CBT Webinar: Week 5

The Conditions Formerly Known as Anxiety Disorders: OCD & PTSD

CBT for OCD

Obsessive-Compulsive Disorder

- *Obsession – a recurrent thought, impulse, or image*
- *Compulsion – a repetitive behavior or mental act*

CBT for OCD

- Focus on belief vs automatic thoughts
- Mindfulness/Metacognitive Work
- Separate in groups

CBT - Characteristics of OCD

- Worry
- Rumination
- Intrusive Thoughts
- Compulsive behaviors
- Thought Suppression
- Overt and Covert Rituals
- Low memory confidence
- "Stop signs"

CBT - "Types" of OCD

- "Relationship"
- "Sexual"
- "Magical Thinking"
- "Religious"
- "Violence"
- Symmetry and Orderliness
- "Contamination"

CBT for OCD – Reasons Coping Responses Backfire

- Strengthen thoughts/Images
- Prevent pt from experiencing info that leads to new beliefs

CBT for OCD

- 2 Metacognitive Beliefs
  - Thought-Event Fusion
  - Thought-Action-Fusion
    - Prospective
    - retrospective

CBT for OCD - ERP

- Standard "Gold Star" treatment for OCD
- Goal is habituation
- Mechanisms of change
  - 1) Neurological nervous system habituation
  - 2) Social learning
- Importance of accepting risk of uncertainty/experience discomfort

CBT for OCD - ERP

- 2 Steps

1) Direct contact with trigger
2) Gradual elimination of safety behaviors

CBT for OCD - ERP

- Step 1: Hierarchy Development
- Step 2: SUDS Rating Scale
- Step 3:Assign SUDS and Order Hierarchy
- Step 4: Expose Gradually

ERP – Standard SUDS

0 = State of Complete Calm
10-30 – A Little Discomfort
40-60 – Moderate Discomfort
70-90 – Extreme Anxiety
90-100 – Worst Fear Ever Experienced

CBT for OCD - ERP

- Example SUDS: Checking Compulsions
  - Lock house door one time before going to bed – 60
  - Turn off faucet w/o checking if dripping – 70
  - Turn off stove – check knobs only 1 x – 80
  - Go to bed with hot ashes in fireplace - 90
  - Use iron, unplug, and leave house w/o checking - 100

CBT for OCD - ERP

- Case Example: Bryan
  - Sexual OCD
  - Vice Principal at middle school
  - Coaches boys and girls basketball
  - Daily Thoughts: "What if I molested that girl?"
  - Daily intrusive images of girls naked
  - Thoughts:
    - "I am disgusting"
    - "I am a pervert"
    - "What if I want them more than my wife?"

CBT for OCD - ERP

- SUDS
  - Watch E television at home with wife -60
  - Compliment girl at Bball practice - 70
  - Make eye contact with girl in class - 80
  - Supervise Lunch on playground – 90
  - Parent teacher conf with girls father - 100

CBT for OCD - ERP

- Cognitive Work
  - "Its just my OCD"
  - "Just bc I think it doesn't make it true"
  - If I really did, kids would not be ignoring me"
  - "If I really did I would not still be teaching"
  - "If I really were a pervert I wouldn't be disgusted"
  - "If I really did, her dad wouldn't praise me at the conference"

CBT for OCD - ERP

- Cue Card
  - "Just because I have these thoughts and images doesn't make me a bad person. They are just symptoms of my condition. I don't believe Tachychardia makes Jimmy a bad person, so it is not fair to believe these make me a bad person. I can still be a loving husband, serve in church, and maybe even have kids of my own one day. My thoughts do not define me and my OCD will not conquer me"

ERP – Final Tid-Bits

1) Work gradually up hierarchy list
2) When anxiety reduced 2-3 days, move on
3) It is not necessary to eliminate ALL discomfort before moving on…just reduction of anxiety
4) Work on need to do exposures perfectly
5) Anticipation anxiety is normal part of process
6) Anxiety is uncomfortable but NOT DANGEROUS

■METACOGNITIVE APPROACHES

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CBT for OCD - Metacognitive Strategies

1) Engagement/Normalizing
2)Detached Mindfulness
3) Exposure and Response Commission
4) Challenging Metacognitive Beliefs
5) Isolating and verbalizing the Belief
6) Behavioral experiments

CBT for OCD - Strategies

1) Engagement/Normalizing

CBT for OCD - Strategies

2)Detached Mindfulness –

- Free association
- Coach through process

CBT for OCD - Strategies

3) Exposure and Response Commission

1) Educate re rituals keeps focus on "obj mode"
2) Traditional ERP – involves intense exposure to feared stimuli as means of habituation
3) Meta keeps focused on thoughts WHILE doing behavior
4) "Changes the game"

CBT for OCD - Strategies

4) Challenging Metacognitive Beliefs –

- What is the real problem?
- What is the importance of the thought?

CBT for OCD - Strategies

5) Isolating and verbalizing the Belief –

"What is the evidence thoughts have power to cause events?"

"How is it some of your thoughts have power but not all of them?"

- Manipulate the content of the thought

CBT for OCD - Strategies

6) Behavioral experiments

- Checking behavior
- Rules Games
- Magic Spray" – Facilitates response prevention
- Full Body Exposure

CBT for PTSD

CBT for PTSD

- 60-70% of North Americans experience 1 traumatic event in lifetime
- 8% of Americans develop lifetime ptsd
- 9.2% of Canadians
- Most trauma survivors never develop ptsd sx and majority who do recover
- Women 2x more likely than men
- Most recovery in 1st 3 months
- When persists for 1 yr almost never remits wo tx

CBT for PTSD

- A normal response to an abnormal event that has outlived its scope and usefulness
- PTSD persists when information is processed in such a way that real past threat is perceived as current

CBT for PTSD

- Flashbacks/dissociation
  - Conceptualized as avoidance
  - Therapists often catastraphize
  - Move from flashback to intentional recall
    - Shift from sensory to verbal
    - Create voluntarily vs surprised by
  - Change meaning associated with
    - Eliminate overgeneralization
    - Acceptance/benefits

CBT for PTSD - Stage 1

- Psychoeducation re PTSD
- Psychoeducation re Neurobiology of Trauma
- Explain Rationale for Exposure based treatment & Obtain Consent
- Teach basic skills (grounding, diaphramatic breathing, distraction, relaxation techniques)

CBT for PTSD - Stage 2 - Exposure

- 3 part summary of life

1. Post Trauma (Impact statement)
2. Pre trauma life (emphasis on positives)
3. Trauma Narrative

Impact Statement

- Views of:
  - Self
  - World
  - Safety
  - Trust
  - Power
  - Competency
  - Intimacy

Trauma Narrative

- Hand written
- First person
- As much detail as possible

CBT for PTSD - Stage 3

- Silver Lining Technique
- Reclaim Former Self
- Preemptive nightmare
- Nightmare Rescripting
- Restructure cognitions related to guilt and shame

- Empirically Supported Treatment Protocal: Foa, Clark

CBT for PTSD - PE

- Emerged from emotional processing theory of PTSD
- Emotional processing is mechanism underlying successful reduction of sx
- Goal is to help pts face traumatic memories and situations associated with them
- Fear is represented in memory as cognitive structure that is program for escaping danger
- Structure includes 1) fear stimuli and 2) fear response and 3) meaning associated with

CBT for PTSD - PE

- Becomes pathological when

1) associations among stimuli do not accurately reflect the world

2)Avoidance beh are evoked by harmless stimuli

3) Excessive and easily triggered response elements interfere with daily function

4) harmless stimulus erroneously associated with threat meaning

CBT for PTSD - PE

- Conditions necessary for successful modification of fear structure:
  - Fear structure must be activated, otherwise it is not available for modifications
  - New information incompatible with fear structure must be incorporated

When this occurs, information that used to evoke anxiety no longer does

- Requires deliberate, systematic confrontation with stimuli that are safe or low probability of harming

Prolonged Exposure (PE) Protocol

- **Session 1**
  - **Overview of PE**
  - **Rationale for Tx**
  - **Collect info relevant to trauma**
  - **Teach diaphramatic breathing**
  - **Assign Homework (Listen to first session 1x)**

Prolonged Exposure (PE) Protocol

- **Session 2**
  - **Review Homework**
  - **Educate client re PTSD and Trauma**
  - **Discuss rationale for in vivo exposure**
  - **Introduce SUDS & construct in vivo hierarchy**
  - **Select in vivo assignments for homework**

Prolonged Exposure (PE) Protocol

- **Session 3**
  - **Review Homework**
  - **Present rationale for imaginal exposure**
  - **Conduct imaginal exposure (45-60 min)**
  - **Process imaginal exposure (15 min)**
  - **Assign Homework**

Prolonged Exposure (PE) Protocol

- **Sessions 4-5**
  - **Review Homework**
  - **Conduct imaginal exposure**
  - **Process imaginal exposure**
  - **Discuss plan for in vivo exposure**
  - **Assign Homework**

Prolonged Exposure (PE) Protocol

- **Sessions 6-9**
  - **Review Homework**
  - **Conduct IE focusing on most troubling aspects**
  - **Process imaginal exposure**
  - **Discuss plan for in vivo**
  - **Assign Homework**

Prolonged Exposure (PE) Protocol

- **Session 10**
  - **Review Homework**
  - **Conduct final exposure**
  - **Process imaginal exposure/discuss how perception of trauma has changed**
  - **Obtain SUDS and compare with initial SUDS**
  - **Discuss key learning points in treatment**