting to compulsive rituals, you will gradually become less anxious. We call this process *habituation*. In short, rituals are difficult to stop because they bring about relief from anxiety or discomfort when you are feeling distressed. However, you are receiving treatment because these rituals are interfering with your ability to function. Through ritual prevention, your therapist will teach you how to stop rituals and you will learn more effective ways of coping and managing your discomfort, ways used by most people, that do not involve rituals.

Why should I do exposure therapy and ritual prevention?

Perhaps you are asking yourself: Why should I suffer the distress of confronting feared situations on purpose without doing some rituals to get relief? Remember that this treatment program is designed to weaken two types of connections that people with OCD have. The first is the connection between distress and the objects, situations, or thoughts that trigger distress. The second connection is between ritualizing and relief from distress. In other words, after you carry out a ritual, you temporarily feel less distress, so you continue to engage in these patterns. By *not* doing rituals, you help to weaken the connection between rituals and feeling better.

In addition to weakening connections, the program is designed to help correct mistaken ideas that are common in OCD that cause considerable distress. These ideas are: (a) the rituals prevent harm from happening to myself and other people; (b) I have to avoid the distressing situation because if I don't avoid it, distress will continue forever and even will worsen; and (c) if I don't avoid or ritualize, the anxiety will get worse to the point that I will "fall apart" or go crazy.

The first idea common in OCD is that it is necessary to avoid or ritualize in order to prevent harm. Most people can think of potential disasters that might happen to them or others if they carry on necessary daily activities such as driving a car. However, because they can think about the risk without intense, disabling distress, they are able to see that the actual risk is so low, it should be ignored. But, many people with OCD become overwhelmed with distress when they think about certain potential disasters that might happen to them or that they may inflict on others. For example, individuals with OCD might become intensely anxious about the thought of their house catching fire, being possessed by the devil, or contracting AIDS. The intense feeling prevents them from making rational and informed judgments about how risky a situation really is and what they can do to protect themselves or others. To be on the safe side, the person with OCD will avoid or ritualize to prevent even the most remote possibility of harm. Consequently, the individual does not have the opportunity to learn that the feared situation is actually quite safe.

The person who carried out checking rituals thinks that "my house didn't catch fire, either because I never use the stove, or because I am always extremely careful to check it." The person who engages in washing rituals thinks, "yes, I did not get sick after my visit to the hospital because I washed my hands with Lysol and scrubbed myself in the shower." This kind of thinking perpetuates avoidance and rituals.

Exposure works against this type of mistaken idea. When you actually confront a mistakenly feared situation again and again, and don't ritualize, you realize that no harm follows. Thus, you recognize that the risk is remote and you learn to ignore it. For example, Stacy was afraid that her house would catch fire, so she refused to use her central heating even in cold weather. For therapy, she practiced starting the heater and leaving it on while she was away from home. After 24 hours, the house was comfortably warm inside, but did not catch fire, and Stacy learned that her fear was unfounded.

Andrew was concerned about getting poisonous household chemicals into food that his family would eat. Therefore, he never went into the kitchen and never used household chemicals. In addition, before eating, he washed his hands, all dishes and glasses extensively so that nothing would be accidentally poisoned. For his therapy, Andrew placed a bottle of oven cleaner on the counter and prepared food for his family and served it without first washing anything. His family enjoyed the food and didn't die from it, and Andrew learned that his fear was groundless.

The second mistaken idea people with OCD tend to have is the belief that they must avoid the distressing situation, or else they will be distressed forever. This leads them to avoid many situations or to ritualize if they can not avoid them. However, during prolonged exposure, intense anxiety gradually decreases ("habituation"). If someone confronts a distressing situation for a prolonged period of time (such as 1-2 hours), the individual will experience a gradual decrease in distress until the distress is gone. As the distress drops, it becomes easier to see whether or not situation is actually dangerous. Later on, if the same or similar situation arises, there will be some distress, but much less than previously.

Because most people tolerate stressful situations for prolonged periods for practical reasons, they have learned that the distress does not persist forever. This program is designed to help you to remain in the distressful situation so that you too will realize that the distress decreases with time.

A third common belief in OCD is that, "if I don't avoid or ritualize, the distress will get so bad that I'll lose control of my mind." For example, Ray was concerned that if things were not arranged neatly and in the right order, he would be so uncomfortable that he would not be able to stand it, and he would lose his mind and be committed to a psychiatric hospital. For his therapy, Ray purposely disordered his office and bedroom and did not put things back in order even though he became distressed. Instead, his discomfort eventually decreased and he did not lose his mind. He learned that anxiety did not persist forever and did not produce insanity.

A program that involves prolonged actual exposure is designed to help you, whether you are afraid of contracting a disease for public bathrooms, causing automobile accidents, discarding something important, saying inappropriate things, or hurting someone with a knife. Naturally, when you first confront a feared situation, you will become distressed. However, if you remain long enough in the situation, and do so repeatedly, the distress will diminish. This experience changes your idea that the distress will last forever and perhaps lead to insanity, because you learn that if you wait it out, the distress decreases.

How will exposure and ritual prevention help reduce OCD?

For actual and imaginal exposure to be helpful, you must become emotionally involved during the exposure. Specifically, the exposure situation must evoke the same kind of obsessional distress that you experience in your daily life. To promote emotional involvement, we will develop exposure exercises that are a good match to the real-life situations that provoke your obsessions and urges to ritualize. If you are mainly distressed by contamination related to cancer, and for your exposure exercise, you visit a hospital with no cancer ward, the exercise will not be helpful because the situation does not match your obsessional concerns. Thus, it will be hard for you to become emotionally involved when your exercises are unmatched to your obsessions.

Even during exercises that are well-matched to your obsessions, you must approach it in a way that involves you emotionally. This means that you must pay attention to the distressing aspects of the exposure situation, rather than try to ignore them, or pretend that they are not there. This is true for both imaginal and actual exposure. For example, if you pretend that a cancer ward is really a cardiac unit in order to reduce your distress, the exercise will be less effective. Therefore, during exposure, you should think about the potential harm that concerns you. For example, if you are afraid of using public restrooms and you go to a public toilet as an exposure exercise, while you are there, you should think about what concerns you about the toilet, such as how dirty it might be, or what type of disease you're afraid of catching. In the same way, during imagery practice, you should include anticipated disasters and work at imagining them as vividly as you can.

Getting the most out of exposure and ritual prevention

Often, when people think about exposure treatment, they don't understand how it is supposed to work. You might think that if you could just decide to do the things that you avoid and also to give up doing rituals, as you are asked to do, you really wouldn't need treatment at all. Well, most people with OCD can temporarily stop their avoidance and rituals, but it is very uncomfortable, and they don't see why anyone would want to go through this. It is true that for this program, you must decide to stop avoiding and ritualizing, but you will learn to do it in a way that has been found to weaken obsessions and compulsions. Not just any kind of

exposure works. Certainly you have had occasions when you accidentally or purposely confronted feared situations, but it did not get rid of your OCD habits. You must do well-designed exercises, and do them correctly, otherwise exposure does not work. In this treatment, exposure exercises will be designed expressly for your OCD symptoms, and your therapist will coach you through them as you practice.

You can see that what you get out of exposure and ritual prevention depends very heavily on what you put into it. It also depends on your therapist coming up with an exposure plan that fits your particular OCD habits. A useful analogy is that of an athlete who gets help from an expert coach. Suppose that a baseball player is in a batting slump and does not know how to get out of it. An expert coach will watch the batter and figure out what has to be done differently. Then practice exercises will be assigned to correct the problem. If the coach is not knowledgeable and does not analyze the batter's problem correctly, or provide useful exercises, no amount of practicing the wrong exercises will correct the problem. On the other hand, if the coach prescribes just the right exercises, but the batter does not follow the coach's instructions, the coaching won't be useful. Also, if the batter agrees with the coach but doesn't practice, even expert coaching will be useless. Exposure therapy is much the same. If your therapist gives you essential exercises to do and you decide that you know better, or you change them around to make them easier, or you reject them, therapy will not be helpful. Also, if you do not practice as much as you should, you will not get the relief that you want.

Sometimes exposure exercises may seem counterintuitive, or not very related to what you want to get out of treatment, but it will be important for you to practice anyway. If you want to hit homeruns, a coach might give you a weight-lifting schedule and a diet. Neither of these exercises look like homerun hitting, but if your muscles are weak or malnourished, your hitting will not be very good. In exposure and ritual prevention, your therapist will probably give you some instructions to do exercises that seem a bit odd, or different from what you would do in day-to-day life. It will be important to follow these instructions if you want to get the relief that you want. Exposure exercises are not simply to practice mimicking what other people do, they are especially designed to weaken your obsessions and compulsions. If you complain that an exercise isn't normal, or isn't something a normal person would do, you are missing the point. Exposure exercises are designed for the purpose of weakening your obsessive-compulsive habits, they are not supposed to be normal exercises. Try to remember this if you start wondering whether a normal person would do the exposure exercise that you are doing.

Summary

In summary, your treatment program will involve two procedures: exposure and ritual prevention. Exposure involves confronting objects or situations that prompt distress and urges to ritualize. Ritual prevention means resisting the urge to perform rituals. Why should you do exposure? These exercises are designed, by you and your therapist, to help you break associations between fear, and the objects or situations that make you feel distressed. Exposure also helps you to learn that confronting these situations will not lead to such terrible anxiety that you would not be able to handle. Ritual prevention is designed to help correct certain beliefs, such as the idea that doing rituals prevents disastrous things like harm to you, or others. By purposely becoming anxious when doing exposure practice, but resisting the urges to perform compulsive rituals, you will learn that these urges to ritualize, and the anxiety/discomfort, will dissipate on their own. This will greatly help reduce your OCD symptoms.

If you think that exposure and response prevention may be difficult at times, you are probably correct. It takes hard work to confront these situations that you would usually avoid. However, in order to reduce OCD, you must practice exposure and find out that anxiety and distress will decrease without rituals. Further, that no terrible things will occur if you do not ritualize. Therefore, as you practice exposure, these exercises become easier and easier, and your urges to ritualize become less and less over the course of treatment. In order to experience these reductions, it will be important to follow the therapist's instructions as your therapist will design exposure practices that are specifically designed to help you with your symptoms. As you can see, if you put a great effort into treatment, your results will be much more than if you do not put much effort.