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NATIONAL REGISTER
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CLINICAL WEBINARS
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TRANSLATING RESEARCH TO PRACTICE

Understanding and Treating OCD

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Jonathan S. Abramowitz, Ph.D. is a Professor of Clinical Psychology at the University of North Carolina at Chapel Hill. His work focuses on OCD and anxiety disorders and he has authored over 300 scientific publications and 15 books. He is Editor-in-Chief of the *Journal of Obsessive-Compulsive and Related Disorders and* a Past President of the Association for Behavioral and Cognitive Therapies. In addition to teaching and research, he maintains a clinical practice specializing in CBT for OCD and anxiety.

Disclosures/Conflicts of Interest

- I, Jonathan S. Abramowitz, Ph.D., have no conflicts of interests or disclosures.

References/Citations

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Learning Objectives

1. Identify the symptoms of OCD and compare them with symptoms of other similar problems.

2. Describe the cognitive-behavioral model of OCD.

3. Demonstrate effective treatments for OCD.

What is the Nature of OCD?

- Unwanted thoughts (obsessions) give rise to anxiety/distress

- Compulsions are performed to reduce this distress, dismiss unwanted thoughts, or reduce the probability that disastrous consequences will occur

- <u>Neutralizing</u> is a cardinal feature of OCD

- Theme-based symptom dimensions

  - contamination, responsibility for harm, unacceptable thoughts, order/symmetry

Learning Theory View of OCD

- Obsessional fear develops through classical conditioning

- The performance of compulsions prevents the extinction of obsessional anxiety

- Compulsions are negatively reinforced by the brief reduction of anxiety they engender

Behavioral Therapy for OCD Includes:

- Procedures that evoke obsessional anxiety
  - Exposure to obsessional cues (floors, driving, unacceptable thoughts)

- Procedures that eliminate the contingency between rituals and anxiety reduction
  - Response prevention (refrain from washing or checking rituals)

Cognitive/Acceptance Models of OCD

- Where do obsessions come from?
  - Intrusive unpleasant thoughts are universal
  - Certain mistaken beliefs lead to misinterpreting unwanted thoughts as facts
    - "Obsessive beliefs" - Thoughts are important, I am responsible, Uncertainty is intolerable
    - "Experiential avoidance" - Tendency to subjectively resist internal experiences

- Compulsions, reassurance, and experiential avoidance
  - Short-term: immediate (temporary) anxiety reduction
  - Long-term: prevent the correction of mistaken beliefs and interpretations
  - Long-term: increased preoccupation ("if you don't want it, you've got it")
  - Long-term: interfere with functioning and quality of life

Rachman, 1997; Salkovskis, 1999

ACT for OCD Focuses On:

- Acceptance
  - Willingness to experience thoughts, anxiety, uncertainty whenever they show up
- De-fusion
  - Observe thoughts, anxiety, uncertainty without trying to control them
- Values
  - Learning to engage in life despite unwanted thoughts, anxiety, and uncertainty

What is <u>not</u> OCD

- Hair-pulling and skin-picking
  - No misinterpretations of unwanted intrusive thoughts
  - "Compulsive" behaviors maintained by positive reinforcement
  - Treatment by habit reversal training

- Hoarding
  - Different cognitive profile (beliefs about possessions)
  - Different approach to treatment

- OC personality traits
  - Characterized by ego-syntonic perfectionism

Comprehensive CBT Program

- Assessment (1-2 sessions)

- Education (1-2 sessions)
  - Draws from ACT and cognitive-behavioral models

- Exposure and response prevention (sessions 4-16)
  - Situational and imaginal exposure in session
  - Inhibitory learning foundation
  - Stopping rituals

- Involvement of a partner/family member

Functional Assessment:
3 Components of OCD

- Unpleasant Internal experiences
  - Thoughts, body sensations, uncertainty, anxiety, etc.
  - Although unpleasant, these are normal, safe, and universal

- Responses to the internal experiences
  - Rituals, reassurance-seeking, avoidance, thought suppression, neutralizing
  - These might work in the short-term, but backfire in the long-run

- Effects on quality of life
  - Work, school, relationships, leisure, etc.
  - The responses (not the private experiences themselves) lead to QOL impairment

Psychoeducation: Draw on ACT Metaphors

- Understanding how OCD works
  - Digging in the hole
- Acceptance
  - Uninvited party guest
- De-fusion
  - Chessboard
- Values
  - Moving through a swamp

Also discussed during exposure trials

Exposure and Response Prevention

- OCD remits when the person comes to believe their obsessions and fears are unfounded *and acts accordingly*

- Simply talking about probabilities is not as convincing as direct evidence from experience
  - People need to directly confront their fears (exposure) and drop their rituals (response prevention) to truly master them

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

Exposure Therapy

- Situational
  - Repeated, prolonged confrontation with situations and stimuli that provoke obsessional fear
    - Contaminants, driving, religious icons, words, numbers, situations, etc.
- Imaginal
  - Confrontation with:
    - Unacceptable obsessional thoughts (sex, violence, immorality)
    - Feared consequences of situational exposures (disaster, uncertainty)
- How does it work?
  - Habituation?
  - Fear extinction?

Setting Up the Treatment Plan

- Generate list of situations and thoughts for exposure

  - Realistically safe
  - Evoke obsessional distress and urges to ritualize

- Patient rates subjective units of discomfort (SUDS) for each situation or thought

- Collaborative effort in generating exposure list

- Generate a list of rituals to target in response prevention

Sample Exposure Lists

- Surfaces (doors, railings)
- Floors
- Garbage cans
- Dumpsters
- Dirty laundry
- Home bathroom
- Public bathroom

- "13"
- "666"
- Duke Blue Devils, NJ Devils
- South Park (devil episode)
- Songs about the devil
- Horror movie
- Satanic Bible

An Inhibitory Learning (IL) Approach to ERP

- Fear associations remain intact during exposure while new safety learning is formed
    - The old and new associations compete with one another

- Important to maximize the likelihood that safety learning will inhibit access and retrieval of fear associations
    - Disconfirm fear-based predictions
    - De-contextualize learning by maximizing variability
    - Combine fear cues to deepen extinction
    - No rituals

Using Exposure to Foster Fear Tolerance

- Increase fear tolerance to inoculate against the return of fear

- How to set up exposures
  - Opportunities to learn that fear predictions are incorrect
  - Opportunities to learn fear tolerance
    - OCD patients: "*Make anxiety go down and my obsessional thoughts go away*"
    - IL approach: "*Learn that anxiety and unwanted thoughts are safe and manageable*"
  - "Bring it on" attitude!
  - Hierarchy vs. list

Frame ERP to Mismatch Expectancies

- When the negative outcome does not occur, we generate safety learning

- What are negative outcomes for OCD patients?
  - Immediate (e.g., throwing up, stabbing someone)
  - Long-term (cancer, becoming a pedophile)
  - Unknowable (hell, do I love someone?)
  - Intolerance of unpleasant internal experiences (body sensations, thoughts)

Expectancy Tracking

- Set up exposure to disconfirm fear-based predictions
  - Probability (90% sure X will happen...)
  - Level of distress tolerance ("I *can* stand anxiety")
  - Length of time patient can resist ritual ("I can get through this without rituals")
- Consolidate learning by asking patients to summarize what they learned
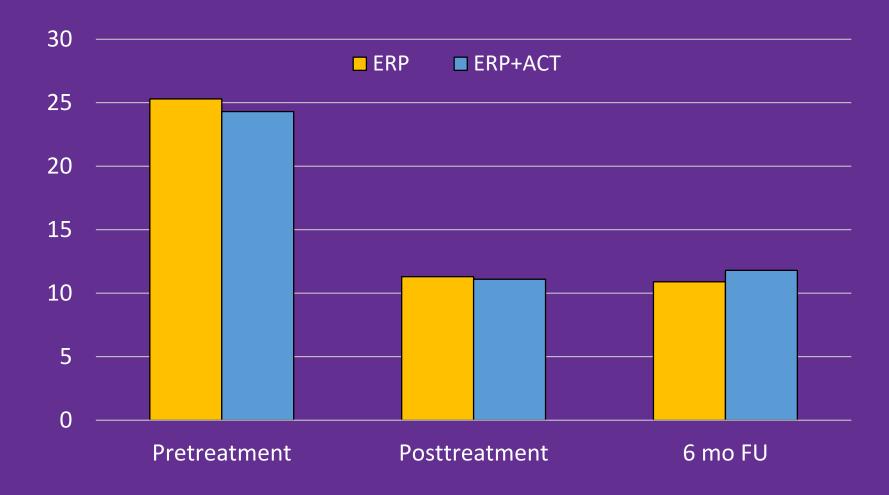 - Emphasize the discrepancy between what was predicted and what occurred

EXPOSURE PRACTICE FORM

Date: _____ Time: _____ Description of task: _____

1. Feared outcome of exposure ("worst case scenario" hypothesis to be tested):

2. Safety behaviors to prevent:

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

Every _____ during the exposure, rate the (b) strength of belief in feared outcome, and (b) confidence in your ability to tolerate distress from 0 to 100.

4. Anticipatory Ratings for (a) _____; (b) _____

	Trial 1	2	3	4	5	6	7	8	9	10
(a) Belief										
(b) Confidence										

	11	12	13	14	15	16	17	18	19	20
(a) Belief										
(b) Confidence										

	21	22	23	24	25	26	27	28	29	30
(a) Belief										
(b) Confidence										

5. What was the outcome of the exposure? What did you learn? (Specifically address #1 above)

6. What could you do to vary ("mix up") this exposure in the future?

Yale-Brown Obsessive Compulsive Scale (0-40)

Twohig, Abramowitz et al. (2018)

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OCD in an Interpersonal Context

- Person with OCD acts to structure their environment to minimize obsessions and anxiety

- Family members often become part of "OCD World"

  - Help person avoid anxiety

  - Help with compulsive rituals

  - Providing ongoing reassurance

  - Constant lectures and arguments

OCD ⟷ Relationship Functioning

- The patient's fears, avoidance, and rituals create interpersonal conflict which exacerbates OCD

- Accommodation by family members maintain OCD symptoms
  - Performed out of love to protect loved one from anxiety
  - Often frustrating for the non-OCD family members

- Chronic stress unrelated to OCD (e.g., finances) increases symptoms

Family Involvement in Treatment

- Assessment of how the family/couple relates around OCD
- Education about OCD in relationship context
- Communication training
- Partner assisted exposure and response prevention
- Alter interactions when managing OCD
  - No accommodation
  - Healthy ways to show care and concern
  - Broaden family/couple behaviors as OCD improves (behavioral activation)
- Focus on more general family or relationship stressors

Q&A

- Dr. Sammons will read select questions that were submitted via the Q&A feature throughout the presentation.

- Due to time constraints, we will not be able to address every question asked.