✓Treatments That Work™

Exposure and Response (Ritual) Prevention for Obsessive-Compulsive Disorder

Second Edition

Therapist Guide

Edna B. Foa

Elna Yadin • Tracey K. Lichner

Exposure and Response (Ritual) Prevention for Obsessive-Compulsive Disorder

✓Treatments *That Work*™

Exposure and Response (Ritual) Prevention for Obsessive-Compulsive Disorder

Therapist Guide

Second Edition

Edna B. Foa • Elna Yadin • Tracey K. Lichner

OXFORD
UNIVERSITY PRESS

OXFORD
UNIVERSITY PRESS

Oxford University Press, Inc., publishes works that further
Oxford University's objective of excellence
in research, scholarship, and education.

Oxford New York
Auckland Cape Town Dar es Salaam Hong Kong Karachi
Kuala Lumpur Madrid Melbourne Mexico City Nairobi
New Delhi Shanghai Taipei Toronto

With offices in
Argentina Austria Brazil Chile Czech Republic France Greece
Guatemala Hungary Italy Japan Poland Portugal Singapore
South Korea Switzerland Thailand Turkey Ukraine Vietnam

Published by Oxford University Press, Inc.
198 Madison Avenue, New York, New York 10016

www.oup.com

Library of Congress Cataloging-in-Publication Data

Foa, Edna B.
Exposure and response (ritual) prevention for obsessive-compulsive disorder : therapist guide / Edna B. Foa, Elna Yadin, Tracey K. Lichner. — 2nd ed.
p. cm. — (Treatments that work)
Includes bibliographical references. ISBN 978-0-19-533528-6
1. Obsessive-compulsive disorder—Treatment. 2. Exposure therapy.
I. Yadin, Elna. II. Lichner, Tracey K. III. Title.
RC533.F597 2012
616.85'227—dc23

2011040384

9 8 7 6 5 4 3 2 1

Printed in the United States of America
on acid-free paper

About Treatments *ThatWork*™

Stunning developments in healthcare have taken place over the past several years, but many of our widely accepted interventions and strategies in mental health and behavioral medicine have been brought into question by research evidence as not only lacking benefit, but perhaps inducing harm. Other strategies have been proven effective using the best current standards of evidence, resulting in broad-based recommendations to make these practices more available to the public. Several recent developments are behind this revolution. First, we have arrived at a much deeper understanding of pathology, both psychological and physical, which has led to the development of new, more precisely targeted interventions. Second, our research methodologies have improved substantially, such that we have reduced threats to internal and external validity, making the outcomes more directly applicable to clinical situations. Third, governments around the world and healthcare systems and policymakers have decided that the quality of care should improve, that it should be evidence-based, and that it is in the public's interest to ensure that this happens (Barlow, 2004; Institute of Medicine, 2001).

Of course, the major stumbling block for clinicians everywhere is the accessibility of newly developed evidence-based psychological interventions. Workshops and books can go only so far in acquainting responsible and conscientious practitioners with the latest behavioral healthcare practices and their applicability to individual patients. This new series, Treatments *ThatWork*™, is devoted to communicating these exciting new interventions to clinicians on the front lines of practice.

The manuals and workbooks in this series contain step-by-step detailed procedures for assessing and treating specific problems and diagnoses. But this series also goes beyond the books and manuals by providing ancillary materials that will approximate the supervisory process in assisting practitioners in the implementation of these procedures in their practice.

In our emerging healthcare system, the growing consensus is that evidence-based practice offers the most responsible course of action for the mental health professional. All behavioral healthcare clinicians deeply desire to provide the best possible care for their patients. In this series, our aim is to close the dissemination and information gap and make that possible.

This newly revised and updated therapist guide outlines a cognitive-behavioral treatment (CBT) program for obsessive-compulsive disorder (OCD) called Exposure and Response (Ritual) Prevention (EX/RP). EX/RP includes five main components: *in vivo* exposure, imaginal exposure, response (ritual) prevention, processing, and home visits. Over the course of 17 to 20 biweekly treatment sessions, OCD patients are exposed to stimuli (in real life or imaginally) that trigger their obsessional distress and their urge to ritualize. These exposures are designed to be gradual so that over time patients come to realize that the things they fear will not necessarily occur if they don't perform their rituals. Treatment includes both therapist-supervised exposures and ritual prevention, and self-monitored exposure and ritual prevention at home. To successfully implement treatment, mental health professionals should be familiar with CBT or have participated in intensive workshops for EX/RP given by experts in this therapy.

EX/RP is a brief CBT-based treatment that has proven scientifically efficacious in numerous studies. In OCD, a severe and often intractable disorder, skillful application of this treatment, and this treatment alone, offers the best hope for recovery. (Patients who are sufficiently motivated and engaged in treatment will no doubt experience a decrease in symptoms and potential mastery over their OCD.)

David H. Barlow, Editor-in-Chief,
Treatments *That Work*™
Boston, MA

References

Barlow, D. H. (2004). Psychological treatments. *American Psychologist, 59,* 869–878.

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, D.C.: National Academy Press.

Acknowledgments

I want to acknowledge the contribution of Dr. Michael Kozak to my conceptualization of the psychopathology that underlies OCD and the mechanisms that underlie exposure and ritual prevention, which are explicated in the manual. Indeed, the present manual is an update and expansion of a previous manual, "Mastery of Your Obsessions and Compulsions," coauthored by Dr. Kozak and myself. I also want to thank Drs. Michael Leibowitz and Blair Simpson for the insight they provided into my view of OCD through many years of collaborations. My thanks are extended to my collaborators at the Center for the Treatment and Study of Anxiety over the past 30 years. Lastly, I want to thank the patients who taught me so much about how to help them.

- Edna B. Foa

To my dear family and friends who taught me about loyalty and generosity; to my colleagues, past and present, whose work is incorporated in this book; and last, but not least, to our patients, together with whom we have learned about struggle, compassion, and triumph.

- Elna Yadin

To my wonderful, vibrant sisters—you keep alive the determined spirit of our parents, and your love, encouragement, and friendship mean the world to me.

- Tracey K. Lichner

This page intentionally left blank

Contents

Chapter 1 *Introductory Information for Therapists*

This therapist guide *Exposure and Response (Ritual) Prevention Therapy for OCD* is accompanied by a client workbook *Treating Your OCD with Exposure and Response (Ritual) Prevention Therapy*. The manuals and treatment are designed for use by therapists who are familiar with cognitive-behavioral therapy (CBT) or who have participated in intensive workshops for exposure and ritual prevention (EX/RP) by experts in this therapy. The manual aims to guide therapists in implementing this brief CBT program that targets symptoms of obsessive-compulsive disorder (OCD). Note: In the field of OCD, the terms "response-prevention" and "ritual-prevention" are used interchangeably. The abbreviations EX/RP and ERP are also used interchangeably when referring to exposure and response (ritual) prevention therapy. Throughout this manual, we will be using the term "ritual prevention" and the EX/RP abbreviation.

Background Information about EX/RP Treatment

This manual describes a CBT program for OCD that includes between 17 and 20 treatment sessions. The first two sessions involve presentation of the cognitive-behavioral model of OCD, a description of the treatment program, and collecting information about the specific clinical picture of the patient. This information includes the patient's history of OCD, exploring the onset and course of the disorder, identifying triggers for the patient's various intrusive, obsessional thoughts as well as delineating the compulsions (rituals) and avoidance patterns. In these two sessions, the therapist also teaches the patient self-monitoring of symptoms, and together with the patient creates a hierarchy of EX/RP exercises.

EX/RP treatment includes the following procedures:

- ***Exposure* in vivo** (i.e., exposure in real life) involves helping the patient confront cues that trigger obsessive thoughts. Cues include objects, words, images, or situations. For example, touching water faucets in a public restroom might trigger germ obsessions (for a detailed discussion see Chapter 3).

- ***Imaginal exposure*** involves asking the patient to imagine in detail the distressing thoughts or situations. It is used primarily to help patients confront the disastrous consequences that they fear will occur if they do not perform the rituals. For example, imaginal exposure may involve a patient imagining contracting a sexually transmitted disease because he did not wash his hands sufficiently after using a public bathroom and consequently being shunned by friends and family (for a detailed discussion see Chapter 3).

- ***Ritual prevention*** involves instructing the patient to abstain from the ritualizing that he or she believes prevents the feared disaster or reduces the distress produced by the obsession (e.g., washing hands after touching the floor and fearing contracting a disease). By practicing ritual prevention the patient learns that the anxiety and distress decrease without ritualizing and that the feared consequences do not occur (for a detailed discussion see Chapter 3).

- ***Processing*** involves discussing with the patient what happened during the exposure as it relates to experiencing changes in anxiety levels, as well as to gaining insights about feared consequences (for a detailed discussion see Chapter 3).

- ***Home visits*** involve planning and executing visits to the patient's home environment, both to help collect important information about the patient's OCD symptoms and to aid in transferring and implementing treatment gains (for a detailed discussion see Chapter 3).

The bulk of the treatment program involves the practice of EX/RP exercises, both in session and as homework assignments, working through more difficult exposures as treatment progresses. These sessions can be conducted once a week, twice a week, or daily in an intensive treatment

program, depending on symptom severity and logistical considerations (see Chapter 3). Treatment includes both therapist-supervised EX/RP and self-monitored EX/RP at home. During the last couple of sessions, an emphasis is placed on relapse prevention and maintenance of gains. The corresponding workbook includes readings and homework assignment forms.

In the first session, the cognitive-behavioral model of OCD is presented, as well as an explanation of how EX/RP treatment relates to this model. It is of utmost importance that the patient has a clear understanding of how and why EX/RP works to reduce OCD symptom severity and related symptoms. Understanding the rationale will motivate patients to encounter the cues that trigger their obsessional distress and resist the urges to ritualize that their obsessional distress generates. Understanding the rationale is particularly important in encouraging patients to complete their homework assignments, which they mostly do without supervision.

Obsessive-Compulsive Disorder

Prevalence and Course of Treatment

Once thought to be a rare disorder, it was estimated that between 2 and 3 million people in the United States suffer from OCD (Karno, Golding, Sorenson, & Burnam, 1988). According to the National Comorbidity Survey Replication, approximately 1.6% of the U.S. population reported experiencing OCD during their lifetime (Kessler, Berglund et al., 2005), with 1% of the sample having the disorder within the past year (Kessler, Chiu, Demler, Merikangas, & Walters, 2005). Age of onset typically ranges from early adolescence to young adulthood, although cases have been reported as young as 2 years old (Rapoport, Swedo, & Leonard, 1992). Males generally develop the disorder earlier in their lives, in the teenage years around ages 13 to 15, while female onset is more likely to occur in young adulthood, ages 20 to 24 (Rasmussen & Eisen, 1990). Among adults the prevalence of OCD is equal for men and women (Rasmussen & Tsuang, 1986). Development of OCD is usually gradual, although acute-onset cases have been reported.

In some cases of childhood OCD, patients experience a very sudden onset following a strep infection. When the infection is treated, the children experience a substantial reduction of symptoms; however, if the infection recurs, the OCD symptoms again increase abruptly (Swedo, Leonard, & Rapoport, 2004). This presentation of OCD is referred to as pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS).

Typically, without treatment, the course of OCD is chronic, with waxing and waning of symptoms over time (Antony et al., 1998; Eisen & Steketee, 1998). However, a small percentage of patients report episodes in which they have OCD interspaced with periods of remission. There are cases where OCD symptoms consistently worsen across a lifetime (Rasmussen & Eisen, 1989). Over time, most individuals continue to meet full criteria for OCD or still show residual symptoms (Steketee, Eisen, Dyck, Warshaw, & Rasmussen, 1999). Although effective treatment significantly improves quality of life among individuals with OCD (Bystritsky et al., 1999), many persons with OCD suffer for years before seeking treatment. One research study found that on average, individuals with OCD wait over 7 years after the onset of significant symptoms before they seek treatment (Rasmussen & Tsuang, 1986).

Impact of OCD

Untreated OCD has a significant negative impact on one's life. Dealing with obsessions and compulsions for hours each day causes severe personal distress and interferes with employment, relationships, and daily activities of life. For those with severe OCD, between 80% and 100% report significant impairment in home, work, relationships, and social life (Ruscio, Stein, Chiu, & Kessler, 2008). Studies have found that 22% to 40% of OCD patients seeking treatment were unemployed compared to a typical 6% unemployment rate for the U.S. general population (Koran, Thienemann, & Davenport, 1996; Steketee, Grayson, & Foa, 1987). Not only do individuals with OCD frequently suffer from job loss (Leon, Portera, & Weissman, 1995), but they also experience interpersonal relationship difficulties (Calvocoressi et al., 1995; Emmelkamp, de Haan, & Hoogduin, 1990; Riggs, Hiss, & Foa, 1992).

Marital distress is reported by about half of married individuals seeking treatment for OCD (Emmelkamp et al., 1990; Riggs et al., 1992). Fifty percent of OCD sufferers report losing friendships and 25% report losing intimate relationships due to OCD symptoms (Gallup, 1990). Celibacy rates are also elevated in OCD populations even relative to other anxiety disorders (Steketee et al., 1987). Overall, OCD is considered one of the top ten causes of disability worldwide (Lopez & Murray, 1998).

Comorbid Disorders

Individuals with OCD commonly present to treatment with other concerns and symptoms, such as depression, phobias, anxiety, and worry (Karno et al., 1988; Rasmussen & Tsuang, 1986; Tynes, White, & Steketee, 1990). Recent findings indicate that over a lifetime, 86% to 90% of individuals with OCD meet criteria for at least one additional DSM-IV disorder (Brown, Campbell, Lehman, Grisham, & Mancill, 2001; Ruscio et al., 2008). Other studies have found that between 50% and 60% of patients with a current diagnosis of OCD also meet criteria for at least one other Axis I disorder (Brown et al., 2001; Lucey, Butcher, Clare, & Dinan, 1994; Rasmussen & Eisen, 1990; Ruscio et al., 2008). Anxiety disorders such as social phobia, specific phobia, and panic disorder appear to be the most common additional diagnosis, with approximately 76% of patients meeting lifetime criteria for these disorders (Ruscio et al., 2008). Weissman et al. (1994) found that approximately half of individuals with a current diagnosis of OCD also meet criteria for another anxiety disorder. Mood disorders are also common for those suffering from OCD. Lifetime occurrence for any mood disorder is 60%, with the most common being major depressive disorder (41%; Ruscio et al., 2008). Other studies have found that approximately 30% of patients with a current diagnosis of OCD also meet criteria for major depression (Crino & Andrews, 1996; Karno et al., 1988; Weissman et al., 1994). This is especially important because some research has suggested that severe depression in particular is associated with poorer CBT outcomes (Abramowitz, Franklin, Street, Kozak, & Foa, 2000; Foa, Grayson, & Steketee, 1982). A relationship of OCD with eating

disorders has also been reported in the research literature. About 10% of women with OCD reported a history of anorexia (Kasvikis et al., 1986), and 33% of women diagnosed with bulimia had a history of OCD (Hudson & Pope, 1987; Hudson et al., 1987; Laessle et al., 1987). Tic disorders also appear to be related to OCD. Between 20% and 30% of individuals with OCD reported a current or past history of tics (Pauls, 1989). Comorbidity estimates of Tourette's and OCD range from approximately 35% to 50% (Leckman & Chittenden, 1990; Pauls et al., 1986).

Diagnostic Criteria for OCD

Here are the American Psychiatric Association (*DSM-IV-TR*, 2000) diagnostic criteria for OCD (p. 462):

A. Either obsessions or compulsions:

Obsessions as defined by (1), (2), (3), and (4):

(1) recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress

(2) the thoughts, impulses, or images are not simply excessive worries about real-life problems

(3) the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action

(4) the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

Compulsions as defined by (1) and (2):

(1) repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly

(2) the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or are clearly excessive

B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. **Note:** This does not apply to children.

C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.

D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder).

E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify if:

With Poor Insight: If, for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable.

Several issues emerging from these criteria are worth noting:

- Obsessions always give rise to distress and anxiety; there are no positive obsessions.

- The content of obsessions is different from everyday worries (e.g., "If I do not repeat the number 4, I will kill my child" vs. "My child will catch cold if I don't dress him in warm underwear").
- The person makes efforts to get rid of the obsessions by pushing them out of his or her mind; this is true for other disorders as well.
- The person also tries to get rid of the obsessions by neutralizing them with some other thought or action; only individuals with OCD neutralize their distressing thoughts.
- For many patients it is not possible to ascertain the presence of Criterion B that: "At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable." This is because most patients present to treatment years after the onset of their symptoms and, if they exhibit poor insight at the present episode, will not remember that in the past they did have good insight.
- The *DSM-IV-TR* (2000) indicates that the person has OCD if he or she demonstrates either obsessions or compulsions. However, the vast majority of patients who were diagnosed in an expert clinic as having OCD had both obsessions and compulsions (Foa et al., 1995). In Chapter 2, we will elaborate on this point and suggest that patients who have only obsessions or only compulsions are unlikely to have OCD.
- The majority of the time the compulsions aim at preventing or reducing the obsessional distress. In the DSM-IV field trial on OCD, over 90% of participants reported that their compulsions aim to either prevent harm associated with their obsessions or to reduce obsessional distress; only 10% perceived their compulsions as unrelated to obsessions (Foa et al., 1995). For example, the obsessional thought of an OCD patient that he might harm someone by neglecting to lock the door will give rise to anxiety or distress. Repetitively checking the door is a behavior that attempts to *reduce* distress and reassure the patient that the feared consequence will not occur. Therefore, if the patient does not demonstrate a clear relationship between the obsession and the compulsion (obsessions are distressing and compulsions aim at reducing this distress), another diagnosis should be considered.

- Obsessions can have unusual or bizarre content as well. For example, an adolescent may fear that if he sits next to, or breathes air near, students who perform poorly in school, he will lose his intelligence. Therefore the adolescent avoids sitting near these students and holds his breath in their company, consequently reducing his anxiety. What distinguishes these unusual thoughts from psychotic symptoms is that the patient usually recognizes the senselessness and unrealistic nature of the obsessions.

OCD Symptom Subtypes

A number of researchers have identified and described OCD subtypes (e.g., Baer, 1994; Feinstein, Fallohn, Petkova, & Liebowitz, 2003; McKay et al., 2004; Summerfeldt, Richter, Antony, & Swinson, 1999). Here we provide the most common subtypes based on symptom presentation.

Contamination and Washing/Cleaning

OCD sufferers with these types of symptoms are consumed with obsessions about contamination by certain objects or situations. Examples include dirt and germs, chemicals, or bodily secretions such as blood or urine. Sufferers may excessively fear contracting hepatitis, a sexually transmitted disease, or a simple cold or flu. For many individuals the contamination obsessions include feared consequences of becoming ill and dying, or of spreading disease to others. However, other individuals with contamination obsessions do not fear disastrous consequences such as becoming ill. Rather, washing and cleaning rituals aim at reducing disgust from touching items that others have touched, for example, ATM buttons or telephone handsets. Others ritualize simply to reduce the anxiety associated with feeling contaminated. Often contamination travels from one object to another. For example, a patient goes shopping and sees a used Band-Aid on the floor and becomes very anxious, leaves the store, and drives home. The patient now feels that the clothes he was wearing, the car, and any items that were in the car are contaminated

and must not be touched. Compulsions often involve "decontamination," such as washing hands excessively, taking long showers, or washing clothes several times. Rituals can involve prevention of contamination, including the use of barriers like wearing gloves, or using paper towels or elbows to open doors. Avoidance of contaminated places or objects is another way to prevent contamination. Avoidance can severely impede the patient's functioning and quality of life, such as closing off most rooms and confining the family to live in a few select areas. Unusual forms of this OCD subtype include fearing contamination by a particular person, a city, "evil," or death.

Obsessions about Causing Harm and Checking

Individuals with obsessions of causing harm to others, themselves, or property often check excessively in order to prevent a certain "catastrophe" from occurring. Common concerns are checking the stove or electrical appliances to prevent fire, checking window and door locks to prevent burglary, and checking the rearview mirror to see if a car or person was hit while driving. Usually these individuals will check an object once, then immediately doubt whether they completed the check properly, and have to check again. Some checkers remain stuck for hours in this frustrating cycle of checking, doubting, and checking again. To gain relief they sometimes ask others to take responsibility for tasks such as locking the house when they leave or supervising them while they check. Obsessions can also involve unwanted thoughts of harming others or themselves by yielding to uncontrollable impulses, such as stabbing someone with a knife, sexually molesting someone, or performing sacrilegious behaviors. Less typical forms of this subtype include fear of harming a newborn child, unintentionally performing socially inappropriate behaviors such as shoplifting or insulting people, or fear of causing the death of a baby in a trashcan because of failure to check all trashcans in one's environment.

Symmetry, Ordering, and Arranging

People with this subtype of OCD have a need to arrange things around them in certain rigid ways, including symmetrical patterns. For instance,

they may need to make the bed impeccably, without a single wrinkle. Others spend a great deal of time making sure that things are in the "right place" and notice immediately when any pattern has been disrupted. They may spend hours picking lint off a couch or lining up the fringe on a rug. Often they become extremely upset if anyone has rearranged their possessions. Usually, these persons do not fear impending disaster. Rather, they are compelled to engage in the ritualistic actions by a general sense of discomfort that arises when things are not presented "perfectly" or until it feels "right."

Sometimes, however, these OCD sufferers do fear a catastrophe if something is not aligned or performed correctly. For example, if a fearful thought comes into their mind, they feel compelled to repeat some action to keep that thought from coming true. So, like those who compulsively check, they aim to prevent or neutralize possible catastrophes. However, unlike checkers, repeaters frequently cannot identify a logical connection between the obsession and compulsion. In fact, a magical quality is often present in their thinking, such as the idea of preventing a spouse from dying by dressing and undressing repeatedly until the thought of the possible death stops. Some OCD sufferers with this subtype engage in repeating actions in order to obtain a "just right" feeling of completeness or satisfaction. If they bump their right leg against a table, they feel compelled to purposely bump their left leg to "even out" the sensation.

Hoarding

Persons with this subtype of OCD collect trivial objects and become very anxious when attempting to rid themselves of these possessions. A person who hoards may walk the street and collect small pieces of paper, storing them at home in case he or she needs them sometime in the future. Hoarded objects can sometimes include broken items and objects perceived by others as trash. While others consider the collections to be useless, the hoarder deems them of great value. Some individuals will collect newspapers for decades in case they need a specific article. In severe cases, the person's entire house is so filled with such collections that a narrow walking path exists or additional space needs

to be rented. A typical fear of discarding items is making a "wrong" decision the person will later regret. Some unusual hoarding obsessions include fear of losing one's identity or of the objects "feeling" rejected and abandoned. For more information and a treatment designed specifically for hoarders, please see *Compulsive Hoarding and Acquiring, Therapist Guide* (Steketee & Frost, 2006).

Mental Ritualizing without Overt Compulsions

As described earlier, the *DSM-IV-TR* (2000) defines OCD compulsions not only as "repetitive behaviors," such as hand washing, ordering, and checking, but also as "mental acts," such as praying, counting, or repeating words silently. Data from the DSM-IV field study also indicated that the vast majority (over 90%) of obsessive-compulsive patients manifest both obsessions and behavioral rituals. When mental rituals are included, just 2% of the sample reported only "pure" obsessions (Foa et al., 1995). Mental rituals, similar to behavioral rituals, serve to reduce obsessional distress or prevent feared harm. Thus, while obsessions are indeed mental events, compulsions can be either behavioral or mental. Individuals with mental compulsions usually enlist repetitive thoughts or images in order to *counteract* or *reduce* the anxiety of their obsessions. The pattern of this subtype of OCD is similar to that of repeating, but the focus is on repetitious ritualistic *thoughts* instead of *behaviors*. The most common rituals are praying, repeating certain words or phrases, and counting. Persons with this subtype of OCD may also try to recall events in detail or repeat a mental list as a way to ensure safety. For example, a patient who is driving a car and hits a bump in the road may experience the obsession "I hit someone and they're lying in the road." An associated mental compulsion may include mentally reviewing her drive down the road as if she were watching a videotape, and decreasing her anxiety by mentally "checking" that no one was on the sidewalk or in the road. Alternatively, she may reassure herself by mentally repeating, "It's okay. It was just a pothole. There's no way I hit someone." While this type of self-reassurance may seem logical and rational, mental rituals can be insidious and take up hours of a patient's time, with the person ratcheting mentally back and forth between the anxiety of the obsession and the calming reassurance of the thinking compulsion.

Less typical forms of this subtype include excessively "figuring out" what action to take (watch TV or read the paper) or what exactly to be thinking about in any given moment.

Poor Insight

A growing consensus emerged that some individuals with OCD maintain a strong belief that what they fear will really come true if they do not ritualize. This led to the *DSM-IV* (1994) diagnostic specifier "with poor insight" (Foa et al., 1995; Insel & Akiskal, 1986; Kozak & Foa, 1994; Lelliott et al., 1988.) This subtype refers to individuals who fail to recognize the senselessness or unrealistic nature of their obsessions and compulsions. Only 4% of OCD patients believe with absolute certainty that their feared consequences will actually occur and do not acknowledge that their reactions to the obsessions are excessive (Foa et al., 1995). Clinically, it is important to evaluate the degree of insight prior to initiating CBT, because fixed beliefs about the consequences of refraining from compulsions have been associated with less positive treatment outcome (Foa, Abramowitz, Franklin, & Kozak, 1999).

When assessing the patient's insight, it is important to remember that for many patients the degree of insight is related to the degree of distress and thus may vary from one situation to another. For example, in the therapist's office a patient may indicate that he is almost certain that he *will not* contract a sexually-transmitted disease after using a public toilet. However, when confronted with a public toilet he may indicate that he is almost certain that he *will* contract the disease. Only patients who consistently express certainty about their feared consequence occurring are to be categorized as having poor insight.

Development of EX/RP Treatment Program and Evidence for Its Efficacy

Cognitive-Behavioral Conceptualization of OCD

Several theories regarding the development and maintenance of OCD symptoms have been put forward. In 1950, Dollard and Miller used Mowrer's two-stage theory to explain the development and maintenance

of fear and avoidance behavior in OCD (Mowrer, 1939, 1960). The theory states that a neutral event begins to elicit fear when it is experienced at the same time as an event that naturally causes distress. The anxiety can be associated with mental events, such as thoughts, and/or physical events, such as bathrooms and trash cans. After the fear is acquired, escape or avoidance behaviors are developed to reduce the anxiety. In OCD, the behavioral avoidance and escape take the form of repeated compulsions or rituals. Like other avoidance behaviors, compulsions are maintained because they indeed reduce the fear. Not only does Mowrer's theory adequately explain fear acquisition (Rachman & Wilson, 1980), it is also consistent with observations of how rituals are maintained: obsessions increase obsessional distress and compulsions aim at reducing this distress. This functional relationship between obsessions and compulsions was confirmed in several experiments with OCD patients (Roper & Rachman, 1976; Roper, Rachman, & Hodgson, 1973).

Foa and Kozak (1985) put forward a theory that OCD manifests several erroneous cognitions. First, OCD sufferers assign a high probability of danger to situations that are relatively safe. For example, an individual with OCD will believe that if he touches the floor without washing his hands thoroughly, he will get a deadly disease and will also cause illness and death in other people whom he touches with his dirty hands. Second, individuals with OCD exaggerate the cost of the bad things that they think can happen. For example, not washing one's hands and getting a minor infection on the finger is viewed as terrible. In addition, Foa and Kozak suggested that individuals with OCD conclude that a situation is dangerous based on lack of evidence for its safety and, therefore, requires constant proof of safety. For example, to feel safe, an OCD sufferer requires a guarantee that the silverware in a restaurant is extremely clean before eating with it. However, rituals that are performed to reduce the likelihood of harm can never totally provide safety and, therefore, must be repeated to increase the certainty. People without OCD, on the other hand, conclude that as long as there is no evidence that a situation is dangerous, then it is safe. Thus, in the preceding example, a person without OCD would use the utensils unless there was something clearly indicating that they are not clean, such as remnants of dried food particles or visible dirt.

Salkovskis (1985) offered a cognitive theory of OCD. He proposed that five assumptions are characteristic of OCD: (1) thinking about an action is the same as doing it; (2) failing to prevent harm is morally equivalent to causing harm; (3) responsibility for harm is not diminished by extenuating circumstances; (4) failing to ritualize in response to a thought about harm is the same as an intention to harm; and (5) one should exercise control over one's thoughts (Salkovskis, 1985, p. 579). Therefore, while patients may feel their obsessions are unacceptable, the compulsions used to reduce the anxiety are deemed acceptable.

How EXRP Was Developed and Tested

Until the mid-1960s, OCD was considered to be a treatment-resistant condition. Psychodynamic psychotherapy and a wide variety of medications had been unsuccessful in significantly reducing OCD symptoms. Exposure procedures had been attempted (e.g., systematic desensitization, paradoxical intention, satiation) as well as operant-conditioning procedures aimed at blocking or punishing obsessions and compulsions (e.g., thought stopping, aversion therapy, covert sensitization). None of these treatment techniques, however, was sufficiently effective to provide hope for OCD sufferers. The first real breakthrough came in 1966, when Meyer described two patients successfully treated with a behavioral therapy program that included prolonged exposure to distressing objects and situations, combined with strict prevention of rituals (EX/RP). Meyer and his colleagues continued to implement EX/RP with additional OCD patients and found that the treatment program was highly effective in 10 of 15 cases and partially effective in the remaining patients. Moreover, 5 years later, only two of the patients in the case series relapsed (Meyer & Levy, 1973; Meyer, Levy, & Schnurer, 1974). All patients were hospitalized during their EX/RP treatment.

Randomized Controlled Trials of EX/RP for OCD

Excitement about the efficacy of EX/RP prompted clinical researchers to conduct controlled studies, which indeed gave empirical support to Meyer's findings. In 1971, Rachman, Hodgson, and Marks conducted a

controlled treatment study of 10 hospitalized patients with chronic OCD. All patients received 15 sessions of relaxation control treatment prior to EX/RP. The patients were then assigned randomly to intensive treatment of 15 daily sessions of either modeling *in vivo* or flooding *in vivo*. Seven patients were given a mean of eight additional sessions; of those, three patients had home visits. In the modeling treatment, exposure was gradual, with patients confronting less distressing situations first and gradually confronting increasingly distressing tasks. Also, the therapist demonstrated the exposure first, encouraging the patient to confront the same task. In the flooding treatment, patients were confronted with the most distressing situations on their hierarchy from the start without therapist modeling. Results indicated significantly more improvement in OCD symptoms in both EX/RP treatments compared to the relaxation treatment, and the patients maintained their gains at 3 months follow-up. No significant difference in outcome was found between the two exposure treatments; however, patients indicated a preference for the gradual exposure treatment. The researchers added 10 more hospitalized patients to the study and found that at 2 years follow-up, three quarters of the total 20 patients were much improved (Marks, Hodgson, & Rachman, 1975).

Influenced by the previous research by Rachman, Marks, and Hodgson, Drs. Foa and Goldstein (1978) studied a series of OCD patients using a quasi-experimental design. Patients' OCD symptom severity was assessed before and after 2 weeks in which the therapists collected information about their OCD, history, and type of symptoms, but no treatment was conducted. Patients were then treated with EX/RP and their symptom severity was assessed again. This study differed in several ways from previous studies. First, for the majority of patients, treatment was conducted as outpatients rather than as inpatients. Second, EX/RP involved 10 rather than 15 daily sessions. Third, influenced by reports about the efficacy of imaginal exposure with phobias (cf., Mathews, 1978), Foa and Goldstein included imaginal exposure in addition to *in vivo* exposure in the EX/RP treatment. During imaginal exposure, therapists described the patients' feared "disasters" that might result from not performing the rituals and asked them to immerse themselves in imagining the scenario described. The treatment program proved quite effective. During the information-gathering stage, no improvement was evident. In contrast, during the 2-week EX/RP phase, a marked and highly significant improvement was found. At follow-up, 66% of

participants were symptom-free, and 20% improved partially. Only three patients did not benefit from the treatment program, which was attributed to overvalued ideation (i.e., poor insight).

After the efficacy of EX/RP and its durability in reducing OCD symptom severity had been established, Foa and her colleagues embarked on investigating the relative contribution of the different components of the treatment program. To this end, they conducted a series of dismantling studies to examine the separate effects of *in vivo* exposure, imaginal exposure, and ritual prevention.

Imaginal Exposure Compared to *In Vivo* Exposure and their Combination

To examine the effect of adding imaginal exposure to EX/RP, Foa, Steketee, Turner, and Fischer (1980) conducted a study that included OCD outpatients with checking rituals who were randomized to two treatments. The first treatment consisted of 10 sessions of a 90-minute uninterrupted imaginal exposure, which focused on the patients' feared consequences if they did not perform their checking rituals; this was followed by a 30-minute *in vivo* exposure to situations that gave rise to an urge to perform checking rituals. The second treatment consisted of 120-minute *in vivo* exposure; no imaginal exposure was conducted. Both groups were asked to refrain from performing checking rituals. At the end of treatment, both groups showed equal improvement, but at follow-up those receiving only the *in vivo* exposure showed some relapse, whereas those receiving both imaginal and *in vivo* exposure maintained their gains. Thus, imaginal exposure seemed to contribute to the maintenance of treatment gains.

In a second study, Foa, Steketee, and Grayson (1985) compared the efficacy of imaginal exposure to that of *in vivo* exposure. OCD outpatients with checking rituals were randomly assigned to one of two treatment conditions: imaginal or *in vivo* exposure. Ritual prevention was not included in the treatments. Both treatments involved 15, 120-minute sessions over 3 weeks and two home visits in the fourth week. Patients improved significantly in their OCD symptoms and continued to improve at follow-up (an average of 10 months post-treatment). No significant differences between treatments emerged at post-test or follow-up.

The authors concluded that both imaginal and *in vivo* exposure offered clinically significant and lasting benefits to patients with OCD.

In sum, although imaginal exposure does not appear essential for immediate outcome, it may enhance long-term maintenance and can be used as an adjunct to *in vivo* exposure for patients who manifest fear of "disastrous consequences" such as burglary in the absence of checking door locks and windows.

The Separate Effects of Exposure and Ritual Prevention

To examine the relative effects of exposure and ritual prevention, Foa, Steketee, Grayson, Turner, and Latimer (1984) randomly assigned patients with contamination obsessions and washing rituals to treatment by exposure only (EX), ritual prevention only (RP), or their combination (EX/RP). Each treatment was conducted intensively (15 daily, 120-minute sessions conducted over 3 weeks) followed by a home visit. Patients in all conditions improved at both post-treatment and follow-up. However, patients in the EX/RP treatment (combining EX and RP) showed superior outcome on almost every symptom measure compared to EX-only or RP-only treatments. This superior outcome of the combined treatment was found at both post-treatment and follow-up. When comparing the outcome of EX only to that of RP only, patients who received EX reported lower anxiety when confronting feared contaminants than patients who had received RP, whereas the RP group reported greater decreases in urges to ritualize than did the EX patients. Thus, it appeared that EX and RP differentially affected OCD symptoms. The findings from this study clearly suggested that EX and RP should be implemented concurrently; treatments that do not include both components yield inferior outcomes.

Other Aspects of How to Conduct EX/RP Treatment

A number of researchers have investigated the logistics of conducting EX/RP, including comparison of stepped exposures to increasingly more distressing situations (gradual exposure) versus exposure to the most

distressing situation from the start of treatment (abrupt exposure); variation in the duration of exposure; importance of the frequency of exposure sessions; and examination of therapist-assisted exposure versus self-exposure. The results of these investigations can assist therapists with their clinical decisions about implementing EX/RP.

Gradual vs. Abrupt Exposures

As described earlier, an early study found no difference in OCD symptom reduction comparing gradual versus abrupt *in vivo* exposures. Patients who confronted the most distressing situations immediately at the start of treatment showed equivalent reduction of OCD symptom severity to those who approached less distressing situations first and gradually confronted increasingly more distressing ones. However, patients preferred the more gradual approach (Hodgson et al., 1972; Rachman et al., 1971). Because patient motivation and agreement with treatment goals are important factors for successful EX/RP, most programs begin by exposing patients to situations of moderate difficulty, gradually progressing to increasingly distressing exposures, and finally reaching the most distressing exposures. See Chapter 5 for more details.

Duration of Exposure

Duration of exposure is also thought to be an important factor in treatment outcome. Thus, prolonged, continuous exposure is more effective than short, interrupted exposure (Rabavilas et al., 1976). Studies have indicated that continuous exposure of approximately 90 minutes' duration leads to anxiety reduction in panic disorder patients (Foa & Chambless, 1978) and to a decrease in the urge to ritualize in OCD patients (Rachman, DeSilva, & Roper, 1976). Although this duration is useful as a general guideline, exposure can be terminated if the patient reports substantial reduction of obsessional distress sooner. Alternatively, exposure could be continued beyond 90 minutes if the patient does not experience anxiety reduction within that time.

Frequency of Exposure Sessions

The optimal frequency of exposure sessions has yet to be established. Intensive exposure therapy programs, typically involving daily sessions over the course of approximately 1 month, have achieved excellent results (e.g., Foa, Kozak, Steketee, & McCarthy, 1992), but positive outcomes have also been attained with twice-weekly and weekly sessions (Abramowitz, Foa, & Franklin, 2003; de Araujo et al., 1995).

Therapist-Assisted Exposure vs. Self-Exposure

Studies investigating the effect of a therapist's presence during exposure have shown inconsistent results. In one study, OCD patients received either therapist-assisted exposure or the medication clomipramine with self-exposure. Immediately after treatment, the therapist-assisted patients evidenced more improvement than those with self-exposure, but this difference was not maintained at follow-up (Marks et al., 1988). However, these results are difficult to interpret in light of the study's complex design. A second study indicated that therapist-assisted treatment was not superior to self-exposure at post-treatment or at follow-up (Emmelkamp & van Kraanen, 1977), although the number of patients in each condition was too small to conclusively interpret these findings. In contrast to these studies, therapists' presence yielded superior outcome in patients with specific phobia who were treated with a single 3-hour exposure session compared to those who received 3 hours of self-exposure (Ost, 1989). Because specific phobias generally are less disabling and easier to treat than OCD, it could be inferred that therapist presence should also positively influence OCD treatment outcome. Most compelling are the results of a meta-analysis conducted by Abramowitz (1996), who found that therapist-administered exposure was associated with greater improvement in OCD and general anxiety symptoms compared to self-exposure. Mataix-Cols and Marks (2006) provided a recent review of the literature on self-help for OCD with minimal therapist contact and concluded that more research is needed. In light of the positive results of the meta-analytical study and the methodological flaws of earlier studies with negative findings, EX/RP

treatment currently includes therapist-assisted exposure within the sessions, combined with self-exposure as homework between sessions.

Overall Efficacy of EX/RP

Since Meyer's (1966) initial positive report of the efficacy of EX/RP with two OCD patients who suffered contamination obsessions and rituals, numerous investigations of EX/RP treatment have been conducted with hundreds of OCD patients. Results clearly show that EX/RP is quite effective in significantly reducing OCD symptoms; moreover, most patients maintain their gains following treatment. A number of randomized controlled trials have found that EX/RP is superior to a variety of control treatments, including placebo medication (Marks, Stern, Mawson, Cobb, & McDonald, 1980), relaxation (Fals-Stewart et al., 1993; Marks, 1981), and anxiety management training (Lindsay et al., 1997). Importantly, Foa and Kozak's (1996) review of 12 treatment studies involving a total of 330 patients found that 83% of patients who completed EX/RP therapy were classified as responding favorably to treatment. In 16 studies reporting long-term follow-up of a total of 376 patients, 76% were considered to have successfully maintained their gains. Furthermore, recent studies have indicated that these successful outcomes for EX/RP are not limited to highly selected scientific samples of OCD patients (Franklin et al., 2000; Rothbaum & Shahar, 2000; Valderhaug, Larsson, Götestam, & Piacentini, 2007; Warren & Thomas, 2001).

Medications for OCD

Interestingly, parallel to the development of effective CBT for OCD, there was a development of medication treatment for the disorder. Clomipramine (Anafranil®) was the first medication that showed efficacy in reducing OCD symptoms (e.g., Fernandez-Cordoba & Lopez-Ibor Alino, 1967). Subsequent research efforts were aimed at further examining the benefits of CBT and medication treatments, as well as determining their relative efficacy for OCD sufferers.

Research in the past two decades has provided a large body of knowledge about the efficacy of medications for OCD symptom reduction, such as the tricyclic antidepressants, including clomipramine (CMI), and the selective serotonin reuptake inhibitors (SSRIs; see Dougherty, Rauch, & Jenike, 2002, for a review). In controlled trials, CMI has been found consistently superior to placebo (e.g., Clomipramine Collaborative Study Group, 1991). Similar positive results versus placebo have been obtained with the SSRIs fluvoxamine (Luvox®; Greist et al., 1995), fluoxetine (Prozac®; e.g., Tollefson et al., 1994), sertraline (Zoloft®; e.g., Greist et al., 1995), and paroxetine (Paxil®; e.g., Zohar et al., 1996). Indeed, the FDA has approved each of these medications as treatments for adult OCD. Compared to tricyclic antidepressants, SSRI medications have shown superior results (e.g., imipramine; Rauch & Jenike, 1998), with CMI (an SRI) showing a stronger and more consistent therapeutic effect than other tricyclics (Pato et al., 1998).

Overall, medication studies suggest that up to 60% of OCD patients benefit from treatment with medication. However, because of the difficulties in treating OCD, medication trials have used a definition of response that is more liberal than depression studies, for example. An OCD patient is considered to have a positive response to medication if symptoms decrease by 25% to 35%. Although these reductions reflect meaningful clinical improvement, many OCD sufferers who respond to medication continue to have clinically significant symptoms, which considerably affect their functioning and quality of life. Therefore, the average outcome achieved by medication responders is moderate at best (Greist, 1990). Moreover, a dramatic rate of relapse has been found when medication treatment was discontinued. In an early controlled double–blind study, 90% of patients relapsed within a few weeks after they were switched from CMI to placebo (Pato et al., 1988). More recent studies, using a slower tapering-off strategy, have not shown such striking relapse rates; nevertheless, the literature overall suggests that medication management alone must be sustained to maintain improvement in OCD symptoms (Dougherty, Rauch, & Jenike, 2002).

Recently, controlled studies have shown an improved effect of SSRI treatment when augmented with atypical antipsychotic medications such as risperidone (Risperdal®), olanzapine (Zyprexa®), and quetiapine (Seroquel®) (e.g., Bystritsky et al., 2004; Denys et al., 2004;

McDougal et al., 2000). Augmentation with these medications may be considered in patients who have substantial residual symptoms with the standard medications and who will not accept, or do not have access to, EX/RP.

EX/RP vs. Medication

As noted, a number of controlled studies have indicated that the tricyclic Anafranil® (an SRI) and the SSRIs are superior to placebo in reducing OCD symptoms (for a review see Greist et al., 1995). However, only a few well-controlled studies have investigated the efficacy of EX/RP compared to medication alone, or to a combined treatment using both.

The first study that included both EX/RP and medication treatment used a complex design that involved treatment with CMI, pill placebo, EX/RP, and/or relaxation (Marks, Stern, Mawson, Cobb, & McDonald, 1980). At week 7, CMI produced significant improvements in mood and rituals over placebo, but only in patients who were initially depressed. EX/RP was associated with greater reductions in rituals, but not with improvement in mood compared to relaxation. Combined EX/RP and CMI treatment showed a slight additive effect that was no longer evident at follow-up. Unfortunately, due to study design flaws these results could not be interpreted with certainty. A follow-up study involved comparisons of CMI, placebo, self-exposure, and therapist-aided exposure (Marks, Lelliott, Basoglu, Noshirvani, Monteiro, Cohen, & Kasvikis, 1988). The results suggested that the addition of EX/RP increased the efficacy of the medication at week 8, but this difference was not maintained at week 23.

An increasing interest in SSRI medications and a growing awareness of the severe side effects associated with CMI encouraged researchers to include SSRIs in comparison and combination studies. In 1990, Cottraux et al. compared the efficacy of fluvoxamine (FLV; Luvox®) versus EX/RP, and combined treatment. Patients were assigned to one of three conditions: FLV with anti-exposure instructions, FLV+EX/RP, and pill placebo (PBO) with EX/RP. In the anti-exposure condition, patients were specifically instructed to avoid feared situations. At the

end of treatment (week 24) there was a small to moderate reduction in rituals for each of the groups. At 6-month follow-up, all treatments showed moderate reduction in rituals, with no significant differences among the treatments. Therefore, in this study, combining EX/RP with SSRI medication was not more effective than administering medication or EX/RP alone.

Hohagen et al. (1998) compared the efficacy of treatment that combined EX/RP and FLV versus EX/RP+PBO. EX/RP in both treatments involved a 3-week assessment period followed by a 4-week regimen of thrice-weekly EX/RP. Both treatments resulted in significant and equal improvement on rituals, but patients who received the combined EX/RP+FLV treatment showed more improvement on obsessions at post-treatment than those who received EX/RP+PBO. Thus, this study indicated some superiority of the combined treatment over EX/RP alone.

Foa et al. (1992) examined whether antidepressant medication improved OCD through a reduction of depressive symptoms or by direct effects on OCD symptoms. The study also determined whether treating depression first with medication would enhance the outcome of EX/RP. The researchers divided OCD patients into depressed (BDI $\geq$ 21; Beck et al. 1996) and mildly depressed (BDI $\leq$ 20) groups. Within each group, patients were then randomly assigned to receive either 6 weeks of treatment by imipramine (Tofranil®) or placebo (PBO). Upon completion of the medication-only phase, all patients received 15 sessions of intensive EX/RP. Contrary to expectations, while imipramine reduced depression in the depressed patients, it did not significantly reduce OCD symptoms in either depressed or mildly depressed patients before EX/RP was introduced at week 6. Moreover, imipramine did not enhance the outcome of EX/RP at post-treatment or at follow-up. OCD and depressive symptoms were both significantly reduced in each of the four groups following EX/RP. This result was found even in the depressed group who initially received placebo before EX/RP.

The first study that used a straightforward design to compare the relative and combined efficacy of CMI, intensive EX/RP, their combination, and PBO was conducted by Foa and colleagues at the University of Pennsylvania and Leibowitz and colleagues at Columbia University (Foa et al., 2005). The EX/RP program included an intensive phase (15, 2-hour sessions conducted over 4 weeks) and a follow-up phase (six brief

sessions delivered over 8 weeks). EX/RP alone was compared to 12 weeks of CMI alone, the combination of EX/RP+CMI, and PBO. At post-treatment, all three active treatments were superior to placebo, and EX/RP was found to be superior to CMI. With regard to combined treatment, EX/RP+CMI was superior to CMI alone, but the combined therapy did not enhance the outcome of EX/RP alone (Foa et al., 2005). Moreover, the rate of relapse was higher following the discontinuation of CMI treatment compared to that of EX/RP alone or the combined treatment (Simpson et al., 2004).

Notably, the design used in the Penn-Columbia study may not have been optimal for identifying an additive effect of CMI to EX/RP because the intensive phase of EX/RP was largely completed before patients reached their maximum dose of CMI. In addition, the combined treatment effects may be more evident when EX/RP is not conducted daily (Foa, Franklin, & Moser, 2002). Indeed, a recent study in pediatric OCD conducted at Penn, Duke, and Brown (Pediatric OCD Treatment Study Team, 2004) found an additive effect for combined treatments when EX/RP was conducted once weekly. However, at the Penn site, the effect size of EX/RP alone was larger than at the other sites, and no additive effect for combined treatment was found at this site.

Augmenting Medication Effects with EX/RP

Most OCD patients who seek treatment are already taking medication, primarily an SRI. However, as noted earlier, most patients suffer from residual OCD symptoms even when treated with an adequate dose of medication; they often seek psychological intervention to further reduce their symptoms. Also, several uncontrolled, open studies found EX/RP added to medication treatment to be effective (Franklin, Abramowitz, Bux, Zoellner, & Feeny, 2002; Kampman, Keijsers, Hoogduin, & Verbraak, 2002; Tolin, Maltby, Diefenbach, Hannan, & Worhunsky, 2004). This state of knowledge in the field prompted Foa and colleagues at Penn and Simpson and colleagues at Columbia to conduct a controlled study that examined whether EX/RP can augment the effects of medication (Simpson, Foa, et al., 2008). Patients on a stable and therapeutic dose of SRI medication, who experienced only partial response,

were randomized to either EX/RP or Stress Management Training (SMT) while being maintained on their medication. EX/RP consisted of 17 sessions delivered twice weekly in 90- to 120-minute sessions, and included both *in vivo* and imaginal exposures. SMT included deep breathing, progressive muscle relaxation, positive imagery, assertiveness training, and problem-solving techniques. At the end of treatment, EX/RP was significantly superior to SMT in further reducing patients' OCD symptoms by at least 25% as an augmentation to medication (Simpson, Foa, et al., 2008). Adding EX/RP also improved patients' functioning and quality of life (Huppert, Simpson, Nissenson, Liebowitz, & Foa, 2009). In other words, continued symptoms of SRI-treated OCD sufferers can be significantly reduced by adding EX/RP. These results were maintained at a 6-month follow-up (Foa et al., 2010).

The results of these two collaborative studies have led to an ongoing randomized controlled trial. Foa and colleagues at Penn and Simpson and colleagues at Columbia are directly comparing the effectiveness of two augmentation strategies for SRI-treated OCD sufferers with residual symptoms: EX/RP versus risperidone (Risperdal®). The aim of the current investigation is to answer the question of which augmentation strategy will be more likely to achieve excellent treatment outcome and improve functioning and quality of life for OCD sufferers who do not gain sufficient improvement from SRI treatment alone. Patients who have received an adequate and stable SRI treatment and who are experiencing continued OCD symptoms are being randomized to 8 weeks of either EX/RP, risperidone, or PBO, while being maintained on their SRI medication. The investigation also includes an additional 24 weeks of the augmentation treatment to determine whether patients maintain their gains or improve even further.

To sum up the conclusions from investigations on the addition of medication to EX/RP treatment, two studies failed to detect an enhanced reduction in OCD symptoms by adding medication to EX/RP (Foa et al., 2005; van Balkom et al., 1998), two studies found a small but temporary effect (Marks et al., 1980, 1988), one study found an effect on depression only (Cottraux et al., 1990), and one study (Hohagen et al., 1998) found an advantage for combined treatment over EX/RP alone on obsessions but not on compulsions. On the other hand, the addition of EX/RP to medication treatment enhanced the efficacy of the

medication (Foa et al., 2005), and residual OCD symptoms can be reduced further by adding EX/RP to medication treatment (Simpson et al., 2008).

The Role of Medications in EX/RP

The studies discussed suggest that while SRI medications do not interfere with EX/RP efficacy, EX/RP does not benefit from the addition of medication. In contrast, the addition of EX/RP to medication does augment its efficacy of reducing OCD symptom severity. Thus, there is no reason to medicate patients before administering EX/RP treatment. At the same time, if patients who have benefited somewhat from medication seek EX/RP to further reduce their suffering, there is no reason to take them off medication before conducting EX/RP. However, after these patients show a stable period of maintaining gains from EX/RP, gradual tapering of medication may be considered. In contrast, OCD patients with severe, comorbid depression can clearly benefit from the administration of SRI medication for several months, with the goal of alleviating their depression and reducing their OCD symptom severity. Such an effect is likely to facilitate their ability to participate more fully in the EX/RP program and consequently to increase their benefit from the treatment.

Expert Consensus on Efficacy of EX/RP

Over the past 20 years or so, a number of expert consensus guidelines have been published regarding treatment of OCD. These practice guidelines evolved over time as knowledge was gained from research studies. By the late 1980s, the role of SSRI medications had become well established, but the issue of whether medication or EX/RP should be the first line of treatment for OCD sufferers was still uncertain (e.g., Quality Assurance Project, 1985). A decade later, expert consensus guidelines for OCD were published in the *Journal of Clinical Psychiatry* (March, Frances, Carpenter, & Kahn, 1997). Sixty-nine expert OCD clinicians completed a questionnaire regarding the best treatment for OCD. Most expert clinicians expressed a preference to begin treating OCD patients with either EX/RP alone or a combination of EX/RP and SSRI

medication, with the decision about using medication depending on symptom severity. The experts tended to use EX/RP alone as the first line of treatment in patients with milder OCD symptoms, and as severity increased, they were more likely to recommend the addition of medication to the EX/RP or the use of medication alone. Combined treatment, using EX/RP and SSRIs, was rated best by experts in terms of efficacy, speed, durability, tolerability, and acceptability (March et al., 1997). In 2003, Greist et al. published expert guidelines for the long-term treatment of OCD in adults based on a review of the literature as well as on the proceedings from the World Council of Anxiety meeting. Both psychotherapy and medication were recommended for OCD, either alone or in combination, with CBT specified as the psychotherapy of choice (Greist et al., 2003). Most recently, the British National Institute for Health and Clinical Excellence conducted a comprehensive examination of the OCD treatment literature (NICE, 2006). In their extensive analysis, the practice guidelines recommended CBT and medication, alone or in combination, depending on functional impairment. They suggested that the initial treatment for patients with mild functional impairment should be brief CBT, including EX/RP. If brief EX/RP does not prove adequate, or if functional impairment is moderate, more intensive CBT (more than 10 sessions) or the introduction of SSRI medication is recommended. When severe functional impairment exists, the combination of EX/RP and SSRI treatment is recommended (NICE, 2006). It was concluded that "based on current evidence, ensuring access to adequate cognitive and/or behavioural therapies would currently appear to provide people with OCD with the best chance of improvement through psychological therapies" (NICE, 2006, p. 108).

Level of Training Required to Conduct EX/RP Effectively

Despite overwhelming evidence for its efficacy, availability of EX/RP treatment for patients continues to be limited. This is because conducting EX/RP proficiently requires training and supervision by experts who have been extensively trained and are experienced in delivering this treatment. To date, the availability of such training is limited despite continuous efforts of experts in the field and professional associations

(e.g., the International OCD Foundation) to provide such training. The major aim of this treatment manual is to widely disseminate detailed knowledge of how to conduct EX/RP with a variety of patients who suffer from OCD. Mental health professionals who would like to expand their knowledge in the use of EX/RP are advised to attend an intensive workshop followed by supervision. Such workshops are available in OCD expert centers, including our center at the University of Pennsylvania, where we periodically conduct intensive 4-day workshops in EX/RP treatment. Information about these workshops is available on our Web site at www.med.upenn.edu/ctsa.

EX/RP for OCD follows the theoretical and practical principles of CBT. Accordingly, we expect that therapists who are trained in CBT will find this treatment program more accessible than therapists without a CBT background. Nevertheless, this manual is designed to be user-friendly for mental health professionals who are trained in other treatment modalities but have experience with anxiety disorders in general, and OCD in particular. In addition to using the manual, supervision with an EX/RP expert or consultation with peers who practice EX/RP will be beneficial with the first few patients.

Risks and Benefits of this Treatment Program

Benefits

Decades of research on EX/RP have yielded findings that clearly support the high efficacy of EX/RP in reducing OCD symptom severity and improving the long-term management of these symptoms. The majority of OCD sufferers experience significant reduction in time spent on obsessions and rituals. EX/RP allows OCD sufferers to "turn down the volume" on their symptoms and regain time and focus, expanding and enjoying their lives and their relationships. However, most OCD patients have residual symptoms and need to remain vigilant to occasional obsessions and to resisting urges to ritualize. In fact, even after the active treatment phase, patients continue to adhere to the EX/RP principles. To maintain treatment gains the OCD sufferer needs to adopt a

lifestyle of managing the OCD symptoms, much like people with diabetes manage their symptoms with good behavioral habits such as monitoring their glucose level, exercising, and eating healthy.

Risks

The primary risks associated with EX/RP are discomfort and emotional distress when confronting anxiety-provoking objects, situations, thoughts, and images during treatment. There may be a temporary exacerbation of obsessional distress due to reduced avoidance and ritualizing, before habituation and change of cognitions take place. The core of EX/RP is confrontation of situations and objects that evoke obsessional distress, which produce an urge to ritualize. The distress and urges decrease over time when patients realize that the anxiety indeed diminishes without ritualizing and avoidance. Also, as noted earlier, through exposure and ritual prevention, patients recognize that their feared consequences do not occur, and this recognition further reduces their obsessions and compulsions.

Alternative Treatments

One alternative treatment to EX/RP for OCD is cognitive therapy, which has been shown to be quite effective in reducing OCD symptom severity (Jones & Menzies, 1998; Wilhelm, 2000). However, there is a great deal of overlap between cognitive therapy and EX/RP treatments. Both EX/RP and cognitive therapy focus on modifying mistaken beliefs through discussion and disconfirmation of predicted disastrous consequences. Furthermore, both treatments use exposure, since cognitive therapy involves "behavioral experiments," which consist of exposing the patients to situations that they imagine will result in the feared consequences. Research studies that have attempted to compare "pure" versions of each treatment are inevitably difficult to interpret, because EX/RP without discussion of feared consequences and cognitive therapy without exposures are necessarily incomplete treatments, and not surprisingly produced less favorable results than standard EX/RP therapy (van Balkom et al., 1998). In studies that have compared standard

EX/RP and cognitive therapy, both treatments have been found to be comparable in reducing OCD symptoms (e.g., Cottraux et al., 2001; Whittal et al., 2005). Notably, a meta-analytic review indicated that cognitive therapies for OCD that included some form of exposure to situations that evoke obsessional distress were superior to those that did not, suggesting that exposure is a powerful component of effective treatment for OCD (Abramowitz et al., 2006).

The efficacy of other interventions for OCD cannot be determined due to the lack of controlled studies. No well-controlled studies are available on psychological interventions such as psychodynamic therapy, hypnosis, virtual reality therapy, homeopathy, or an integrated psychological approach. Furthermore, no well-designed single case studies have been published on other psychological interventions or alternative complementary therapies (NICE, 2006). Surgical alternatives may hold promise for treatment-refractory patients with severe symptoms and significant related impairment (Pallanti, Hollander, & Goodman, 2004), although long-term follow-up data about the maintenance of gains from surgical procedures for OCD are not yet available. Patients inquiring about alternative approaches to EX/RP should be informed that, with the exception of cognitive therapy, there is no evidence base to support psychotherapies other than EX/RP.

Outline of This Treatment Program

This treatment is a 17-session program, with a frequency of two sessions per week for a period of 8.5 weeks. Each session lasts approximately 2 hours. It is preferable to space sessions with maximal intervening days, such as on Monday and Thursday, or Tuesday and Friday, so that inter-session time is never prolonged. For each day that there is no therapy session, patients are assigned exposure homework. Inter-session phone contacts of 15 to 30 minutes will take place once a week on one of the days that you do not meet with the patient face to face. The purpose of the phone call is to check in, assess progress, and offer encouragement and support.

In general, the first two sessions are devoted to assessment and treatment planning. The remaining sessions involve supervised exposure and ritual prevention.

Specifically, in Session 1 the therapist begins to collect information on the patient's OCD symptoms and history. The rationale and description of the treatment are presented to the patient. Self-monitoring is introduced. Session 2 continues with the gathering of information in order to generate a treatment plan. Using the scale of Subjective Units of Discomfort (SUDS), a hierarchy of items for exposure is created.

Starting with Session 3, exposure and ritual prevention are practiced at each visit, with increasingly difficult exposures attempted through Session 8. If appropriate for the patient's symptoms, scripts for imaginal exposures are generated. At approximately the eighth visit, the highest item on the patient's hierarchy should be confronted. The ninth through 16th sessions then involve repeating or varying previous exposures and introducing additional, anxiety-provoking stimuli that were not included in the patient's hierarchy. If practical, one or two home visits for patient observation and exposure coaching is recommended. Additional visits to the patient's home may be made if there is continued difficulty with home-based practice.

The final session includes an evaluation of the patient's progress in treatment and preparation for the patient's return to normal behavior, with discussion of strategies to maximize relapse prevention. It is important to note that although relapse prevention has been incorporated throughout the treatment, a special emphasis will be placed on that aspect during the final session. Lastly, four to six follow-up weekly phone calls are scheduled with the patient to help ease his or her transition from the active treatment phase.

Use of the Patient Workbook

The patient workbook will aid therapists in delivering EX/RP. It contains brief information and instructions to patients that follow the format of this manual, as well as all the forms used during treatment sessions and for homework assignments. These include forms for creating an exposure hierarchy, daily ritual monitoring, conducting *in vivo* and imaginal exposure, and tracking imaginal and *in vivo* exposure homework. Patients will find the workbook extremely helpful for reviewing the information about OCD and EX/RP treatment that they

received from their therapist, for recording their daily ritual prevention, for noting observations during homework exercises, and for reinforcing what they have learned in sessions. Patients may photocopy forms from the workbook or download multiple copies from the Treatments *That Work*™ Web site at www.oup.com/us/ttw.

All of the forms used by the therapist in EX/RP, including those that should be handed out to the patient, are included in this therapist guide. Therapists may photocopy forms (e.g., exposure homework recording forms, EX/RP therapy information) from the guide or download multiple copies from the Treatments *That Work*™ Web site.

This page intentionally left blank

Chapter 2 *Assessment*

As noted in Chapter 1, intrusive repetitive thoughts and images as well as repeated ritualistic actions are characteristics of mental disorders other than OCD. To ensure that OCD patients receive the most effective treatment, it is crucial to make an accurate diagnosis by conducting a detailed assessment of the patient's symptoms. Initial misdiagnosis, incomplete evaluation of current comorbidities, or overlooking important OCD symptoms can derail the therapist's treatment efforts. A comprehensive evaluation of the patient and an in-depth understanding of specific symptoms and severity level set the stage for effective, targeted treatment planning. A detailed and careful assessment is particularly important in the case of OCD patients because of the wide variety of symptoms that OCD patients display, as described in the previous chapter. In addition, many mental disorders, such as depression and generalized anxiety disorder (GAD), involve repeated and intrusive, distressing thoughts; other mental disorders, such as trichotillomania, Tourette syndrome, autism, and schizophrenia, involve repetitive and even ritualistic actions. This overlap between the symptoms that characterize OCD and other mental disorders often results in misdiagnosis by mental health professionals who do not have extensive expertise in OCD.

How can the clinician distinguish between OCD and other disorders that include intrusive, distressing thoughts or repetitive actions? First, the vast majority of OCD sufferers demonstrate *both* repetitive obsessions (i.e., intrusive thoughts or images) and compulsions (i.e., repetitive, ritualistic actions). Second, only individuals with OCD manifest a clear functional relationship between most of their obsessions and compulsions, in that obsessions give rise to distress and compulsions aim to reduce (i.e., neutralize) this distress. Third, only individuals with OCD manifest mental

compulsions, which are thoughts aimed at neutralizing the obsessional distress. While there are a few exceptions to any one of these features, their absence should prompt clinicians to explore alternative diagnoses.

In most clinical settings an optimal comprehensive assessment is conducted in the following manner: (1) identifying the specific obsessions and compulsions; (2) assessing the level of severity of OCD; and (3) conducting a diagnostic interview to determine the presence of OCD and any comorbid diagnoses. This order is recommended because most OCD patients are eager to discuss their OCD symptoms with their therapists, and conducting a general diagnostic interview first can be frustrating for the patients. However, in some research settings and OCD expert clinics, a diagnostic interview is conducted before a comprehensive assessment of OCD. In any case, it is helpful to corroborate the clinician's assessment with patient self-report measures regarding OCD diagnosis, types of obsessions and compulsions, and severity of symptoms. When possible, self-reports should be completed before the diagnostic interview, so that the information patients provide can be included in overall diagnostic determination.

Assessment of OCD Types of Symptoms and Severity

The most widely used OCD interview tool to assess both OCD symptoms and OCD severity is the Yale-Brown Obsessive Compulsive Scale (Y-BOCS; Goodman et al., 1989a, 1989b). It is used by clinicians who deliver CBT and/or medication as well as by researchers in most studies of OCD. The Y-BOCS is a standardized, semi-structured interview that consists of a symptom checklist and a group of questions that determine overall OCD symptom severity. The symptom checklist is administered first, followed by assessment of the overall severity of the obsessions and compulsions. The checklist is an excellent tool for understanding the range of symptoms experienced by the patient, and is particularly useful for treatment planning. The severity scale is the most accurate tool for determining level of severity and treatment progress.

The completion of the checklist provides the clinician with a comprehensive picture of the patient's obsessions and compulsions. Furthermore,

leading patients through the entire range of OCD symptom manifestations begins the process of patients' awareness of their own OCD symptoms. It also helps patients understand which of their overall difficulties are related to OCD and which are not. Going through the checklist allows the clinician to detect symptoms that the patient may not mention spontaneously, which is crucial for a comprehensive EX/RP treatment plan and its success. Importantly, by the therapist detailing the extensive array of OCD symptoms, patients often develop confidence in the therapist's understanding of OCD, which can contribute to hopefulness and positive expectations of therapy.

The Y-BOCS checklist asks about specific OCD symptoms, beginning with clearly defining obsessions and compulsions and the difference between them. If the patient has other diagnoses, the clinician can explain how these OCD symptoms differ. Once it is confirmed that the patient understands these terms, the clinician states that obsessions will be discussed first. Obsessions include the following categories: harm, contamination, sexual, hoarding/saving, religious (scrupulosity), need for symmetry or exactness, miscellaneous, and somatic obsessions. It is important to use examples of each obsession in order for the patient to fully understand the specific obsession. Some examples are provided in the Y-BOCS; the therapist can also use examples from his or her own experience. For example, the therapist can ask, "Do you have fears that you will harm others because of not being careful enough, such as being involved in a hit-and-run motor vehicle accident?" The clinician then indicates on the checklist whether the patient experienced that obsession in the past week using the following three categories: Never, Current, or Past (this category is endorsed if the symptoms used to be present in the past but are no longer bothersome). Next, the therapist reminds the patient of the definition of compulsions and proceeds through the compulsions checklist. Compulsions include the following categories: washing/cleaning, checking, repeating, counting, ordering/arranging, mental compulsions, and miscellaneous compulsions. It is important to pay particular attention to mental compulsions. This is because many patients still think of OCD symptoms in the traditional manner, which defined obsessions as mental events (e.g., thoughts, images, and urges), and compulsions as overt behaviors (e.g., checking, washing, ordering). Thus, the patient may not be aware that "neutralizing"

thoughts are actually compulsions and not obsessions. For example, repeating in one's mind the number "4" to neutralize the distress caused by thinking about the number "6," which represents the devil, or conjuring up a positive image in response to a disturbing obsession. Other mental compulsions involve self-reassurance, such as mentally repeating the sentence "I am okay, nothing bad will happen." Certain items on the Y-BOCS checklist are asterisked, prompting the clinician to consider differential diagnosis. For example, "ritualized eating behaviors" can indicate anorexia or bulimia, and "fear of doing something embarrassing" can indicate social anxiety disorder.

After completing the Y-BOCS checklist, the clinician determines the three primary obsessions, compulsions, and avoidances. For avoidances, the clinician identifies primary situations that the patient avoids because they trigger obsessions. For example, if one of the patient's main obsessions is contamination by bodily fluids, a main avoidance item might be public restrooms. This information is clinically helpful to the EX/RP therapist because it summarizes the target symptoms for EX/RP treatment.

Y-BOCS Severity Rating Scale

The Y-BOCS severity scale includes 10 items: the first 5 items assess severity of obsessions and the remaining 5 items assess severity of compulsions. These ratings are based on the range of symptoms endorsed by the patient during the checklist assessment.

The clinician rates the obsessions and compulsions separately on the following aspects, using a 5-point scale ranging from 0 (no symptoms) to 4 (extreme symptoms): time occupied by the symptoms, degree of interference with functioning, level of distress, attempts to resist, and level of control over the symptoms. Goodman et al. (1989a, 1989b) suggested the following guideline for determining level of OCD severity: 0 to 7 subclinical, 8 to 15 mild, 16 to 23 moderate, 24 to 31 severe, 32 to 40 extreme.

In addition to the 10 items described, the Y-BOCS includes seven scales: insight into obsessions and compulsions, avoidance, degree of indecisiveness, overvalued sense of responsibility, pervasive slowness/disturbance

of inertia, pathological doubting, global severity, global improvement (since initial rating), and reliability. These are not included in determining the severity level of OCD, but may be valuable for the treatment planning of EX/RP.

It is important to assess OCD severity level before treatment, after treatment, and at any time when a patient's symptom status needs to be determined, such as in deciding when to terminate treatment, or when to resume treatment if relapse is suspected. Patients and therapists alike find it gratifying to directly compare quantified pre- and post-treatment scores in successful EX/RP.

Assessment of Insight

As noted in the introduction, the DSM-IV requires a determination of whether the patient has poor insight. Poor insight, or what is often referred to as "overvalued ideation," reflects cognitive rigidity with respect to the obsessional belief that the consequence the patient fears will indeed come true if he or she does not ritualize. An example of overvalued ideation is "if I do not check that I locked the door, my home will definitely be burglarized." While the DSM-IV views poor insight as either present or absent, Foa, Kozak, et al. (1995) found it to vary along a continuum of strength. To assess the level of insight, the clinician needs to first identify the belief underlying the patient's main OCD symptom. Importantly, beliefs such as "if I don't ritualize I will not be able to tolerate my distress" are not considered instances of poor insight. Also, as described in the introduction, only patients who *consistently* express certainty that their feared consequence would occur if they refrain from ritualizing are categorized as having poor insight.

The determination of strength of belief is important because the degree of insight was found to predict response to both EX/RP and medication. In particular, assessing overvalued ideation provides information about the patient's potential ability to modify his or her obsessional beliefs during EX/RP. The most frequently used instrument to comprehensively assess level of insight is the Brown Assessment of Belief Scale, which is described in the section that follows.

Brown Assessment of Beliefs Scale

The Brown Assessment of Beliefs Scale (BABS; Eisen et al., 1998) is a seven-item, semi-structured rating scale with questions and anchors that are used to determine the degree of insight an individual has regarding his or her beliefs. It is used in a number of psychiatric disorders, and is especially helpful with OCD patients. As noted previously, to administer the scale, the clinician first determines the principal belief and the consequences of the patient not performing her compulsions. BABS items include conviction, perception of others' views, explanation of differing views, fixity of beliefs, attempts to disprove beliefs, insight, and (optionally) ideas of reference. Each item is scored from 0 (nondelusional or least pathological) to 4 (delusional or most pathological), and the total score ranges from 0 to 24. Poor insight is indicated by a total BABS score of 12, with a 3 for the conviction item (fairly or completely convinced belief is true).

Diagnostic Interview

Several diagnostic tools are available. Among the most frequently used and most comprehensive is the Structured Clinical Interview for DSM-IV-R (SCID; First et al., 1997). Another frequently used diagnostic tool is the Mini International Neuropsychiatric Interview (M.I.N.I. version 5.0.0; Sheehan et al., 1998), which is a streamlined, straightforward assessment of 14 Axis I disorders, including sections for suicide and, optionally, antisocial personality disorder.

Whichever Axis I assessment instrument the clinician chooses, it is crucial to ensure that the patient meets criteria for OCD (see Chapter 1) and to determine existing comorbidity. If the patient suffers from several disorders, the clinician and the patient need to determine which of the disorders is the most distressing and which is the most interfering with daily functioning at the time of the assessment. This discussion will establish which of the disorders should be treated first. For example, if the patient meets criteria for both OCD and Major Depressive Disorder, the clinician needs to judge whether the depression is so severe that the patient would be unable to gather the energy, concentration, and motivation to engage fully in an EX/RP treatment program, either

during therapy sessions or while doing homework assignments. In this case, the depression should be addressed first. On the other hand, if the depression is secondary to, or driven by the OCD-related distress and is not extremely severe, the OCD should be treated first. In most cases, successful EX/RP produces reduction in both OCD and depressive symptoms.

Thus, any diagnosis that is the primary contributing factor to a patient's distress and interference in life should be the focus of therapy. Otherwise, the symptoms will likely hinder motivation and compliance with EX/RP treatment. Unless the primary symptoms are specifically addressed by the therapist, the patient may leave treatment believing EX/RP does not work, will be less likely to re-enter EX/RP treatment, and will feel hopeless to improve his or her OCD symptoms in the future.

Self-Report Measures

As noted earlier, self-reports can add relevant information to the diagnostic process in terms of further assessing OCD symptoms and comorbid disorders. In addition to better understanding the patient's OCD symptoms, self-report measures can provide a window into the current problematic symptoms the patient is experiencing, and suggest areas for further clinical investigation. Questionnaires can be particularly useful for alerting clinicians to potential comorbidities or personality traits that could affect or interfere with treatment, as well as to differential diagnosis.

There are several self-report inventories that assess OCD symptom severity. Among them are the Maudsley Obsessional Compulsive Inventory (MOCI; Hodgson & Rachman, 1977), the Vancouver Obsessional Compulsive Inventory (VOCI; Thordarson et al., 2004), and the PADUA Inventory (PI-WSUR; Sanavio, 1988; Van Oppen, Hoekstra, & Emmelkamp, 1995). In this book we will discuss only the Obsessive Compulsive Inventory–Revised (OCI-R; Foa, Huppert, et al., 2002). There are also many self-report inventories assessing anxiety and mood disorders. Examples of such inventories include the PTSD Symptom Scale (PDS; Foa, Amir, et al., 1997), the Panic Disorder Severity Scale (PDSS; Shear et al., 1997), Depression Anxiety Stress

Scales (DASS-21; Lovibond & Lovibond, 1995), and the Social Interaction Anxiety Scale (SIAS; Mattick & Clarke, 1998). The Beck Depression Inventory (BDI; Beck, Rush, Shaw, & Emery, 1979) is a widely used self-report inventory for depression.

Obsessive Compulsive Inventory–Revised

The OCI-R is a particularly useful instrument for assessing the range of OCD symptoms. It can also be used to monitor OCD symptom severity and improvement during EX/RP treatment. The OCI-R is an 18-item self-report measure that assesses the distress the patient currently experiences regarding his or her obsessions and compulsions. In addition to the total score, six subscale scores are calculated (washing, checking, ordering, obsessing, hoarding, and neutralizing). The instrument was found to have good internal consistency, test–retest reliability, and discriminant validity (Foa, Huppert, et al., 2002; Hajcak et al., 2004; Huppert et al., 2007). A clinical cutoff score of 21 differentiates OCD patients from non-patients (Foa, Huppert, et al., 2002). The OCI-R has been translated into many languages (e.g, Spanish [Fullana et al., 2005], Italian [Sica et al., 2009], Korean [Lim et al., 2008], German [Gonner, Leonhart, & Ecker, 2007, 2008], and French [Zermatten, Van der Linden, Jermann, & Ceschi, 2006]).

The usefulness of the OCI-R, as well as its reliability and validity in assessing OCD symptoms and their severity, has been noted by several researchers. Importantly, the OCI-R was found to be sensitive to treatment effects and pre- to post-test change on the instrument to reflect improvement in OCD and related symptoms of depression, anxiety, and global functioning both in the United States and in Germany (e.g., Abramowitz & Deacon, 2006; Abramowitz, Tolin, & Diefenbach, 2005; Gönner, Leonhart, & Ecker, 2008).

Differential Diagnosis

As noted in Chapter 1, the high comorbidity of OCD with other disorders such as depression and other anxiety disorders, as well as the

similarity between the criteria for OCD and other mental disorders, can create diagnostic predicaments for the clinician. In the sections that follow we review some diagnostic difficulties and provide recommendations for making differential diagnostic judgments.

Depressive Rumination

The brooding that occurs during depressive episodes can sometimes be difficult to distinguish from obsessions. The differences are in the content of the thoughts and the patient's reported reactions to them. Depressive thoughts are generally negative, pessimistic ruminations about the self, others, and the world (Beck et al., 1979). The content is typically a range of thoughts, often shifting, and is less specific than repetitive obsessions. Ruminations of guilt, failure, and hopelessness are experienced by the individual as appropriate and mood-congruent (i.e., ego-syntonic). They are not experienced as intrusive, nor do they cause high anxiety. For example, a depressed individual can have ruminations concerning suicide and can be emotionally drawn to these ideas.

Obsessions are similarly always negative. However, in contrast to depressive ruminations, the reactions of OCD sufferers to their obsessions are distress over having the thoughts and a desire to avoid, resist, or suppress the thoughts. OCD patients report obsessions as inappropriate and intrusive (i.e., ego-dystonic). However, because a large percentage of OCD sufferers are also depressed, an individual can have ruminations about his or her symptoms never improving or OCD destroying his or her relationships.

Other Anxiety Disorders

OCD often co-occurs with other anxiety disorders, and diagnostic criteria are sometimes similar across anxiety disorders. Therefore, it is important to investigate the fear underlying the symptoms. For example, individuals with post-traumatic stress disorder (PTSD) related to an attack often avoid crowds in order to protect themselves from another attack. In contrast, OCD sufferers may avoid crowds to protect

themselves from being contaminated and contracting an illness or from harming someone they accidentally bump into (with possible repetitive checking or apologizing).

Similar to depressive ruminations, the worries of individuals with GAD are experienced by the individual as appropriate (i.e., ego-syntonic), albeit excessive. Their concerns are about real-life circumstances such as being fired, divorced, or bankrupt and are perceived by the patient as rational, although exaggerated. On the other hand, OCD obsessions are often ego-dystonic, such as an urge to kill or sexually molest one's child. Also, GAD sufferers seldom resist or suppress their worries, even though they cause anxiety. OCD sufferers attempt to avoid or suppress their obsessions. Moreover, OCD sufferers perform rituals to prevent their feared consequences, whereas GAD sufferers do not.

In the absence of rituals, the avoidance associated with specific phobias can appear similar to OCD. For example, a dog phobic, who is afraid of being bitten, will avoid places such as public parks or will escape when encountering a dog. Once out of proximity of the dog, the anxiety will diminish. In contrast, an OCD individual who fears being contaminated by dogs will also avoid dogs; however, removing the dog will not reduce distress because the dog-related contamination continues to be present until washing and cleaning rituals are performed.

Body Dysmorphic Disorder (BDD), Eating Disorders, Hypochondriasis

The most effective way to differentiate these types of fears from OCD symptoms is to assess for content specificity of the patient's thoughts and behaviors. In OCD, multiple obsessions are experienced, whereas most individuals with the above disorders typically suffer from a single obsessional content. In BDD, the preoccupation is with imagined physical defects and may involve checking in the mirror. With anorexia or bulimia, concerns are focused on body weight and compulsive behavior is limited to eating issues, such as chewing food a certain number of times before swallowing or cutting up food in a particular manner. In hypochondriasis, concerns are restricted to health, and the focus is on physical symptoms leading the individual to fear that he or she currently has a disease or illness. OCD patients, in contrast, typically

obsess about a wide variety of content areas such as harming other people, being irresponsible, contracting a disease, or performing sexual deviations.

Impulse Control Disorders and Body-Focused Repetitive Behaviors (BFRBs)

Compulsive behaviors are involved in disorders such as pathological gambling, kleptomania, and trichotillomania; in BFRBs behaviors may include skin picking, nail biting, or mouth chewing. The discriminating factor from OCD is that these behaviors involve a pleasure response by the patient, even if for a temporary period. As opposed to OCD, distress in these disorders is experienced by the consequences of the behavior, such as financial problems or physical changes. In OCD, rituals cause anxiety reduction, but not pleasure, and distress is caused by the obsessions and the frustration of the senselessness and wasted time of the compulsions.

Tourette Syndrome and Tic Disorders

To differentiate the vocal or motor behaviors of Tourette syndrome and tic disorders from compulsions, the functional relationship between these behaviors and any obsessive thought must be examined. Tics generally lack the intent of neutralizing a feared consequence. In a small minority of cases, however, when compulsions are performed repeatedly over a number of years, they can become automatic and disconnected from their obsessions (Mansueto & Keuler, 2005). However, upon probing, OCD patients will usually be able to connect their behavior to a past obsession.

Delusional Disorder and Schizophrenia

Some individuals with typical OCD obsessions such as contamination and harm may present with obsessions of delusional intensity (Foa, Kozak, et al., 1995). It is important to note that only about 4% of OCD patients report total conviction that their obsessions and compulsions are realistic. These individuals will receive the specifier of "poor insight"

or "overvalued ideation" (see Chapter 1). In contrast, patients suffering from psychotic symptoms are completely convinced of their delusions, which tend to fall into categories such as persecutory, referential, and grandiose. Moreover, psychotic patients do not engage in rituals that have a functional relationship with their delusions.

It is also important to recognize that the content of obsessions in OCD may be quite bizarre, similar to delusions of schizophrenia, but bizarreness does not preclude a diagnosis of OCD. For example, teenagers in particular sometimes have fears of identity changes, such as losing their intelligence if they sit next to underachieving students, their immorality if "contaminated" by a pencil used by a suspected drug abuser, or their fitness if they breathe in the air exhaled by an overweight person.

It is also important to ascertain that no other symptoms of a formal thought disorder are present in a patient with OCD with poor insight, such as loose associations, thought insertion or projection, hallucinations, or flat or grossly inappropriate affect. OCD patients should recognize that their thoughts are a product of their own mind, and are not imposed from outside sources.

Obsessive-Compulsive Personality Disorder (OCPD)

The preoccupation with details, perfectionism, and rigidity seen in individuals with OCPD can be differentiated from OCD by evaluating the patient's resistance and distress. Thoughts and behaviors are experienced in OCPD as appropriate and ego-syntonic, therefore, no fear or resistance accompanies these behaviors and concerns. There is a sense of value, even righteousness, regarding their perfectionistic behaviors, and they often feel that others should be acting similarly. The concerns of individuals with OCPD seldom provoke resistance or feel like "wasted time," nor do they cause distress. In fact, these individuals express a strong preference for their rigid activity.

Who Should Receive EX/RP

EX/RP should be conducted with individuals who meet criteria for OCD, and for whom OCD is the primary diagnosis at the time of being

referred to treatment. In other words, severe depression, active suicidality, substance dependence, or any diagnosis that would interfere with a patient's ability to engage in treatment should be addressed first. EX/RP with individuals who exhibit OCD and comorbid psychotic symptoms should proceed only if the treatment exercises do not exacerbate the thought disorder symptoms.

In general, OCD with poor insight is not a contraindication to conducting EX/RP. Although individuals with extreme overvalued ideation show poorer treatment outcome, they do benefit some from the treatment. Individuals with mild to moderate levels of overvalued ideation benefit from EX/RP as much as those with no overvalued ideation. Thus, EX/RP can be effective as long as the individual has sufficient flexibility in his or her thinking to make changes in his or her beliefs (Foa, Abramowitz, et al., 1999).

As with any psychotherapy, patients who are sufficiently motivated and distressed with their current circumstances will most likely work to make changes in their life. Individuals with severe OCD symptoms should be encouraged to seek professional assistance (Foa & Wilson, 2001). Sometimes, well-meaning loved ones of an individual suffering from OCD accommodate the symptoms and become enmeshed in the rituals. This can foster dependency and complacency, which decreases motivation to change. Motivational interviewing techniques can be particularly useful in these situations, at the beginning of therapy, as well as when ambivalence or avoidance regarding exposures becomes a problem (Swanson et al., 1999).

How to Introduce EX/RP Treatment to the Patient

When the patient is judged to be an appropriate candidate for EX/RP treatment after the assessment, the clinician should provide a description of the treatment, including what it entails and its expected benefits. The patient needs this information in order to make an informed decision whether to commit to EX/RP treatment. The clinician begins with a brief description of the cognitive-behavioral view of OCD, the rationale for EX/RP, a description of the EX/RP components, and an explanation of how the treatment works to ameliorate OCD symptoms.

Next, the clinician describes the factors that are important for ensuring a successful outcome. These include discussing the frequency of the sessions (i.e., benefits of once-weekly, twice-weekly, or daily sessions), the need to set aside time for practicing EX/RP between sessions, the motivation to "conquer" OCD and adopting the goal of achieving remission rather than a modest improvement, and recruiting the support of significant others when necessary. Throughout the introduction of this treatment, the clinician should emphasize that successful EX/RP entails a willingness to tolerate distress in the short term in order to reap the long-term benefits.

Chapter 3 *Treatment Components of Exposure and Ritual Prevention*

As noted in the introduction, EX/RP includes five main components: *in vivo* exposure, imaginal exposure, ritual prevention, processing, and home visits. Each of these components is described in this chapter and illustrated with several examples.

In Vivo Exposure

Exposure *in vivo* is the natural way in which we reduce fears in ourselves and in our children. Examples include learning to ride a bike in spite of the danger of falling off, approaching a swimming pool in spite of the danger of drowning, staying in an unlit room in spite of fear of the dark, learning to drive a car in spite of fear of driving, etc. Beginning in the 1960s, *in vivo* exposure was the most commonly used procedure to treat anxiety disorders, in particular specific phobias such as fear of elevators or heights. It continues to be the component of CBT treatment that is most often used for pathological anxiety. Exposure *in vivo* consists of a class of techniques, the common element of which is helping the patient confront stimuli that he or she fears and avoids despite the fact that these stimuli are not extremely dangerous.

OCD patients are exposed to stimuli that trigger their obsessional distress and their urge to ritualize. For example, a person with obsessional fear of bodily fluids may be exposed to sweat, saliva, or blood; a person with fears of causing a flood accidentally may be exposed to leaving a faucet dripping; a person who fears that something bad will happen if he does not arrange his things in a certain order may be asked to leave his belongings in disarray or in the "wrong" order.

As noted in the introduction, exposure can be abrupt or gradual. Abrupt exposure, or flooding, maximizes the effect by going directly to the most distressing situation, while systematic desensitization moves gingerly in small steps, coupled with relaxation to minimize anxiety and distress. Systematic desensitization has not worked well with OCD. Both abrupt and gradual approaches have been shown to be effective in other anxiety disorders; however, patients express a preference for gradual exposure. So, nowadays, exposure is done in a gradual way but with bigger increments, beginning with moderately distressing stimuli so that the patient can experience the accomplishment of noticeable and meaningful steps.

In vivo exposure is implemented in EX/RP in the following sequence. First, the rationale for how *in vivo* exposure helps to reduce OCD symptoms is presented. Then the concept of a Subjective Units of Discomfort Scale (SUDS) is introduced, and the patient's anchors are determined on that scale. This is followed by the creation of a list of triggering stimuli (situations, objects, thoughts) arranged in a hierarchy from less distressing to more distressing, based on ratings according to the SUDS levels. And finally, *in vivo* exposure exercises are tailored to confront those items on the hierarchy, both in session and as homework practices.

Why Do *In Vivo* Exposure?

Presentation of the rationale uses emotional processing theory of OCD, which combines elements of conditioning theory and information processing theory. Certain cues trigger the obsessions that generate distress or emotional discomfort. Organisms, including humans, tend to reduce the discomfort by either escaping or avoiding such situations. In the case of patients with OCD, however, escape or avoidance does not always help to reduce the distress. For example, unlike a person with a dog-phobia whose distress diminishes when the possibility of encountering a dog is minimized, OCD checkers continue to worry about not checking sufficiently even after they are removed from the situation. Similarly, OCD washers continue to worry that the contamination has spread even if they are not in direct contact with the contaminating agent. Because escape and avoidance do not help reduce the distress as it does with phobics, OCD sufferers use compulsions in an attempt to do so.

Avoiding or ritualizing reduces the distress temporarily, and this reduction reinforces these behaviors and strengthens the habit of using them in future encounters with the triggering stimuli.

However, the use of avoidance and rituals maintains the patients' belief that unless they avoid or ritualize the distress and the urge to ritualize will last in perpetuity and may even cause them to lose their minds. This interferes with the patients' opportunity to find out that even without avoiding and ritualizing the anxiety will decrease. Moreover, these habits maintain the belief that many patients have that something bad, other than distress itself, might happen if they do not avoid or ritualize.

How Does Exposure Help Reduce the OCD Symptoms?

Through exposure without avoidance or rituals, patients learn several things: (1) anxiety/distress/urge to ritualize does not last forever and decreases even without escaping, avoiding, or ritualizing. This way, the strength of the habit to ritualize or avoid is weakened and this, in turn, reduces the urge to engage in these behaviors; (2) patients whose OCD symptoms include fear of disastrous consequences such as dying from illness, or causing a fire or a flood, learn that these feared consequences do not occur. In other words, exposure, together with refraining from avoidance and rituals, disconfirms the patient's anticipated dreaded consequences, including that anxiety lasts forever or that it mounts uncontrollably until it produces a "breakdown." For example, a person with magical thinking whose obsession was to wait for a specific time on the clock before making a phone call or sending an e-mail because of a fear of harm befalling a loved one will learn that despite performing those actions without regard to the time, the feared consequence does not occur.

Implementing *In Vivo* Exposures

Choosing Situations

Most stimuli that evoke obsessional fears and urges to ritualize lend themselves to *in vivo* exposures. Examples include touching

contaminated objects and places, using "bad" numbers or words, using sharp objects, driving on a bumpy or crowded road, etc.

Selecting and Ordering Exposures

Items from the list of situations to be confronted are chosen in ascending order, beginning with those in the midrange of anxiety/distress. The first few items should be done in a way that allows patients to learn the principles of exposure without avoidance and ritualizing and that will result in a noticeable decrease in their level of anxiety despite the fact that they are not avoiding or performing rituals. Exposures done in session are then assigned as homework for patients to complete on their own. In each of the subsequent sessions, items are selected from the patient's exposure hierarchy, addressing increasingly higher levels of anxiety/distress. Exposures at the top of the list (the most anxiety-provoking) are usually conducted approximately at midpoint through treatment (around Session 8). The remaining sessions are devoted to repetition of the most difficult items in a variety of ways, incorporating new items that were discovered during treatment, and broadening the generalizability of exposure principles to potentially similar situations as a tactic for relapse prevention.

OCD sufferers often have several obsessional content areas. Thus, for example, a person might have fears of contamination, blasphemy, and throwing things away. The first step would be to identify the underlying feared consequence of each in order to find out whether they have a common element. For example, all of these fears could be related to the consequence of "being a bad person." Alternatively, each of those could have a separate underlying feared consequence. Contamination could cause disease; blasphemy could result in being punished; and throwing things away could be wasteful or disrespectful.

There are several ways of implementing *in vivo* exposures when there is more than one content area. One would be to develop a hierarchy for each area and then to choose one to begin with based on the area of functioning the person needs to address first. For example, in the situation just described, three hierarchies would be developed, one for each content area (contamination, blasphemy, and throwing things away).

The contamination hierarchy may be the most urgent if the person is having difficulty going to work due to fear of contracting a disease there.

Another way of implementing *in vivo* exposure would be to create one hierarchy across all three content areas. The advantage of this approach is that patients then learn to address their obsessional fears, whatever they are, in a tiered fashion, by increasing levels of difficulty. This approach is likely to teach the sufferers the principle of generalization, which may help them with relapse prevention and with insight into future presentations of OCD symptoms. A disadvantage could be that some patients will be unable to tolerate changes in more than one content area at a time.

Imaginal Exposure

Imaginal exposure is a powerful tool in the treatment of OCD, the versatile utility of which is sometimes overlooked. It employs the person's ability to use his or her imagination as a vehicle for exposures that cannot be easily or ethically done in real life. Imaginal exposure involves patients vividly imagining themselves in the situations they fear, situations that evoke their urges to perform rituals and the negative consequences that they fear will happen because they refrain from ritualizing. It is often clear that even when discussing the imaginal exposure techniques with an OCD sufferer, the idea of imagining these scenarios creates a strong degree of discomfort that can come close to matching an actual encounter with that circumstance.

Why Use Imaginal Exposure?

The purpose of imaginal exposure is several fold:

1. To promote extinction of thoughts and images by repeatedly imagining them and thus decreasing the negative affect associated with them. At this point it is important to have a discussion with the patient about a commonly expressed fear, which is that the decreased distress associated with such extinction does not promote a moral tolerance or even a desire for the abhorrent

thoughts or images. Such a discussion should occur only once; repeating this discussion several times can be perceived by the patient as permission from the therapist to assign responsibility to the therapist rather than to themselves for the "badness" of imagining bad and immoral things.

2. To promote increased tolerance of the distressing emotions associated with the obsessional thoughts or images. Thus, instead of coping with the distress by avoidance or ritualizing, the patient learns to accept the presence of the negative emotions, to tolerate and to cope with them. This teaches the patient that he or she can experience distress without "falling apart" and establishes a sense of mastery in the face of the negative emotions.

3. To create a scenario that describes the entire progression of events leading to the ultimate feared consequences. The details of the scenario must match the degree of negative emotions that accompany the thoughts or images, often making it into a worst-case scenario. This allows the patient to confront thoughts and images that he or she has been avoiding thinking about, and highlights the sequence of steps and events that would be entailed on the way to the ultimate feared consequence.

4. To learn that repeated exposure to this form of anxiety as well (i.e., one that is produced by imagination) leads to habituation and symptom reduction. Thus, volitional repetition of the fully developed imaginal scenario results in a gradual decrease in the experienced distress caused by the obsessional content.

5. To help the patient disentangle the "thought–action fusion" (Shafran, Thordarson, & Rachman, 1996)—that is, to distinguish between thoughts and actions or reality. Patients discover that allowing themselves to entertain horrendous thoughts or images does not necessarily make them come true. This allows patients to learn that they do not have the control either to cause a bad consequence by thinking about it, or to prevent it by not thinking about it or by performing rituals.

6. To create exposures for feared consequences that cannot be tested in reality, because they are either in the future, vague, impractical,

unethical, or illegal. A sample of those include contracting cancer, going to hell, losing one's essence, causing someone's death, or committing a crime.

7. To teach patients that the likelihood of such negative events is rather low and that the cost they are paying to protect themselves or others from these low-probability events is rather high. This highlights to patients the high price they are paying to maintain their avoidance and performance of compulsions. The cost often manifests in many forms, such as loss of time, energy, money, career, and relationships.

8. To help make the patient feel more fully understood by the therapist, who seems to know exactly what the patient's feared consequence may be. This promotes the patient's sense of trust and confidence in the therapist's ability to provide him or her with helpful therapeutic interventions.

9. By addressing the underlying core fear in imagination, the patient may then more easily stop a wide array of compulsions, all of which were aimed at reducing the distress emanating from and driven by this feared consequence. This provides an effective and time-saving intervention for what otherwise would require a long series of *in vivo* exposures.

Implementing Imaginal Exposures

Choosing Scenarios for Imaginal Exposure

To maximize the effectiveness of imaginal exposure, it is essential to identify the patient's underlying core fear. The therapist should explore with the patient exactly what that core fear is, and how far the feared consequence goes. Although many OCD patients have similar core fears, the therapist should not infer this information but rather find out the specific details with each individual patient. Thus, for example, one patient with harm obsessions might fear being arrested for a crime and put in jail, causing great shame to the family, while another patient might fear going to hell for that crime. Another feared consequence

commonly expressed by patients is the fear of "losing it" or "going crazy." It is important to identify exactly what that means to the patient and what he or she envisions would be the worst-case scenario should that happen. Another important subtlety that should not be overlooked when working to identify underlying fears is the heightened sense of responsibility that OCD sufferers often hold onto. Thus, for example, a checker might feel little anxiety or distress if someone else had made the decision not to check whether the doors and windows were shut but would have extreme anxiety or distress if he were responsible for locking them without checking. In this case the personal responsibility for the feared consequence occurring must be included in the imaginal exposure. To help the patient develop the script and uncover the ultimate feared consequence, it is often helpful to ask the patient: "What is so bad about that?" or "How does it end?"

Conducting Imaginal Exposure

Once the therapist and patient collaboratively identify the feared outcomes of a given situation, they work to create a script that includes a step-by-step unfolding of the worst-case scenario. The details of the script should paint a vivid picture for the patient of his or her most feared situation and its consequences. The script should "go to the extreme." For example, if a patient fears stabbing her husband with a knife while preparing dinner, the script would depict exactly that scenario. As mentioned, the therapist should also help the patient identify the "end result" of the scenario. For example, the imaginal exposure for the patient just described might also include her getting arrested and going to jail, or going to hell for stabbing her husband. This type of script is very different from one in which the patient is simply using a knife while making dinner with her husband. The latter scenario lends itself to *in vivo* exposure.

Creating an Imaginal Exposure Script

The first few scripts are often prepared together by the therapist and patient during the session, and later on in treatment by the patient alone

as homework (a blank Imaginal Exposure Script Worksheet is provided in the appendix). Imaginal exposures can be done hierarchically, with more severe concerns and feared consequences being included in images in later sessions. Scripts should be recorded in session and listened to both in session and for homework. The recording can be made either by the therapist or by the patient, using present tense and bold statements. The patient reports his or her ratings of distress while listening to the imaginal exposure or records them on the Exposure Homework Recording Form in the appendix.

The greater the detail of the images, the more effective they are in evoking the desired result. Equal emphasis should be placed on including external/situational stimuli (e.g., the heaviness of the knife, the sound of the husband's scream) and internal/cognitive or physiological responses (e.g., thoughts of going to hell, heart racing) in the imagined scene. Similarly, the more emotionally engaged patients are in imaginal exposures, the more effective they are. To become as emotionally engaged as possible, patients should listen to imaginal exposure recordings with their eyes closed at times that they are not busy with anything else (e.g., they should *not* listen to the recording in the car when they are driving).

When Not to Use Imaginal Exposure

Imaginal exposure is not appropriate for all patients who have OCD. The following are guidelines for when *not* to use imaginal exposure:

- **No feared consequences.** If a patient cannot articulate feared consequences of his obsessional fears (i.e., he does not believe that anything bad will happen if he confronts his feared stimulus).
- ***In vivo* exposure situations are readily available.** If the patient's feared situations/stimuli can all be confronted in real life (*in vivo*), it is preferable to use *in vivo* exposure to imaginal exposure.
- **Patient has difficulty with imagination.** If the patient demonstrates difficulty being able to bring a vivid image of the intended situation or stimulus to mind, imaginal exposure will not be helpful.

Ritual prevention is an essential ingredient in the success of this evidence-based treatment. As noted in the introduction, exposure without ritual prevention produces outcomes inferior to the combination of exposure and ritual prevention. Exposure to a situation that triggers obsessional fear with the deliberate omission of the compulsion or ritual will enhance the extinction of that fear. Patients should be reminded of the specific instructions for ritual prevention on the first day of exposure as well as periodically during treatment. You will be discussing the rules for ritual prevention with patients and giving them a handout describing the guidelines. If the rules outlined for patients do not adequately cover the type of ritual(s) displayed by the patient, provide the patient with a written set of instructions modeled after these forms.

Important Note to Therapist

It is important to understand the gradual nature of EX/RP and to present the principles both of exposure and of ritual prevention with the *realistic* expectation that patients cannot just quit their ritualizing "cold turkey." The goal is to set up the expectation that ritual prevention is an integral component of the effectiveness of this treatment and that complete ritual prevention is to be aimed for in the long run. During the first few sessions of treatment, the patient is encouraged to reduce ritualizing by some measurable amount, for example by 50%, and to continue to further reduce rituals as treatment progresses. Setting realistic and attainable goals will serve to increase the patient's success, which in turn will act to motivate him or her to continue working up the hierarchy. Rigid application of the ritual prevention rules may result in discouragement and dropping out of treatment.

At home, ritual prevention can be aided by recruiting a relative or a friend predesignated by the patient as a support person who is instructed to be available to the patient should he or she have difficulty controlling a strong urge to perform the ritual. The patient is to report any such concern to the designated support person, who will remain with the patient until the urge decreases to a manageable level. Observed

difficulties with ritual prevention are reported to the therapist by the patient. The support person is instructed to strongly encourage the patient to withhold the ritual, but no physical force is used and arguments should be avoided.

Processing

Processing the patient's experience with him or her during and after *in vivo* exposure and after imaginal exposure is an important part of EX/RP treatment. It allows patients to learn several important facts: (1) They learn to recognize that, rather than mounting uncontrollably, noticeable reductions in anxiety levels occur during the exposures, even without ritualizing; (2) They find out that repeated exposures bring about continued reductions in their anxiety levels and help to sustain those decreases over time; (3) They learn that they can manage their distress without having to resort to time- and energy-consuming avoidance or rituals; and (4) They realize that their feared consequences are either disconfirmed or shown to have a low probability of actually materializing. This last point taps into the OCD patient's erroneous beliefs, as discussed in the following section.

What Happens During Processing?

Framing Exposures as "Hypothesis Testing"

This EX/RP program does not include formal cognitive restructuring. Rather, this program uses exposures as a means of hypothesis testing. The effects of exposure without ritual performance are conceptualized as a change in patients' beliefs once they have experiences that disconfirm the erroneous beliefs that are part of their OCD. Exposures should be framed as opportunities to test hypotheses about feared consequences brought on by obsessional distress. The exact nature of the hypothesis testing will vary greatly from patient to patient, since the concerns held by patients with OCD are so idiosyncratic. It is essential that the therapist spend time coming to an understanding of each patient's unique

feared consequences so that exposures can be designed in a way that optimally test out these personalized beliefs.

"Feeling Bad" as a Consequence

For some patients, "feeling bad" is the only consequence that they experience when they are exposed to their feared stimuli. It is difficult for them to imagine that they could be exposed to the feared stimuli and not feel terrible. EX/RP allows patients to test this prediction and to learn that their feelings of discomfort will decrease as they stay in the situation, even if they do not engage in rituals. Furthermore, they will find out that the more times they encounter the feared stimuli without engaging in rituals, the less distressed they will feel. The therapist should help the patient come up with specific testable predictions. For example, "If I touch doorknobs in a public place and don't wash my hands, my anxiety will continue to be at a distress level of an 80. It will never get easier." Patients should then keep track of their SUDS during exposures and across exposures, which will help them realize that (1) their anxiety decreases over the course of an exposure and (2) the stimuli will gradually elicit less anxiety with repeated exposures.

Worrying About the Consequences of "Feeling Bad"

For some patients, their feared consequences extend beyond feeling very distressed: they fear that because their anxiety will never go away, they will lose their mind or go crazy, or that anxiety will harm their health in some way (e.g., "I'll have a heart attack"). EX/RP allows patients to test these predictions and to learn that their anxiety will not remain forever, will not cause them to lose their minds, and will not damage their health. For example, if a patient said: "If I touch doorknobs in a public place and can't wash my hands, my anxiety will be so bad that I'll just go crazy." The exposure can be carried out at the beginning of the session, and the therapist and patient can then check in on the prediction ("I'll go crazy") at the end of the session. Patients will learn that their anxiety decreased over time and that even if it did not do so during the session, their dire predictions have not been supported.

Specific Feared Consequences

Many patients can articulate very specific predictions about what they think will occur if they expose themselves to feared stimuli and don't engage in rituals. As already noted, treatment is most effective when the therapist has a clear understanding of the exact nature of these feared consequences. Having this level of understanding is essential for designing exposures that tap into the patient's unique fear structure.

For example, two patients with a fear of using public restrooms might have very different feared consequences, and thus will necessitate different exposures to test their predictions. One patient might say, "I think I am going to get a stomach bug and I will know if I have one by tomorrow morning." The patient can advance a prediction about how likely it is that he will get sick (e.g., "I'm 100% sure"), and can then evaluate the prediction the next day. Another patient might fear that she will get contaminated by the cleansers used to clean public bathrooms and might worry that the chemicals in them will cause her to lose her intelligence. She might predict that if she stayed in a public bathroom for more than a minute or two, she would no longer do well in school. For this patient, an exposure might involve spending time in a public bathroom that has just been cleaned before a big test at school. This would allow the patient to test the very specific prediction that the cleansers would hurt her performance in school.

Some predictions are more difficult to evaluate through *in vivo* exposure because the consequences are far off in the future (e.g., "all of these exposures to chemicals will mass together and I will get cancer in 20 years") or very difficult to evaluate repeatedly (e.g., "If I use public bathrooms, I will get AIDS"). These kinds of fears are best addressed with imaginal exposure, for example, about getting cancer or AIDS (see information on imaginal exposure earlier in the chapter).

Overestimation of the Importance of Thoughts

Patients with OCD place too much importance on the meaning of their thoughts. For example, they may equate the obsessional fear of doing something inappropriate with actually wanting to do this

(e.g., "If I think about killing my child, it must mean I want to kill my child ") or that it reflects their true nature (e.g., "I must be a bad person if I'm thinking these horrendous thoughts"). This is very much related to thought–action fusion, which is the belief that thinking a thought increases the probability of an event, or even causes the event to occur (e.g., "If I think of my daughter being possessed by the devil, it means that I will have actually sold her soul to the devil").

One effect of this type of mistaken thinking is that patients try hard to suppress these thoughts (e.g., "don't think about violence" or "don't think about the devil"). Unfortunately, the more they try to avoid thinking about that particular content, the more they think about it. This is a commonly encountered phenomenon, and many patients can relate to trying to not think about a delicious food when they are on a diet—and finding themselves thinking about it all the time! You can illustrate the point by asking the patient to not think about his or her mother's face. Most people will smile instantly and acknowledge that the first thing that came to their mind upon that request was an image of their mother's face! The therapist can use this type of experiment to demonstrate to OCD patients that trying to suppress the thoughts or images increases their presence, and that inviting the thoughts rather than fighting them will paradoxically decrease the frequency and intensity of these thoughts.

To demonstrate to patients that having a thought is not equal to wanting to act on the thought, or making the thought actually occur, you can ask them to think about something not related to their OCD, beginning with a thought that has low negative valence. For example, you can ask patients to think intentionally about making a book fall off a bookshelf in the office and have them realize that even if they think about this very deliberately, their thoughts do not equal actions. Then, you can move on to something more sinister but still unrelated to the patient's OCD. For example, you can ask the patient to think about robbing a bank or about a terrorist attack. This will demonstrate to the patients that they can think about these bad outcomes, and even wish for them, but that they still are unlikely to happen. Once patients "buy" the notion that thoughts do not equal actions, they will be more willing to do exposures to the fear-eliciting thoughts that lie at the core of their OCD, and they will find out that the same absence of feared consequence applies to these thoughts as well. Imaginal exposure is especially useful in demonstrating this point.

Intolerance of Uncertainty

Some patients with OCD cannot endure feeling uncertainty and are, therefore, compulsively seeking guarantees and reassurance. These patients typically engage in a variety of checking rituals. For example, a patient who checks the mailbox to make sure the mail went in properly will not be able to tolerate the feeling of not checking. He or she will become very distressed by feeling "unsure." Ideally, these patients will engage in ritual prevention when it is prescribed and will naturally learn to tolerate these feelings of uncertainty. For patients who find these feelings intolerable, there are a few ways to address this difficulty:

- Ask the patient: "How long does it take you to feel 100% sure?" or "Even after doing your rituals, do you feel 100% sure?" The idea is to demonstrate to patients that their rituals aren't particularly helpful and that their *cost* is greater than their benefit. Patients often spend a lot of time engaging in rituals with very little payoff in terms of anxiety reduction. Helping patients see how much time they are committing to an unhelpful endeavor can motivate them to try things in a different way.

- Review with patients the validity of their feared consequences, but *only once*. You would not want to do this repeatedly, since it can become another form of reassurance. But you can review with patients once, "What would happen if by accident you dropped your mail on the floor of the post office under the mailbox?" or "What would happen if you made a mistake on your rent check or forgot to sign it?" The "downward arrow" technique can be used with patients to get at their most feared consequence. Leading patients through this will often show them that their feared consequences are unlikely—for instance, "I guess someone would pick up my mail and put it in the box for me" or "I guess the management company would call me and let me know my check was incorrect or missing a signature."

- Reassure patients *only once*. Patients who have intolerance for uncertainty seek a lot of reassurance and recruit others into their compulsions. For example, if a patient's OCD is about harming others, he may ask repeatedly if you are *sure* that it is OCD, and

not that he really is at risk of harming others. The goal is to respond to patients' concerns just one time. While you most certainly want to comfort them, you do not want to feed into their need for certainty and become part of their ritual.

Home Visits

Why Do Home Visits?

Home visits are a useful component of treatment that helps to identify the impact of the OCD in the home environment and to implement the treatment principles by successfully transferring the newly acquired practices of exposure and ritual prevention to "where the OCD lives." The purpose of a home visit is twofold:

1. To help the therapist and patient explore where and how the OCD has captured parts of the patient's territory, whether at home or in other personal environments, such as the patient's workplace or classroom (if the patient is a student)
2. To coach the patient on how to do exposure and ritual prevention in the home environment so as not to allow any "uncovered territory," whether obvious or subtle. Thus, for example, a patient may have developed a habit of never touching his bed until he has showered and become totally "clean" or may have a designated "safe" place in the home, reserved solely for his use.

Rules of Therapist Behavior during Home Visits

The following may be a case of stating the obvious, but there should be clearly stated "rules of conduct" for when a therapist makes a home visit. After all, this may be the place of residence of the patient's family, and a home visit for OCD treatment often involves access into the patient's and his or her family's personal space. It is important that the family understand ahead of time the exact purpose of the home visit; they may wish to make arrangements to stay out of the way or participate, depending on the choice stated by the OCD sufferer.

Timing of Home Visits

Home visits can be conducted at any time after the initial information-gathering sessions. The timing will depend largely on what purpose the home visit will serve. Sometimes it is useful to conduct the home visit early in treatment so as to help map and identify those areas where OCD interferes with the person's functioning. At other times, the home visits can be interspersed between other sessions, so as to help the sufferer apply the exposure and ritual prevention exercises into the areas in the home designated by the OCD as the "Holy of Holies"—that is, the places that are the most "safe" or "clean." Thus, for the treatment to be effective and to prevent as much relapse as possible, it is important to break the boundaries between "safe/unsafe" or "clean/dirty." In some cases, the home visits can be reserved for the end of treatment, when the emphasis is more on relapse prevention and maintenance of gains.

This page intentionally left blank

Chapter 4 *Session 1: Treatment Planning Part I*

(Corresponds to Chapter 3 of the workbook)

Timeline

1 session (120 minutes)

Materials Needed

- Information-Gathering Form
- Obsessive-Compulsive Disorder: Some Facts handout
- Self-Monitoring Forms
- Appointment Schedule
- Telephone Contact Notes

Outline

- Gather a general history from the patient.
- Collect initial information on patient's OCD symptoms and history.
- Explain OCD to the patient.
- Present the rationale for treatment.
- Describe the treatment program.
- Introduce self-monitoring.

- Introduce inter-session phone contacts and schedule the first call.
- Assign homework.

Taking a General History (25 minutes)

Introduce yourself to the patient if this is the first session with him or her. Using the Information-Gathering Form provided, take information about the following: patient's age, marital/relationship status, children, living arrangement, and current work situation. Also, solicit information from the patient regarding the following areas and record a summary of each on the information form: medical history, education, employment, financial situation, relationships with family, relationships with friends, dating history, and marital history.

OCD Information Gathering (40 minutes)

After taking a general history, collect information about the patient's obsessive-compulsive symptoms using the guidelines for each category provided below in this section. Summarize the information on the Information-Gathering Form. You should have available the Y-BOCS checklist that was completed previously during the patient's intake evaluation. Indicate to the patient that you, as the therapist, need a detailed understanding of his or her symptoms so that you can individualize the therapy procedures for him or her.

Guidelines for Information-Gathering Categories

Obsessions

Collect information about the patient's obsessions; the circumstances (objects or situations, thoughts or images, and physical sensations) that evoke obsessional anxiety/distress.

- **External Cues**. Specifically elicit information about objects (e.g., urine, blood, pesticides) or situations (e.g., locking a door, driving

over bumps, hearing a certain word or sentence) that constitute sources of high anxiety or discomfort.

- **Internal Cues**. Inquire about thoughts, images, or impulses that provoke anxiety, shame, or disgust, such as sexually graphic images, certain numbers, impulses to stab loved ones, thoughts of being contaminated, or worries of negligence such as leaving the gas burners on.
- **Bodily Sensations.** Inquire about bodily sensations that disturb the patient, such as rapid heart beat, pains, difficulty swallowing, or tightness at the temples.

Consequences of External and Internal Cues

Elicit information about harm that the patient believes will be caused by the external objects or situations he or she indicated as evoking anxiety. A good way to identify patients' feared consequences is to ask them what they fear will happen if they do not perform their rituals. Some examples of feared consequences are getting a disease from touching a contaminated object; a burglary due to a door not being locked properly; or losing intelligence by being close to environmental hazards or to a person with perceived low intelligence. For some patients the feared consequence might simply be the feeling of being extremely anxious or becoming highly distressed because of feeling "weird" or of not feeling "just right."

Elicit information about possible harm that the patient thinks can be caused by internal cues:

- Thoughts, images, or impulses (e.g., "God will punish me," "I may actually stab my child")
- The long-term experience of high anxiety (e.g., "This anxiety will never go away and I will always be highly distressed," "My general health will suffer," "I will faint," "I will lose control")

Avoidance Patterns

Ask the patient for information regarding his or her avoidance behaviors:

- **Passive Avoidance**. Gather a list of all situations or objects that the patient avoids (e.g., using public bathrooms, stepping on brown spots on the sidewalk, seating one's child in a shopping cart while shopping, driving). Attend to subtle avoidance practices (e.g., touching doorknobs on the least-used surface, or designating clean and dirty hands, driving at times of least traffic).
- **Rituals (i.e., compulsions)**. List all ritualistic behaviors, including washing, cleaning, checking, repeating an action, ordering and arranging objects, requesting reassurance, and mental rituals (such as praying, neutralizing thoughts, "good" numbers). Many patients exhibit more than one type of compulsion.
    - Explore the subtle rituals, such as the use of moist towelettes or sanitizers to decontaminate hands, because these are substitutions for a washing ritual. Ask patients about behaviors they engage in that they consider different from or more frequent than what other people do (note that many OCD patients actually do not know what others do).
    - Ask specifically about mental ritualizing, such as repeating prayers or phrases, conjuring up a "good" image after seeing or picturing a "bad" one, or any other form of neutralizing thoughts that are purposely invoked to reduce distress.

Relationship between Avoidance Behaviors and Fear Cues

Ascertain the functional relationship between the fear cues and the avoidances associated with them. That is, explore with the patient whether the latter reduce anxiety and discomfort elicited by the former or whether they are intended to prevent some dreaded consequence.

Onset and History of OCD

Collect information about the events that took place around the time of onset of the patient's symptoms or about the circumstances when the symptoms flared up and became functionally debilitating. Inquire about the course of the problem and any previous psychiatric treatment for the obsessive-compulsive symptoms, noting the provider and the type, duration, and outcome of the treatment.

What is OCD? (10 minutes)

After completing the Information-Gathering Form, explain OCD to the patient. You may wish to say something like the following:

> *You have a set of symptoms that, as you know are called obsessive-compulsive symptoms. These include thoughts, feelings, and behaviors that are extremely unpleasant, unproductive, and difficult to get rid of on your own. We call them obsessions. Usually, obsessions involve thoughts, images, or impulses that come to mind against your will. These thoughts are accompanied by unwanted feelings of extreme distress/anxiety or guilt, shame, and disgust, and strong urges to do something to reduce the distress. One way in which people try to reduce their anxiety is by avoiding situations, objects, or thoughts that evoke this anxiety. However, with people who suffer from OCD, avoidance or escape from the things that evoke their anxiety does not work well. For example,* [give example from the patient's own OCD symptoms here].
>
> *Because, as with all people with OCD, your attempts to avoid the situations or thoughts that cause you the distress do not work well or they reduce the distress for a short time only, you developed habits of doing certain actions or thinking special thoughts, which we call rituals, to try to reduce your distress. Unfortunately, performing these rituals also does not work all that well, and the distress decreases for only a short time before coming back again. Often, you find yourself doing more and more rituals to try to get rid of the distress, but even*

then, the rituals reduce the distress only temporarily, and soon you find yourself putting so much time and energy into rituals that do not work that other areas of your life get seriously disrupted. For example, you … [give example from patient's symptoms]

Give examples of obsessions and compulsions from the patient's own repertoire to help show the functional relationship between them. Engage the patient in a discussion of this conceptualization to help him or her understand this functional relationship. Inquire if the patient has any questions.

If the patient wants to know why he or she has OCD, explain that there are several theories about the origin of OCD, but that it is impossible to know for sure how and why it develops in individuals. It is probably a combination of many genetic, biological, and environmental factors. What is important is that this treatment does not depend on knowing what caused the patient's OCD. Rather, it depends on understanding the nature of the patient's current obsessions and compulsions.

Rationale for Treatment (20 minutes)

How Does Exposure Help Reduce the OCD Symptoms?

Next, present the rationale for treatment. Explain that this treatment involves exposure and ritual prevention (EX/RP). Begin by explaining how *in vivo* exposure works using the narrative given below. In addition, with patients whose OCD symptoms include feared disastrous consequences that cannot be included in *in vivo* exposures, you will then explain how imaginal exposure will help them.

Rationale for *In Vivo* Exposure

I am going to explain to you how in vivo *exposure together with ritual prevention helps overcome your OCD symptoms. When you confront situations that cause you distress and you stay in the situation for a long enough time without escaping or doing rituals, you will learn several things:*

First, you will learn that the anxiety/distress does not last forever. In fact, it decreases even without escaping, avoiding, or ritualizing. Also, you will find out that at the same time that your anxiety decreases, your urge to ritualize and to escape from the situation also decreases. This way, your habit of performing rituals will weaken.

For patients whose OCD includes disastrous consequences such as dying from illness, or causing a fire or a flood, add the following explanation:

By confronting places that cause you distress without escaping them or performing rituals, you will learn that the things you are afraid will happen if you don't ritualize actually do not happen. For example, … [give example from the patient's OCD symptoms here]. *You will also learn that anxiety does not last forever and that you do not have a "nervous breakdown." On the contrary, after you do the same exposure several times, you will feel that* ***you*** *are in control and that you can overcome your OCD. Any questions about this?*

For those patients whose feared consequences are about bad things happening in the remote future or that are vague or not easily subject to disconfirmation, the explanation can go as follows:

By confronting the things that trigger your fears about something bad happening in years to come, you will learn to live with doubt and to tolerate the uncertainty just like most people who don't really know what the future holds. Avoiding, escaping, or ritualizing in response to the triggers only gives you the illusion of control over bad events that can occur in the future, while in fact they strengthen your OCD symptoms in the present.

For patients with fears they cannot be exposed to in real life because they are dangerous, illegal, immoral, or impossible to create, the tool of imaginal exposure is introduced and explained as follows:

To help you with these objects, images, situations, or thoughts that trigger these disastrous consequences, I will obviously not recommend the use of in vivo *exposures. Instead, I will teach you how to do exposures in imagination to the worst-case scenario that your OCD is presenting to you coupled with ritual prevention so that you can learn that although allowing the thoughts in increases your distress level, you*

can tolerate that and find out that your anxiety will decrease just like with the in vivo *exposures.*

Rationale for Imaginal Exposure

After introducing the concept of imaginal exposure, continue to explain the rationale:

I now want to explain to you how imaginal exposure works to reduce your OCD symptoms. Imaginal exposure can help you in several ways. In imaginal exposure you and I will write down in detail the things that you are afraid will happen to you or to other people because you did not avoid them or because you did not ritualize enough. I will ask you to repeatedly imagine that these things actually happen. How will imagining that these bad things actually happen help you?

First, you will learn that repeatedly imagining that the terrible things you are afraid of will indeed happen will help you get used to these thoughts. You will gradually be able to think about them without experiencing high levels of anxiety or distress.

Second, you will learn that even though your anxiety decreases when thinking about the things you are afraid of happening, you are not likely to start engaging in those fear-evoking behaviors. For example, getting used to intrusive bad thoughts about contracting a terminal disease in the future does not make you prone to now becoming a careless person who is oblivious to standards of healthy lifestyle practices.

Third, just like with the in vivo *exposure, you will learn to accept your negative thoughts and feelings and to cope with them rather than to try and get rid of them. This will teach you that you can experience distress without "falling apart," and that you can establish a sense of mastery in the face of the negative emotions.*

Another reason why imaginal exposure works is that it will teach you that thinking about the horrible thoughts or images does not make them come true. Thinking about things does not make them happen.

When you learn all these things, you will realize that you do not need to work hard to push your unwanted thoughts out of your mind or perform rituals in order to prevent the bad things from happening.

Description of Treatment (5 minutes)

Once the patient understands the rationale for treatment, describe the format of the exposure and ritual prevention program. Tell the patient that during the next session or two, you will continue to collect information about his or her symptoms in order to identify the various situations and thoughts that generate his or her discomfort or anxiety. Together, you will then arrange these situations in a hierarchy according to the degree of distress they generate. Exposure treatment will begin at Session 3. Exposure involves confronting situations and thoughts that the patient avoids because they generate anxiety and urges to carry out ritualistic behavior. You will meet with the patient twice a week to conduct exposure practice under your supervision. Patients will learn how to do exposure so that on the days when you do not meet, they can practice successfully on their own. You will schedule telephone contacts once a week on one of the days that you do not meet with the patient face to face. The purpose of the phone call is to check in, assess progress, and offer encouragement and support.

Explain to the patient that therapy will, at times, seem demanding, and that dedicating time and putting in effort are key in getting good results. Elicit and carefully answer any questions patients may have about the exposure and ritual prevention program.

Self-Monitoring (10 minutes)

Introduce self-monitoring of the obsessions and compulsive rituals to the patient and emphasize its importance in the following way:

> *It is very important for the success of your treatment that we have an accurate picture of how much you engage in obsessive thinking and compulsive behavior. Having a clear picture of how much of your time is taken up by your OCD will help you and me to monitor your*

progress and to adjust the treatment program accordingly. Therefore, I will ask you to record symptoms every day during this week.

Explain that since it is not always easy to report accurately on how much one engages in obsessive-compulsive behavior, you will spend some time now and in the next session going over some rules for how to record symptoms. Direct the patient to the example of a partially filled out and to the blank Self-Monitoring Forms in the workbook. Carefully go over the instructions found in the workbook with the patient. Practice with the patient by filling out the form with him or her using an imaginary day of his or her life. Use the following general rules to guide the patient:

- Make sure to record both overt and mental rituals.
- Use your watch to monitor the time you spend on your rituals.
- Write the time immediately on your monitoring form.
- Do not save the recording to the end of the day or the beginning of the next day, because you will likely forget details.
- Write a short sentence to describe the trigger for ritualizing.
- Use a descriptive word or two and not a long paragraph for each ritual.

Scheduling Phone Contact (5 minutes)

Explain the inter-session phone contacts to the patients as follows:

As I mentioned before, we will be meeting twice a week for the next few months. We'll spend this week and next collecting more information, developing a treatment plan, and practicing some exposures. Thereafter, our sessions will be devoted to practicing exposure and ritual prevention, and developing practices for you to conduct on your own.

Each day of treatment, whether you come to see me or not, you will have something to practice, because repeated practice is the best way to achieve the most benefit from exposure and ritual prevention.

To help you, we will schedule a telephone call between each in-person session. This way, we can troubleshoot, clarify questions that come up, or just check in about how you are doing with the assignments. I will call you at the designated time that we schedule together. If you anticipate a problem being available for the call, please notify me beforehand and we will reschedule the call.

These phone calls are an important and necessary part of the therapy and missing them is akin to skipping an appointment. To maximize the benefit of the treatment, please try not to miss these calls.

Use the Appointment Schedule in the patient's workbook to enter the time of the session previously scheduled for the first week. Then, schedule a time for a 15- to 30-minute phone call this week. Exchange phone numbers with the patient and have the patient record the clinic phone number (or your personal number) on the schedule. Explain that you will be responsible for calling the patient at the specified time. Guidelines for making the first phone call are provided at the end of the chapter. Go over the Telephone Tips and Reminders in the workbook with the patient.

Homework (5 minutes)

- Have the patient complete Self-Monitoring Forms each day and bring them to the next session.
- Have the patient review the handout entitled "Obsessive-Compulsive Disorder: Some Facts" to solidify an understanding of the disorder.
- Have the patient review the corresponding chapter in the workbook.
- Have the patient note the scheduled time for the inter-session phone call and review the Telephone Tips and Reminders in the workbook.

The content of the first phone contact should focus on troubleshooting with self-monitoring, if needed, and checking to make sure that the patient is reading the workbook material assigned in the first session. Use the following outline for the first call:

- Ask about how self-monitoring of rituals is going. Express how important self-monitoring is in developing the most effective treatment plan in the second session.
- Remind the patient to complete the monitoring form at the time that rituals occur so that the form is as accurate as possible. Ask questions that will help you assess if the patient is accurately monitoring the amount of time spent on rituals. Remind the patient that triggers should be described in short simple sentences and rituals described briefly.
- If the patient has not been self-monitoring, ask about the obstacles that have come up and try to problem-solve. Encourage patients to begin promptly and remind them that, like any skill, this may take practice.
- Remind the patient to bring the completed monitoring forms to the second session.
- Remind the patient that it is important to read the material on OCD in the workbook for the next session.

Enter the time of the call and make a brief note about the nature of the phone contact on the Telephone Contact Notes form provided.

Chapter 5 *Session 2: Treatment Planning Part II*

(Corresponds to Chapter 4 of the workbook)

Timeline

1 session (120 minutes)

Materials Needed

- Treatment Planning Form
- Understanding EX/RP Therapy for OCD handout
- Hierarchy Form
- Appointment Schedule
- Telephone Contact Notes

Outline

- Review patient's self-monitoring.
- Review the rationale for treatment.
- Collect detailed information about patient's OCD symptoms.
- Rate patient's discomfort and create hierarchy of items.
- Generate treatment plan.
- Establish treatment contract with patient.
- Assign homework.
- Schedule phone contact.

Self-Monitoring Review (5 minutes)

Start the session by going over the Self-Monitoring Forms completed by the patient. Read descriptions of triggers; modify these as needed. Remind the patient that triggers should be described in short simple sentences. Ask questions that will help you assess if the patient is accurately monitoring the amount of time spent on rituals. Write comments in the space provided on the Treatment Planning Form provided in the appendix. Instruct the patient to continue monitoring symptoms.

Review of Rationale for Treatment (10 minutes)

Tell the patient that in this session you are going to continue to ask about his or her specific OCD symptoms in order to begin to develop a treatment plan that is tailored to his or her symptoms. First, however, you would like to review with him or her why and how the treatment works.

Ask the patient whether he or she has any questions before going on. Inform him or her that this week's reading in the workbook will help him or her to better understand the therapy. In the next session, you and the patient will discuss the rationale further, as needed.

Collecting Detailed Information about OCD Symptoms (50 minutes)

Expand and elaborate on the information you have collected in the first session. In this session, focus on getting the patient to tell you about *specific* situations, thoughts, or images that evoke distress or anxiety. This information will form the basis for generating the treatment plan for the patient and, therefore, should be detailed. Before developing the treatment plan, introduce the patient to a commonly used cognitive-behavioral tool to communicate distress or discomfort levels.

Subjective Units of Discomfort (SUDS)

Introduce the patient to the scale of Subjective Units of Discomfort (SUDS) and assist him or her in establishing anchor points for his or her own 0, 50, and 100 SUDS, using the following dialogue:

As you know, the treatment program consists of gradually approaching situations that provoke discomfort. To prepare your treatment program, we will generate a list of the specific situations that provoke your OCD discomfort and then rate each situation according to how much discomfort it generates in you. For convenience, let's speak about the degree of discomfort in numbers. We will use a scale called the Subjective Units of Distress Scale, referred to as "SUDS" for short. This scale ranges from 0 to 100, where 0 means that you feel no discomfort whatsoever and 100 indicates that you are extremely distressed, the most uncomfortable you've ever felt. Can you describe a situation you have experienced that caused you no distress at all? We will call that your 0. Now, describe a situation you have experienced that caused you the worst distress ever. We'll call that your 100. Can you identify a situation in which you were distressed but still found it manageable? We'll call that your 50. Now let's try using the scale. How much discomfort do you feel right now?

After establishing the SUDS anchors, demonstrate to the patient how one can arrange situations from the least distressing to the most distressing.

Guidelines for Information-Gathering Categories

Go through each of the following categories with the patient and record specific items and SUDS for each on the Treatment Planning Form provided in the appendix. Use the examples below to guide your inquiry.

External Feared Situations

Drawing from the information you have collected, choose situations that evoke anxiety in the patient and have the patient estimate his or her SUDS for each. Examples:

- Touching a doorknob of a public bathroom (50 SUDS)
- Sitting on the toilet seat in a public bathroom (70 SUDS)
- Touching what looks like dried-up blood (90 SUDS)

Fear-Evoking Thoughts

Elicit specific details about the patient's thoughts and images, as well as the circumstances surrounding their occurrence. Have the patient rate SUDS. Examples:

- "When I'm lying awake in bed at night, I am afraid that in a state of sleep I will unwillingly go to the kitchen, take a knife and kill my baby" (90 SUDS)
- "I am afraid that when I am driving I will veer into oncoming traffic and cause an accident" (75 SUDS)

Fear of Bodily Sensations

Explore whether the patient has fears of bodily sensations, and elicit the reasons for the patient's fears. Have the patient rate SUDS for specific fears. Examples:

- "When my vision seems blurry, I worry that I have a brain tumor" (85 SUDS)
- "When I swallow, I am very aware of the sensation in my throat and I fear that I'll choke to death" (90 SUDS)

Consequences

Record all the details of harm anticipated by the patient if he or she were to refrain from ritualizing. Have the patient rate SUDS for specific consequences. Examples:

- "If I don't check the stove before I go to bed, then my house will catch on fire, and my spouse and children will die of smoke inhalation" (100 SUDS)
- "If I don't wash my hands thoroughly after using the bathroom, I will get sick" (70 SUDS)
- "If I don't pray correctly and with intent, I will end up going to hell" (95 SUDS)

- "If I don't wash my hands after using house cleaners, I may poison my children" (80 SUDS)

Harm from Long-Term Anxiety

Determine the patient's specific fears of harm from long-term anxiety that help maintain ritualizing behaviors. Have patient rate SUDS for specific harm. Examples:

- "I am afraid that if I don't wash my hands repeatedly, I will get more and more anxious until I go crazy" (80 SUDS)
- "I am afraid that if I stop checking, I'll be so nervous that I won't be able to do my job and will be fired" (70 SUDS)

Passive Avoidance

Specify situations the patient avoids because of his or her fears. Examples:

- "I don't use public bathrooms because I am afraid of contracting an STD."
- "I don't prepare meals for my family because I am afraid I will poison them."
- "I don't use my stove in case I forget to turn it off and cause a fire."
- "I don't go to church anymore because I don't want to have blasphemous thoughts there."

Rituals

Record the details of the patient's daily experience with each ritual. Example:

- "I get up in the morning and I first use the toilet. Then I clean the toilet and everything around it, just in case there were splashes.

I then wash my hands thoroughly up to the elbows. Then I clean the shower and the faucets so I can take a shower in a clean bathroom."

- "When I am getting ready to go to sleep at night, I have to make sure my pillow, sheets, and covers are perfectly straight and without any wrinkles. I then have to look at the alarm clock four times to make sure it is set right. I have to get into the bed a certain way each time. I do all of this because if I don't, I feel that something bad will happen to my mother."

Generating the Treatment Plan (30 minutes)

On the basis of the information collected and recorded on the Information-Gathering and Treatment Planning Forms, develop a treatment program with the patient. Use the following guidelines.

Rules for Selection of Exposure Situations

1. Choose items for exposure (i.e., items or situations or thoughts that evoke discomfort and urges to ritualize) according to patients' self-report of their discomfort-evoking capacity.
2. Arrange all designated items hierarchically according to SUDS levels evoked and present in ascending order beginning at the midpoint of the patient's discomfort level. That is, if the top item evokes 100 SUDS, a 50-SUDS item is chosen first. You can use the Hierarchy Form in the appendix, or the hierarchy can be typed into an Excel spreadsheet, which makes it easier to sort by increasing SUDS. This can be done in session or in preparation for the next session, when exposures begin.
3. Map out the exposures to be practiced at each of the exposure sessions and record these on the Treatment Planning Form. This will act as an exposure guide for the treatment. *Note*: This plan should not be used rigidly, since patients vary in their ability to tolerate distress, and lack of flexibility in applying EX/RP might

result in discouragement and premature dropout. Furthermore, one of the lessons we would like sufferers of OCD to learn is increased tolerance to uncertainty, and a requirement for rigid adherence to a plan sends a mixed message. The plan should be used as a mutually agreed-upon template for change.

- Most items should be done first during the office visits (with the therapist), and then practiced for homework.
- The most disturbing items should be reached approximately during the midpoint of treatment (around Session 8).
- Sessions 9 through 15 are repetitions of Session 8 with variations, focusing on those items that provoke the most discomfort.
- Sessions 16 and 17 are devoted to relapse prevention and planning of continued practice, and can be home visits (if not done earlier in the treatment as needed).

4. Omit exposure to an item when it evokes minimal or no discomfort for several successive days.

Use the following examples of *in vivo* exposures for a washer, a checker, and a person protecting against "loss of essence" in order to select appropriate exposure items for each session. Homework assignments generally mirror the exposure conducted that session, with the patient conducting the exposure in his or her own environment, as opposed to in the therapist's office. Note that these case descriptions are for illustration purpose only and are therefore somewhat general. The hierarchies you create for your patients will include many more situations tailored very specifically to the patients' individual set of triggers.

Case Example: Amy

Amy felt contaminated by bodily fluids, including blood, feces, urine, and sweat, and by contact with others. Her feared consequence was contracting a debilitating disease. Each treatment session included exposure to contaminants.

The following hierarchy was constructed for Amy. Note that these items all have in common her feared consequences of contracting a disease.

1. Touching doorknobs (50 SUDS)
2. Handling newspapers used by others (60 SUDS)
3. Touching sweaty surfaces (75 SUDS)
4. Going to the bathroom without washing (80 SUDS)
5. Using public bathrooms (90 SUDS)
6. Shaking hands with Red Cross workers (100 SUDS)

During *in vivo* exposure treatment, the following sequence was pursued:

- Sessions 1 and 2: Information gathering and treatment planning
- Session 3: Amy walked with the therapist through the building touching all doorknobs, contaminating herself repeatedly. She also held newspapers left behind by people in the office waiting room. For homework, she practiced touching doorknobs at other public places that she frequently avoided (e.g., work, restaurants, bookstore).
- Session 4: Amy touched used newspapers and doorknobs. Contact with sweat was introduced by having her ask someone to swab a tissue under their armpit, and then she touched her hair and face with her hands after touching the contaminated tissue. She then ate a snack without washing. For homework, Amy continued these exercises and did not wash her hands before eating.
- Session 5: Increasing the exposure to other people's sweat was done by having Amy touch exercise machines at the local gym and not washing. For homework, she continued coming in contact with objects in her neighborhood that other people's sweat and unwashed hands would have contaminated.
- Session 6: Exposure began with contact with other people's sweat. Bodily fluids were then introduced by having Amy hold a paper towel or a tissue very lightly soiled with her own bodily waste, touching her hair and face without washing. For homework, she

continued to touch the paper towel and did not wash. Every day, she re-contaminated herself with it without washing.

- Session 7: Exposure to public toilet seats were added by having Amy place her hands on the toilet seat at the clinic or another public place. For homework, she was instructed to practice the same at a public toilet at a local bookstore or restaurant.
- Session 8: Exposure to blood was introduced by holding a test tube with blood at the office. For homework, Amy was instructed to touch brown spots in public places that she thought could be dried blood.
- Sessions 9 to 15: Daily exposure to the three items that provoked the greatest discomfort was continued. Exposure included going to a busy and relatively "dirty" public place such as a train station and using the toilet, and visiting a hospital waiting room where people come to get blood drawn. Homework focused on the objects used during the treatment session. Periodic contact with lesser contaminants was continued throughout.
- Sessions 16 and 17: To help Amy transfer her skills to her home environment and to enhance relapse prevention, home visits were scheduled. The purpose of the home visits was to make sure there were no designated areas of "safety" or "cleanliness." Amy was encouraged to continue to spread all her feared contaminants into her entire home, leaving no "safe havens."

Case Example: Mike

Mike feared harming others when driving his car or by failing to check appliances, locks, lights, and such at home. He worried about his 4-year-old daughter, fearing that he would drop her while carrying her over a hard floor or that she would fall downstairs because he was not supervising her enough. To prevent these catastrophes, Mike checked repeatedly.

The following hierarchy was constructed for Mike:

1. Turning lights and stove on or off without looking back (50 SUDS)
2. Locking doors and windows without checking (60 SUDS)

3. Leaving electrical appliances plugged in (70 SUDS)
4. Imaginal exposure about being responsible for his daughter falling down the basement stairs because of lack of supervision (75 SUDS)
5. Carrying daughter while walking on hard-surface floors (85 SUDS)
6. Driving on highways without retracing route (100 SUDS)

During *in vivo* exposure treatment, the following sequence was pursued:

- Sessions 1 and 2: Information gathering and treatment planning
- Session 3: Mike was required to turn the lights on and off once, and to turn the stove on and off once. After each action he was required to leave the room immediately and focus his attention on his failure to check these objects. This procedure was repeated throughout the session using different switches. For homework, Mike continued to do these exposures by himself.
- Session 4: Exposure to situations from the previous session was repeated with the addition of opening and closing doors and windows once, without checking.
- Session 5: Exposure to the above situations was continued. In addition, Mike was taught to do an imaginal exposure to his feared consequence of being responsible for harm to his daughter due to his lack of supervision. For homework, Mike listened to his imaginal exposure.
- Session 6: Mike was exposed to all situations presented on the previous session with the addition of carrying his daughter in his arms while walking on a hard wood or concrete floor.
- Session 7: After initial exposure to previous situations, Mike was instructed to drive alone on a non-busy street without retracing his route. He reported to the therapist every 20 minutes.
- Session 8: Mike was instructed to drive alone on the busy highway without retracing his route. He reported to the therapist every 20 minutes.

- Sessions 9 to 15: Exposure to all of the above situations under various conditions was continued, with particular emphasis on the most difficult items. Homework was assigned daily. It consisted of practicing situations that were introduced during the treatment sessions.

Case Example: Ryan

Ryan feared "turning into someone else," which to him meant that by coming in contact with someone he perceived as "bad," he would acquire those undesirable characteristics and lose his own "essence." Ryan avoided places in his local area (e.g., school, swimming pool, library) where he used to encounter the "contaminating" individual, and engaged in an elaborate cleaning and decontaminating ritual before entering his own room.

The following hierarchy was constructed for Ryan:

1. Using the contaminating person's name (50 SUDS)
2. Going to the library (60 SUDS)
3. Going swimming at the local swimming pool (70 SUDS)
4. Bringing book bag and swimming trunks into the house (80 SUDS)
5. Sitting on the bed in own room without decontaminating (90 SUDS)

During *in vivo* exposure treatment for Ryan, similar steps as above were conducted.

Contract between Therapist and Patient (15 minutes)

Establishing an agreement between patient and therapist is particularly important for this therapy since the patient will be conducting many exposure practices on his or her own. Describe the rules for treatment to the patient as follows:

Now I would like to discuss our plan for the next several weeks of therapy, beginning with our next visit. As we talked about in our

previous sessions, you will be confronting the things that bother you. You will also be gradually refraining from your rituals [specify which rituals] *as they relate to these triggers. Remember that the idea is to learn to live without having to avoid or do rituals to achieve relief from the distress. It would be very helpful if, during the treatment period, a family member or a friend is available to stay with you and support you. I will ask you to do exposure to the situations we planned for each day. When you are here at the office, I will be there to help you, but when at home, you will have to do exposure by yourself or with the help of a family member or a friend whom you have designated as your support person.*

I expect that you will be anxious before exposure to a new situation, and I trust that you are motivated to follow the program without allowing the OCD to argue with us to change it. As you know, we will start with the least disturbing fears and work our way up to the worst ones. Although I will encourage you to do the exposure exercises to these situations, I will not force you to do them. You will be the one actually doing the exposures with my support and help. I know that it may be hard at first, but it will get easier with practice. Remember, I will be there with you, or will be just a phone call away.

Beginning after the next session, you will be asked to resist even strong urges to ritualize. If you are afraid of giving in to the urge, you should contact your support person or me immediately, before you carry out a compulsive act, so we can help you resist the urges. Occasionally, people find that they engaged in a ritual without thinking about it because it is such an automatic habit. If this happens to you, record it on your self-monitoring form and be sure to re-expose yourself immediately to the situation or thought that generated the rituals. During treatment, to maximize the effect of the exposures, you will be encouraged not to do even those behaviors that other people normally do. For instance, many people do [give example of patient's compulsive act], *but* ***you*** *should refrain from doing that since you want to get over your fears as quickly as possible, and this is the best way to achieve that goal.*

Reiterate that during exposure sessions you will ask the patient to expose himself or herself to the situations planned in advance for that day. You

will be as supportive as you can when the patient becomes uncomfortable and will try to help him or her to continue with the exposure. Emphasize that it is important that the patient do the exposures volitionally (that is, out of his or her own free will), which helps minimize his or her arguments or efforts to delay them.

Remind the patient that on one of the days of the week when he or she does not visit the office, you will talk over the phone. The patient will do planned exposure homework and record it on the homework forms. You will ask about that homework during phone calls and you will want to see the forms at each session.

Remind the patient that at the next meeting, you will teach him or her how to do the first few exposures and ritual prevention. You will spend a lot of time working on this and will begin with the easiest items on the exposure hierarchy [specify these for the patient]. Tell the patient to think of you as his or her coach, someone he or she can rely on for tips and suggestions about how to overcome OCD.

Answer any questions that the patient has at this point. Do not proceed until the patient agrees to the treatment plan.

Homework (5 minutes)

- Have the patient continue completing Self-Monitoring forms.
- Have the patient review the corresponding chapter in the workbook.
- Give the patient the Understanding EX/RP Therapy for OCD handout.
- Schedule a time for the inter-session phone appointment and have the patient review the Telephone Tips and Reminders in the workbook.

Scheduling Phone Contact (5 minutes)

As in Session 1, schedule a phone contact between sessions with the patient. Have the patient record the date and time of the call on the

Appointment Schedule in the workbook. Remind the patient to complete the homework before the call.

Phone Contact 2

The content of the second phone contact should focus on troubleshooting with self-monitoring, if needed, and checking to make sure that the patient is reading the workbook material assigned in the first and second sessions. Use the following outline for the call:

- Ask about any problems with self-monitoring. Remind the patient to complete the Self-Monitoring Form at the time that rituals occur so that the form is as accurate as possible. Remind the patient to bring the completed monitoring forms to the next session.
- If the patient has *not* been self-monitoring, ask about the obstacles that have come up and try to problem-solve. Request that he or she begin promptly and remind him or her that, like any skill, this may take practice. Also emphasize that this is an important part of treatment.
- Remind the patient that it is important for him or her to read the workbook material on OCD and exposure and ritual prevention for the next session.
- Remind the patient that at the next session, he or she will begin exposure practice with the least anxiety-evoking item on the hierarchy. If the patient needs to bring materials from home for exposure, remind him or her to do so.

Enter the time of the call and a brief note about the nature of the phone contact on the Telephone Contact Notes form.

Chapter 6 *Session 3: Exposure and Ritual Prevention—Introducing* In Vivo *Exposure*

(Corresponds to Chapter 5 of the workbook)

Timeline

1 session (120 minutes)

Materials Needed

- Therapist Exposure Recording Form
- Patient Rules for Ritual Prevention handout
- Exposure Homework Recording Form
- Appointment Schedule
- Telephone Contact Notes

Outline

- Review patient's self-monitoring.
- Conduct *in vivo* exposure.
- Give patient instructions for self-exposure.
- Instruct patient on the rules of ritual prevention.
- Assign homework.
- Schedule phone contact.

Self-Monitoring Review (5 minutes)

Begin the session by going over the patient's completed Self-Monitoring Forms. Focus on the descriptions of triggers and rituals. Ask the patient to elaborate on when the triggers occurred and what exactly he or she had to do to alleviate the distress associated with them. Explore the nuances of the feared consequences and identify the patient's worst-case scenario. Instruct the patient to continue monitoring.

In Vivo Exposure (80 minutes)

Before introducing *in vivo* exposure, read the rationale for *in vivo* exposure in Chapter 4. Begin the presentation of the first *in vivo* exposure exercise by ascertaining that the patient clearly understands the rationale. Briefly summarize the rationale for *in vivo* exposure as follows:

> *Remember we went over the reasons why confronting the objects or situations that provoke your obsessional fears without performing rituals will help reduce your OCD symptoms. Exposure with ritual prevention will teach you that anxiety does not last forever but instead it decreases over time, and that your urge to ritualize, to escape, or to avoid will diminish as well. You will learn that you can tolerate your obsessional anxiety without "falling apart." You will also find out that your worst fears are disconfirmed—that is, what you are afraid will happen if you don't ritualize will not really happen.*

Discuss with the patient the exposure that you had collaboratively planned for that day's session and describe, at the outset, exactly what he or she will be asked to do. Participate with the patient in the exposure, as this will enhance his or her resolve to take this first step. Furthermore, it helps create an atmosphere of trust in the process and improved rapport with the therapist. For example, it helps greatly if you sit on the floor with the patient the first time he or she does this exposure.

Each type of exposure may require its own specific set of instructions; however, the following instructions can be used as a guide for washing and checking rituals.

You may want to introduce the exposure with the following dialogue:

> *Today, your exposure exercise is to touch* [specify item(s)]. *This means that I will ask you to touch it with your whole hand, not just with the fingers, and then to touch your face and hair and clothing all over yourself so that no part of you remains uncontaminated. Then I'll ask you to "sit" with it, repeatedly touching the contaminated material to your face, hair, and clothes during the rest of the session. I know that your distress level is likely to increase, but remember: anxiety will eventually decrease! It is important that while contaminating your face and your body you will allow yourself to think about the harm you are afraid will occur (e.g., disease) because you won't be washing or cleaning after this exposure. I know that this exposure will cause you discomfort, but I'm sure that you can do it. In fact, you'll find out that the more you do it, the easier it gets. Okay, here is* [item]; *go ahead and touch it.*

Give the patient the object to hold (or ask him to touch it) and then ask him or her to touch the object or the "contaminated" hands directly to his or her face, hair, and clothing. Contact with the contaminant should be continuous throughout the session and touching of face, hair, etc., should be repeated every few minutes throughout the 45- to 60-minute exposure, immediately prior to inquiring about the patient's discomfort level (SUDS).

Every 5 minutes ask the patient, "*What is your level of anxiety or discomfort from 0 to 100 right now as you focus on what you're touching?*" This can be shortened to "*What is your level?*" once the patient understands the question. Record this number on the Therapist Exposure Recording Form in the appropriate place (a copy of these forms is provided in the appendix).

During or after the *in vivo* exposures, it is important to discuss with patients their interpretation of the reduction in their distress levels. This is part of the processing component of EX/RP. Patients will find out through their own exposure experience that their feared consequences have not occurred; as part of processing, help the patient elaborate on this realization. At the end of the session, note on the Therapist Exposure Recording Form the degree of ritual prevention achieved (i.e., how much was the patient able to refrain from ritualizing during the exposure), the lessons learned by the patient (i.e., what meaning was the

patient able to derive out of the exposure experience), and any unusual events or difficulties.

Checking Rituals

The situations to which individuals with checking rituals are exposed vary from patient to patient and from session to session. The following example can be used as a guide:

> *Now, as we had planned, I'd like you to write out the checks to pay your monthly bills without inspecting them carefully. Just put them in their envelopes, seal them, and then we will place them in the mailbox quickly without checking even once that they have been done properly. You will then send out a few e-mails without checking whether you made mistakes or used insulting language. While doing this, I would like you to worry about the harm that might occur because you have not been checking your actions, but don't let the thoughts interfere with doing the activities.*

During the exposure, record the patient's anxiety/distress level every 5 minutes on the Therapist Exposure Recording Form (see previous instructions). At the end of the session, note the degree of ritual prevention achieved, lessons learned by the patient, and any unusual events or difficulties.

Comments during Exposure Sessions

The following are examples of comments to be introduced during and after exposure *in vivo*, after imaginal exposure, and on inspection of homework assignments to enhance processing of information that disconfirms the patient's expectation that anxiety, distress, and urge to ritualize will last forever.

If Anxiety or Distress Has Been Decreasing

- *You are discovering that the anxiety indeed decreases when you stay long enough in the situation that you are afraid of.*

- *Note that you are much less anxious than you were in the beginning of the session.*
- *I can see that you are more relaxed this time than during last session's exposure.*
- *As you can see, the more you confront this situation, the association with anxiety becomes weaker and weaker.*
- *As you are finding out, anxiety does not last forever.*
- *As predicted, you're describing feeling less of an urge to ritualize.*
- *You're finding out that the things you are afraid will happen if you don't escape or ritualize do not really happen. Like touching doorknobs in public places without washing hands does not cause you to get very sick or inflict illness on your children.*
- *You will find out that checking the entrance door lock only once does not cause robbery of your home*.

If Anxiety Has Not Been Decreasing Much

- *Today your anxiety persisted. This happens occasionally. I encourage you to continue at home doing exposure to* [specify], *just the way we did it here. For your anxiety to decrease noticeably, you should maintain the exposure for approximately an hour at a time.*
- *Today your anxiety did not decrease by much. We will continue to work on this item until it gets easier.*

Instructions for Self-Exposure (15 minutes)

After exposure practice under your supervision in session, give the patient instructions for self-exposure. Emphasize to patients the importance of their being able to do exposures on their own, without your help. Therefore, they will be practicing the exposure exercises on the days when they don't have sessions. At this stage in treatment, the patient usually continues to practice the exposures that were conducted during

the most recent session. The inter-session phone calls will be used to discuss the patient's progress with homework assignments. Explain to patients that self-exposures should be done long enough for them to experience a noticeable reduction in their anxiety level. Individuals vary greatly in the length of time that this occurs, but the patient should devote approximately 2 hours to the exposure homework. You can use the following narrative to convey this point:

> *For homework, I ask you to do exposures as similar as possible to the situations we practiced, discussed, and planned during the session. I'll ask you to do these exposures for approximately 2 hours each day. In special circumstances when you can't continually be in the exposure situation for long enough time periods, you and I will devise a plan to make sure that your exposures last long enough for you to experience a meaningful reduction in your anxiety level.*

Inform patients that sometimes you may ask them to do a new exposure as homework if it cannot be done in the office because of the logistics of the situation. For example, an important exposure may require touching an object that is fixed in place at home or elsewhere and cannot be brought in or easily reached from the office.

At each session, you will specify what the patient is to do prior to the next phone call. Ask patients to keep a record on the Exposure Homework Recording Form of what they did and when, and how uncomfortable they felt, using the SUDS scale, during the exposure. Indicate to patients that they should be ready to discuss the homework exposures at the next phone contact. Inquire if the patient has any questions before proceeding.

Assigning Exposure Homework (5 minutes)

Collaboratively with the patient, agree upon those items from the hierarchy that will be practiced before the next session. Have the patient record the assignment on the Exposure Homework Recording Form in the workbook. Remind the patient that he or she is to do the exposures just as you did together in the session and that each situation should be done long enough for the anxiety to decrease. Every 10 minutes during exposure, the patient should write down his or her anxiety level. Sum up with the following instructions:

Pay attention to the time so you don't forget to note your anxiety level. You should repeat at home exactly what we did here in the session. That means long exposures, without doing any rituals. Remember, it will not be helpful for you to confront the situation and then leave it abruptly before you notice feeling somewhat better.

Tell patients that if they have any problems or comments about the homework, they can write a brief note on the Exposure Homework Recording Form as a reminder to raise them during the phone contact.

Ritual Prevention (5 minutes)

As mentioned in Chapter 3, patients should be reminded of the specific instructions for ritual prevention on the first day of exposure as well as periodically during treatment. Discuss the rules for ritual prevention and give the patient the Patient Rules for Ritual Prevention handout. If the rules outlined for patients do not adequately cover the type of ritual(s) that your patient has, provide your patient with a written set of instructions modeled after these forms.

A Special Note on the Rules for Ritual Prevention

The rules for ritual prevention may seem harsh to people in general and especially to OCD sufferers. We don't expect that every patient will be able to stop performing his or her rituals all at once. However, the rules are given out at the beginning of treatment to emphasize that strict ritual prevention is an essential component of EX/RP in order to reach an excellent outcome. Many OCD patients who have participated in this treatment program have been able to reduce or eliminate their ritualizing and to achieve a good therapeutic outcome.

A Special Note on Mental Rituals

It is important to be particularly attentive to mental rituals that your patients may be doing. Most people associate rituals with overt

behaviors like washing, checking, or arranging. But some rituals are mental rituals, such as saying a special word or prayer, or counting up to a certain number to neutralize an obsession. Patients must refrain from doing these rituals, just as they do with the more overt behavioral rituals.

For many patients, mental rituals take the form of self-reassurance in order to decrease their distress (e.g., "Of course I am not going to stab Joe when making dinner. I am a good person" or "Everyone else uses public bathrooms and doesn't get sick, so I guess I'll be okay too"). These kinds of thoughts are tricky, since they might seem like pretty sensible thoughts to entertain. However, it is essential to figure out with the patient what is the **function** of the thoughts. If the thoughts function to decrease anxiety, they are rituals and must be prevented.

At the same time, it is essential that patients don't try to stop the obsessive thoughts that elicit the urge to ritualize. Patients should understand that obsessive thoughts cause anxiety or distress, but if they try to stop having them, the thoughts will typically become stronger. So obsessive thoughts should not be fought against and suppressed. Instruct patients that instead of reassuring themselves, they should try deliberately to bring on the obsessive thoughts as a form of exposure. It can be helpful to actually write down these concepts for patients:

> Obsessive thought → brings on anxiety/distress → leave thought alone or deliberately bring it on!

> Mental rituals → decrease anxiety/distress → don't do rituals!

Patients often don't know what they should do if they refrain from performing mental ritual. It can be helpful to say to patients, "*It's okay if the obsessive thoughts that triggered the urge to ritualize continue to buzz around in your head for a while. The important thing is to not give into that urge. Instead, get busy with something else*." Help patients figure out things they might be able to do instead of doing rituals (e.g., call a friend, go for a run, read a book). This is not the same as deliberately distracting themselves so they do not think about the obsessive thought. Rather, it is a way for them to pass time while they are allowing the thoughts to be present.

If this strategy is not helpful for patients, they can be instructed to actually "agree" with the OCD. Instead of reassuring themselves that the

feared consequence won't happen, they can purposefully think that it will. They can think, "Yes, I am a bad person" or "Yes, I am going to get sick from using this bathroom, but I'm doing it anyway." The idea is to not run away from anxiety, but rather to bring it on in order to demonstrate that thinking anxious thoughts does not cause bad things to happen.

Homework (5 minutes)

- Have the patient do self-exposures as planned and record the practice information on the Exposure Homework Recording Form.
- Have the patient read the Patient Rules for Ritual Prevention handout.
- Have the patient review the corresponding chapter in the workbook.
- Have the patient continue completing Self-Monitoring Forms.
- Schedule a time for the inter-session phone call.

Scheduling Phone Contact (5 minutes)

As in previous sessions, schedule a phone contact between sessions with the patient. Have the patient record the date and time of the call on the Appointment Schedule. Remind the patient to complete the homework before the call.

Phone Contact 3

The content of the third phone contact should focus on troubleshooting with self-exposure and ritual prevention, as well as self-monitoring. Use the following outline for the call:

- Check the patient's progress with the exposure homework that was assigned during the third session. Ask questions to determine

whether the patient did exposure, and whether he or she remained in the situations until distress decreased. Assess how long the patient remained in the exposure situation, and how much of a decrease he or she experienced.

- If exposure homework was not completed, assess the obstacles, and problem-solve as needed. Encourage the patient to try again. If the practice was avoided due to anxiety, suggest the patient try it once before the next session. Remind the patient that he or she should expect to feel distress at first, but this will dissipate just as it did during the session. Tell him or her that tolerating the distress now will yield a calmer future. Chapter 10 of this guide has therapist suggestions for patients who consistently do not complete exposure homework practices. If needed, remind the patient that he or she agreed to follow your directions as part of this therapy, even though it meant dealing with high anxiety at times.
- Assess the patient's success or failure with ritual prevention instructions.
- If the patient has been engaging in rituals, suggest that he or she re-contaminate or re-expose immediately after ritualizing.
- Ask about any problems with self-monitoring. Remind the patient to complete the Self-Monitoring Form at the time that rituals occur so that the form is as accurate as possible. Also, remind the patient to continue to bring the forms to the sessions.
- If the patient has not been self-monitoring, inquire about the obstacles that have come up and try to problem-solve. Request that he or she begin monitoring promptly, and remind him or her that, like any skill, this may take practice. You may wish to stress again that this is an important part of treatment.

Enter the time of the call and make a brief note about the nature of the phone contact on the Telephone Contact Notes form provided.

Chapter 7 *Session 4: Exposure and Ritual Prevention—Introducing Imaginal Exposure*

(Corresponds to Chapter 6 of the workbook)

Timeline

1 session (90–120 minutes)

Materials Needed

- Therapist Exposure Recording Form
- Imaginal Exposure Script Worksheet
- Exposure Homework Recording Forms
- Appointment Schedule
- Telephone Contact Notes
- Device to record imaginal exposure script (if needed)

Outline

- Review patient's self-monitoring and exposure homework.
- Introduce and conduct imaginal exposure (if needed).
- Conduct *in vivo* exposure.
- Give patient instructions for self-exposure.

- Assign homework.
- Schedule phone contact.

Self-Monitoring Review and Exposure Homework (5 minutes)

Begin the session by going over the patient's completed Self-Monitoring Forms. Ask the patient for clarifications, if needed, to make sure you understand the triggers, the rituals, and the underlying fears. Modify the hierarchy items as needed. Instruct the patient to continue monitoring. Go over the *in vivo* exposure homework and praise compliance. Allow patients to describe what they have done and their experiences regarding changes in their distress levels during the exposures.

Describe to the patient from the outset the *in vivo* and/or imaginal exposures planned for that day's session.

Imaginal Exposure (45 minutes)

Before the beginning of the session, read the rationale for imaginal exposure in Chapter 4. Begin the first imaginal exposure exercise by summarize the rationale for imaginal exposure to ascertain that the patient clearly understand how this type of exposure will help his or her OCD symptoms. Briefly summarize the rationale for imaginal exposure as follows:

> *I now want to explain to you how imagining that the things you are most afraid of will actually happen will help you get over your OCD. First, by imagining these things over and over, you will gradually be able to think about them without experiencing high levels of anxiety or distress. Second, you will learn that thinking bad thoughts without distress does not result in you actually doing these things. Third, just like in* in vivo *exposure, you will learn to accept your negative thoughts and feelings and to cope with them rather than to try and get rid of them. And lastly, imaginal exposure will teach you that having horrible thoughts or images does not make them come true. Thinking about things does not make them happen.*

For further information about the rationale for imaginal exposure, when to use imaginal exposure, and how to create imaginal exposure scripts, see Chapter 3. Also, consult the following points about imaginal exposure:

- Can be useful in reducing both obsessions and compulsions, and is generally a must for those described as "pure" obsessionals or who are "mental ritualizers;" that is, patients who exhibit repetitious negative thoughts that they can't control and that are very upsetting to them
- Is used especially for exposures that cannot be conducted in reality for moral, ethical, or practical reasons (e.g., burning down the patient's home)
- Is used for long-term future consequences that cannot be detected immediately (e.g., brain damage in 30 years)
- Is most commonly used for harm obsessions
- The most difficult exposures to do (e.g., having to imagine killing one's own family)
- Needs to be vivid and detailed
- Used to demonstrate to the patient that thinking bad thoughts is not the same as doing bad things
- Can invoke the patient's imagined "worst-case scenario"
- Can be effective for sexual obsessions
- Can work for religious scrupulosity with patients who are unwilling or unable to push the boundaries of their religion; especially helpful for consequences after death (e.g., going to hell)
- Can have multiple catastrophic consequences due to imperfect performance (for perfectionism)
- Is very useful for concepts of ambiguity or doubt (e.g., never knowing whether something had happened or will happen)
- Is not needed when *in vivo* exposures can tap into fears of contamination, responsibility, and harm

Imaginal Exposure Instructions

Create the imaginal exposure scenario collaboratively with the patient, using the Imaginal Exposure Script Worksheet. During imaginal exposure, ask the patient to sit in a chair and give him or her the following instructions:

> *Today you will be imagining* [the patient's scene]. *I'll ask you to close your eyes so that you won't be distracted. Please picture this scene as fully and as vividly as possible, not like you're being told a story, but as if you are experiencing it now, right here. Every few minutes I will ask you to rate your distress level on the SUDS scale from 0 to 100. Please answer quickly and stay with the image.*

Record the patient's anxiety level every 5 minutes on the Therapist Exposure Recording Form. Audio-record the imaginal exposure and give the audio track to the patient. Listening to the audio track will be part of the session's homework.

Example of an Imaginal Exposure Scene

A patient fears that she will cause her children harm because she is not careful or vigilant enough. The feared consequence in this case is one that cannot be disconfirmed in an *in vivo* exposure because it is immoral or unethical to do and because it is based on a prediction for the future. Therefore, an imaginal exposure works best.

A sample imaginal exposure script for this patient would look something like this:

> *I am going to the store and buying groceries without carefully checking the expiration dates and whether the packages are properly sealed. I am leaving my cart unattended while I go to the fruits and vegetables stand. I am taking the ones from the top of the pile and putting them all in my cart. On my way home, I realize that I am running low on gas. I stop at the gas station and fill up, getting some gas on my hands in the process. I then go into the station to buy a lottery ticket, leaving my car unlocked and unattended. When I come back, I notice that*

someone had tampered with the things in my car but I am oblivious because I am too interested in the numbers I chose for the lottery ticket. I am driving home and putting my groceries away. It is time for dinner so I am making dinner for my family. In the evening, my four children are complaining that they have stomachaches and they all become sick, throwing up and running a high fever. I am rushing them to the emergency room and the doctors are telling me that my children have been poisoned by something they have eaten. They are suffering terribly and I know that it is all my fault. The little one dies first. My husband, his parents, and my parents all accuse me of being a terrible irresponsible person and all eyes are on me, the child murderer. The other children are dying too. Everyone in the town where I live hates me for what I did. I am miserable for the rest of my life, living with the pain of knowing that it was my responsibility to take care of my children and yet I didn't. Because of me, they all died a horrible, painful death. I am disowned by my remaining family and shunned by my friends because no one wants to be associated with an evil woman like me.

In Vivo Exposure and Ritual Prevention (45 minutes)

Conduct the *in vivo* exposures planned for this session in the same manner as described in Session 3. Monitor the patient's pattern of SUDS during the exposure and discuss the changes in distress levels and the meaning of those changes to the patient.

Instructions for Self-Exposure (5 minutes)

After exposure practice under your supervision, give the patient instructions for self-exposure in a manner similar to that described for Session 3. Again, emphasize to patients that it is important to practice the exposure on their own on the days when they don't have sessions, and at this earlier stage of treatment, the exposures given for homework should be the ones conducted during the most recent session. If imaginal exposure was conducted and audio-recorded during the session, instruct patients to listen to the entire recording without interruption, two times a day,

separated by at least a few hours. They should listen to the recording with their eyes closed at times they are not busy with other activities. Instruct patients to record their SUDS level on the Imaginal Exposure Homework Recording Form just before starting the recording (Pre). When the recording is over, patients should immediately record their final SUDS level (Post), as well as the highest level of SUDS reached during the exposure (Peak).

Homework (5 minutes)

- Have the patient do self-exposures as agreed upon and record SUDS on the relevant Exposure Homework Recording Form.
- Have the patient review the corresponding chapter in the workbook.
- Have the patient continue completing Self-Monitoring Forms.
- Schedule a time for the inter-session phone call.

Scheduling Phone Contact (5 minutes)

As in previous sessions, schedule a phone contact between sessions with the patient. Instruct the patient to record the date and time of the call on the Appointment Schedule. Remind the patient to complete the homework before the call.

Phone Contact

The content of the phone contact should focus on troubleshooting with self-exposure and ritual prevention, as well as self-monitoring. Use the following outline for the call:

- Check the patient's progress with the exposure homework that was assigned during the session. Ask questions to determine whether the patient did exposure, and whether he or she remained in the situation until the distress decreased. Assess how long the patient

remained in the exposure situation, and how much of a decrease he or she experienced.

- If imaginal exposure was assigned as homework, make sure the patient is listening to the recording and noting SUDS.
- If the patient did not complete the exposure homework, help him or her trouble-shoot and problem-solve as needed. Encourage the patient to make a renewed effort.
- Assess the patient's success or failure with ritual prevention instructions.
- If the patient has been engaging in rituals, remind him or her to re-expose immediately after ritualizing.
- Inquire whether the patient experienced difficulties with self-monitoring.
- Provide encouragement and support.

Enter the time of the call and make a brief note about the nature of the phone contact on the Telephone Contact Notes form.

This page intentionally left blank

Chapter 8 *Intermediate Sessions: Continuing Exposure and Ritual Prevention*

(Corresponds to Chapter 7 of the workbook)

Timeline

10 to 12 sessions (90–120 minutes each)

Materials Needed

- Therapist Exposure Recording Form
- Exposure Homework Recording Forms
- Appointment Schedule
- Telephone Contact Notes
- Device to record imaginal exposure script (optional)

Outline

- Review patient's self-monitoring and homework.
- Conduct *in vivo* exposure and processing.
- Conduct imaginal exposure and processing (as needed).
- Make home visits (as needed).

- Review patient's progress.
- Address relapse prevention.
- Assign homework.
- Schedule phone contact.

Overview of Sessions

The following sessions are conducted according to the format used for Sessions 3 and 4. Exposure and ritual prevention are practiced at each visit. with increasingly difficult exposures attempted through the sessions. At approximately the eighth visit, the highest item on the patient's hierarchy should be confronted. The work from then onward involves repeating or varying previous exposures and introducing relevant stimuli that were not included in the patient's original hierarchy. Self-monitoring and ritual prevention remain in effect throughout therapy. Homework and self-monitoring forms are inspected at the start of each session. Homework is assigned and phone contacts are scheduled at the end of each session. Periodic progress checks should be made throughout the sessions.

If practical, one or two home visits for patient observation and exposure coaching are recommended. Additional visits to the patient's home may be made if there is continued difficulty with home-based practice.

Exposure and Ritual Prevention

Exposure sessions do not necessarily need to occur in the office or at the patient's home. Sessions can take place in any environment or at any location where the patient has had particular difficulty with OCD symptoms. For many patients, the environment they are protecting the most is at home. For other patients, the most difficult environment may be at work, at a store, in a public building, or at a hospital. Sessions should be carried out "where the OCD lives" for each individual patient. Creativity and flexibility are extremely important.

Use observation of the patient's behavior and functioning in the environment to collaboratively develop relevant exposure exercises. Coach the patient in performing such exposure exercises during the on-location session or at the home visit, and assign homework involving self-exposure practice that continues and extends what was done during the on-location or home visit session.

Home Visits

As mentioned in Chapter 3, home visits can be done at any point during treatment from Session 3 on. Home visits are designed to provide the therapist with an opportunity to observe the patient's functioning in the home environment, to identify areas of difficulty, and to coach the patient in creating exposures in his or her home environment. For most patients treatment includes one or two home visits, with additional visits when applicable.

For hoarders, it is often useful to schedule a home visit early in the treatment to assess the extent of hoarded material as well as the ability of the patient to comply with the instructions to discard that material. It may be important to schedule more home visits for a hoarder, especially when there is a need to sort through large quantities of materials. These home visits complement the office visits during which the hoarder brings material to the session for practice in sorting and discarding.

Progress Review

Periodically, take time to review the progress patients have made. Discuss what differences they notice in their own behavior, their tolerance for obsessional thoughts, and their ability to function in various environments (e.g., home, work, social situations).

If little improvement has been made, address reasons for the lack of progress. Has the patient experienced difficulty completing homework exposures? Have ritual prevention rules been difficult to follow? Point

out to the patient the various areas where stricter compliance with the principles of therapy might lead to more noticeable gains. Make sure to problem-solve related to obstacles to adherence.

Relapse Prevention

CBT in general and EX/RP in particular teaches patients to be their own therapists so that they can continue to apply the principles once treatment is over. Patients should recognize that they will have challenges with respect to their OCD in the future, but knowing how to handle these challenges is the key to prevent relapse. Relapse prevention should be introduced early in treatment and revisited periodically. Throughout treatment, you should let patients know that they are likely to have intrusive thoughts from time to time even if treatment is very successful. Be sure to:

- Tell patients that the experience of intrusive thoughts is not indicative of relapse; after all, even people without OCD experience odd or unusual thoughts from time to time.
- Help patients see that the key to relapse prevention is knowing what to do about these thoughts. Explain that it is fine to recognize the thought ("Hmmm, that's an unusual thought!"), but they should not respond to it by trying to make it go away or by neutralizing it.
- Stress that to maintain their gains from treatment, patients must refrain from engaging in any rituals (whether behavioral or mental) or in avoidance behaviors.
- Ensure that patients know how to set up their own exposures, since they might need to do this on their own in the future if a particular thought begins to cause them problems. The best way to help patients learn the necessary skills to battle their OCD is to have them take a progressively more active role in their treatment by suggesting that they design their own exposures and homework assignments. Also, patients should be encouraged to seize opportunities to work on their OCD symptoms as they naturally

occur in the environment. Acquiring the habit of "leaning into anxiety" rather than of running away from it is predictive of a good long-term outcome.

Homework

- Have the patient conduct the agreed-upon self-exposures and record SUDS on the relevant Exposure Homework Recording Form.
- Have the patient review the corresponding chapter in the workbook.
- Have the patient continue completing Self-Monitoring Forms.
- Schedule a time for the inter-session phone call.

Assignments for practicing exposure are given at each session and recorded on the patient's Exposure Homework Recording Form. If the patient demonstrates good skills and can advance up the hierarchy by himself or herself, then items not practiced in the session may be assigned for homework. However, if the patient has difficulty with in-session exposure, it is best to assign exposures that have already been confronted in sessions. This is especially important during the earlier sessions. Remind the patient to bring all Self-Monitoring Forms and Exposure Homework Recording Forms to the sessions.

Scheduling Phone Contact

At the end of each session, schedule a phone contact for one time between sessions using the patient's Appointment Schedule. Let the patient know exactly what will be discussed during each phone call. This includes:

- Progress with homework
- Any problems that might arise

Patients should write down problems on the Exposure Homework Recording Form so that they remember to raise these issues during phone calls or in sessions. Remind patients to have completed the homework *before* the call.

Enter the time of the call and make a brief note about the nature of the phone contact on the Telephone Contact Notes form.

Chapter 9 *Final Session*

(Corresponds to Chapter 8 of the workbook)

Timeline

1 session (90–120 minutes)

Materials Needed

- Therapist Exposure Recording Form
- Exposure Homework Recording Forms
- Appointment Schedule
- Telephone Contact Notes
- Guidelines for "Normal Behavior"
- Device to record imaginal exposure script (optional)

Outline

- Review patient's progress.
- Prepare patient for return to normal behavior.
- Address relapse prevention.
- Assign homework.
- Schedule follow-up phone contacts.
- Conclude therapy.

Overview of Session (5 minutes)

The final session includes an evaluation of the patient's progress in treatment and preparation for the patient's return to normal behavior, with discussion of strategies to maximize relapse prevention. It is important to note that although relapse prevention has been incorporated throughout the treatment, a special emphasis needs to be placed on that aspect during the final session.

Progress Review (45 minutes)

At the final session of exposure, take some extra time to review the progress that the patient has made. Evaluate what has been accomplished and what else is required to improve the outcome. It is extremely important to discuss with patient the differences they notice in their own behavior, their tolerance for obsessional thoughts, and their ability to function in various situations. This is because patients often forget how impaired they used to be, and how far they have come due to their hard work and determination. Help patients to identify the components of exposure and response (ritual) prevention that have helped them get their OCD symptoms under control. This will help them use these strategies in the future, when they are unaided by the therapist or other supporting persons in their life.

Return to Routine Behavior (15 minutes)

Next, introduce the patient to rules of "normal" washing, cleaning, checking, etc. Ritual prevention requirements are relaxed to enable the patient to return to what can be considered a "normal" routine. Refer the patient to the workbook appendix. If these guidelines do not apply to the patient's symptoms, create individualized guidelines for the patient.

Relapse Prevention Instruction for Final Session (10 minutes)

As mentioned earlier, in the final sessions of treatment, you should discuss relapse prevention in greater detail. Be sure to:

- Help patients reflect on how far they have come in treatment. One good way to do this is to re-rate the items on the patient's hierarchy.
- Help patients make a list of the strategies that have helped them make these gains. For example: (1) Don't avoid situations just because they trigger your OCD symptoms; (2) Remember what you have learned about exposure—it is always less difficult than it seems at first; and (3) Give up your need to be 100% certain about things. Patients can look back on this list if OCD begins to cause problems for them again in the future.
- Help the patient make a specific plan for tackling any issues that may be left over after treatment has concluded.
- Give patients an OCD quiz: Ask them what they would do if their OCD symptoms came back or if they experienced a new OCD symptom that they never experienced before. You can engage the patient in a role-play in which you play the part of the patient and the patient plays the part of the therapist and instructs you on what to do.
- Make sure patients have a plan in place for what to do if relapse occurs. Offer patients the option of calling you when they notice signs of a lapse if they find it difficult to tackle it on their own.

Homework (5 minutes)

In the final session, the "homework" is to continue implementing the skills of *in vivo* and imaginal exposures with ritual prevention that were learned, practiced, and mastered during the active treatment phase.

Scheduling Follow-Up Phone Contacts (5 minutes)

Schedule four to six follow-up weekly phone calls with patients to help ease their transition from the active treatment phase. The function of these phone calls is a brief check-in with patients to help them troubleshoot any problems that may arise, and to support the continuity and maintenance of gains. Document the content of the phone calls.

Conclusion of Therapy (5 minutes)

Bid farewell and schedule an appointment for a checkup, as needed.

Chapter 10 *Problems Commonly Encountered during Exposure and Ritual Prevention (EX/RP)*

Common Difficulties during Exposure Treatment

Below we discuss problems that may arise during EX/RP treatment for OCD and methods for handling them.

Noncompliance with Ritual Prevention Instructions

Most of the time, patients will be upfront about ritual prevention violations. These violations can be addressed with some of the motivational techniques described later in this chapter. When such violations occur, patients should be instructed to undo the ritual, such as re-contaminating themselves after washing or cleaning. Particularly early on in treatment, patients might automatically perform their rituals, often out of sheer habit. Here again, it is essential that patients undo or spoil the ritual. For example, if patients automatically wash their hands upon coming home, they should touch something that they perceived as contaminated from outside the house. It takes some creativity on the part of the therapist to help patients figure out how to undo certain rituals. For example, a patient whose ritual was that he needed to walk back and forth through a door an even number of times until it felt "just right" would undo this ritual by walking back and forth through the door again either just once or an uneven number of times. The undoing is designed to bring back his anxiety and make him worry that something bad would happen to his loved ones. Remind patients that each time they can fight their OCD in this way, they are taking a step forward toward conquering their OCD.

On rare occasions, however, patients actively try to conceal from the therapist ritualistic activity that was mutually decided upon as a target for ritual prevention that week. Be sure to address this difficulty in a matter-of-fact manner and without expressing frustration or anger, as illustrated:

> *I understand that you have been having difficulty not checking the front door lock several times before leaving the house. For the treatment to work well for you, it is important to adhere to the ritual prevention component. If you are having a hard time not doing the ritual, make sure to let me or your designated support person know so that we can help you overcome the urge to ritualize.*

Emphasize the implications of not employing ritual prevention for treatment outcome (i.e., poor prognosis for recovery). If the patient responds with a renewed agreement to keep the contract, you do not need to pursue the issue further. However, if this is a recurring difficulty, you should discuss with the patient the ritual prevention rules and the rationale for these rules, and re-examine whether the patient is indeed ready for and committed to the treatment at the present time:

> *It seems that right now you are unable to stop ritualizing as we had agreed upon at the outset. For the treatment to be effective, it is essential that you do so during treatment. Every time you relieve your discomfort by ritualizing* [washing, checking, repeating, etc.], *you prevent yourself from learning that anxiety would have declined eventually without rituals and that you are able to tolerate the anxiety until it declines without "falling apart." Doing exposures to feared situations without stopping the rituals is not helpful. How can we work together to help you follow the "no rituals" rule?*

It is sometimes necessary to offer patients smaller, more manageable steps to help them achieve success with ritual prevention. If the patient is agreeable to these suggestions and is willing to commit to those, then treatment can continue. However, if the patient is unwilling or unable to make a strong commitment to this modified ritual prevention program, then a conversation about the readiness and timing of treatment is warranted:

> *It is very hard for some people to resist the urge to ritualize, and it may be that you are just not ready yet and will feel more able to do so*

at a future point. It is much better for you to suspend treatment now than to continue under unfavorable conditions, since the result is likely to be unsatisfactory. Failure to gain from the treatment would only leave you more hopeless about future prospects for improvement.

Although blatant breaches of the ritual prevention instructions are relatively rare, the replacement of rituals with less obvious avoidance patterns is quite common. For example, patients often use other, more subtle, forms of "decontamination" instead of hand washing to relieve the anxiety. Some examples of replacement washing rituals include using hand creams or lotions, brushing off hands, and blowing off "germs." These too should be included in the ritual prevention instructions. Direct questioning of the patient to solicit such information can proceed as follows:

Now that you've stopped your rituals, have you found that you are doing anything else to relieve your anxiety that is like a ritual? Sometimes people find themselves doing little things that substitute for the longer compulsive acts. Has this happened to you?

If the patient answers yes, repeat the rationale for ritual prevention and emphasize the need to stop doing this new behavior. For successful ritual prevention, the patient needs to understand that the *function* of the ritual to relieve anxiety is the factor that maintains OCD, regardless of the length or nature of the ritual. Patients need to be reminded that as long as they do any kind of rituals, they will continue to believe that the rituals protect them from their feared outcomes, such as getting very ill, losing control, or falling apart. Thus, rituals interfere with the process of disconfirming the patient's belief about disastrous consequences.

Continued Passive Avoidance

Some individuals carry out the required exposure and refrain from ritualizing, but continue or even increase their passive avoidance behaviors. Examples include placing "contaminated" clothing back in the closet for

a second wearing but making certain it does not touch the clean garments, or delaying entry into or departure from a public bathroom until another person heads for the door, thereby eliminating the need to touch the doorknob in order to open the door. These behaviors reflect reluctance to embrace the treatment fully. Their persistence impedes the patient's realization that exposure to the feared situation is not harmful and hinders habituation of anxiety to these situations. Therefore, similarly to reluctance to completely refrain from rituals, persistent avoidance is also a predictor of poor outcome. The continued failure to give up avoidance patterns calls for a re-evaluation of the patient's understanding of the rationale of EX/RP and commitment to the treatment. Approach the patient about passive avoidance as follows:

> *I know that you continue to separate your dirty underwear from other dirty clothes when you do your laundry even when it would be logical to wash them together. Why do you separate them?* [Wait for response.] *Would it upset you to wash them together?*

If the answer is yes, assign the activity as homework and continue as follows:

> *Are there any other "avoidances" like this that you are doing? I just want to remind you that by continuing to protect yourself in this way, you don't allow yourself to realize that nothing terrible will happen if you do not avoid, and your anxiety will not decrease over time. In the past, because your distress was so high, you ritualized in order to reduce the anxiety and the obsessional distress. In addition, you also avoided situations that triggered your obsessions. Both the rituals and the avoidance have maintained your OCD. Now that you are in treatment, it's important to actually do the opposite of avoidance—you should "seek the anxiety" instead of running away from it. The more opportunities you can seize to work on your OCD, the greater benefit you will get from treatment. This means not only doing your assigned homework, but also really starting to live a life without OCD. You can ask me or your support person to help you break the avoidance patterns. If despite these sources of help you still can't bring yourself to do an exposure without doing some avoiding at this time, perhaps it*

would be better to wait until you feel more ready to try the treatment program at a later date.

Arguments: Balking

You should not engage in arguments with your patients about what they will and will not do during treatment. You and your patient are expected to follow the agreement you made at the beginning of treatment. As part of the agreement, don't ask patients to expose themselves to unplanned situations without first discussing the exposure plan during the previous session. In turn, patient are expected and encouraged to adhere to the exposures planned for the session. If patients balk at a planned exposure or attempt to reduce the intensity of the exposure, you should empathize with their discomfort, inquire about the reasons for the hesitation, and encourage them to proceed with the plan. When trust and rapport have been established, patients are often willing to try the exposure. If the exposure exercise planned for the session provokes more distress than was expected or the patient can handle at the time, ask the patient to come up with an exposure that will be an interim step towards the original goal. Thus, flexibility combined with persistence to follow the exposure plan keeps the collaborative nature of the treatment intact and offers hope, whereas arguments disrupt the therapeutic alliance. If this approach fails, the patient needs to be reminded of the treatment contract. You may say:

I'm sorry to see that you are having trouble deciding to do this. I'll support you as much as I can during the exposure if you become upset by it. Remember that this is the next step we agreed on, and I will be doing you a disservice if I were to reinforce your tendency to avoid. If you really don't feel you can do it at this very moment, then we will stop for now and resume a little later in the session when you feel ready.

An exception to this occurs in the case of emotional overload, which is described in the following section.

Emotional Overload

Occasionally during treatment a patient becomes overwhelmed by fear or other emotions that are not directly related to the exposure practices. These intense emotions can be manifested as bouts of crying, shaking, extreme lethargy, etc. For example, a patient may be upset by a recent event (such as a spouse threatening to leave if he doesn't improve) or by fears of facing future plans (such as living on her own or getting a job). When the patient exhibits such reactions, further exposure is inadvisable. This is because the patient is unlikely to adequately attend to the exposure exercise and, as a result, will not process the fact that his or her anticipated harm does not materialize. Also, under such heightened arousal, the obsessional distress is unlikely to diminish. Instead of proceeding with the planned exposure, you should encourage the patient to talk about the source of this emotional distress, and only after the patient is less agitated proceed with the exposure. Sometimes it is best to postpone the exposure practice until the next session.

Family Reactions

Since family members have often experienced years of frustration with the patient's symptoms, it is not surprising that some are impatient and expect treatment to progress quickly and to result in complete symptom remission. When these expectations are not met, they may express disappointment and anger. Often patients can benefit from inviting family members to attend part of an early session in order to educate them about OCD, EX/RP, and the role they can play in helping the patient make gains from treatment.

Some family members zealously try to aid in the OCD treatment, only to find out that their efforts are counterproductive. They may be so relieved that their loved one is finally in treatment that they abruptly stop behaviors that they had to do in the past to cater to the OCD-related demands. This abrupt change can backfire. Consider the example of a husband who has been accustomed to entering his home through the basement, immediately removing his clothes and showering to

"decontaminate" himself before entering the main part of the house. It would be unhelpful for him to suddenly come in through the front door and sit down on his wife's favorite couch in his "dirty" clothes after his wife's second treatment session. Early in treatment, family members should be respectful of the gradual pace of EX/RP and should not expose patients to feared objects or situations until they are ready.

Some family members have difficulty stopping their enabling behavior and may need guidance about how to stop catering to the patient's OCD-related demands. Years of accommodation to the patient's particular requests have established familial habits that are hard to break. Family members may find it difficult to stop performing a variety of activities that they have come to regard as their responsibility because of the OCD patient's wishes to avoid feared contexts, such as checking doors and windows on behalf of the patient. Since such patterns may hinder progress in treatment, you should inquire about such habits from both the patient and family members and prescribe appropriate alternative behaviors that maximize the patient's exposure and minimize avoidance. For example, the aforementioned husband might need some encouragement to come in through the front door and sit down on his wife's favorite couch once this exposure has been assigned. He will also need to know how to deal with her reaction to this exposure. If patients react with anger, their family members should remind them that they are collectively waging a battle against OCD, not against each other.

Another type of ritual that is common among family members is providing reassurance. There are several ways to help family members refrain from reassurance when the patient asks for it. The first is to identify and label the patient's request for reassurance as a ritual. The best way to recognize when a question is a request for reassurance is to look at the function of the behavior: if the answer to the question serves to decrease anxiety, the question is likely a ritual. Instruct family members to resist responding to the question by bringing up the rationale for treatment (e.g., "Do you think your question is a ritual? Remember that we agreed with Dr. X that if you asked me for reassurance, I would not give it" or "Remember that Dr. X told us that if I answer the question, it's likely that you'll feel better for a short while, but it will make your OCD stronger"). This strategy puts the "blame" on the treatment rather

than on the family member. Finally, family members can help redirect patients so that they can more easily resist seeking reassurance. For example, a family member could say, "Why don't we go and watch some TV together?" or "Why don't we go for a walk?" While patients should not try to stop the obsessive thought, it is best for them to distract themselves from urges to ritualize. The important outcome for distracting the patient under this circumstance is to help him or her refrain from ritualizing in response to an obsession.

Final Note to the Therapist: How to Increase Patients' Motivation to Comply with EX/RP

Here are some final tips and strategies for increasing patients' motivation to engage in treatment:

- Right from the start of therapy, frame treatment as a battle against OCD that you and the patient are waging together. Treatment is *not* a battle between you and the patient. Emphasize to the patients that when you encourage them to do something, it is because your experience tells you that the exercises that you prescribe will help them beat their OCD. Help them see that time is better spent *doing* exposures, rather than discussing why they should or should not do them. Also point out that you would not ask patients to do anything that you would not do yourself.
- Encourage patients to be fully on board. Discourage them from drawing lines in the sand (e.g., "I will step on brown spots on the pavement, but I won't go to a place where there is blood, like a hospital" or "I will refrain from washing my hands before eating a cookie myself, but not before offering one to my children").
- If patients are resistant early in treatment, remind them that EX/RP is done gradually through the use of a hierarchy of feared situations. Explain to the patients that when they reach the items at the top of the hierarchy, they will feel less anxious than they feel now because they will have tackled items lower on the hierarchy. Help patients reach the conclusion that: (a) their

anxiety decreases without rituals and (b) their feared consequences do not occur in, during, or after exposure to their feared situations. This will help them approach the items at the top of the hierarchy because their mistaken beliefs will be weakened by the time they even confront them.

- Use analogies to demonstrate to patients why drawing lines in the sand puts them at risk for relapse. Examples include: *"If you had cancer, what would happen if your doctor took out the tumor, but left a few cancer cells behind?" "If you weeded your garden, but left some weeds behind, what would happen to your garden?"* Help patients realize that leaving "bits" of OCD behind increases the likelihood of relapse. Help patients understand that by doing so they are cheating themselves out of being able to benefit fully from treatment despite their hard work.

- Make use of the "hip pocket patient." By this, we mean that you should have examples at the ready about other patients whose cases may serve as encouragement for your own patient. For example, *"We once had a patient who was really scared of getting AIDS from blood. She agreed to do everything on her hierarchy—stepping on brown spots on the pavement, touching books at the AIDS library, etc. However, she would not go and sit in the waiting room at the local hospital where blood draws are taken. She was terrified of being in a place where there was so much blood, and she steadfastly refused to go. She finished treatment feeling pretty good until a few months later, when a blood drive came to her office building! She was so terrified that in one day, all of her concerns came back and she began to engage in avoidance again, including the things she had tackled successfully in treatment."*

- Help patients embrace a life without OCD by asking them to consider all the things that they want to do but are unable to do now because of OCD. Spend time discussing with the patient the cost of OCD; by doing so you will facilitate their ability and willingness to do difficult exposures and to adhere firmly to ritual prevention. Motivators might include returning to

work or changing jobs; establishing relationships or making more time for existing relationships; engaging in enjoyable activities (e.g., reading books, traveling, devoting time to a hobby); or being able to do things with greater ease (e.g., practicing religion, doing homework, accomplishing tasks at work).

Appendix

Information-Gathering Form

Name of Therapist_____ Date _____

Name of Patient _____

Address _____

_____

_____

_____

Telephone Number _____

Age of Patient _____

Marital Status _____

Number of Children and Ages

_____

_____

_____

Living Arrangement

_____

_____

_____

Current Work Situation

_____

_____

_____

Obsessions (Anxiety/Discomfort-Evoking Material)

External Cues: Sources of anxiety/discomfort (e.g., feces, urine, parents, hometown)

_____

_____

_____

Internal Cues:

Thoughts, images, impulses, doubts (e.g., "God is bad")

_____

_____

_____

Internal Cues:

Bodily sensations (e.g., heart palpitations, sweat)

_____

_____

_____

Consequences

Harm from external sources (e.g., V.D. from using public toilets)

_____

_____

_____

Harm from internal cues (e.g., "I will go crazy")

_____

_____

_____

Harm from experiencing long-term high anxiety

Avoidance Patterns

Passive Avoidance

Avoidance of Activities that Produce Rituals

Relationship between Avoidance and Fear Cues

Events Surrounding Onset of Problem

Historical Course of Problem

History of Psychiatric Treatment for Obsessive-Compulsive Problems and Other Problems

General History

Medical History

Educational History

Employment History

Financial History

Previous and Current Relationship with Parents

Previous and Current Relationship with Siblings

Previous and Current Relationships with Friends

Dating/Sexual History

Previous and Current Relationship with Spouse

Overview of OCD

It is estimated that approximately 2% to 3% of the population in the United States has obsessive-compulsive disorder (OCD). It has been observed in all age groups, from school-aged children to older adults. OCD typically begins in adolescence but may start in early adulthood or childhood. The onset of OCD is typically gradual, but in some cases it may start suddenly. Symptoms fluctuate in severity from time to time, and this fluctuation may be related to the occurrence of stressful events. Because symptoms usually worsen with age, people may have difficulty remembering when OCD began, but they can sometimes recall when they first noticed that the symptoms were disrupting their lives.

Learning more about your OCD symptoms will help you get the most out of this treatment. OCD is a set of symptoms that, as you may know, include thoughts, feelings, and behaviors that are extremely unpleasant, unproductive, and difficult to get rid of on your own. Usually, these involve thoughts, images, or impulses that come to mind against your will (**obsessions**). These thoughts are accompanied by unwanted feelings of extreme distress or anxiety (or guilt, shame. or disgust) and strong urges to do something to reduce the distress. One way in which people try to reduce their anxiety is by avoiding situations, objects, or thoughts that evoke this anxiety. However, with people who suffer from OCD, avoidance or escape from the things that evoke their anxiety does not work well.

Because, as with all people with OCD, your attempts to avoid the situations or thoughts that cause you the distress do not work well, you developed habits of doing certain actions or thinking special thoughts (**rituals** or **compulsions**) to try to reduce your distress. Unfortunately, performing these rituals also does not work all that well, and the distress decreases for only a short time before coming back again. Often you find yourself doing more and more ritualizing to try to get rid of the distress, but even then the rituals do not reduce the distress permanently, and soon enough you are putting so much time and energy into rituals

(that do not work that well anyway) that other areas of your life get seriously disrupted.

Causes of OCD

The reasons why some people develop obsessions and compulsions while others don't are unknown. Many researchers suggest that people with OCD have abnormal brain chemistry involving *serotonin*, a chemical that is important for brain functioning. Unusual serotonin chemistry has been observed in people with OCD, and medications that relieve OCD symptoms also change serotonin levels. However, it is not known whether serotonin chemistry is truly a key factor in the development of OCD.

There is also evidence that OCD has a hereditary factor and is more prevalent in some families than others. Most likely there is a combination of factors, such as biological/genetic and environmental aspects, that contribute to the development of OCD.

Some experts have suggested that specific "thinking mistakes" occur in OCD. Examples of such thinking mistakes are:

- Unless one avoids the triggers or ritualizes in response to them, the anxiety or distress will last forever or will cause a nervous breakdown
- Thinking about an action is the same as doing it, or wanting to do it.
- If one does not ritualize, the things one is afraid will happen actually do happen.
- If one does not try to prevent harm, it's the same as causing harm or condoning it.

To treat OCD, you will have to learn a new way of addressing your obsessions without resorting to avoidance or rituals. Your therapy is designed to do this, and your therapist knows exercises that will be helpful in achieving this goal. These exercises are called **exposure and response (or ritual) prevention** (EX/RP), and you will learn more about them in the next session.

Sample Self-Monitoring Form (partially filled out)

Time of Day	Situation/Activity/Thought that evokes the distress and urge to ritualize	SUDS (0–100)	Description of ritual	Number of minutes spent on ritual
7 am	Made breakfast	60	Checked stove	10 minutes
8 am	Took out the garbage	70	Hand washing	4 minutes
9 am				
10 am	Bathroom—urination	80	Hand washing	5 minutes
11 am				
Noon	Left house	75	Checked locks	15 minutes

Use the following general rules to guide your monitoring:

- Make sure to record both overt and mental rituals.
- Keep track of the time you spend on your rituals.
- It is best not to save the recording to the end of the day or the beginning of the next day, because you will likely forget details.
- Write a short sentence to describe the trigger for ritualizing.
- Use a descriptive word or two and not a long paragraph for each ritual.

Self-Monitoring Form

Date: _____

Time of Day	Situation/Activity/Thought that evokes the distress and urge to ritualize	SUDS (0–100)	Description of ritual	Number of minutes spent on ritual
6 am				
7 am				
8 am				
9 am				
10 am				
11 am				
Noon				
1 pm				
2 pm				
3 pm				

Self-Monitoring Form (*Continued*)

Time of Day	Situation/Activity/Thought that evokes the distress and urge to ritualize	SUDS (0–100)	Description of ritual	Number of minutes spent on ritual
4 pm				
5 pm				
6 pm				
7 pm				
8 pm				
9 pm				
10 pm				
11 pm				
Midnight				

Appointment Schedule

Wk	Monday	Tuesday	Wednesday	Thursday	Friday
1	__|	__|	__|	__|	__|
2	__|	__|	__|	__|	__|
3	__|	__|	__|	__|	__|
4	__|	__|	__|	__|	__|
5	__|	__|	__|	__|	__|
6	__|	__|	__|	__|	__|
7	__|	__|	__|	__|	__|

- Phone number: _____
- Discuss your assignments with your therapist. Your therapist will want to hear about your progress. You will be able to report on whether you understood the assignment. Indicate how often you were able to do the exposures and for how long. Tell your therapist whether you are experiencing changes in discomfort and urges to perform rituals.
- If any problems arise, write them down before the phone call so that you remember to discuss them during the call.
- If you forgot to do homework, do not avoid telling your therapist. He or she will not be upset with you and will troubleshoot with you about why this happened and help you solve the problem so you can benefit from the practice. By not discussing problems with homework you may affect your own improvement. The therapist can suggest strategies to help with remembering, such as using reminder notes, setting an alarm clock, asking a friend or a family member to remind you, scheduling homework at a regular time each day, etc.
- The therapist will also help you assess the extent to which not doing the homework may be a form of fearful avoidance. If you are avoiding homework because of anxiety, remind yourself that it is expected that one will feel distressed when engaging in exposure. However, it is important to work on the homework despite accompanying anxiety or distress since the long-term payoff is relief from obsessive-compulsive symptoms.
- You might avoid homework exposures because they provoke anxiety about making mistakes. If perfectionism is involved, the therapist will encourage you to do some of the homework imperfectly on purpose, as a way of beginning to practice new habits of doing things "wrong."
- Make sure you know the date and time of the next therapy session.

Telephone Contact Notes

Patient_____ Phone number: _____

Date & Time	Notes

Treatment Planning Form

Name of Therapist _____ Date _____

Name of Patient _____

Comments about Patient's Self-Monitoring:

_____

_____

_____

Obsessions (Anxiety/Discomfort-Evoking Material)

External Cues: specific situations, circumstances, and/or objects:

Situation	SUDS
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	

Internal Cues: thoughts, images, or impulses (e.g., "God is bad," "I feel an urge to stab my daughter"), or bodily sensations that cause fear:

Cue	SUDS
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Consequences: harm from external sources (e.g., "I will get an STD if I use public toilets in restaurants"), from internal cues, or from long-term anxiety:

Type of Harm	SUDS
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Avoidance Behavior

Passive Avoidance (specific situations):

Situations	SUDS (if situation NOT avoided)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Rituals:

Ritual (description in detail)	SUDS (if ritual NOT done or interrupted)
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Ritual (description in detail)	SUDS (if ritual NOT done or interrupted)
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	

Cognitive-behavioral therapy (CBT) is a type of treatment that helps individuals cope with and change problematic thoughts, behaviors, and emotions. The treatment you are beginning is a specialized type of CBT for obsessive-compulsive disorder (OCD) called **Exposure and Ritual Prevention (EX/RP)**. Some people refer to the same treatment as Exposure and Response Prevention (ERP). This treatment is designed to help you achieve symptom relief without resorting to engaging in avoidance or rituals. EX/RP consists of four main components: *in vivo* exposure, imaginal exposure, ritual prevention, and processing:

- **In Vivo *Exposure:*** Exposures in "real life" entail deliberately approaching a feared object or situation that evokes anxiety and distress (for example, coming in contact with contaminants and staying in their presence for a period of time; leaving one's possessions in disarray; eating a certain food in spite of fear of throwing up).
- ***Imaginal Exposure:*** Exposures in imagination entail visualizing oneself in the feared situations, including the consequences of the feared situations (for example, visualizing driving on the road and hitting a pedestrian; losing one's intelligence; contracting a deadly disease).
- ***Ritual Prevention:*** Entails refraining from ritualistic behavior (for example, leaving the kitchen without checking the appliances; touching dirty laundry without washing one's hands)
- ***Processing:*** Entails examining the change in your level of distress and in your beliefs after having experiences that disconfirm those erroneous beliefs that are part of your OCD. Exposures will be framed as opportunities to test hypotheses about feared consequences brought on by obsessional distress.

What is Exposure?

Exposure is a procedure in which you purposefully confront objects or situations that you know produce distress and you stay in the presence of

those objects or situations long enough for your anxiety to decrease on its own. **In vivo *exposure*** is a type of exposure that involves confronting feared objects and situations in real life. For example, a person who fears contamination by being in a public restroom would purposefully visit a public restroom and stay there for a long enough time to have his or her anxiety begin to decrease. As is often the case, you may believe that your discomfort will escalate or last forever unless you avoid such situations or escape from them when your anxiety or distress starts to rise. You may feel that you couldn't otherwise handle the situation. However, as you will find out, this is not necessarily true. At first you can expect to feel anxiety or discomfort, since these are situations that are designed to activate your fears. However, after repeated exposure practice, such situations will no longer make you feel as uncomfortable as they once did.

Many sufferers have expressed the following bewilderment: If exposure works, why hasn't my distress become less severe through the many encounters with situations that have provoked obsessions and anxiety in the past? The answer is that simply provoking an obsession is not enough. Exposure to the trigger of the obsessional distress requires that it be done for a long enough time to allow the distress to diminish on its own, without removing yourself from the situation or without performing a ritual. In addition, like almost all learning of new skills, the exposure must be done repeatedly to have an optimal effect, thus helping to break the OCD.

Sometimes it is impossible or impractical to actually confront your feared situation and its perceived consequences through *in vivo* exposure. For example, a person may fear that his house will burn down if he does not thoroughly check to ensure that the stove or an iron has been turned off. It would not be a good idea to suggest that the person burn his house down to allow him to confront that kind of fear. Instead, the person can confront the harm resulting from not checking thoroughly by visualizing the house fire in his imagination. In ***imaginal exposure***, you create in your mind a detailed and vivid sequence of images depicting the catastrophic disaster that you believe will occur if you do not avoid or ritualize. As with the *in vivo* exposure, the obsessional distress gradually decreases during imaginal exposure.

Imaginal exposure is also helpful for individuals whose obsessions occur spontaneously and are not triggered by any identifiable situation. For

example, a person might have an unwanted and intrusive sexual thought at any time or place. This thought may cause her great distress. In this case, there is no particular situation for the person to confront, and the person can't practice remaining in the exposure situation for a prolonged period of time. With imaginal exposure, the sexual image can be brought up repeatedly, without trying to eliminate it or neutralize it with a ritual.

Imaginal exposure may also be used to make subsequent *in vivo* exposure practices easier for you. If you are extremely distressed about the idea of confronting a situation or object that provokes your distress, you may find it helpful to *imagine* confronting it first. The decrease in your distress during imaginal exposure will carry over to the *in vivo* exposure.

What is Ritual Prevention?

When persons with OCD encounter their feared situations or have obsessional thoughts, they become anxious and feel compelled to perform ritualistic behaviors to reduce the distress. Exposure practices can cause this same distress and the same urge to ritualize. Therefore, in treatment, ***ritual prevention*** is practiced to break the habit of ritualizing. We know that rituals are difficult to stop because they bring relief from anxiety or discomfort. However, the performance of these rituals is currently greatly interfering with your ability to function in a variety of settings, and is one of the main reasons that you have sought treatment. Ritual prevention requires that you stop ritualizing, even though you are still having urges to do so. Your therapist will teach you how to stop rituals and will introduce you to healthier ways of coping with and managing your distress and discomfort.

What is Processing?

Processing is an important part of EX/RP. It entails a discussion of your experience during or after an exercise using exposure and ritual prevention and what you have learned from that experience. You will realize several facts: (1) Rather than mounting uncontrollably, your anxiety or distress may rise at first but it will eventually begin to fall, even though

you are not engaging in avoidance or a ritual. (2) Doing exposures repeatedly results in continued reduction in your distress and helps keep those lower levels anxiety over time. (3) You can indeed manage your distress without having to resort to avoidance or rituals that cost you precious time, a lot of energy, and often money too. (4) You realize that your fears about bad consequences happening if you do not avoid or ritualize is either proven false or shown to have a low probability of actually materializing. (5) Even if your fears of bad consequences cannot be proven wrong, you will learn that you can live with the doubt, the uncertainty and the feeling that you do not have control over events in the future.

An additional optional component of EX/RP treatment is a home visit, which involves the therapist coming to help you with exposures in your home environment. Home visits are conducted on an "as needed" basis and the details decided upon in collaboration between you and your therapist. This is especially helpful if you find it difficult to apply what you have learned during the office visits to your daily activities at home or if there are subtle avoidance patterns or rituals that would otherwise not be noticed and addressed and are clearly keeping you from recovering.

Why Should I Do Exposure 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?" It is true that after you carry out a ritual, you t*emporarily* feel less distress. This temporary relief is what makes you continue to engage in the ritual, which in turn makes your OCD stronger. However, by *not* performing rituals, and learning to tolerate the distress produced by confronting the triggers, you ultimately weaken your OCD, which will improve your quality of life.

How Involved Do I Need to Be in Exposure and Ritual Prevention?

For *in vivo* and imaginal exposure to be helpful, you must become emotionally engaged during the exposure exercises. Specifically, the exposure situation must evoke the same kind of obsessional distress that you

experience in your daily life when you encounter these situations. To promote emotional engagement, we will develop exposure exercises that are a good match to the real-life situations that provoke your obsessions and urges to ritualize. For example, if you are distressed by contamination related to cancer and you visit a hospital with no cancer ward, the exercise will not be helpful. This is because the situation does not match your fear, so it will be hard for you to become emotionally engaged.

During the exposure exercises that are a good match to your obsessions, you should pay attention to the distressing aspects of the exposure situation, rather than try to ignore them or distract yourself. This is true for both *in vivo* and imaginal exposure. For example, in the previous 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. To make the exposure effective, you should think about the potential harm that concerns you. For example, if you are afraid of using public restrooms, a good exposure exercise will be to go to a public restroom. While there, you must think about what concerns you have about the restroom, such as how dirty it might be or what diseases you are afraid of contracting by using it. Similarly, during imaginal exposure, you should include anticipated disasters and focus on imagining them as vividly as you can.

How Can I Get the Most Benefit out of Exposure and Ritual Prevention?

When people hear about exposure treatment, they often do not understand how it works. You might think that if you can just decide to do things that you avoid and give up doing rituals, you really wouldn't need treatment at all. Most people with OCD can temporarily stop their avoidance and rituals, but they find that doing so is very uncomfortable, and after a while they may find themselves wondering why anyone would willingly want to go through it. Certainly you have had occasions when you accidentally or purposefully confronted feared situations, but your OCD habits persisted. To increase the success of exposure and ritual prevention, you must do well-designed exercises, and do them correctly. In this treatment, exposure exercises will be designed specifically for your OCD symptoms, and your therapist will coach you as you practice them.

What you get out of exposure and ritual prevention depends heavily on what you put into it. It also depends on you and your therapist collaboratively coming up with an exposure plan that fits your particular OCD symptoms. Sometimes exposure exercises may seem counterintuitive or even extreme, but it will be important for you to practice them anyway. A legitimate inquiry is often made by sufferers of OCD whether "normal people" do those extreme things. The answer is that extreme measures are required for extreme disease conditions. So, for example, "normal people" do not get radiation and/or chemotherapy unless they are fighting cancer. You are willingly participating in exposure and ritual prevention in order to best fight your OCD.

Hierarchy Form

Exposure to Be Practiced	SUDS	Suggested Treatment Session

Therapist Exposure Recording Form

Date: _____

1) Exposure practiced in Session: _____

_____

	SUDS	Comments
Beginning	____	
5 minutes	____	
10 minutes	____	
15 minutes	____	
20 minutes	____	
25 minutes	____	
30 minutes	____	
35 minutes	____	
40 minutes	____	
45 minutes	____	
50 minutes	____	
55 minutes	____	
60 minutes	____	

2) Exposure practiced in Session: _____

_____

	SUDS	Comments
Beginning	____	
5 minutes	____	
10 minutes	____	
15 minutes	____	
20 minutes	____	
25 minutes	____	
30 minutes	____	
35 minutes	____	
40 minutes	____	
45 minutes	____	
50 minutes	____	
55 minutes	____	
60 minutes	____	

Exposure Summary Notes:

Ritual Prevention _____

Processing (lessons learned) _____

_____

Washing

- During the treatment period, avoid using water on your body for several days. This includes no hand washing, no rinsing, no wet towels, no washcloths.
- The use of creams and other toiletry articles (powder, deodorant, etc.) is permitted unless you find that use of these items reduces your feeling of contamination and/or distress.
- Shave using an electric shaver.
- Water is permitted for drinking and brushing teeth, but take care not to get it on your face and hands.
- Showers are permitted every 3 days, for 10 minutes each—this includes hair washing. Ritualistic or repetitive washing of specific areas of the body (genitals, hair) during showers is prohibited. Showers should be timed by your designated support person, but you need not be observed directly.
- While at home, if you have an urge to wash or clean and you are afraid you cannot resist, talk to your designated support person and ask him/her to remain with you until the urge decreases to a manageable level.
- You should report difficulties with ritual prevention to your therapist.

Checking

- Only "normal" checking is permitted for most items (such as one check of door locks) unless otherwise recommended by your therapist.
- For items ordinarily *not* checked (for example, empty envelopes to be discarded), all checking is prohibited.

- While at home, if you have an urge to check and you are afraid you can't resist, talk to your designated support person and ask him/her to remain with you until the urge decreases to a manageable level.
- You should report difficulties with ritual prevention to your therapist.

Special Instructions:

Exposure Homework Recording Form

1) Situation to practice: _____

_____

Date: _____		Date: _____		Date: _____	
	SUDS		SUDS		SUDS
Beginning	____	Beginning	____	Beginning	____
10 minutes	____	10 minutes	____	10 minutes	____
20 minutes	____	20 minutes	____	20 minutes	____
30 minutes	____	30 minutes	____	30 minutes	____
40 minutes	____	40 minutes	____	40 minutes	____
50 minutes	____	50 minutes	____	50 minutes	____
60 minutes	____	60 minutes	____	60 minutes	____

Comments or Difficulties:

2) Situation to practice: _____

_____

Date: _____		Date: _____		Date: _____	
	SUDS		SUDS		SUDS
Beginning	____	Beginning	____	Beginning	____
10 minutes	____	10 minutes	____	10 minutes	____
20 minutes	____	20 minutes	____	20 minutes	____
30 minutes	____	30 minutes	____	30 minutes	____
40 minutes	____	40 minutes	____	40 minutes	____
50 minutes	____	50 minutes	____	50 minutes	____
60 minutes	____	60 minutes	____	60 minutes	____

Comments or Difficulties:

Imaginal Exposure Script Worksheet

Feared Consequence: _____

Imaginal Exposure Homework Recording Form

1) Exposure exercise that you practiced _____

Date & Time Spent	SUDS			Date & Time Spent	SUDS		
	Pre	Post	Peak		Pre	Post	Peak

Comments or Difficulties:

2) Exposure exercise that you practiced _____

Date & Time Spent	SUDS			Date & Time Spent	SUDS		
	Pre	Post	Peak		Pre	Post	Peak

Comments or Difficulties:

Guidelines for "Normal Behavior"

These are general guidelines for returning to "normal" behavior. Obviously, there are exceptions under certain circumstances that are dictated by common sense or standard procedures for certain jobs (e.g., tending to a baby, working in food preparation, hospital work).

General Guidelines

- Continue to do exposures to objects or situations that used to disturb you on a weekly basis.
- Do exposures more often if objects or situations are still disturbing.
- Make a point to confront a situation deliberately if you detect a tendency to avoid it.
- Remember that the action you perform should not be aimed at reducing anxiety or distress (e.g., washing, checking, praying). If it does, delay the behavior until the anxiety has decreased.

Washing

- Take one 10-minute shower daily.
- Wash your hands for no longer than 30 seconds.
- Restrict your hand washing to the following:
  - Before meals
  - After using the bathroom
  - After handling greasy or visibly dirty things

Checking

- Do not check more than once objects or situations that used to trigger an urge to check.

- Do not check at all in situations that your therapist has advised you do not require checking.
- Do not assign responsibility for checking to friends or family members.

Other Guidelines

References

Abramowitz, J. S. (1996). Variants of exposure and response prevention in the treatment of obsessive compulsive disorder: A meta-analysis. *Behavior Therapy, 27,* 583–600.

Abramowitz, J. S. (2006). The psychological treatment of obsessive-compulsive disorder. *Canadian Journal of Psychiatry, 51*(7), 407-416.

Abramowitz, J. S., & Deacon, B. J. (2006). Psychometric properties and construct validity of the Obsessive-Compulsive Inventory–Revised: Replication and extension with a clinical sample. *Journal of Anxiety Disorders, 20*(8), 1016–1035.

Abramowitz, J.S, Foa, E. B, & Franklin, M. E. (2003). Exposure and ritual prevention for obsessive-compulsive disorder: Effects of intensive versus twice-weekly sessions. *Journal of Consulting & Clinical Psychology, 71,* 394–398.

Abramowitz, J. S., Franklin, M. E., Street, G. P., Kozak, M. J., & Foa, E. B. (2000). Effects of comorbid depression on response to treatment for obsessive-compulsive disorder. *Behavior Therapy, 31,* 517–528.

Abramowitz, J. S., Tolin, D. F., & Diefenbach, G. J. (2005). Measuring change in OCD: Sensitivity of the Obsessive-Compulsive Inventory–Revised. *Journal of Psychopathology and Behavioral Assessment, 27*(4), 317–324.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders.* Washington, D.C.: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (Revised 4th ed.). Washington, D.C.: Author.

Antony, M. M., Downie, F., & Swinson, R. P. (1998). Diagnostic issues and epidemiology in obsessive-compulsive disorder. In R. P. Swinson (Ed.), *Obsessive-compulsive disorder: Theory, research, and treatment* (pp. 30–32.). New York: The Guilford Press.

Baer, L. (1994). Factor analysis of symptom subtypes of obsessive compulsive disorder and their relation to personality and tic disorders. *Journal of Clinical Psychology, 55*(3, Suppl), 18–23.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979) *Cognitive therapy of depression.* New York: Guilford, 1979.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory-II*. San Antonio, TX: Psychological Corporation.

Brown, T. A., Campbell, L. A., Lehman, C. L., Grisham, J. R., & Mancill, R. B. (2001). Current and lifetime comorbidity of the DSM-IV anxiety and mood disorders in a large clinical sample. *Journal of Abnormal Psychology, 110*(4), 585–599.

Bystritsky, A., Ackerman, D. L., Rosen, R. M., Vapnik, T., Gorbis, E., et al. (2004). Augmentation of serotonin reuptake inhibitors in refractory obsessive-compulsive disorder using adjunctive olanzapine: A placebo-controlled trial. *Journal of Clinical Psychiatry, 65,* 565–568.

Bystritsky, A., Saxena, S., Maidment, K., Vapnik, T., Tarlow, G., & Rosen, R. (1999). Quality-of-life changes among patients with obsessive-compulsive disorder in a partial hospitalization program. *Psychiatric Services, 50*(3), 412–414.

Calvocoressi, L., Lewsin, B., Harris, M., Trufan, S. J., Goodman, W. K., McDougle, C. J., & Price, L. H. (1995). Family accomodation in obsessive-compulsive disorder. *American Journal of Psychiatry, 152*(3), 441–443.

Clomipramine Collaborative Study Group (1991). Clomipramine in the treatment of patients with obsessive compulsive disorder. *Archives of General Psychiatry, 48*, 730–738.

Cottraux, J., Mollard, L, Bouvard, M., Marks, L, Sluys, M., Nury, A. M., Douge, R., & Ciadella, P. (1990). A controlled study of fluvoxamine and exposure in obsessive-compulsive disorder. *International Clinical Psychopharmacology, 5,* 17–30.

Cottraux, J., Note, I., Yao, S. N., et al. (2001). A randomized controlled trial of cognitive therapy versus intensive behavior therapy in obsessive compulsive disorder. *Psychotherapy & Psychosomatics, 70*, 288–297.

Crino, R. D., & Andrews, G. (1996). Obsessive-compulsive disorder and axis I comorbidity. *Journal of Anxiety Disorders, 10*(1), 37–46.

De Araujo, L. A., Ito, L. M., Marks, I. M., & Deale, A. (1995). Does imaginal exposure to the consequences of not ritualising enhance live exposure for OCD? A controlled study: I. Main outcome. *British Journal of Psychiatry, 167,* 65–70.

Denys, D., de Geus, F., van Megen, H. J., & Westenberg, H. G. (2004). A double-blind, randomized, placebo-controlled trial of quetiapine

addition in patients with obsessive-compulsive disorder refractory to serotonin reuptake inhibitors. *Journal of Clinical Psychiatry, 65,* 1040–1048.

Dollard, J., & Miller, N. L (1950). *Personality and psychotherapy: An analysis in terms of learning, thinking and culture.* New York: McGraw-Hill.

Dougherty, D. D., Rauch, S. L. & Jenike, M. A. (2002). Pharmacological treatments for obsessive compulsive disorder. In P. E. Nathan & J. M. Gorman (Eds.), *A guide to treatments that work* (2nd ed., pp. 387–410). London: Oxford University Press.

Eisen, J. L., Phillips, K. A., Baer, L., Beer, D. A., Atala, K. D., & Rasmussen, S. A. (1998). The Brown assessment of beliefs scale: Reliability and validity. *American Journal of Psychiatry, 155,* 102–108.

Eisen, J. L., & Steketee, G. (1998). Course of illness in obsessive-compulsive disorder. In L. J. Dickstein, M. B. Riba, & J. M. Oldham (Eds.), *Review of psychiatry* (Vol. 16). Washington, D.C.: American Psychiatric Press.

Emmelkamp, P. M. G., de Haan, E., & Hoogduin, C. A. L. (1990). Marital adjustment and obsessive-compulsive disorder. *British Journal of Psychiatry, 156,* 55–60.

Emmelkamp, P. M. G., & van Kraanen, J. (1977). Therapist-controlled exposure *in vivo:* A comparison with obsessive-compulsive patients. *Behaviour Research and Therapy, 15*, 491–495.

Fals-Stewart, W., Marks, A. P., & Schafer, J. (1993). A comparison of behavioral group therapy and individual behavior therapy in treating obsessive compulsive disorder. *Journal of Nervous and Mental Disease, 181,* 189–193.

Feinstein, S. B., Fallon, B. A., Petkova, E., & Liebowitz, M. R. (2003). Item-by-item factor analysis of the Yale-Brown Obsessive Compulsive Scale Symptom Checklist. *Journal of Neuropsychiatry and Clinical Neurosciences, 15*(2), 187–193.

Fernandez-Cordoba, E., & Lopez-Ibor Alino, J. (1967). Monochlorimipramine in mental patients resisting other forms of treatment. *Actas Luso-Españolas de Neurología y Psiquiatría, 26*(2), 119–147.

First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (1997). *Structured clinical interview for DSM-IV axis I disorders (SCID-I), clinical version, user's guide*. Washington, D.C.: American Psychiatric Publishing, Incorporated.

Foa, E. B., Abramowitz, J. S., Franklin, M. E., & Kozak, M. J. (1999). Feared consequences, fixity of belief, and treatment outcome in patients with obsessive compulsive disorder. *Behavior Therapy, 30,* 717–724.

Foa, E. B., Amir, N., Gershuny, B., & Molnar, C. (1997). Implicit and explicit memory in obsessive-compulsive disorder. *Journal of Anxiety Disorders, 11*(2), 119–129.

Foa, E. B., & Chambless, D. L (1978). Habituation of subjective anxiety during flooding in imagery. *Behaviour Research and Therapy, 16*, 391–399.

Foa, E. B., Franklin, M. E., & Moser, J. (2002). Context in the clinic: How well do CBT and medications work in combination? *Biological Psychiatry, 51,* 989–997.

Foa, E. B., & Goldstein, A. (1978). Continuous exposure and complete response prevention in the treatment of obsessive-compulsive neurosis. *Behavior Therapy, 9,* 821–829.

Foa, L B., Grayson, J B., & Steketee, G. (1982). Depression, habituation and treatment outcome in obsessive-compulsives. In J. C. Boulougouris (Ed.), *Practical applications of learning theories in psychiatry*. New York: Wiley.

Foa, E. B., Huppert, J. D., Leiberg, S., Langner, R., Kichic, R. Hajcak, G., & Salkovskis, P. M. (2002). The Obsessive-Compulsive Inventory: Development and validation of a short version. *Psychological Assessment, 14*(4), 485–496.

Foa, E. B., & Kozak, M. J. (1985). Treatment of anxiety disorders: Implications for psychopathology. In A. H. Tuma & J. D. Maser (Eds.), *Anxiety and the anxiety disorders.* Hillsdale, NJ: Erlbaum.

Foa, E. B., & Kozak, M. J. (1996). Psychological treatments for obsessive compulsive disorder. In M. R. Mavissakalian & R. P. Prien (Eds.), *Long-term treatments of anxiety disorders* (pp. 285–309). Washington, D.C.: American Psychiatric Press.

Foa, E. B., Kozak, M. J., Goodman, W. K., Hollander, E., Jenike, M. A., & Rasmussen, S. (1995). DSM-IV field trial: Obsessive compulsive disorder. *American Journal of Psychiatry, 152,* 90–96.

Foa, E. B., Kozak, M. J., Steketee, G., & McCarthy, P.R. (1992). Treatment of depressive and obsessive-compulsive symptoms in OCD by imipramine and behavior therapy. *British Journal of Clinical Psychology, 31,* 279–292.

Foa, E. B., Liebowitz, M. R., Kozak, M. J., Davies, S., Campeas, R., Franklin, M. E., Huppert, J. D., Kjernisted, K., Rowan, V., Schmidt, A. B., Simpson, H. B., & Tu, X. (2005). Randomized, placebo-controlled trial of exposure and ritual prevention, clomipramine, and their combination in the treatment of obsessive-compulsive disorder. *American Journal of Psychiatry, 162*, 151–161.

Foa, E. B., Simpson, H. B., Liebowitz, M., Williams, M., Powers, M., & Cahill, S. (2010). Augmenting SRI treatment with exposure and ritual prevention (EX/RP) for obsessive-compulsive disorder: Long-term outcome. Manuscript in preparation.

Foa, E. B., Steketee, G., & Grayson, J. B. (1985). Imaginal and in vivo exposure: A comparison with obsessive-compulsive checkers. *Behavior Therapy, 16*(3), 292–302.

Foa, E. B., Steketee, G., Grayson, J. B., Turner, R. M., & Latimer, P. (1984). Deliberate exposure and blocking of obsessive-compulsive rituals: Immediate and long-term effects. *Behavior Therapy, 15,* 450–472.

Foa, E. B., Steketee, G., Turner, R. M., & Fischer, S. C. (1980). Effects of imaginal exposure to feared disasters in obsessive-compulsive checkers. *Behaviour Research and Therapy, 18,* 449–455.

Foa, E. B., & Wilson, R. (2001): *Stop Obsessing!: How to Overcome Your Obsessions and Compulsions* (Revised Edition). New York: Bantam Books.

Franklin, M. E., Abramowitz, J. S., Bux, D. A., Zoellner, L. A., & Feeny, N. C. (2002). Cognitive-behavioral therapy with and without medication in the treatment of obsessive compulsive disorder. *Professional Psychology: Research and Practice, 33,* 162–168.

Franklin, M. E., Abramowitz, J. S., Kozak, M. J., Levitt, J., & Foa, E. B. (2000). Effectiveness of exposure and ritual prevention for obsessive compulsive disorder: Randomized compared with non-randomized samples. *Journal of Consulting and Clinical Psychology, 68,* 594–602.

Fullana, M. A., Tortell-Feliu, M., Caseras, X., Andion, O., Torrubia, R., & Mataix-Cols, D. (2005). Psychometric properties of the Spanish version of the Obsessive-Compulsive Inventory–Revised in a non-clinical sample. *Journal of Anxiety Disorders, 19*(8), 893–903.

Gallup (1990). *A Gallup study of obsessive-compulsive sufferers.* Princeton, NJ: Gallup Organization Inc.

Gonner, S., Leonhart, R., & Ecker, W. (2007). The German version of the Obsessive-Compulsive Inventory–Revised: A brief self-report measure for the multidimensional assessment of obsessive-compulsive symptoms. *Psychotherapie Psychosomatik Medizinische Psychologie, 57*(9–10), 395–404.

Gonner, S., Leonhart, R., & Ecker, W. (2008) The Obsessive-Compulsive Inventory–Revised (OCI-R): Validation of the German version in a sample of patients with OCD, anxiety disorders, and depressive disorders. *Journal of Anxiety Disorders, 22*(4), 734–749.

Goodman, W. K., Price, L H., Rasmussen, S. A., Mazure, C., Fleischmann, R. L, Hill, C. L, Heninger, G. R. & Charney, D. S. (1989a). The Yale-Brown Obsessive-Compulsive Scale. I. Development, use, and reliability. *Archives of General Psychiatry*, *46*,1006–1011.

Goodman, W. K., Price, L H., Rasmussen, S. A., Mazure, C., Delgado, P., Heninger, G. R., & Charney, D. S. (1989b). The Yale-Brown Obsessive-Compulsive Scale. II. Validity. *Archives of General Psychiatry*, *46*, 1012–1016.

Greist, J. H. (1990). Treatment of obsessive-compulsive disorder. Psychotherapies, drugs, and other somatic treatments. *Journal of Clinical Psychiatry*, *51*, 44–50.

Greist, J. H., Bandelow, B., Hollander, E., Marazziti, D., Montgomery, S. A., Nutt, D. J., Okasha, A., Swinson, R. P., Zohar, J. (2003). WCA recommendations for the long-term treatment of obsessive-compulsive disorder in adults. *CNS Spectrums, 8*(8, Suppl 1), 7–16.

Greist, J. H., Jefferson, J. W., Kobak, K. A., Katzelnick, D. J., & Serlin, R. C. (1995). Efficacy and tolerability of serotonin reuptake inhibitors in obsessive compulsive disorder: A meta-analysis. *Archives of General Psychiatry*, *46*, 53–60.

Hajcak, G., Huppert, J. D., Simons, R. F., & Foa, E. B. (2004). Psychometric properties of the OCI-R in a college sample. *Behaviour Research and Therapy, 42*(1), 115–123.

Hodgson, R. J., & Rachman, S. (1977). Obsessional-compulsive complaints. *Behaviour Research and Therapy, 15*(5), 389–395.

Hodgson, R. J., Rachman, S., & Marks, L. M. (1972). The treatment of chronic obsessive-compulsive neurosis: Follow-up and further findings. *Behaviour Research and Therapy, 10,* 181–189.

Hohagen, F., Winkelmann, G., Rasche-Raeuchle, H., Hand, I., Konig, A., Munchau, N., Hiss, H., Geiger-Kabisch, C., Kappler, C. Schramm, P., Rey, E., Aldenhoff, J., & Berger, M. (1998). Combination of behaviour therapy with fluvoxamine in comparison with behaviour therapy and placebo: Results of a multicentre study. *British Journal of Psychiatry, 173*, 71–78.

Hudson, J. I., & Pope, H. G. (1987). Depression and eating disorders. In O. G. Cameron (Ed.), *Presentations of depression: Depressive symptoms in medical and other psychiatric disorders.* Oxford, England: John Wiley & Sons.

Hudson, J. I., Pope, H. G., Yurgelun-Todd, D., Jonas, J. M., & Frankenburg, F. L (1987). A controlled study of anorexia nervosa and obsessive nervosa. *British Journal of Psychiatry, 27*, 57–60.

Huppert, J. D., Simpson, H. B., Nissenson, K. J., Liebowitz, M. R., & Foa, E. B. (2009). Quality of life and functional impairment in obsessive-compulsive disorder: A comparison of patients with and without comorbidity, patients in remission, and healthy controls. *Depression and Anxiety, 26,* 39–45.

Huppert, J D., Walther, M. R., Hajcak, G., Yadin, E., Foa, E. B., Simpson, H. B., & Liebowitz, M. R. (2007). The OCI-R: Validation of the subscales in a clinical sample. *Journal of Anxiety Disorders, 21*, 394–406.

Insel, T. R., & Akiskal, H. S. (1986). Obsessive-compulsive disorder with psychotic features: A phenomenologic analysis. *American Journal of Psychiatry, 143*(12), 1527–1533.

Jones, M. K., & Menzies, R. G. (1998). Danger ideation reduction therapy for obsessive-compulsive washers: A controlled trial. *Behaviour Research and Therapy, 36,* 959–970.

Kampman, M., Keijsers, G. P. J., Hoogduin, C. A. L., & Verbraak, M. J. P. M. (2002). Addition of cognitive-behaviour therapy for obsessive-compulsive disorder patients non-responding to fluoxetine. *Acta Psychiatrica Scandinavica, 106*(4), 314–319.

Karno, M. G, Golding, M., Sorensen, S. B., & Burnam, A. (1988). The epidemiology of OCD in five U.S. communities. *Archives of General Psychiatry, 45*, 1094–1099.

Kasvikis, Y. G., Tsakiris, F., Marks, 1. M., Basoglu, M., & Noshirvarii, H. F. (1986). Past history of anorexia nervosa in women with obsessive-compulsive disorder. *International Journal of Eating Disorders, 5*, 1069–1075.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 593–602.

Kessler, R. C., Chiu, W. T., Demler, O., Merikangas, K. R., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 617–627.

Koran, L. M., Thienenmann, L. L., & Davenport, R. (1996). Quality of life for patients with obesessive-compulsive disorder. *American Journal of Psychiatry, 153*(6), 783–788.

Kozak, M. J., & Foa, E. B. (1994). Obsessions, overvalued ideas, and delusions in obsessive-compulsive disorder. *Behaviour Research and Therapy, 32,* 343–353.

Laessle, R. G., Kia, S., Fichter, M. M., Wittchen, H., & Pirke, K. M. (1987). Major affective disorder in anorexia nervosa and bulimia: A descriptive diagnostic study. *British Journal of Psychiatry*, *151*, 785–789.

Leckman, J. F., & Chittenden, E. H. (1990). Gilles de la Tourette's syndrome and some forms of obsessive-compulsive disorder may share a common genetic diathesis. *L'Encephale, XVI*, 321–323.

Lelliott, P. T., Noshirvani, H. F., Basoglu, M., Marks, I. M., & Monterio, W. O. (1988). Obsessive-compulsive beliefs and treatment outcome. *Psychological Medicine, 18,* 697–702.

Leon, A. C., Portera, L., & Weissman, M. M. (1995). The social costs of anxiety disorders. *British Journal of Psychiatry, 166(Supp 27),* 19–22.

Lim, J. S., Kim, S. J., Jeon, W. T., Cha, K. R., Park, J. H., & Kim, C. (2008). Reliability and validity of the Korean version of Obsessive-Compulsive Inventory - Revised in a non-clinical sample. *Yonsei Medical Journal, 49*(6), 909-916.

Lindsay, M., Crino, R., & Andrews, G. (1997). Controlled trial of exposure and response prevention in obsessive-compulsive disorder. *British Journal of Psychiatry, 171,* 135–139.

Lopez, A. D., & Murray, C. J. L. (1998). The global burden of disease, 1990–2020. *Nature America, 4*(11), 1241–1243.

Lovibond, P.F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy, 33*(3), 335–343.

Lucey, J. V., Butcher, G., Clare, A. W., & Dinan, T. G. (1994). The clinical characteristics of patients with obsessive compulsive disorder: A descriptive study of an Irish sample. *Irish Journal of Psychological Medicine, 11*(1), 11–14.

Mansueto, C. S., & Keuler, D. J. (2005). Tic or compulsion? It's tourettic OCD. *Behavior Modification, 29*, 784–799.

March, J. S., Frances, A., Carpenter, D., & Kahn, D. (1997). The Expert Consensus Guideline Series: Treatment of obsessive compulsive disorder. *Journal of Clinical Psychiatry, 58*(Suppl 4), 1–72.

Marks, I. M. (1981). Review of behavioral psychotherapy, I: Obsessive-compulsive disorders. *American Journal of Psychiatry, 138*(5), 584–592.

Marks, I. M., Hodgson, R., & Rachman, S. (1975). Treatment of chronic obsessive-compulsive neurosis by *in vivo* exposure. *British Journal of Psychiatry, 127,* 349–364.

Marks, I. M., Lelliott, P., Basoglu, M., Noshirvami, H., Monteiro, W., Cohen, D., & Kasvikis, Y. (1988). Clomipramine self-exposure, and therapist-aided exposure for obsessive-compulsive rituals. *British Journal of Psychiatry, 152*, 522–534.

Marks, I. M., Stern, R. S., Mawson, D., Cobb, J., & McDonald, R. (1980). Clomipramine and exposure for obsessive-compulsive rituals—I. *British Journal of Psychiatry, 136*, 1–25.

Mataix-Cols, D., & Marks, I. M. (2006). Self-help with minimal therapist contact for obsessive–compulsive disorder: A review. *European Psychiatry, 21*(2), 75-80.

Mathews, A. (1978). Fear-reduction research and clinical phobias. *Psychological Bulletin, 85*(2), 390–404.

Mattick, R. P., & Clarke, J. C. (1998). Development and validation of measures of social phobia scrutiny fear and social interaction anxiety. *Behaviour Research and Therapy, 36*(4), 455–470.

McDougal, C. J., Epperson, C. N., Pelton, G. H., Wasylink, S., & Price, L. H. (2000). A double-blind, placebo-controlled study of risperidone addition in serotonin reuptake inhibitor-refractory obsessive-compulsive disorder. *Archives of General Psychiatry, 57,* 794–801.

McKay, D., Abramowitz, J S., Calamari, J. E., Kyrios, M., Radomsky, A., Sookman, D., Taylor, S., & Wilhelm, S. (2004). A critical evaluation of obsessive-compulsive disorder subtypes: Symptoms versus mechanisms. *Clinical Psychology Review, 24*, 283–313.

Meyer, V. (1966). Modification of expectations in cases with obsessional rituals. *Behaviour Research and Therapy, 4,* 273–280.

Meyer, V., & Levy, R. (1973). Modification of behavior in obsessive-compulsive disorders. In H. E. Adams & P. Unikel (Eds.), *Issues and trends in behavior therapy*. Springfield, IL: C. C. Thomas.

Meyer, V., Levy, R., & Schnurer, A. (1974). A behavioral treatment of obsessive-compulsive disorders. In H. R. Beech (Ed.), *Obsessional states*. London: Methuen.

Mowrer, O. A. (1939). A stimulus-response analysis of anxiety and its role as a reinforcing agent. *Psychological Review, 46*, 553–565.

Mowrer, O. A. (1960). *Learning theory and behavior*. New York: Wiley.

National Institute for Health and Clinical Excellence. *Obsessive compulsive disorder.* Clinical Guideline 31. www.nice.org.uk/CG031 (last accessed Aug. 18, 2006).

Ost, L. G. (1989). One-session treatment for specific phobias. *Behaviour Research and Therapy, 27,* 1–7.

Pallanti, S., Hollander, E., & Goodman, W. K. (2004). A qualitative analysis of nonresponse: management of treatment-refractory obsessive-compulsive disorder. *Journal of Clinical Psychiatry (Special Issue: Beyond Refractory Obsessions and Anxiety States: Toward Remission), 65*(Suppl 14), 6–10.

Pato, M. T., Pato, C. N., & Gunn, S. A. (1998) Biological treatments for obsessive-compulsive disorder: Clinical applications. In R. P. Swinson, M. M. Antony, & M. A. Richter (Eds.), *Obsessive-compulsive disorder: Theory, research, and treatment* (pp. 327–348). New York: Guilford Press.

Pato, M. T., Zohar-Kadouch, R., Zohar, J., & Murphy, D. L (1988). Return of symptoms after discontinuation of clomipramine in patients with obsessive-compulsive disorder. *American Journal of Psychiatry, 145*, 1521–1525.

Pauls, D. L (1989). *The inheritance and expression of obsessive-compulsive behaviors.* Proceedings of the American Psychiatric Association, San Francisco.

Pauls, D. L, Towbin, K. E., Leckman, J. F., Zahner, G. E., & Cohen, D. J. (1986). Gilles de la Tourette's syndrome and obsessive-compulsive disorder. *Archives of General Psychiatry, 43*, 1180–1182.

Pediatric OCD Treatment Study Team (2004). Cognitive-behavioral therapy, sertraline, and their combination for children and adolescents with obsessive-compulsive disorder: The Pediatric OCD Treatment Study (POTS) randomized controlled trial. *Journal of the American Medical Association, 292,* 1969–1976.

Quality Assurance Project. (1985). Treatment outlines for the management of obsessive compulsive disorders. *Australian and New Zealand Journal of Psychiatry, 19,* 240–253.

Rabavilas, A. D., Boulougouris, J. C., & Stefanis, C. (1976). Duration of flooding sessions in the treatment of obsessive-compulsive patients. *Behaviour Research and Therapy, 14*, 349–355.

Rachman, S., DeSilva, P., & Roper, G. (1976). The spontaneous decay of compulsive urges. *Behaviour Research and Therapy, 14*, 445–453.

Rachman, S., Hodgson, R., & Marks, I. M. (1971). The treatment of obsessive-compulsive neurosis. *Behaviour and Research Therapy, 9*(3), 237–247.

Rachman, S., & Wilson, G. T. (1980). *The effects of psychological therapy*. Oxford, England: Pergamon Press.

Rapoport, J. L., Swedo, S. E., & Leonard, H. L. (1992). Childhood obsessive compulsive disorder. 144th Annual Meeting of the American

Psychiatric Association, "Obsessive compulsive disorder: Integrating theory and practice" (1991, New Orleans, Louisiana). *Journal of Clinical Psychiatry*, 53(4, Suppl), 11–16.

Rasmussen, S. A., & Eisen, J. L. (1989). Clinical features and phenomenology of obsessive-compulsive disorder. *Psychiatric Annals, 19*, 67–73.

Rasmussen, S. A., & Eisen, J. L. (1990). Epidemiology of obsessive-compulsive disorder. *Journal of Clinical Psychiatry, 51*, 10–14.

Rasmussen, S. A., & Tsuang, M. T. (1986). Clinical characteristics and family history in DSM III obsessive-compulsive disorder. *American Journal of Psychiatry, 1943,* 317–382.

Rauch, S. L., & Jenike, M. A. (1998). Pharmacological treatment of obsessive compulsive disorder. In P. E. Nathan & J. M. Gorman (Eds.), *A guide to treatments that work* (pp. 358–376). New York: Oxford University Press.

Riggs, D. S., Hiss, H., & Foa, E. B. (1992). Marital distress and the treatment of obsessive-compulsive disorder. *Behavior Therapy, 23,* 585–597.

Roper, G., & Rachman, S. (1976). Obsessional-compulsive checking: Experimental replication and development. *Behaviour Research and Therapy, 14,* 25–32.

Roper, G., Rachman, S., & Hodgson, R. (1973*).* An experiment on obsessional checking. *Behaviour Research and Therapy, 11,* 271–277.

Rothbaum, B. O., & Shahar, F. (2000) Behavioral treatment of obsessive-compulsive disorder in a naturalistic setting. *Cognitive and Behavioral Practice, 7,* 262–270.

Ruscio, A. M., Stein, D. J., Chiu, W. T., & Kessler, R. C. (2008). The epidemiology of obsessive-compulsive disorder in the National Comorbidity Survey Replication. *Molecular Psychiatry* [epub Aug. 26, 2008].

Salkovskis, P. M. (1985). Obsessional compulsive problems: A cognitive-behavioral analysis. *Behaviour Research and Therapy, 23,* 571–583.

Sanavio, E. (1988). Obsessions and compulsions: The Padua Inventory. *Behaviour Research and Therapy, 26*(2), 169–177.

Shafran, R., Thordarson, D. S., & Rachman, S. (1996). Thought–action fusion in obsessive compulsive disorder. *Journal of Anxiety Disorders*, *10*, 379–391.

Shear, M. K., Brown, T. A., Barlow, D. H., et al. (1997). Multicenter collaborative Panic Disorder Severity Scale. *American Journal of Psychiatry, 154*(11), 1571–1575.

Sheehan, D. V., Lecrubier, Y., Sheehan, K. H., Amorim, P., Janavs, J., Weiller, E., Hergueta, T., Baker, R., & Dunbar, G. C. (1998). The

Mini-International Neuropsychiatric Interview (M.I.N.I.): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *Journal of Clinical Psychiatry, 59*(20), 22–33.

Sica, C., Ghisi, M., Altoe, G., Chirir, L., Francheschini, S., Coradeschi, D., & Melli, G. (2009). The Italian version of the Obsessive Compulsive Inventory: Its psychometric properties on community and clinical samples. *Journal of Anxiety Disorders, 23*(2), 204–211.

Simpson, H. B., Foa, E. B., Liebowitz, M. R., Ledley, D. R., Huppert, J. D., Cahill, S., Vermes, D., Schmidt, A. B., Hembree, E., Franklin, M., Campeas, R., Hahn, C., & Petkova, E. (2008). A randomized, controlled trial of cognitive-behavioral therapy for augmenting pharmacotherapy in obsessive-compulsive disorder. *American Journal of Psychiatry, 165*(5), 621–630.

Simpson, H. B., Liebowitz, M. R., Foa, E. B., Kozak, M. J., Schmidt, A. B., Rowan, V., Petkova, E., Kjernisted, K., Huppert, J. D., Franklin, M. E., Davies, S. O., & Campeas, R. (2004). Post-treatment effects of exposure therapy and clomipramine in obsessive-compulsive disorder. *Depression and Anxiety, 19*(4), 225–233.

Steketee, G., Eisen, J., Dyck, I., Warshaw, M., & Rasmussen, S. (1999). Predictors of course in obsessive compulsive disorder. *Psychiatry Research, 89*(3), 229–238.

Steketee, G., & Frost, R. O. (2006). *Compulsive hoarding and acquiring*. New York: Oxford University Press.

Steketee, G., Grayson, J. B., & Foa, E. B. (1987). A comparison of characteristics of obsessive-compulsive disorder and other anxiety disorders. *Journal of Anxiety Disorders, 1*(4), 325–335.

Summerfeldt, L. J., Richter, M. A., Antony, M. M., & Swinson, R. P. (1999). Symptom structure on obsessive-compulsive disorder: A confirmatory factor-analytic study. *Behaviour Research and Therapy, 37*(4), 297–311.

Swanson, A. J., Pantalon, M. V., & Cohen, K. R. (1999). Motivational interviewing and treatment adherence among psychiatric and dually diagnosed patients. *Journal of Nervous and Mental Disease, 187*(10), 630–635.

Swedo, S. E., Leonard, H. L., & Rapoport, J. L. (2004). The pediatric autoimmune neuropsychiatric disorders associated with streptococcal infection (PANDAS) subgroup: Separating fact from fiction. *Pediatrics, 113*(4), 907–911.

Thordarson, D. S., Radomsky, A. S., Rachman, S., Shafran, R., Sawchuk, C. N., & Hakstian, A. R. (2004). The Vancouver Obsessional Compulsive Inventory (VOCI). *Behaviour Research and Therapy, 42*(11), 1289–1314.

Tolin, D. F., Maltby, N., Diefenbach, G. J., Hannan, S. E., & Worhunsky, P. (2004). Cognitive-behavioral therapy for medication nonresponders with obsessive-compulsive disorder: A wait-list-controlled open trial. *Journal of Clinical Psychiatry, 65*, 922–931.

Tollefson, G. D., Rampey, A. H., Jr., Potvin, J. H., et al. (1994). A multicenter investigation of fixed-dose fluoxetine in the treatment of obsessive-compulsive disorder. *Archives of General Psychiatry, 51,* 559–567.

Tynes, L. L., White, L., & Steketee, G. S. (1990). Toward a new nosology of obsessive-compulsive disorder. *Comprehensive Psychiatry, 31,* 465–480.

Valderhaug, R., Larsson, B., Götestam, K. G., & Piacentini, J. (2007). An open clinical trial of cognitive-behaviour therapy in children and adolescents with obsessive-compulsive disorder administered in regular outpatient clinics. *Behaviour Research & Therapy, 45,* 577–589.

van Balkom, A. J. L. M., de Haan, E., van Oppen, P., Spinhoven, P., Hoogduin, K. A. L., Vermeulen, A. W. A., & van Dyck, R. (1998). Cognitive and behavioral therapies alone and in combination with fluvoxamine in the treatment of obsessive compulsive disorder. *Journal of Nervous and Mental Disease, 186,* 492–499.

Van Oppen, P., Hoekstra, R. J., & Emmelkamp, P. M. G. (1995). The structure of obsessive-compulsive symptoms. *Behaviour Research and Therapy, 33*(1), 15–23.

Warren, R., & Thomas, J. C. (2001). Cognitive-behavior therapy of obsessive-compulsive disorder in private practice: An effectiveness study. *Journal of Anxiety Disorders, 15,* 277–285.

Weissman, M. M., Bland, R. C., Canino, G. J., Greenwald, S., Hwu, H. G., Chung Kyoon, L., et al. (1994). The cross-national epidemiology of obsessive compulsive disorder. *Journal of Clinical Psychiatry, 55*(3 Suppl), 5–10.

Whittal, M. L., Thordarson, D. S., & McLean, P. D. (2005). Treatment of obsessive-compulsive disorder: Cognitive behavior therapy vs. exposure and response prevention. *Behaviour Research and Therapy, 43*, 1559–1576.

Wilhelm, S. (2000) Cognitive therapy for obsessive compulsive disorder. *Journal of Cognitive Psychotherapy: An International Quarterly, 14*(3), 245–259.

Woo, C., Seok-Man, K., Lim, Y., & Shin, M. (2010) The Obsessive-Compulsive Inventory–Revised (OCI-R): Psychometric properties of the Korean version and the order, gender, and cultural effects. *Journal of Behavior Therapy and Experimental Psychiatry, 41*, 220–227.

Zermatten, A., Van der Linden, M., Jermann, F., & Ceschi, G. (2006). Validation of a French version of the Obsessive-Compulsive Inventory–Revised in a non-clinical sample. *European Review of Applied Psychology, 56*, 151–155.

Zohar, J., Judge, R., & OCD Paroxetine Study Investigators (1996). Paroxetine versus clomipramine in the treatment of obsessive-compulsive disorder. *British Journal of Psychiatry*, *169*, 468–474.

About the Authors

Edna B. Foa, Ph.D., is a Professor of Clinical Psychology in Psychiatry at the University of Pennsylvania and Director of the Center for the Treatment and Study of Anxiety. She received her Ph.D. in Personality and Clinical Psychology from University of Missouri at Columbia in 1970. Dr. Foa devoted her academic career to study the psychopathology and treatment of anxiety disorders, primarily obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD). Her research aiming at delineating theoretical frameworks, targeted treatments, and treatment mechanisms of pathological anxiety has been highly influential and she is currently one of the world leading experts in the areas of PTSD and OCD. The treatment program she has developed for PTSD sufferers has received the most evidence for its efficacy and has been disseminated in the US and around the world.

Dr. Foa has published 18 books and over 350 articles and book chapters and has lectured extensively around the world. Her work has been recognized with numerous awards and honors, among them the *Distinguished Scientific Contributions to Clinical Psychology Award* from the American Psychological Association; *Lifetime Achievement Award* presented by the International Society for Traumatic Stress Studies; *Lifetime Achievement Award* presented by the Association for Behavior and Cognitive Therapies; TIME 100 most influential people of the world; 2010 *Lifetime Achievement in the Field of Trauma Psychology Award* from the American Psychological Association; and the Inaugural International Obsessive Compulsive Disorder Foundation Outstanding Career Achievement Award.

Elna Yadin, Ph.D., is a psychologist and director of the OCD clinic at the Center for the Treatment and Study of Anxiety at the University of

Pennsylvania. Dr. Yadin received her Ph.D. in Physiological and Experimental Psychology from Bryn Mawr College in 1979 and respecialized in clinical psychology in 1995. Her neuroscience and clinical interests focus on the study and treatment of anxiety disorders, with an emphasis on OCD and PTSD. Her scholarly publications include scientific articles on brain mechanisms of anxiety and relief from fear and on treatment of anxiety disorders in children, adolescents, and adults. Dr. Yadin has been invited to speak nationally and internationally and has taught workshops on the use of evidence-based treatments for anxiety disorders.

Tracey K. Lichner, Ph.D., is a psychologist and director of supervision at the University of Pennsylvania's Center for the Treatment and Study of Anxiety. Dr. Lichner received her Ph.D. in clinical psychology from the Catholic University of America in Washington, D.C., in 2002. Previously at Johns Hopkins University School of Medicine, she participated in research investigating the genetics of OCD. She has conducted comprehensive clinical interviews, nationally and internationally, with hundreds of family members with OCD. At the Center for the Treatment and Study of Anxiety, she has taught in numerous workshops for mental health professionals on the treatment of OCD, PTSD, and grief. Dr. Lichner's professional interests include psychotherapy and the dissemination of evidence-based treatment for OCD, PTSD, and prolonged grief disorder.