Introduction to Exposure and Response Prevention for Obsessive-Compulsive Disorder in Youth

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Who we are

Clinical psychologists specialized in treating OCD and anxiety disorders

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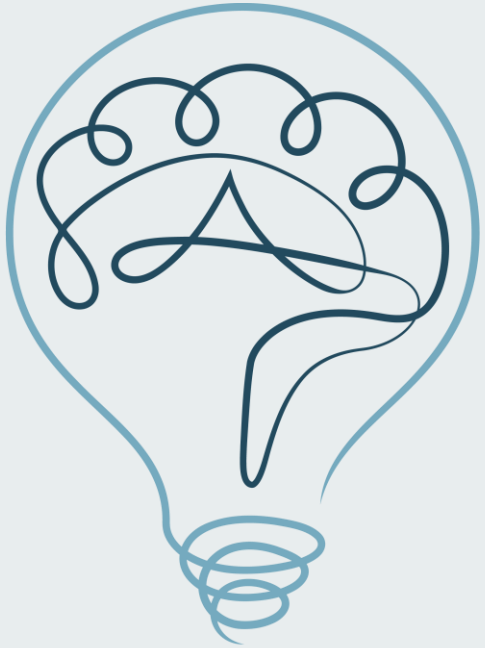

Anchored Approach

Clinical Consulting

- Customized individual consultation
- Small group clinical consultation
- In-house and virtual workshops for teams

...and more

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Workshop Outline

1. Overview of Obsessive-Compulsive Disorder (OCD) in youth
2. Assessment and treatment planning for Exposure and Response Prevention (ERP)
3. Interactive exercises
4. Questions and resources

OCD in Youth

Why is this topic important?

- OCD is common and has many different faces
- Delayed diagnosis and misdiagnosis
- Delayed start of treatment
- Improper, sub-optimal treatments
- Misconceptions about ERP
- Difficulty accessing evidence-based care

DSM-5 Criteria for OCD

A. Presence of obsessions, compulsions, or both

Obsessions: Recurrent and persistent thoughts, urges, and/or images that are experienced as intrusive and unwanted and that cause marked anxiety and/or distress

Compulsions (Rituals): Repetitive behaviors that are observable or performed mentally to neutralize obsessions or reduce distress associated with them

DSM-5 Criteria for OCD

The obsessions and compulsions are:

B. time consuming or cause clinically significant distress or impairment in functioning.

C. not due to physiological effects of substance use or a medical condition.

D. not better accounted for by symptoms of another mental health condition.

Specifier: Insight (good/fair, poor, absent/delusional)

Specifier: Current or past history of a tic disorder

Epidemiology

- Prevalence = 2-4%
- Earliest age diagnosed = 2 to 3 years
- Typical age of onset = 8 to 11 years
  - Boys = 9-11 years
  - Girls = 11-13 years
  - Adult onset = 19-20 years
- Male:female gender ratio = 3:2
  - Evens out in adolescence

Trajectory and Impact

- Developmental influences on symptom content
  - **Harm and contamination/illness** themes common at younger ages
  - **Sexual, moral, and religious** themes emerge more in adolescence
- Negative impact on academically, socially, family, and other areas of functioning
- Increased risk of substance use, depression, suicidal ideation and attempts

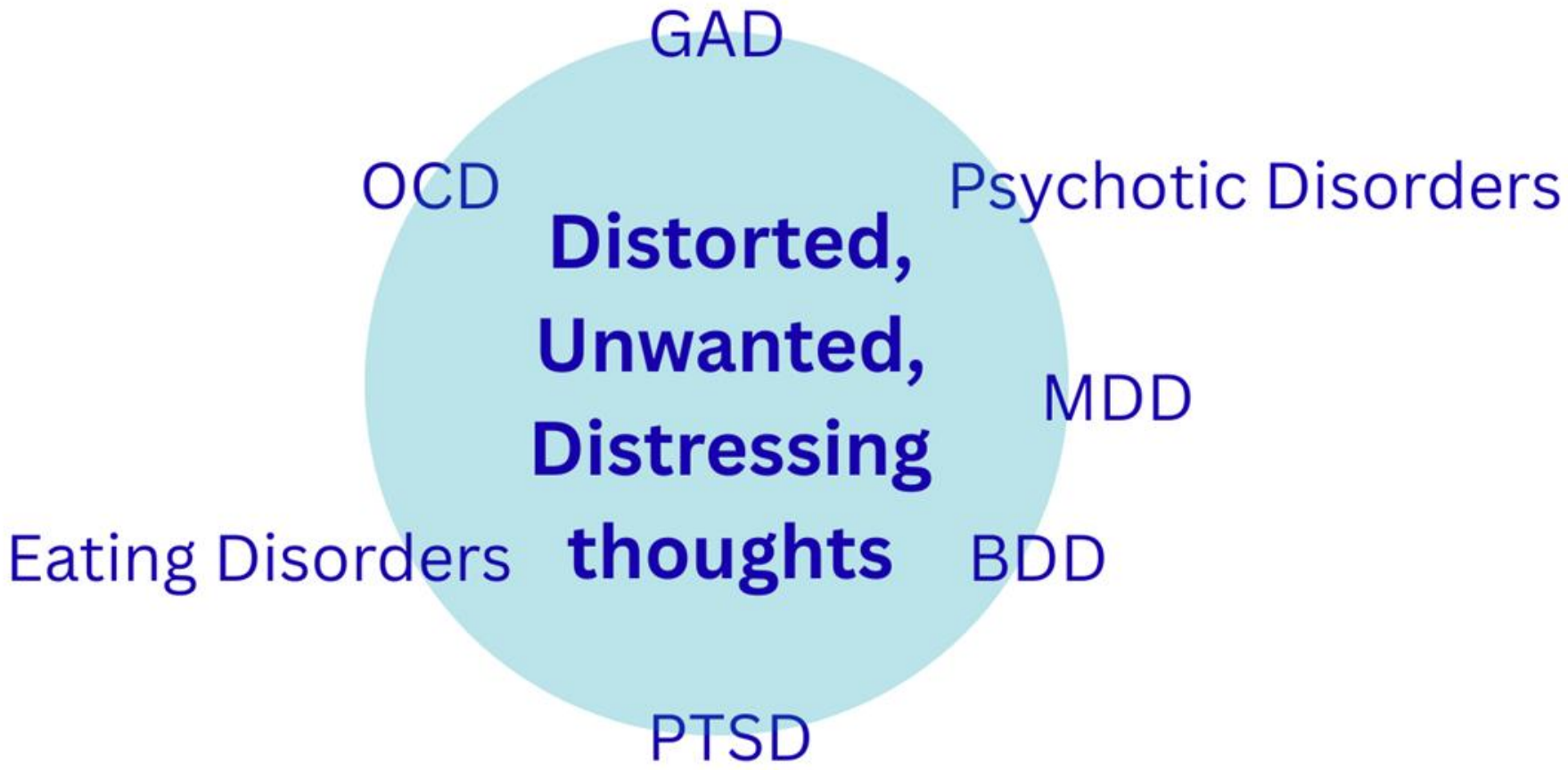
Comorbidity

- Rates are high relative to those for adult OCD
- Other anxiety disorders are the most common
- Other common comorbidities:
  - Attention-deficit hyperactivity disorder
  - Conduct and oppositional defiant disorder
  - Tic disorders
  - Unipolar depressive disorders

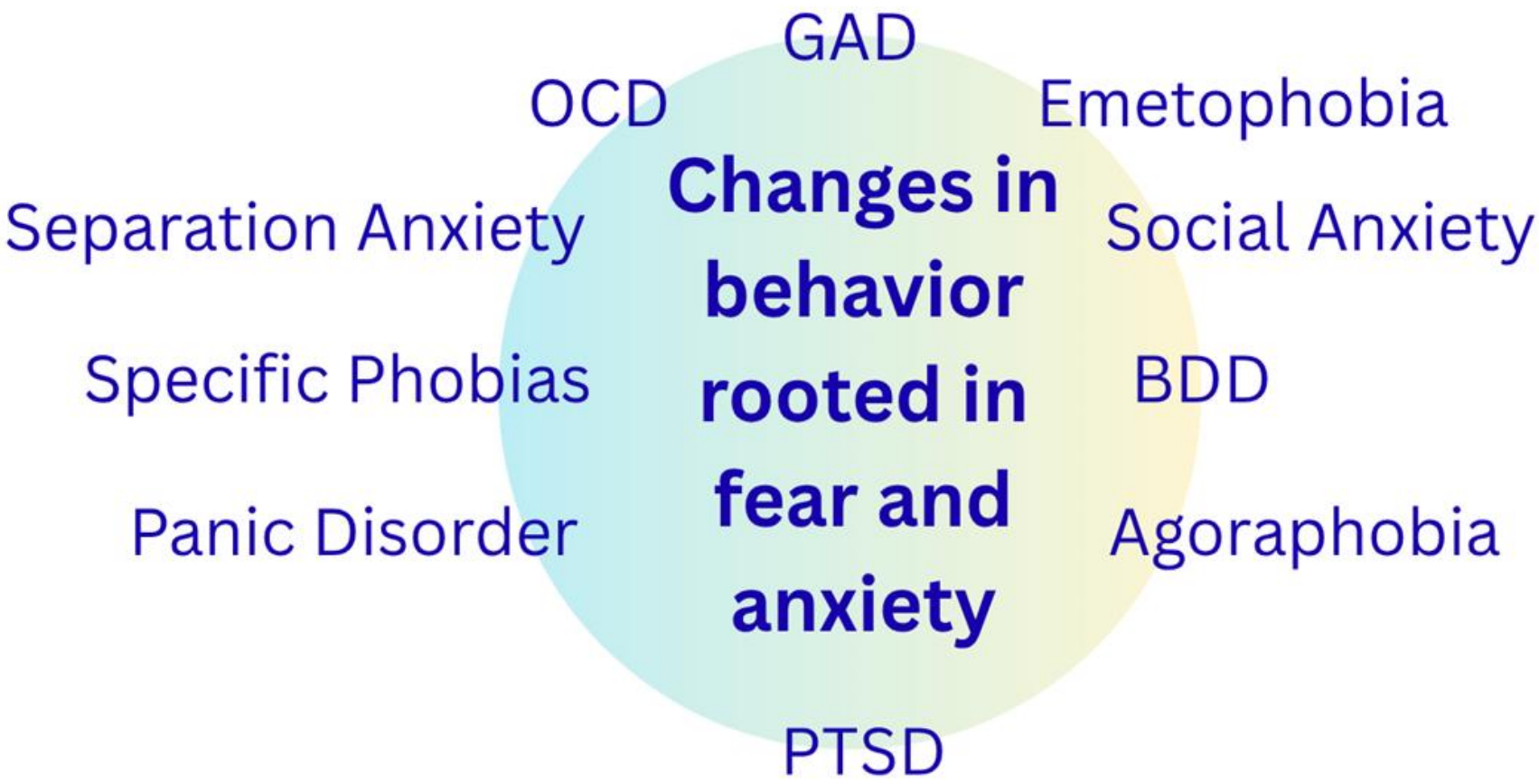
Assessment and Treatment Planning for ERP

Differential Diagnoses

- Separation anxiety disorder
- Generalized anxiety disorder
- Social anxiety disorder
- Panic disorder & agoraphobia
- Specific phobias
- Eating disorders
- Post-traumatic stress disorder
- Tic disorder
- Autism spectrum disorder
- Body dysmorphic disorder
- Body-focused repetitive behavior disorders (e.g., hair pulling)
- Psychotic disorder
- Depression



Graphic of distorted, unwanted, distressing thoughts as a diagnostic feature of various disorders



Graphic of changes in behavior rooted in fear and anxiety as a diagnostic feature of various disorders

Disorder	Type of distressing thoughts	Emotion driving behavior change	Characteristic behaviors
OCD	Intrusive, sometimes nonsensical; heterogeneous content	Anxiety, disgust, tension/ incompleteness	Compulsions, avoidance
GAD	Worry across several domains	Anxiety, worry	Reassurance-seeking, perfectionism
Separation anxiety disorder	Harm befalling or separation from caregivers	Anxiety	Avoidance of separation, checking on caregivers
Social anxiety disorder	Being negatively evaluated or embarrassed	Anxiety, embarrassment, shame	Avoidance of social situations

Disorder	Type of distressing thoughts	Emotion driving behavior change	Characteristic behaviors
OCD	Intrusive, sometimes nonsensical; heterogeneous content	Anxiety, disgust, tension/ incompleteness	Compulsions, avoidance
Panic disorder & agoraphobia	Catastrophizing bodily sensations and having a panic attack	Fear and anxiety	Avoidance of physiological arousal and public situations
Specific phobias	Anticipating and catastrophizing contact with feared stimulus	Fear and anxiety	Avoidance of feared stimulus
PTSD	Intrusive memories and thoughts of the trauma	Fear and anxiety	Avoidance of trauma reminders, hypervigilance

Disorder	Type of distressing thoughts	Emotion driving behavior change	Characteristic behaviors
OCD	Intrusive, sometimes nonsensical; heterogeneous content	Anxiety, disgust, tension/ incompleteness	Compulsions, avoidance
Tic disorders	Premonitory urges	Wide range	Tics
Body-focused repetitive behaviors	Sensory urges, need to engage in the behavior	Wide range	BFRBs
Body dysmorphic disorder	Preoccupation with perceived flaw in physical appearance and others' reactions to it	Anxiety, embarrassment, shame	Appearance-focused rituals and avoidance

Disorder	Type of distressing thoughts	Emotion driving behavior change	Characteristic behaviors
OCD	Intrusive, sometimes nonsensical; heterogeneous content	Anxiety, disgust, tension/incompleteness	Compulsions, avoidance
Eating disorders	Preoccupation with weight, food, shape, size	Anxiety	Binge eating, restriction, compensatory behaviors
Autism spectrum disorder	Restricted, intense interests; need for routine/predictability	Anxiety may be present	Stimming, repetitive behaviors
Major depressive disorder	Negative ideas about the self, world, future	Sadness, guilt, hopelessness	Withdrawal, psychomotor impairment
Psychotic disorders	Delusions	Wide range	Bizarre behaviors, withdrawal, disorganized speech

Symptom-Focused Assessment

1. Nature of child's symptoms
    a. Differential diagnosis
    b. Identifying obsessions and compulsions
2. Family accommodation of child's OCD symptoms

Validated Symptom Assessment Scales

CY-BOCS and CY-BOCS-II: Children's Yale-Brown Obsessive Compulsive Scale

- Two parts:
    1. 10- (or 11-) item severity measure with checklist of OCD symptoms for ages 7-17
    2. Clinician-administered semi-structured interview

Validated Symptom Assessment Scales

ChOCI-R: Child Obsessional Compulsive Inventory-Revised

- 38-item measure of presence and severity of OCD symptoms for ages 7-17
- Parent- and child-report versions

Obsessions

Contamination	Concern with dirt, germs, bodily waste, chemicals, sticky substances
Harm	Fear of harming self or others due to carelessness or loss of control, intrusive violent images/words, being responsible for something terrible happening
Sexual	Thoughts, images, impulses, content around homosexuality “am I gay” thoughts involving children or incest
Perfectionism	Evenness/exactness, needing to know, fear of forgetting or losing , not saying just the right thing, not being understood
Religious/Scrupulosity	Fear of offending God or religious objects, concern with right or wrong morally
Magical thoughts	Lucky/unlucky numbers, colors, times of the day, fear of saying certain things
Hoarding	Need to collect and save useless items
Other obsessions	Intrusive non-violent thoughts, images, sounds, words, music, numbers; Existential concerns, transforming mentally or physically

Compulsions

Washing/cleaning	Excessive or ritualized handwashing, showering, bathing, toothbrushing, grooming, cleaning of items, other measures to prevent contamination (barriers)
Checking	Checking for items, checking associated with washing/dressing, checking that did not/will not harm others or self or something bad happening, checking that did not make a mistake, checking tied to somatic obsession
Repeating	Re-reading, re-writing, erasing, need to repeat activities, need to repeat phrases or re-telling
Ordering/arranging	Symmetry/evening up, putting something in proper order
Mental	Counting, cancelling out bad thoughts with good thoughts, prayer to prevent, self-reassurance
Compulsions involving others	Confessing, reassurance, having someone do something
Avoidance	Avoiding triggers
Hoarding	Excessive collecting, saving, and difficulty discarding
Additional compulsions	Hoarding, superstitious games, eating behaviors, list making, blinking or staring

Family Accommodation

- Participation in or facilitation of child's compulsions and/or avoidance
- Maintains the OCD cycle
- Occurs in the majority of families, often daily
- Predicts poorer treatment outcome
- Positively correlated with caregiver burden and functional impairment

Validated Family Accommodation Scales

- **FAS-SR-CA:** Family Accommodation Scale for OCD, Self-Rated Child and Adolescent Version
  - Part 1: Report of child's symptoms
  - Part 2: 19-item measure of family member's responses to child's OCD

Functional Assessment

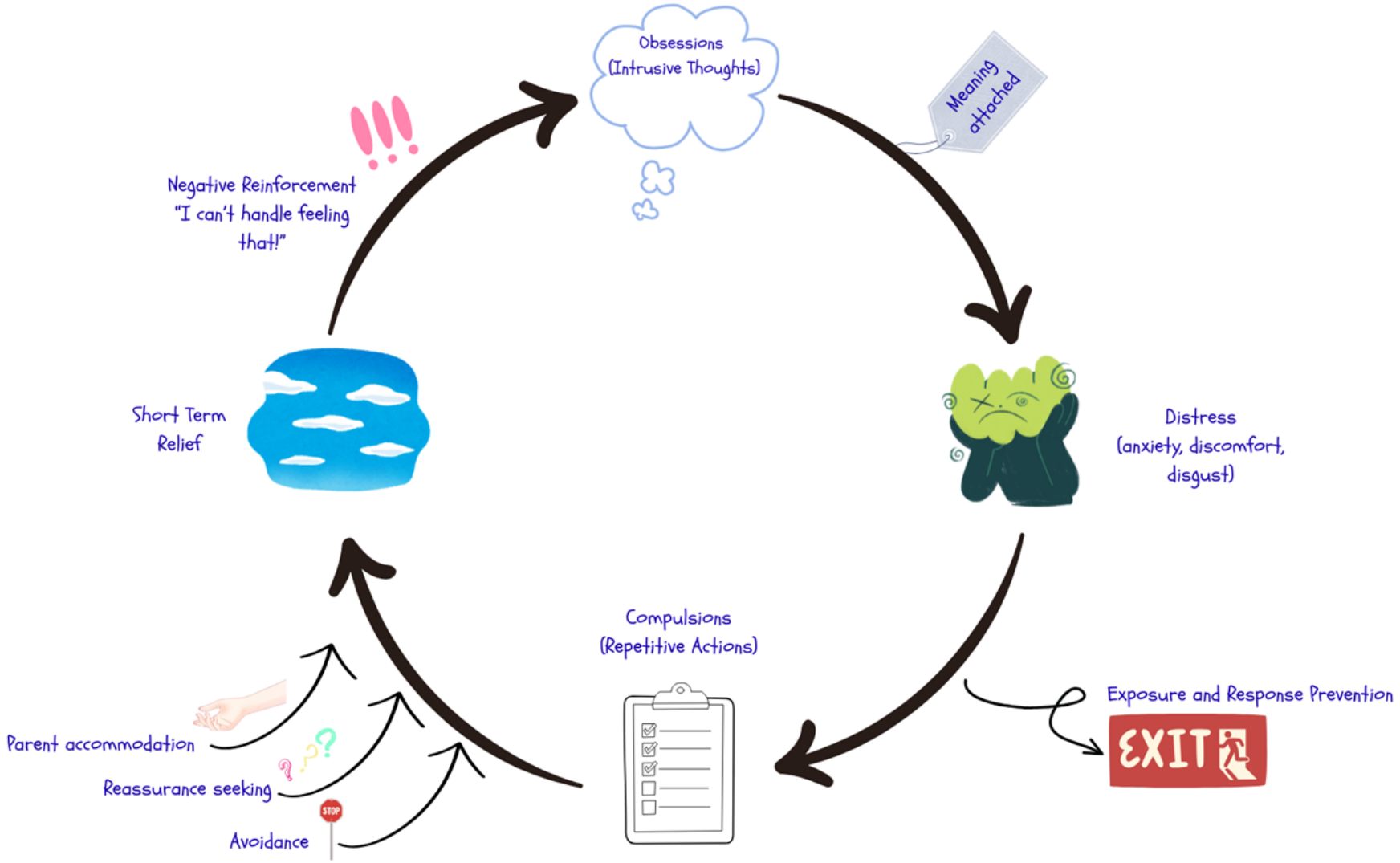
Continues differential diagnosis

1. Understanding the motivation(s) underlying symptoms
2. Understanding obsessions and compulsions in context

Understanding What Underlies OCD

- Meaning and interpretation of intrusive thoughts
  - Cognitive fusion: thoughts as facts
  - Thought-action fusion: thoughts as having power over events or the same as action
- Desire for perfection or a sense of “just right”
- Difficulty tolerating uncertainty
- (Mis)appraisals of what it means to feel anxious
  - Dangerousness, duration, tolerability, consequences

The OCD Cycle



Graphic of the OCD Cycle

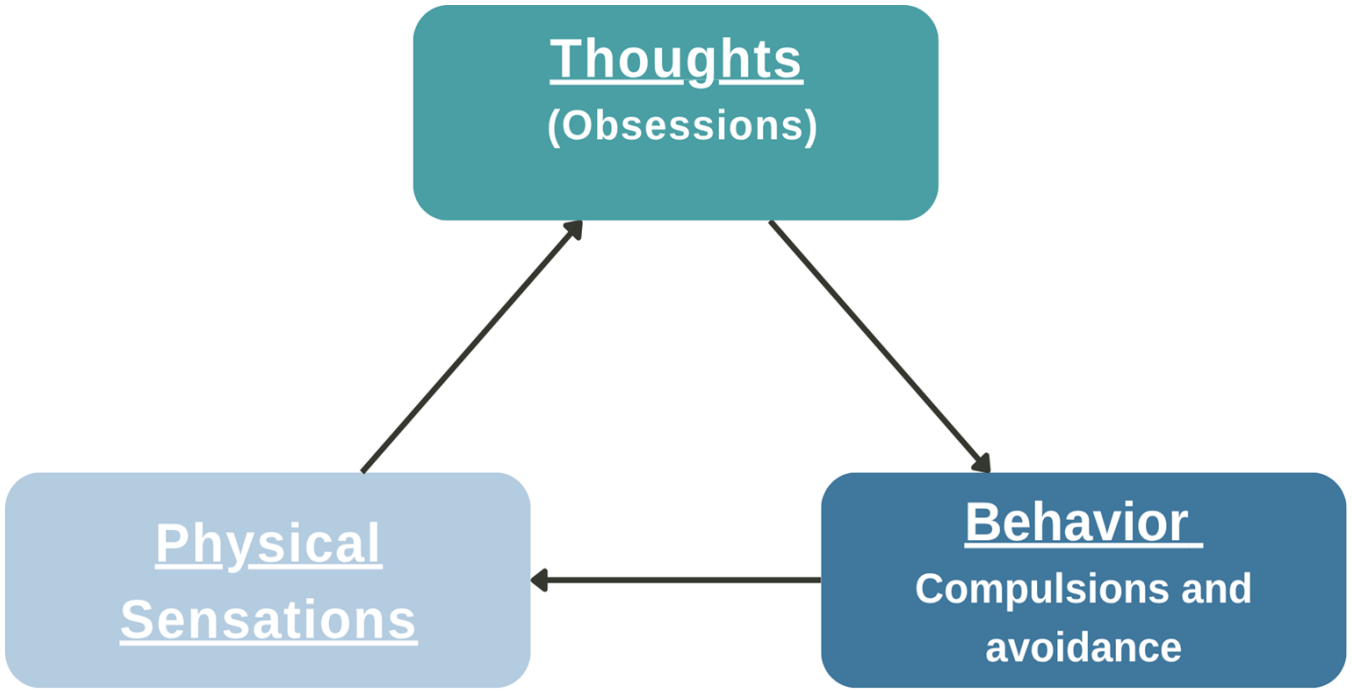
Functional Assessment: Understanding OCD Symptoms in Context

Antecedents

What precedes and activates the response (OCD)

- Proximal & distal
- Internal & external

Response



Consequences

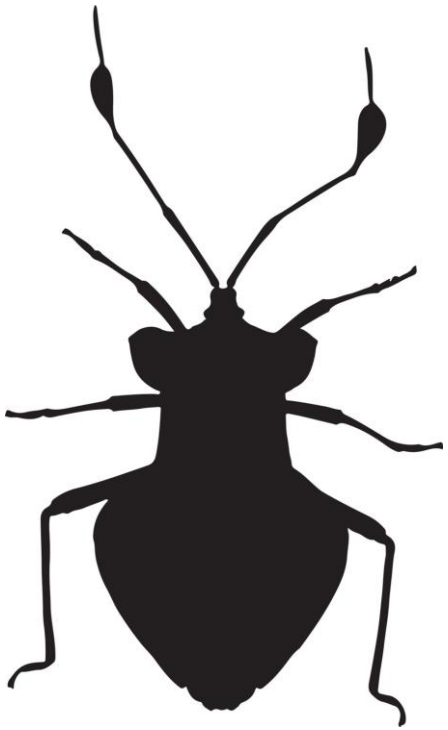
What occurs as a result of compulsions or avoidance

- Long- and short-term
- For the child and family

Functional Assessment: Transformation OCD

Antecedents

Seeing an insect



Response

Thoughts
(Obsessions)
"I will turn into an insect"

Physical Sensations
- Racing heart
- Dizziness

Behavior
Compulsions and avoidance
- Wash hands
- Eat with eyes closed
- Demand parents remove insect
- Tell parents to look for more insects

Consequences

Short-term:

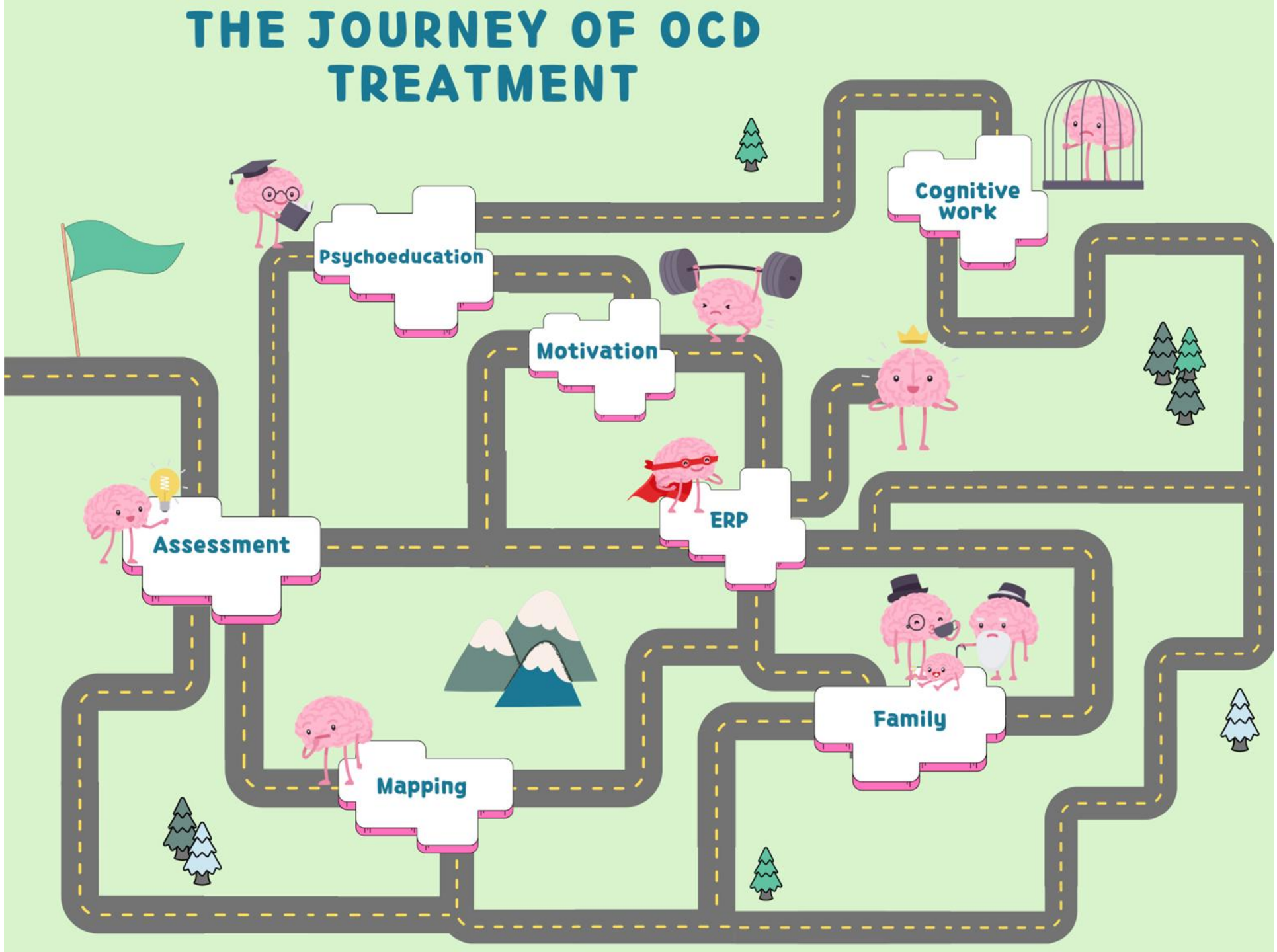
Anxiety relief for child

Long-term:

OCD symptoms and family accommodation maintained & worsen

Waypoints Along the Journey of OCD Treatment

- Assessment
- Psychoeducation
- Motivation
- Cognitive work
- Mapping symptoms
- Family-focused work
- *ERP*



Graphic of The Journey of OCD treatment

ERP: Exposure

Purposefully provoking obsessive thoughts

→ Antecedents from functional assessment

- “Make a brave move”
- “Be a brave explorer”
- “Face my obsessive fears”
- “Take a swing at OCD”

Modalities of Exposure

Imaginal

Develop a brief, present-tense story that incorporates core fear and sensory details

In Vivo

Encounter real situations or physical objects that provoke obsessive thoughts

Interoceptive

Elicit anxiety-provoking physical sensations

Best practice = Combined modalities

ERP: Ritual Prevention

Eliminating compulsions and avoidance behavior, including family accommodation

→ Behavior response from functional assessment

- “Break OCD’s rules”
- “Not do what OCD tells me to do”
- “Practice giving up rituals and avoidance”
- “Disobey OCD’s demands even 0.1%”

Variations of Ritual Prevention

- **Modify:** Change some aspect of ritual
- **Delay:** Increase amount of time before engaging in ritual
- **Reduce:** Decrease time or repetitions of ritual
- **Refrain:** Do not engage in ritual at all

Functional Assessment: Transformation OCD

Antecedents

Purposefully look at an insect

Response

Thoughts
(Obsessions)
"I will turn into an insect"

Physical Sensations
- Racing heart
- Dizziness

Behavior
Compulsions and avoidance
- *Don't* wash hands
- Eat with eyes *open*
- Parents *do not* remove insect
- *Don't ask* parents to look for more insects

Consequences

Short-term:

Child is anxious

Long-term:

Reduction in obsessive distress, compulsions/ avoidance, and family accommodation

Proposed Mechanisms of ERP

Habituation

- Focus on decreasing distress
- Key indicator of success is within- and between-session reduction in distress
- Aiming for decreased distress over repeated ERP trials
- Exposure ends when distress has decreased

Proposed Mechanisms of ERP

Inhibitory Learning

- Focus on learning new, competing information
- Key indicators of success are expectancy violations, tolerance, generalization of learning
- Aiming for increased tolerance and feelings of competence
- Exposure endpoint does not depend on reduction in distress, which may not change

Creating an ERP Plan

1. **What exactly will I do to face an OCD fear and/or make OCD loud on purpose?**
2. **What compulsion(s) will I to try to resist during the exercise?**
    a. **How will I try to resist the compulsion?**
        i. **I won't do it at all**
        ii. **I will wait to do it for _____ sec/min**
        iii. **I will change it by _____ (e.g., doing it "incorrectly")**
        iv. **I will put a limit on it by only doing it for _____ sec/min and/or ____ times**
3. **What scares me most about doing this? What does OCD say will happen?**
    a. **How loud do I think OCD will get? (0-10)**
    b. How much do I believe in my ability to "hang out" with uncomfortable feelings that show up? (0-10)
4. What do I want to learn from doing this and why?
5. How will I know if I met my goal for the exercise?

Case Examples

Role Play: Questions for Maddie and Parents

Differential diagnosis

- Identify potential obsessions and compulsions

Functional assessment

- Identify antecedents and consequences

Maddie, 9

“No one else in my family makes sure things are clean, so I spray the doorknobs with Lysol every night before bed. They are all really gross, like they don’t always wash their hands when they come in the house. They wear clothes from outside the house and even get in their beds. They are just so dirty. I don’t want to touch anything they’ve touched. People at school are so gross, too. Everyone is always sick there and I wish I could just be homeschooled.”

Maddie's Parents

"Lately Maddie has been on us all of the time about being cleaner. She has been using a washcloth to open doors, pulling her sleeves down over her hands when she doesn't. She comes into the house and immediately changes her clothes and yells at us that we should, too. If we're in the kitchen, she pops up and asks, "Did you wash your hands?" If we say yes, sometimes she still says, "Do it again, so I can see it." I think we are pretty cautious about hygiene, but she is way out of hand. She washes her hands if she just goes on the back deck and doesn't even touch anything."

Maddie’s Obsessions

- “I might get COVID and that kills people sometimes.”
- “What if I got COVID and killed someone in my family?”

Core fear: “Someone would die and it would be my fault.”

Maddie's Compulsions

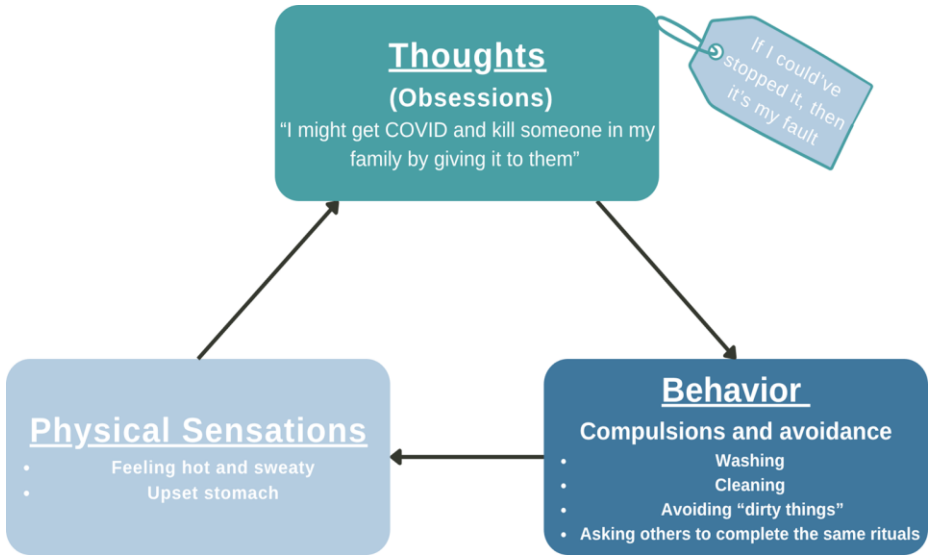
- Spraying door knobs with Lysol nightly
- Using a barrier over hands to open doors
- Changing clothes upon entering the home
- Asking parents to:
  - Change clothes upon coming home
  - Confirm and demonstrate their hand washing
  - Avoid items perceived as contaminated

Functional Assessment: Maddie

Antecedents

- Being around “dirty” / “gross” people (e.g., in school)
- Entering home with unwashed hands & clothes
- Touching unsanitized doorknobs
- Being around or touching unwashed items

Response



Consequences

Short-term:

- Maddie feels relief

Long-term:

- Maddie’s OCD persists
- Negative impact on social and academic functioning
- Stress and increased conflict within the family

*Theme = lack of control over cleanliness of environment

Treatment goals for Maddie and family

Exposure: Approach and interact with “contaminated” objects

- Touch doorknobs
- Cross contamination
- Go to places where there are “gross” people

Ritual Prevention: Reduce use of barriers

- Resist using washcloth, sleeves to cover hands
- Resist changing out of clothes upon arriving home
- Resist cleaning doorknobs
- Resist excessive hand washing

Family: Reduce family accommodations

- Stop providing cleaning products
- Stop completing tasks for Maddie (e.g., getting her food)
- Stop heeding Maddie’s cleaning/avoidance requests

Tyler, 16

“My parents are upset because they think I’m praying too much and worrying, but it’s not that big of a deal. I just want to make sure I’m a good person. I don’t want God to be mad at me. Sometimes, I’ll be watching a show and I think, “Was I just attracted to that actor?” I try to see see if I got turned on. Like, maybe I’m gay and I don’t know it, and maybe God would be mad at me if that was true. So I’ll turn it off and go pray that I’m a good person. Or if I think I was rude to someone, I’ll pray that God forgives me. And then I pray the same prayer every night to make sure I’m a good person. But like I said, it’s just not a big deal.”

Tyler's Parents

"We think it's important you understand we are not a religious family. When the kids were really little, we would go to church about once a year, and my husband was raised half Jewish, so we did a little education on that, but really we just aren't religious. But at 14, all of the sudden Tyler starts talking about God, and being a good person, and looking into like what prayers to say, and asking to go to church. At first, we didn't want to squash his exploration, so we brought him a couple of times, but then he started asking us all of the time, "Am I a good person?" and "Do you think I could talk to the pastor and ask if he thinks I can go to heaven even though I think I kind of lied to my friend?" And it will be a white lie, like not telling his friend that he got an A on a test that the friend really struggled with. Lately, he's been asking if we think he's straight. We don't care what his sexual orientation is, but he's come home with crushes on girls since Pre-K, so it feels like a strange question. And I don't know what's going on at bedtime, but we will hear him speaking to himself really late at night for up to an hour. We're pretty sure he is praying."

Tyler’s Obsessions

- Scrupulosity
  - “I don’t want God to be mad at me.”
  - “I pray that I’m a good person.”
  - “Can I go to heaven even though…”
- Sexual orientation
  - “Maybe I’m gay and I don’t know it.”

Core Fear: “I can’t really know myself.”

Tyler’s Compulsions

- Excessive praying
- Reassurance seeking
- Bodily checking (e.g., examining bodily reactions to see if he is “turned on”)

Functional Assessment: Tyler

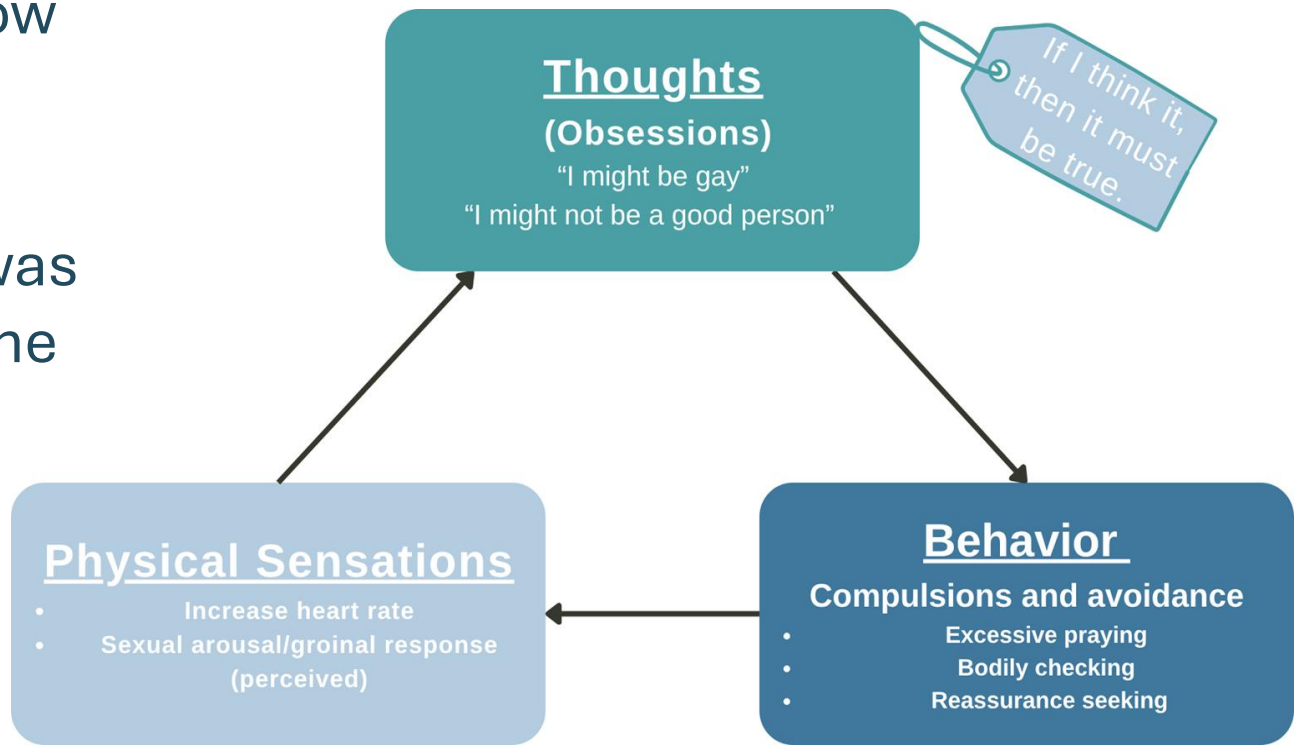
Antecedents

- Watching a show with a certain actor
- Perceiving he was rude to someone
- Telling a lie
- Going to bed

*Theme =

Difficulty with uncertainty about his morality and sexual orientation

Response



Consequences

Short-term:

- Tyler feels relief

Long-term:

- Tyler's OCD persists
- Social and academic functioning declines
- Negative impact on seeking romantic relationships
- Family stress

Design treatment goals for Tyler and family

Exposure: Interact with triggering materials and context
- ↳ Engage with uncertainty about morality/sexuality

Ritual Prevention: Reduce avoidance, alter rituals
- ↳ Resist asking for reassurance
- ↳ Resist/alter prayers
- ↳ Resist checking and scrutinizing bodily reactions

Family: Reduce family accommodations and reassurance
- ↳ Limit answering questions about sexuality and morality

Ready, Set, ERP for Tyler

- Watch a TV show with the actor that has triggered the obsessive doubt about attraction
- Alter the prayer he says in order to be a “good person” with nonsensical content
- Play “Two Truths and a Lie”
- Imaginal script about never being able to know who he truly is

Creating an ERP Plan

1. **What exactly will I do to face an OCD fear and/or make OCD loud on purpose?**
2. **What compulsion(s) will I to try to resist during the exercise?**
    a. **How will I try to resist the compulsion?**
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        iii. **I will change it by _____ (e.g., doing it "incorrectly")**
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    b. How much do I believe in my ability to "hang out" with uncomfortable feelings that show up? (0-10)
4. What do I want to learn from doing this and why?
5. How will I know if I met my goal for the exercise?

Interactive Exercises

Activity 1

Differential Diagnosis

Work with a partner to generate interview questions to ask during an intake session with the patient and their family members.

The purpose is to clarify the nature of the child's symptoms and whether they likely reflect OCD.

Activity 2

OCD Symptom Assessment

Identify and list the individual obsessions and compulsions described in the vignettes.

Some vignettes are not representative of OCD and may not involve obsessions or compulsions.

Activity 3

Functional Assessment to Develop Treatment Goals

Complete the Functional Assessment form to identify the OCD cycle. Then use the Treatment Goals Planning form to outline ERP targets.

- **What is the primary exposure target, and how will you guide your client to approach their obsessional trigger?**
- **What is the primary goal of ritual prevention, and how will you guide your client to resist?**
- **How will you guide the family to reduce reduce accommodation of the client's OCD symptoms?**

Activity 4

Ready, Set, ERP!

Use the Creating an ERP Plan form to develop an in-session ERP for the client in your vignette.

Keep your functional assessment top of mind to design a plan that addresses the client's core obsessional fear.

Questions?

Resources

International OCD Foundation: *https://kids.iocdf.org*
Anxiety and Depression Association of America: *https://adaa.org*
Peace of Mind: *https://peaceofmind.com*
OCD Game Changers: *https://ocdgamechangers.com*
OCD Stories podcast: *https://theocdstories.com*
Not Alone Notes: *https://notalonenotes.org*

Resources: Assessment Measures

CY-BOCS: *https://ocdscales.com*

Ch-OCI-R:
https://novopsych.com/assessments/diagnosis/obsessional-compulsive-inventory-ocd-child-self-report

https://novopsych.com/assessments/diagnosis/obsessional-compulsive-inventory-revised-parent-choci-r-p

Family Accommodation Scale:
https://ysph.yale.edu/familyaccommodationocd