Symptom Management

- OCD is not something that goes away or is cured
  - Important to normalize setbacks
  - Psychoeducation about OCD is important
  - Some clients might get stuck in wanting thoughts to go away completely
    - Compulsive search for the “perfect” therapist; therapist shopping for the “just right” person who can “fix” them

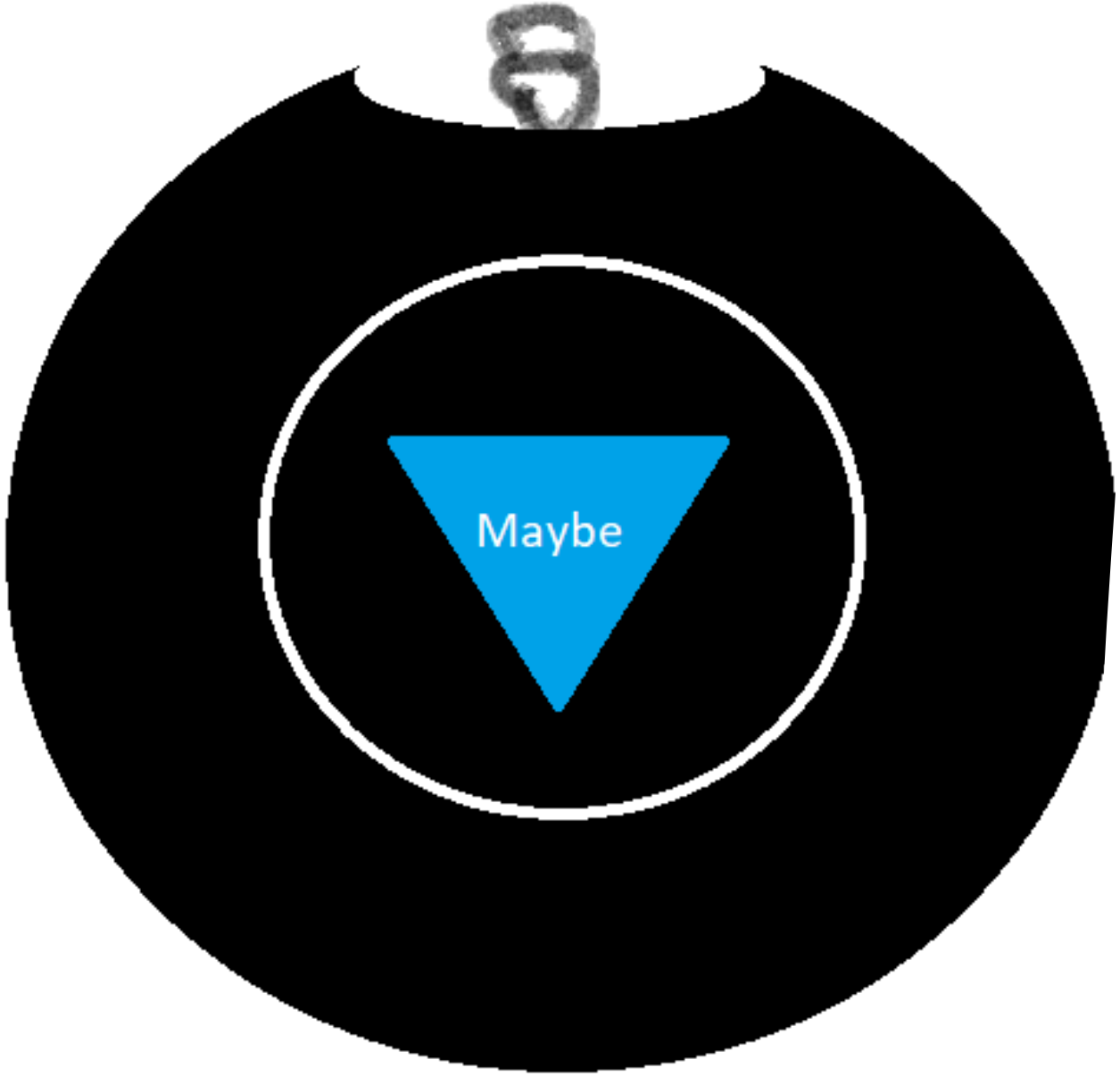
- Treatment becomes about learning how to manage your symptoms, live through your values, and eventually become your own ERP therapist

Symptom Management

- OCD tends to focus on the negative/minimize the success; help client recognize success and practice **self-compassion**
- Teach relapse prevention*
  - Identify triggers and vulnerabilities; plan for red flags of a setback**
  - Distinguish setbacks from relapse
  - Agree on plan to address setbacks
- With progress, you can titrate sessions down and eventually just have “booster” and “tune-up” sessions

*Jon and Shala’s Top 10 Tips For Coping with OCD and Relapse Prevention

**Grayson, Jonathan. *Freedom from Obsessive Compulsive Disorder: A Personalized Recovery Program for Living with Uncertainty.* Penguin-Putnam. NYC, NY. 2014.



More on Response Prevention and Decreasing Compulsions

- Maybe yes/Maybe no
- Non-engagement responses
- Reassurance seeking
  - Reassurance logs/journals
  - Reassurance tickets
  - Sorry cards

Ethics and Risk Management

Ethics of ERP

Ethical considerations of ERP

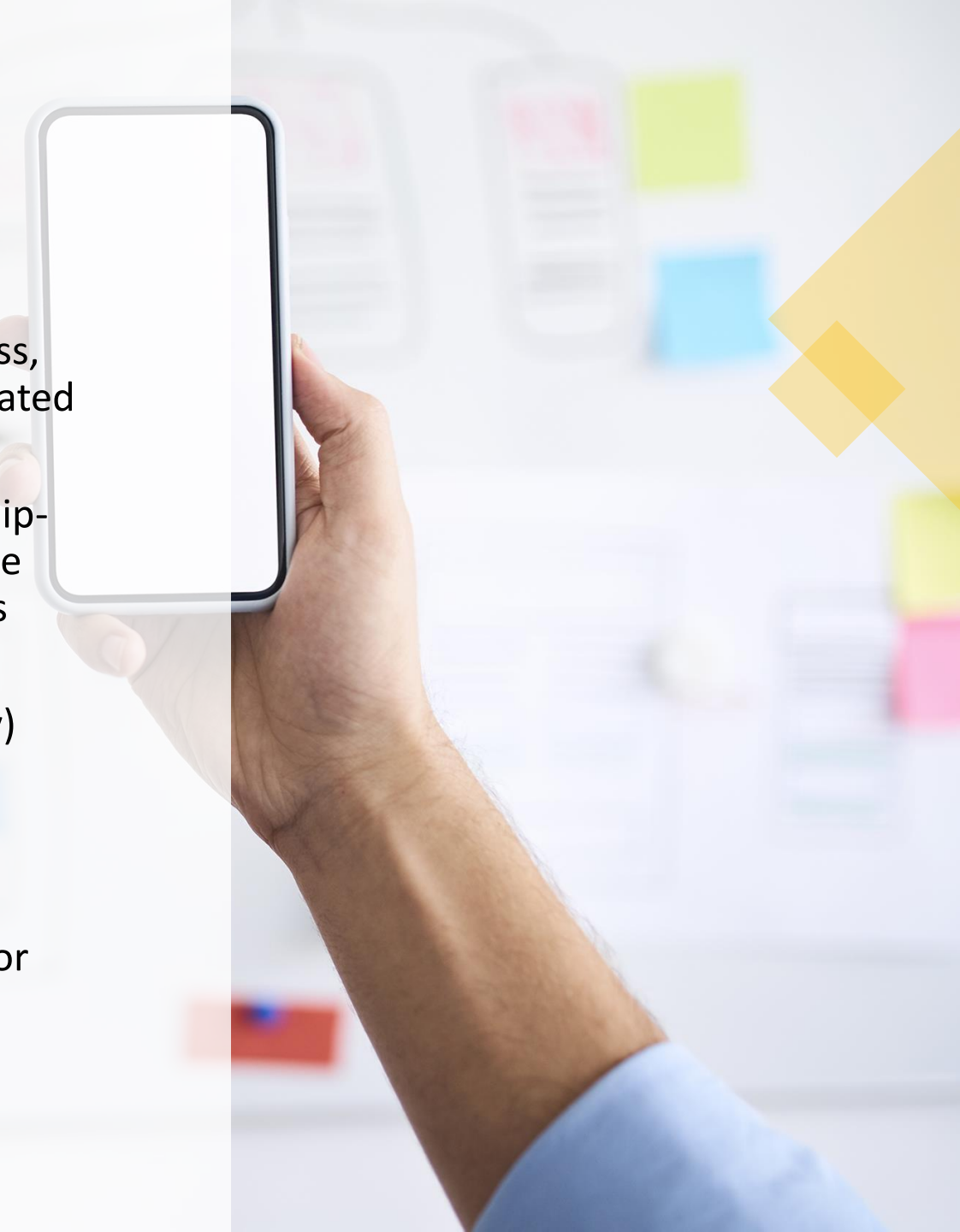
- Some fears with doing exposures
  - Do the ends justify the means
  - Will it generalize
  - Doing something to someone vs with
  - It’s rigid/does not consider individual needs
  - It’s basically torture

(Olatunji, Deacon, & Abramowitz, 2009)

What to do…

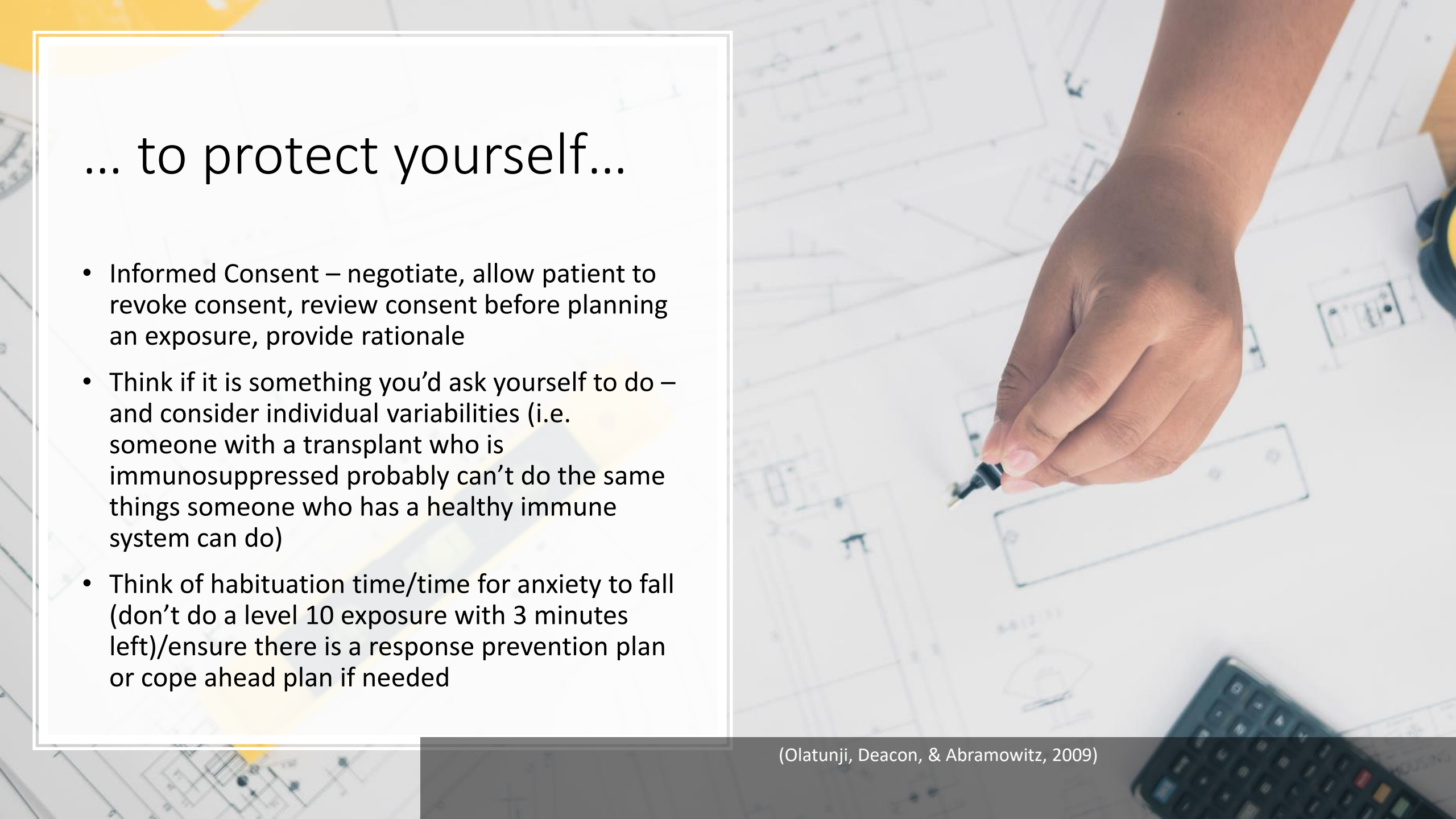
- Inform patients that they are likely to have temporary distress, but that it will (hopefully) eventually be beneficial with repeated practice
- Exposure therapy was thought to be effective and relationship-oriented (maybe due to patients not being intimidated by the increase of anxiety being temporary as it is something that is already experienced)
- Review of literature indicates that there are not many (if any) reports or legal action due to exposures
- Of course, to practice, you should be competent in exposure therapy
- It is important to consider your own distress and tolerance for distress – it's not easy watching someone go through the exposure process!

(Olatunji, Deacon, & Abramowitz, 2009)



… to protect yourself…

- Informed Consent – negotiate, allow patient to revoke consent, review consent before planning an exposure, provide rationale
- Think if it is something you'd ask yourself to do – and consider individual variabilities (i.e. someone with a transplant who is immunosuppressed probably can't do the same things someone who has a healthy immune system can do)
- Think of habituation time/time for anxiety to fall (don't do a level 10 exposure with 3 minutes left)/ensure there is a response prevention plan or cope ahead plan if needed



(Olatunji, Deacon, & Abramowitz, 2009)

… and your client

- Sometimes exposures do not go as planned, remind patients it is a test of the feared outcome – is the feared outcome harmless or harmful? Consider risk vs reward
- Potentially crossing boundaries with off site exposures– patients already experience anxiety and F/F/F responses are not inherently dangerous
- Boundary violation with out of office sessions can be mitigated with informed consent

(Olatunji, Deacon, & Abramowitz, 2009)

Risk Management

- ERP can be done in the office AND outside of the office
- Some things to consider:
  - Is the client appropriate for in vivo and outside the office exposures?
  - Is it clinically necessary for this type of exposure to be done?
  - Does my program have any protocols around these types of exposures?
    - Consent form
    - Risk/Waiver
    - Home/environment safety checklist

Criteria for in-vivo/out of office exposures

Candidates NOT appropriate for in-vivo (out of office) exposure	Candidates appropriate for in-vivo (out of office) exposure
• **Actively suicidal/homicidal/self-harming** • **Active ego-syntonic violent ideations** • **History of assaultive behaviors** • **History of repeated anti-social behaviors** • **Active substance use (intoxicated at time of appointment)** • **History of risk-taking and impulsive behaviors** • **Low distress tolerance/emotion regulation** • **Have never attended in-person sessions at the CU Anschutz OCD Program** • **Have never participated in any type of exposure therapy** • **Have issues more pressing than OCD (e.g. eating disorder, substance misuse or abuse, self-harm behaviors, lack of housing, etc.)** • **Substantial cognitive impairment**	✓ Attending sessions regularly in-person at the CU Anschutz OCD Program ✓ Reasonable distress tolerance/emotion regulation (reasonable enough to remain safe and not engage in maladaptive or dangerous coping strategies) ✓ Have demonstrated ability to tolerate exposures in the office setting ✓ Sober and refraining from other self-medicating/numbing behaviors ✓ Motivated and engaged in treatment ✓ Ability to plan for safety if distress/increased anxiety persists at the end of session

ERP Risk Hierarchy

Lower risk	In-office exposures → consider using virtual reality to increase the number of exposures that can be done in-office
	In-building exposures (e.g. bathroom, kitchen)
	On-campus exposures (e.g. campus shuttle, gym)
	Off-site in the community (e.g. bus, nail salon, store)
Higher risk	Off-site in a patient's home/driving or riding with a patient