Key Principles of Exposure and Response Prevention (ERP) for OCD

By: Danny Zamir, Psy.D.

President of the Anxiety and Panic Disorders Clinic of Santa Barbara

https://anxietysantabarbara.com/

Poll #1 What brought you to this webinar?

1: I am a mental health professional who wants to learn about ERP

2: I am looking for tools to address my own OCD

3: I have a loved one with OCD

4: Other/ I am just interested in the topic

Poll #2 Have you ever administered ERP

1: Yes

2: No

Outline

- What is OCD?
  - Diagnosis
  - Prevalence
  - What causes OCD?
  - Prognosis
- What is ERP?
- Assessment of OCD
- Key Principles of ERP for OCD
- Case Example
- Questions

What is OCD?

- **OCD is a neuropsychological disorder (Foa and Lichner, 2012)**
  - Involves "**Obsessions**, which are recurrent and persistent thoughts, impulses, or images that are experienced as intrusive and inappropriate and cause marked anxiety and distress".
  - Involves "**Compulsions** (or rituals) which are repetitive behaviors, thoughts, or images that the person person feels compelled to perform in response to an obsession or a certain rule that must be applied rigidly."
  - Compulsions are often "performed to neutralize or reduce the distress that accompanies the obsession."
  - Themes of obsessions can include contamination, symmetry, harming others, taboo sexual behaviors, relationships disolving, religious themes, bad things happening, and illness.

OCD diagnosis

[DSM-IV versus DSM-5 diagnosis comparison]

https://www.helpguide.org/articles/anxiety/obssessive-compulsive-disorder-ocd.htm

Prevalence

Image Credit Gracia Lam

- OCD is common and can be highly debilitating
- Lifetime prevalence of OCD is about 2.3%
- 1 year prevalence is 1.2%
- OCD is one of the 10 leading causes of disability in the world (Law and Boisseau, 2019)
- Over half of all OCD cases caused severe distress and impairment and only 14.6% were mild cases.

  https://www.nimh.nih.gov/health/statistics/obsessive-compulsive-disorder-ocd

What causes OCD?

- Genes: Twin and family studies show that overall, genetics contribute a little over half (45-65%) of the risk of developing OCD.
- About 25% of people with OCD have an immediate family member with the disorder.
- “Research suggests that OCD involves problems in communication between the front part of the brain and deeper structures of the brain.” The communication between these brain regions involves the use of serotonin. (https://iocdf.org/about-ocd/what-causes-ocd/)
- Environmental, behavioral, and cognitive factors also impact the development of OCD.
- Overvaluing the importance of thoughts (non-clinical study)
- Intolerance of uncertainty

Prognosis (Lack, 2012)

- 40 years ago, there were no empirically supported treatments for OCD.
- Now we have both medications that can help treat OCD and empirically-supported treatments designed specifically to address the core symptoms of OCD.
- Medications such as SSRI's are more effective for adults with OCD than for children with OCD. Medications for OCD tend to have high rates of relapse.
- Cognitive behavioral treatments such as ERP have higher effect sizes and lower relapse rates than medication treatments for OCD. (Foa et al., 2005)

Prognosis continued

- Overall, 50-72% of people treated for OCD with ERP show long term recovery from OCD. (Hansen et al., 2018);(Law and Boisseau, 2019)
- Intensive short-term treatment with ERP was found to be highly effective for OCD in just 4 days (Hansen et al. 2018)
- OCD commonly co-occurs with other psychological disorders including other anxiety disorders and depression.

Empirically Supported Psychological Treatments for OCD

- ERP - Empirically supported treatment status: Strong Research Support 1998 and 2015
- CBT - Empirically supported treatment status: Strong Research Support in 1998, but Treatment pending re-evaluation research support status given in 2015
- ACT: Modest Research Support
- Some therapists have negative feelings about exposure and that has hindered the dissemination of ERP. However, it is clearly the one treatment with the strongest base of empirical support.

Assessment of OCD (Foa et al., 2012)

- General History
- Y-BOCS or OCIR
- Obsessions
  - Cues that trigger obsessions
  - Content of obsessive thoughts
- Compulsions
  - Behavioral
  - Mental
  - Avoidance behaviors (Subtle compulsions)

Assessment of OCD continued (Foa et al., 2012)

- Feared outcomes if they don't compulse
  - Fear of prolonged anxiety?
  - Fear of bad things happening?
  - Core fear underneath surface fears (downward arrow)
- Onset and history of OCD
  - Triggering event
  - Previous treatment

What is ERP? (Foa et al., 2012)

ERP falls under the umbrella of CBT, but has components that are specifically tailored to the treatment of OCD.

5 main components

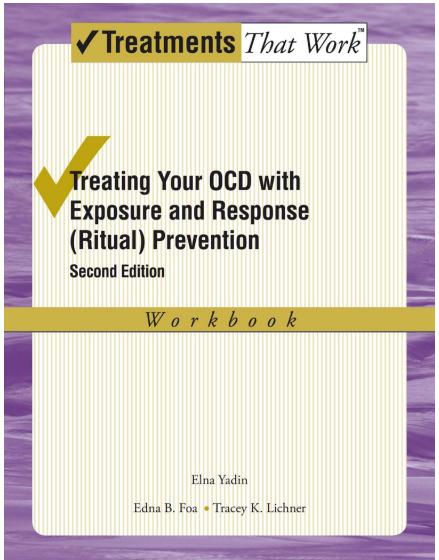
1: In vivo exposure (flooding versus gradual exposure)

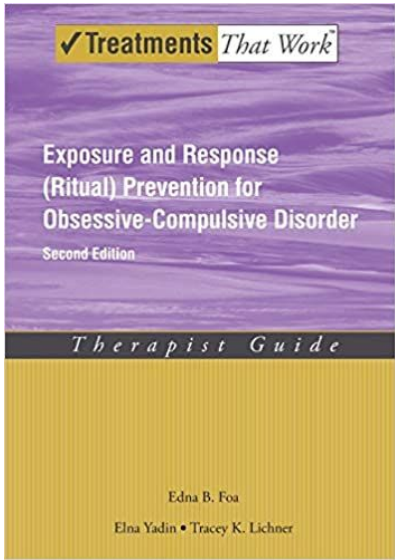
2:Imaginal exposure

3: Ritual prevention

4: Processing

5: Home visits

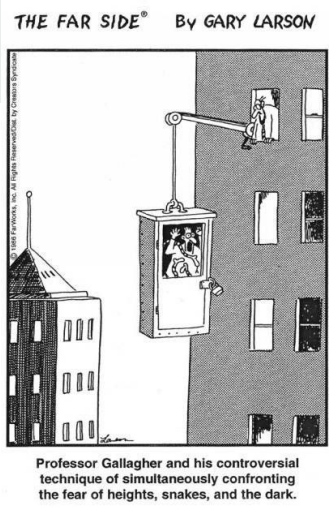




In Vivo Exposure

- Explain the rationale for in vivo exposure and how it reduces OCD symptoms. Engaged in psychoeducation and help the person to understand their OCD symptoms as this can lead to an immediate sense of relief.
    - Habituation
    - Emotional processing theory
- Introduce the concept of subjective units of distress and develop anchors
- Develop a hierarchy of triggering stimuli
- In vivo exposures are tailored to tackle items on the hierarchy

How does exposure work for OCD?



Professor Gallagher and his controversial technique of simultaneously confronting the fear of heights, snakes, and the dark.

Through exposure without compulsions, people are able to learn

1. Anxiety and an urge to engage in compulsions doesn't last forever. Learning this weakens the urge to compulse.
2. Feared consequences do not occur.

"Exposure, together with refraining from avoidance and rituals, disconfirms the patient's dreaded consequences, including that anxiety will last forever or that it mounts uncontrollably until it produces a "breakdown." (Foa et al., 2012)

- Framing exposures as hypothesis testing leads to changes in beliefs that maintain OCD
- Doing exposures in session and not only assigning it as homework is predictive of better outcomes in ERP.
- It is important for a therapist to know their own limits when engaging in in-vivo exposure.

Imaginal Exposure (Foa et al., 2012)

Credit: Getty Images/Peter Dazeley

Imaginal exposure is a very useful tool in the treatment of OCD.

1. It leads to habituation to disturbing thoughts and images and their extinction.
2. Instead of using compulsions, the person learns to tolerate the presence of negative emotions. This gives the person more confidence in their resilience and inner strength.
3. Allows you to play out worst case scenarios and events that wouldn't be possible with in-vivo exposure.
4. Helps people overcome thought-action fusion. Playing out horrible scenarios doesn't make them come true. They are able to learn that their thoughts don't cause bad things to happen.
5. Addressing the core fear in imaginal exposure allows us to get at the root of the OCD process without having to do a bunch of different in-vivo exposures.

Engaging in imaginal exposure (Foa et al., 2012)

- Collaboratively create a script that involves the blow by blow of the worst case scenario.
- Create an in depth description of the feared situation.
- The script should include the most extreme version of the feared situation and should include the feared outcome.
- Can use a hierarchy with imaginal exposure.
- Include lots of detail.
- Imaginal exposure shouldn’t be used when in-vivo exposure is possible.

Response (Ritual) Prevention (Foa et al., 2012)

- Essential ingredient
- Enhances habituation and extinction
- Therapist manual has specific rules for ritual prevention that can be modified for the specifics of a person's OCD
- Ritual prevention can be done gradually
- Support from a friend or relative can be helpful

Processing (Highlight key principles)(Foa et al., 2012)

- Occurs during and after in-vivo exposure and after imaginal exposure.
- Helps illustrate important points including
    - Anxiety reduces during exposures, even without compulsing (within session habituation
    - Repeated exposures lead to between session habituation and ongoing reductions in anxiety and distress
    - Rituals aren't needed to get relief from urges and distress
    - Feared consequences have a very low probability of happening

Additional principles in ERP

- Don’t engage in repetitive reassurance giving as you don’t want to become part of their compulsion
- Help people to develop greater tolerance of uncertainty
- Help people to understand that their specific obsessions reflect their values in the inverse (i.e. people have harm obsessions about people they love or don’t want to hurt and they are extremely unlikely to act on these intrusive thoughts).

Home Visits (Foa et al., 2012)

When possible, home visits are a useful tool in therapy.

1. Helps the therapist see how the compulsions impact the person at home
2. Allows the therapist to coach the person on how to do exposure and response prevention at home so as not to allow any rituals to fall through the cracks.

Home visits can be done early in treatment or at other points in treatment depending on the purpose. Can be done at end of treatment for relapse prevention.

Case Example

- Julie is a 28 year old, heterosexual, engaged, white, female, in her final year of graduate school.
- She presented for therapy (via telehealth) due to a high level of distress and impairment from obsessions and compulsions. Her obsessions spanned several categories including obsessions about being poisoned, obsessions about pedophilia, and obsessions about break-ins or things being stolen.
- Her compulsions included avoiding canned foods, checking carbon monoxide detectors, avoiding eating at most restaurants, avoiding children, checking to see if she had a sexual reaction when she saw or interacted with children, checking locks repeatedly, and checking the stove repeatedly.
- She was highly motivated for treatment and came already knowing that she had OCD. She had been in therapy in the past, but didn't find it helpful. She contacted the Anxiety and Panic Disorders Clinic as she had heard that ERP was a more effective treatment for OCD.

Case Example Continued

- Began with an assessment and she clearly met diagnostic criteria for OCD with good insight.
- She also met diagnostic criteria for GAD.
- Engaged in psychoeducation about OCD and ERP. She was highly relieved to get psychoeducation on pedophilia-OCD especially and cried when she was told that this was not indicative of risk of her harming children.
- Created a hierarchy of compulsions to tackle and began with exposure to foods that felt risky. Created a sub-hierarchy within this specific domain.
- Engaged in in-vivo exposure and response prevention in session to eating different foods and assigned additional in-vivo homework assignments

Case Example Continued

- Starting exposures caused marked anxiety, but progress was rapid and rewarding
- In a few weeks, she overcame her food compulsions and was able to eat out at restaurants and eat canned food she bought at the farmer's market.
- As food related compulsions dropped off, we added in other domains including gas (checking, fixation on carbon monoxide detectors) and security (eliminating checking door lock and bike lock).
- Finally, we tackled pedophilia compulsions via in-vivo exposure (spending time at a friend's house who has kids, spending time in a park) and imaginal exposure (going to logical extreme of being arrested and going to jail)
- Determined that the underlying fears were of dying or having her freedom taken away and losing the life that she has, which is going very well and which she values highly.

Case Example Continued

- Response prevention was incorporated into each exposure
- Processing occurred during and after each exposure and she was able to internalize that
    - Anxiety came down even when she didn't compulse
    - Repeated exposures led to decrease in obsessions and decrease in urge to compulse
    - Feared consequences never took place leading her to change her belief that they were something that she had to worry about
    - Her obsessions reflect her values (valuing her life, valuing her freedom, and not wanting to hurt children)

Case Example Continued

- With telehealth, most sessions were conducted while Julie was in her home and so the core aspects of home visits were incorporated throughout therapy and we were able to do in-vivo exposures to items in her home.
- Julie achieved remission from OCD during treatment (12 sessions) and we engaged in relapse prevention focused on identifying potential triggers, ongoing weekly exposures that she will do on her own, and vigilance against compulsions returning.

Questions?

References

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Resources

International OCD Foundation: https://iocdf.org/

https://beyondocd.org/

List of Empirically Support Treatments: https://div12.org/diagnosis/obsessive-compulsive-disorder/

https://www.nimh.nih.gov/health/statistics/obsessive-compulsive-disorder-ocd

https://www.amazon.com/Treating-Exposure-Response-Prevention-Therapy-ebook/dp/B00O143O5O

https://www.amazon.com/Exposure-Response-Prevention-Obsessive-Compulsive-Disorder/dp/0195335287/ref=sr_1_4?crid=AQA2N6YBOUQV&keywords=foa+ocd&qid=1648788075&sprefix=foa+ocd%2Caps%2C193&sr=8-4

https://www.psychologytoday.com/us for finding an ERP therapist