COMPASS
HEALTH CENTER

O18 OCD & CA Patient Packet

Name: _____

Welcome to the OCD and Anxiety program at Compass Health Center.

We know making the decision to start treatment is often not an easy one, and we are grateful you have entrusted Compass with your care. Our goal is to work alongside you throughout the treatment process to help you reach your goals, reduce symptoms, and improve your quality of life.

The OCD and Anxiety program at Compass is a specialty program designed to specifically treat obsessive compulsive disorder, and anxiety disorders such as social phobia, panic disorder, agoraphobia, illness anxiety disorder and specific phobia. All treatment programs at Compass are in a group format, with evidence-based modalities including exposure response prevention, cognitive behavioral therapy, dialectical behavioral therapy, and acceptance and commitment therapy.

Exposure response prevention (ERP) in particular will be an integral part of your treatment plan in the OCD and Anxiety Program. ERP will focus on gradually facing your identified anxiety and OCD triggers, without engaging in the typical safety behaviors or rituals intended to decrease anxiety. Over time, engaging in ERP will allow for a reduction in anxiety, creation of safety learning, and improved overall functioning.

Throughout your treatment, there will be material for you to read to educate yourself further about OCD, anxiety disorders and exposure response prevention. The goal of this material is to provide a road map for you to rely on during treatment, and a helpful resource to maintain even after you have discharged from Compass. Below you will find a brief summary of each section of this patient material.

Information on diagnoses treated: Learn more about the symptoms of obsessive-compulsive disorder, social phobia, panic disorder, agoraphobia, specific phobia, and illness anxiety disorder, and how these may impact you.

Specific symptom dimensions of OCD: Take a further look at common symptom presentations of obsessive-compulsive disorder, including violent and sexual obsessions, contamination concerns, religious or relationship obsessions and many more.

Specific treatment modalities and common co-morbidities: An overview of the evidence-based treatments used at Compass: cognitive behavioral therapy (CBT), acceptance commitment therapy (ACT), dialectical behavior therapy (DBT), and information on common co-occurring conditions.

Overview of Exposure Response Prevention: Exposure response prevention as a treatment modality is explained, as well as how you can incorporate an ERP mindset or lifestyle into your everyday life outside of Compass.

Core beliefs and core fears: Information on how to identify the core fears behind your anxiety and OCD symptoms, in order to ensure you are appropriately targeting and challenging these during treatment.

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Accommodations: Learn about what accommodations are, who is doing them for you, ways they can interfere with treatment and how to start challenging these.

Hierarchy building, identifying triggers, SUDS scale: Learn how to identify your specific anxiety triggers, build your own hierarchy of fears list, and identify your subjective units of distress for each item, all of which will be used in ERP treatment on a daily basis.

Tracking progress: How to track progress with exposures, as well as success with resisting rituals and other safety behaviors.

Information on measures and how they support progress: Information about the outcome measures you will complete in treatment that can paint a picture of your progress.

Trouble shooting in ERP: What to do if you run into concerns with ERP, and how to course correct.

Relapse prevention: How to maintain gains you have made in treatment and continue to engage in ERP outside of Compass to help prevent relapse.

We know that starting a treatment program can be overwhelming, and your treatment team is here to help. We want to keep you informed on what you can expect during your time at Compass, and the ways you can help yourself achieve the maximum benefit from treatment. See below for recommendations on how to get the most out of treatment.

Read the patient material each day as assigned. This material will be a review of areas covered in group, and other aspects you are working on in treatment. Do not hesitate to reach out to your primary therapist if you have questions about what you are reading.

Attend program daily, and on time. Make a commitment to yourself to get to treatment each day, and to stay in groups for their duration.

Communicate with your treatment team. Let your primary therapist and prescriber know if you have questions, concerns or need to discuss something.

Engage in exposures daily during allocated program time, as assigned for homework, and throughout the rest of the program day. Find ways to challenge yourself to resist rituals and safety behaviors or approach your anxiety that will help you continue to progress in treatment.

Plan to commit to Compass for the recommended length of stay, which is an estimated 10 weeks in the OCD and Anxiety program between PHP and IOP programs. Data shows that patients who stay in the OCD and Anxiety program for this period achieve more symptom reduction and are more likely to prevent future relapse and re-entry into treatment.

We look forward to working with you throughout your treatment at Compass and walking with you as you begin to challenge your OCD and anxiety symptoms!

Diagnoses Treated in Compass OCD and Anxiety Program

Obsessive Compulsive Disorder

What it is: Obsessive compulsive disorder is characterized by a cycle of unwanted, repetitive thoughts that are distressing to the person (obsessions), followed by a strong urge to engage in repetitive behaviors or mental acts, meant to decrease the anxiety brought on by the obsession (compulsions). While most individuals with OCD report anxiety as the primary emotional response to obsessions and triggers, feeling disgust or "not just right" is also common. Engaging with these obsessions and compulsions is time consuming, highly distressing, and can result in impaired functioning in work, school, relationships, and other aspects of daily life.

How it impacts you: People with OCD often describe feeling controlled by the unwanted thoughts, images, and urges they experience. Obsessions can feel ever present and typically create significant distress. Most people attempt to get rid of or neutralize the thoughts by engaging in time-consuming physical or mental compulsions, which impairs one's ability to live a complete life. All areas of life can be affected including self-care, school, work, maintaining relationships, or even activities like eating and sleeping. Research suggests that everyone experiences thoughts we may find strange, disturbing or out of line with our values from time to time. Individuals without OCD may be able to move on from these quickly, without assigning them excessive importance or power, with their mind accurately sorting them into a "junk" or "unimportant" pile, requiring no further attention. For individuals with OCD, these obsessive thoughts get sorted into a "this must mean something" pile, and the person feels they need to do something to rid themselves of the thoughts/images to ensure physical and/or emotional safety.

What it looks like: OCD will look different for each individual, as it can attach itself to any important theme or idea in your life. While the OCD cycle of distressing obsessions, followed by urges to engage in compulsions is consistent, the content or focus of these can vary greatly. Some presentations of OCD include: unwanted and distressing violent or sexual thoughts; a need for symmetry, evenness or order; excessive concerns such as contamination from germs, dirt, bodily waste, chemicals; and many more. We will talk more about specific symptom dimensions of OCD in a later section. OCD is often considered the "doubting disorder" and is characterized by an intolerance for uncertainty in one or more specific areas, for example: "How can I be sure that I will not act on the scary, violent thought that just popped into my head?" Individuals with OCD often report that they find themselves questioning or doubting the things that are most important to them, increasing their feelings of distress.

Treatment for OCD: Exposure response prevention is the gold standard for treatment of obsessive-compulsive disorder. It is a form of Cognitive Behavioral Therapy that will be an integral part of your treatment at Compass. Studies show a majority of patients with OCD will benefit from ERP and/or medication management. ERP looks at identifying your feared triggers, gradually facing these head on, while refraining from use of safety behaviors such as compulsions and avoidance. The goal of ERP is both habituation (reduced anxiety response over time), and new learning about your ability to handle your experience of anxiety. We will take a more in depth look at ERP in future readings, and how you can incorporate an ERP, "approach vs. avoid" mindset into your everyday life. In addition to ERP, we will also incorporate cognitive behavioral therapy, acceptance and commitment therapy, and dialectical behavioral therapy to support you in areas of cognitive restructuring, distress tolerance, values aligned living and further skill building.

Social Anxiety Disorder

What it is: Social anxiety disorder is characterized by extreme fear of social or performance situations where you may face potential judgement or scrutiny. The individual fears that they may act in a way that would be humiliating or embarrassing in front of others. For some, this fear may be generalized across most social situations, and for others this may be related to specific social situations, such as performing in front of others or meeting new people.

How it impacts you: People with social anxiety disorder often try hard to avoid situations that make them anxious or endure them with significant amounts of distress. For individuals with social anxiety, situations that hold potential for judgement can be a long list, and may include things like attending work or school, talking to others in these settings, eating with others, writing or doing other tasks in front of others, meeting new people, attending a party or other social gathering, and many more. Social anxiety disorder can severely limit the options that feel realistic for individuals when it comes to areas like work, school, social life, and more.

What it looks like: People with social anxiety disorder often avoid situations that involve the perceived risk of judgement, rejection, ridicule or embarrassment. When they do come into contact with these situations, or even when thinking about engaging socially, they may experience significant distress. This distress can present as physical symptoms, such as shortness of breath, and increased heart rate, emotional symptoms like increased nervousness, as well as distressing and often distorted thoughts about other's judgements, their likelihood to be embarrassed, or make a mistake. These symptoms can all contribute to the avoidance behavior often seen with Social anxiety disorder.

Treatment for Social Anxiety Disorder: Using exposure and response prevention (ERP), individuals gradually confront frightening social situations and the potential feared outcomes. The goal of exposure work is to habituate to the anxiety you experience, where this becomes lower over time, and to create new learning. New learning may include that the chances of rejection are typically lower than they may have believed, AND that even if rejection or judgement occurs it is tolerable. Treatment for social anxiety disorder at Compass Health Center will also incorporate cognitive behavioral therapy, acceptance and commitment therapy, and dialectical behavioral therapy to support patients in areas of cognitive restructuring, distress tolerance, values aligned living and further skill building.

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Panic Disorder

What it is: Panic disorder is when an individual experiences recurrent, unexpected panic attacks, and then becomes extremely fearful of another attack occurring. This may result in significant worry about future attacks, or a behavior change related to the attacks, for example no longer doing certain activities or going to certain places where you previously had a panic attack. A panic attack is a discrete period of intense discomfort in which at least four of the following symptoms are present:

- Feeling dizzy, unsteady, lightheaded, or faint
- Derealization (feelings of unreality) or depersonalization (being detached from oneself)
- Fear of losing control or going crazy
- Fear of dying
- Numbness or tingling sensations
- Chills or hot flashes
- Palpitations, pounding heart, or accelerated heart rate
- Sweating
- Trembling or shaking
- Sensations of shortness of breath or smothering
- Feeling of choking
- Chest pain or discomfort
- Nausea or abdominal distress

How it impacts you: People with panic disorder are fearful of panic itself, specifically the physiological symptoms that accompany a panic attack, and the meaning that may have become attached to these. People without panic disorder may still experience situational panic attacks at times, and find them uncomfortable, but do not experience the intense fear, and other functional impairments that go along with panic disorder. It is common for people with panic disorder to avoid people, places, and situations that evoke these physical symptoms, e.g., exercise, driving, drinking caffeine. People may also become fearful and avoidant of previous situations or places where they have experienced a panic attack in the past. This can result in limitations on how people move through the world due to their concerns about experiencing a panic attack, such as the adoption of unhelpful "rules" or safety behaviors, like needing a loved one to be with you while driving, needing to always know where the nearest hospital is, etc.

What it looks like: People with panic disorder become hyper aware of physiological sensations in their bodies, (e.g., quickened heartbeat, dizziness, tingling sensations). These sensations are then misinterpreted as signs of threat (e.g., "I'm dying," "I'm having a heart attack," "I'm going to faint"), which results in a panic attack. Individuals may find that during panic attacks, they engage in behaviors to try to control, put an end to the experience, or ensure their safety through acts such as seeking reassurance from a loved one, leaving their current environment, or going to a hospital. Eventually, every panic attack comes to an end, and individuals with panic disorder are left worrying and anticipating when the next attack may occur, thus continuing the cycle of panic.

Treatment for Panic Disorder: Using exposure and response prevention (ERP), individuals confront the physical sensations that they are fearful of by inducing these symptoms in session in a gradual, systematic manner. These types of exposures are called interoceptive exposures. By confronting these symptoms, we can habituate to the anxiety that accompanies the feeling of physical arousal and create new safety learning that each physical sensation does not necessarily equate to danger. Common interoceptive exposures include spinning (induces dizziness, nausea, light-headedness), breathing through straws (induces breathlessness, dizziness, light-headedness), and running in place (induces racing heart, sweating). ERP for panic disorder will also focus on challenging avoidance and gradually approaching feared triggers associated with panic (places, events, situations, etc.), while disengaging from safety behaviors. Treatment for panic disorder at Compass Health Center will also incorporate cognitive behavioral therapy, acceptance and commitment therapy, and dialectical behavioral therapy to support patients in areas of cognitive restructuring, distress tolerance, values aligned living and further skill building.

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Agoraphobia

What it is: Agoraphobia is when an individual has a marked fear about two or more of the following situations, specifically due to concerns about having a panic attack or panic-like symptoms:

- Using public transportation
- Being in open spaces
- Being in enclosed spaces (e.g., shops, theaters, cinemas)
- Standing in line or being in a crowd
- Being outside the home alone

The individual may avoid these situations altogether or may experience significant anxiety when having to endure them or require a companion to be with them to tolerate them. The anxiety causes significant distress for the individual or interferes with areas of their functioning.

How it impacts you: Individuals with agoraphobia fear that they may be trapped in any of the above situations and be unable to access help or support if they start to have a panic attack, or other potentially embarrassing symptoms. Some individuals with agoraphobia may also experience panic attacks, or meet criteria for panic disorder, however, not all individuals with agoraphobia have this experience. Individuals with agoraphobia often have difficulty feeling safe in new or public places and find that their comfort zone can be very limited, at times just the confines of their home or other select identified "safe" places/situations. This often results in individuals feeling unable to attend things that may be important to them such as an important work conference, a favorite musician performing a concert, or more basic activities of daily living such as taking the train or bus to work or waiting in line at the grocery store.

What it looks like: People with agoraphobia typically avoid the situations that produce fear and anxiety for them. They may have difficulty leaving the home, or may require a companion to be with them when they do go to public places such as the grocery store, a shopping mall, riding the bus, etc. Individuals with agoraphobia may engage in other safety behaviors if they do find themselves in these triggering situations such as identifying an escape route or plan if they start to feel uncomfortable panic like symptoms or begin to feel trapped. This cycle of avoidance and escape often perpetuates the beliefs that these situations are not safe or are unmanageable.

Treatment for Agoraphobia: Treatment for agoraphobia focuses on exposure response prevention to gradually come into contact with feared situations, as well as the emotions, physical sensations and thoughts that come up in these situations. Exposure response prevention helps individuals to gradually face their fears, in order to habituate to the anxiety they feel and challenge beliefs about their inability to handle these situations. Exposure response prevention may focus on spending gradually increasing periods of time alone, outside of the home, and in various environments that are anxiety provoking, while refraining from safety behaviors such as calling a loved one for reassurance, leaving if you experience panic symptoms, etc. Treatment for agoraphobia at Compass Health Center will also incorporate cognitive behavioral therapy, acceptance and commitment therapy, and dialectical behavioral therapy to support patients in areas of cognitive restructuring, distress tolerance, values aligned living and further skill building.

Illness Anxiety Disorder

What it is: Illness anxiety disorder is characterized by an excessive fear of having or getting a serious illness. Individuals with illness anxiety disorder experience these fears despite a lack of symptoms or diagnosed conditions to substantiate them. Individuals with illness anxiety disorder often feel hypervigilant about their health and bodily responses or changes, which they may interpret as signs of a feared illness.

How it impacts you: People who struggle with illness anxiety spend a significant amount of time trying to manage their illness related fears. There are various things people do to manage these thoughts (see below in "What it looks like). Regardless of the safety behaviors or avoidance used, the time dedicated to this is excessive and gets in the way of fulfilling major life roles with work, family, friends or school. For example, someone with a fear of having/getting HIV might check their glands for swelling over and over, to the point that it interferes with their work or school performance. They may also seek excessive reassurance from friends or family, putting strain on these relationships in the process.

What it looks like: People with health anxiety differ in how they manage their fears. Some people engage in frequent checking behaviors, where they are regularly checking their throat for spots, their skin for skin cancer etc. Many people with illness anxiety seek reassurance from loved ones about their health concerns. Some repeatedly seek reassurance from medical professionals. This is called "care seeking" illness anxiety. Individuals may go to multiple doctors or medical professionals looking for reassurance that they are not seriously ill, never quite satisfied in the long term with what they are told. Others may avoid contact with health care providers all together (called care-avoidant illness anxiety) usually out of fear they will be given terrible news about an illness or diagnosis if they do seek care. This can lead to individuals missing important preventative wellness appointments such as yearly physicals, mammograms, etc.

Treatment for Illness Anxiety Disorder: Exposure therapy for illness anxiety focuses on reducing avoidance and decreasing safety behaviors related to your health status. This may involve refraining from things like reassurance seeking, checking for signs of a medical condition, and using Google or Web MD to research illnesses. Exposures focus on helping people increase connections to thoughts and fears of illness and to tolerate these experiences and sensations. For people with the care avoidant Illness Anxiety, exposure will be focused on contact with medical professionals. One of the main focuses of treatment is to learn to accept the inevitable uncertainty that exists around our health status, and to find ways to connect further with the present moment and your values. Treatment for illness anxiety disorder at Compass Health Center will also incorporate cognitive behavioral therapy, acceptance and commitment therapy, and dialectical behavioral therapy to support patients in areas of cognitive restructuring, distress tolerance, values aligned living and further skill building.

Specific Phobia

What it is: Specific phobia is when an individual has a specific fear of an object or situation that is excessive and unreasonable and causes significant distress or impairment in their functioning. Common presentations of specific phobia include fear of certain animals such as dogs, snakes, or insects, fear of heights, closed spaces, blood/injections, storms, flying, throwing up and more.

How it impacts you: Individuals with specific phobia find that coming into contact with their feared object or situation almost always results in an immediate anxiety response, which can include panic attacks, intense fear, and looking for ways to escape. Individuals with specific phobia recognize that their fear may be out of proportion to the realistic threat of the situation, yet this knowledge does not provide relief or a reduction in feelings of anxiety. Individuals with specific phobia typically engage in extensive avoidance behaviors in an attempt to avoid coming into contact with their fear.

What it looks like: For individuals with specific phobia, their life may start to feel limited by avoidance behaviors and rules put in place to avoid coming into contact with their fear. For example, an individual with a phobia of dogs may avoid obvious places such as dog parks, and animal shelters, but may also struggle to visit a friend's home who has a dog, or to walk in the neighborhood where they may come into contact with one. An individual with a phobia of throwing up may avoid situations, people, activities, or objects that they believe may make them more susceptible to vomiting. This could include certain foods, eating outside of the home, and going to school or public places where it may be difficult to get to a bathroom. While some of these avoidance behaviors may be obvious, it is also possible that the individual may engage in more subtle avoidance behaviors such as refraining from watching television/movies or reading books that may have content related to their phobia. For individuals with specific phobia, their fear is reinforced by these avoidance behaviors, creating faulty beliefs that they are only safe because they have avoided contact with their identified fear.

Treatment for Specific Phobia: Exposure response prevention is the recommended treatment for specific phobia and will be an important part of your treatment plan at Compass. For specific phobia, ERP involves gradually coming into contact with your identified fear. For example, an individual with a phobia of spiders may first work on just saying and writing the word spider, then build up to looking at pictures of spiders, watching videos of spiders, eventually walking outside in places where spiders may be, etc. Gradually coming into contact with your identified fear while refraining from safety behaviors will allow for habituation (decreased anxiety response over time), as well as new safety learning. Treatment for specific phobia at Compass Health Center will also incorporate cognitive behavioral therapy, acceptance and commitment therapy, and dialectical behavioral therapy to support patients in areas of cognitive restructuring, distress tolerance, values aligned living and further skill building.

Symptom Dimensions of OCD

If you have had previous treatment for OCD, you may already be familiar with some of the various presentations and ways individuals can experience OCD. However, OCD is often misdiagnosed or goes undiagnosed because of the many different ways that obsessions and compulsions can present. While people may commonly think of OCD as obsessions about germs, or excessive hand washing or checking behaviors, there are many different dimensions of OCD symptoms. People who live with OCD may experience symptoms across multiple dimensions at once and may note that their OCD has shifted over time from one area to a new one. Listed below are some of the common categories of obsessions and compulsions, as well as examples of what this may look like. For individuals living with OCD, it is helpful to understand that these are commonly experienced obsessions and compulsions, although not an exhaustive list. Feel free to highlight or circle any of the areas that you experience symptoms in.

Obsessions: Unwanted, repetitive, distressing thoughts

Contamination: Obsessive concerns about germs, dirt, bodily waste, environmental contaminants, certain chemicals or cleaners, sticky substances/residues, obsessive fears about yourself or others becoming ill from contamination.

Violent: Obsessive fears about harming others or yourself, such as stabbing someone, poisoning someone, harming a child or baby, violent intrusive images of murder, or dismembered bodies, fears of acting on unwanted impulses such as pushing someone in front of a train or swerving into another car while driving.

Sexual: Obsessive thoughts of a sexual nature that are unwanted and distressing, such as violent sexual thoughts, sexual thoughts about family members or friends, or sexual thoughts focused on children or animals.

Relationship: Obsessive, distressing thoughts focused on your partner or the status of your relationship, often characterized by excessive doubting, such as “how do I know if we are actually in love?” or “what if this person is not the right one for me?”.

Religious/Moral: Religious obsessions refer to obsessive concerns about sinning, blasphemy, or somehow violating religious doctrine. This may include obsessive doubts about your own religious beliefs. Religious or moral obsessions can impact individuals across religious traditions, including those who do not identify with a spiritual or religious affiliation at all. Moral obsessions may focus on fear of wrongdoing, harming someone else inadvertently through things like providing bad advice, being dishonest or negligence. These concerns may focus on a sense of over responsibility for other’s well-being or safety.

Symmetry/Order/Perfectionism: Obsessive concerns about things being even, in a certain order or "perfect." This may include obsessions about handwriting, emails or other work/calculations needing to be without error, or books, papers or household items being in a specific order. Symmetry obsessions also could focus on things needing to feel even or "just right" on both sides of an individual's body or in their activities of daily living (walking, touching things, etc.)

Existential: Intrusive and repetitive distressing thoughts about philosophical questions that cannot easily be answered. Examples of this may be obsessions about the purpose or meaning of life, or obsessions questioning reality, or the truth of one's own existence.

Identity: Obsessive thoughts and doubts focused on an individual's identity. For example, obsessions may focus on gender identity or sexual orientation (doubting if you actually are the gender identity or sexual orientation you currently identify with, questioning "how do I really know?"). Other examples may include obsessive fears that you could be racist, sexist, ageist, etc. or concerns that you may impulsively blurt out something that could be harmful to someone else's identity. Identity obsessions may also include concerns about taking on specific qualities of those around you, for example, physical or mental disabilities, economic status, etc.

Somatic: Obsessive concerns about automatic bodily processes such as blinking, swallowing, breathing and more. Somatic obsessions may look like hypervigilance and attention to other bodily processes such as your heart rate, or bladder pressure. Obsessions may focus on fears that your body may not do these processes correctly without being hyper aware and focusing attention on them. Obsessions may also focus on concerns that you will never be able to stop thinking about these processes.

Compulsions: Repetitive behaviors or mental acts intended to reduce anxiety

Cleaning/Washing: Excessive hand washing, showering, tooth brushing, cleaning, toilet or other grooming routines. Excessive cleaning routines of your home or specific areas of your home, car, household items or personal belongings. Behaviors to avoid coming into contact with areas or items perceived as "contaminated" such as having family members throw out garbage for you, or handle certain products/chemicals, or wearing gloves if you are going to come into contact.

Checking: Checking compulsions can be related to several different areas or concerns, such as preventing a mistake, preventing harm from coming to yourself or someone else, preventing something bad from happening, or checking related to bodily/health concerns. Examples may include excessive checking of locks, stove, other appliances being turned off, checking your

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reading or writing multiple times to try to establish certainty that you understood correctly or did not make a mistake, checking multiple times while driving, checking news outlets to ensure there was not an accident you may have caused. Checking can also come in the form of reassurance seeking, for example checking repeatedly with loved ones that you have not done anything to harm them physically or emotionally or checking with doctors that you have not hurt yourself in some way.

Counting: Compulsions that involve counting various objects or during activities you may be engaging in. Examples may include counting tiles on the floor, pictures on the wall, or counting while you are doing something such as washing your hands, or walking. Individuals may feel that they need to count to a certain "right" number, or that they need to be fully focused on their counting without distractions, otherwise feeling compelled to start over.

Ordering: Spending excessive time ordering personal belongings or items in your household, such as books on a bookshelf, papers in a folder, electronic files on your computer in a certain way.

Repeating: Compulsions that focus on repeating or redoing things, such as going in and out of a doorway, brushing your hair, turning a light switch on and off, saying certain things, re-reading or re-writing something until it feels "right" or that you have fully understood it. All of these things may be repeated a specific number of times, or until the individual has achieved a "right" feeling.

Confessing: Confessing unwanted and distressing thoughts, images, urges or sensations to another person. Confession serves a similar purpose to reassurance seeking, in that the individual often confesses thoughts in order to get feedback from another person (explicit or implicit) that they are not dangerous or bad.

Mental: Repetitive mental acts that occur in response to obsessions. This may look like mentally engaging in some of the other identified compulsions such as mentally counting to a certain number in your head or mentally checking by replaying a previous action or situation in your head to try to establish certainty about it. Mental compulsions can also include things like praying in a ritualistic way or replacing bad thoughts with good thoughts in your head to neutralize distress.

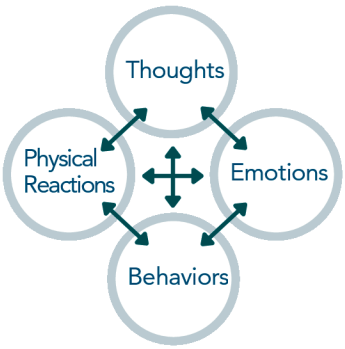
ERP treatment at Compass will target the specific obsessions or compulsions that you experience, as well as core fears and themes that may underlay several of these areas. In future readings, we will talk more about how to identify core fears, and a specific assessment, the Yale Brown Obsessive Compulsive Scale (YBOCS) that we will use to assess the types and severity of OCD symptoms.

Specific treatment modalities and common co-morbidities

In addition to engaging in daily ERP both at Compass and for homework, your treatment program will include a skills curriculum informed by cognitive behavioral therapy (CBT), acceptance and commitment therapy (ACT) and dialectical behavior therapy (DBT). Read below to learn more about each of these treatment modalities.

Overview of CBT

CBT is an evidence-based, present-focused, therapy proven effective for treating numerous different presenting issues including anxiety disorders, OCD, PTSD, mood disorders, and substance use disorders. CBT centers around the interconnectedness of our thoughts, emotions, behaviors, and physiological responses.



Behavioral Interventions

CBT recognizes that physical reactions and emotional states are often beyond conscious control. We can no more choose to stop feeling sad or tired than we could choose to grow wings and fly. There is, however, conscious control over behavior, and to a lesser extent cognition. All human behavior is a choice. We choose how and when to act, and when not to act. CBT recognizes that certain behaviors can directly impact how one feels physically and emotionally and can also impact how or what someone thinks. Behavioral interventions in CBT may include facing fears directly and decreasing avoidance, using role play to prepare for potentially problematic interactions or stressful situations, and increasing engagement in identified pleasurable, rewarding, or healthy activities.

Cognitive Interventions

CBT also notes the connection between thoughts and other parts of the CBT cycle. CBT suggests that the way we perceive a situation can have a direct impact on our emotional response to that situation, as well as our behavioral response. At times, we may not comprehend situations objectively, especially those that cause us distress. Rather we often interpret situations in a distorted fashion due to our core beliefs, assumptions, and automatic negative thoughts. CBT offers skills to reduce distress by helping us to identify our cognitive distortions (errors in our thinking), challenge the validity of our thoughts, and then reframe our thinking towards more realistic, balanced, and helpful cognitions.

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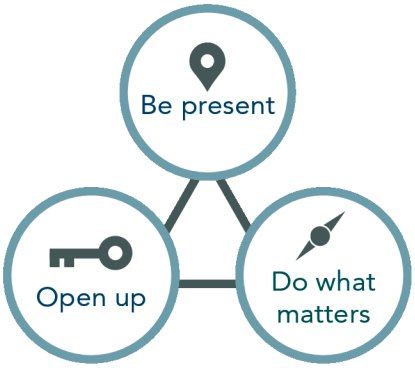
Overview of ACT

Acceptance and commitment therapy, or ACT is a third wave cognitive behavioral model of therapy developed by Stephen Hayes. The first important premise of ACT states that human suffering is often driven by the assumption that our own thoughts are literal and valid interpretations of the world around us. Assuming all that we think must be true regularly elicits significant emotional distress, and this distress drives our behavior. A second key assumption in ACT is that humans regularly engage in futile efforts to control internal experiences. Suffering is magnified as people attempt to control their difficult thoughts and their painful emotions. A third important premise of ACT is that, in the process of trying to control the uncontrollable, humans regularly forsake important and meaningful activities tied to what they value most. This leads to a life not only full of suffering but one devoid of meaning.

- Contact the Present
- Observing Self

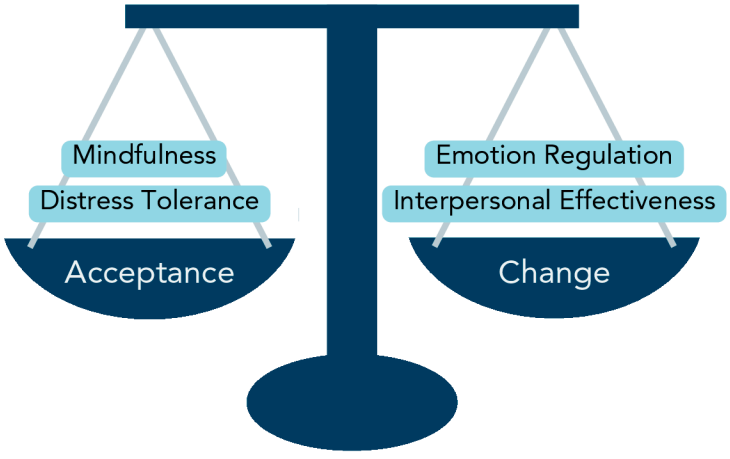


- Defusion
- Acceptance
- Values
- Committed Action

The remedy for these problems, from an ACT framework is "Open up, be present and do what matters". It is human nature to want to control that which is painful or difficult. This is an effective strategy when it comes to managing the environment around us. It is how we as a species have evolved into a complex society. Where this strategy is less effective is when we attempt to control our own inner experiences.

Overview of DBT

Dialectical behavior therapy or DBT is an evidence-based treatment designed by Dr. Marsha Linehan. DBT is effective in treating disorders related to difficulty regulating emotions including borderline personality disorder, depression, PTSD, and eating disorders. DBT skills were designed to help people "increase resilience and build a life worth living" by helping individuals change behavioral, emotional, thinking, and interpersonal patterns associated with problems in living.



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DBT is centered around the dialectic of acceptance and change; we must walk the middle path between the two, balancing acceptance ("I'm doing the best I can", "this is how things are right now") and change ("I need to try differently for things to be different"). DBT skills are organized into four tenets: Mindfulness, Distress Tolerance, Interpersonal Effectiveness, and Emotion Regulation. We often draw this diagram on the board and frame the first two tenets listed as falling more under the Acceptance umbrella and the latter two under the Change umbrella. While at Compass, you will attend groups on skills from all tenets of DBT, focused on support in learning to both regulate and tolerate intense emotional experiences.

Many individuals with OCD or an anxiety disorder also experience depression and vice-versa. Mood disorders and OCD or anxiety disorders are two of the most common co-morbid psychiatric conditions. We know that these conditions impact and influence one another. Depressive symptoms may already be present, or develop due to feelings of hopelessness, distress and isolation that can go hand in hand with OCD or anxiety.

For OCD specifically, there are other common co-morbidities including anxiety disorders such as GAD or panic disorder, neuro-developmental disorders such as attention deficit hyperactivity disorder, or obsessive-compulsive related disorders such as hair pulling or skin picking (trichotillomania or excoriation disorder). Your treatment at Compass will focus on treating the whole person and addressing comorbid diagnoses and symptom presentations with the use of evidence-based treatment, including ERP, CBT, DBT and ACT.

Overview of Exposure Response Prevention

Exposure Response Prevention (ERP) is a type of cognitive behavioral therapy in which an individual purposefully and repeatedly comes into contact with fears (thoughts, situations, physical sensations, etc.), without the use of safety behaviors or compulsions, with the goals of decreasing anxiety, and learning to relate to their anxiety in a different way. ERP is evidence-based treatment for OCD and anxiety disorders, and will be a focus of your treatment at Compass.

Oftentimes, OCD and anxiety disorders can influence the ways we engage with life and how we choose to respond in challenging situations. The goal of ERP is to build our ability to tolerate discomfort, so we can be more flexible with our responses and make choices aligned with our values, rather than with what anxiety dictates for us.
Individuals have the potential to learn the following from ERP:

1. Anxiety, like any other emotion, does decrease over time, with nothing but the passage of time, and without the use of compulsions and safety behaviors.
2. Anxiety often predicts far worse outcomes (internally and externally) than reality proves.
3. Even when undesirable outcomes occur, individuals are able to get through the external experiences and can tolerate the internal discomfort more effectively than they typically believe.
4. Individuals can live out a meaningful, values-driven life in the face of anxiety.

There are multiple different types of exposures that you will engage in during ERP. Different types of exposure will be appropriate or most helpful at different times during treatment, and it is likely you will engage in all the different kinds of exposure during the treatment process. Read below to learn more about the different kinds of exposures.

In-vivo exposure: Coming directly into contact with feared situations, objects, thoughts, etc. For example, In-vivo exposures may include touching feared surfaces, driving, giving a speech, speaking to a stranger, etc. In-vivo exposures are powerful because they give you the opportunity to identify your feared outcome and directly prove or disprove the occurrence of this when you come into contact with your feared stimuli. For example, if Mary believes she will become sick if she touches the public door handles without using a barrier, and then does this, and does not in fact become sick after, this is helpful data for her to take in.

Imaginal Exposure: Imaginal exposures are designed to allow you to confront your feared beliefs/outcomes through vivid imagery and speech. Imaginal exposures may be helpful when in-vivo exposures are not always possible. Imaginal exposures may also be lower-level items on your hierarchy to begin with and build your way up to corresponding in-vivo exposures.

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Imaginal exposures can also be helpful in acknowledging and sitting with the core fears behind the symptoms you experience. For example, Mary in our above example may have first started with imaginal exposures of writing out a worst-case scenario about touching the public door handles and becoming sick prior to actually engaging in this. In writing this scenario, Mary may also have found that these symptoms are actually rooted in a fear of then getting her family sick and being responsible or guilty because of this. Writing the worst case scenario about touching door handles may have been helpful in Mary developing this insight and zooming in on her core fears. Examples of imaginal exposure include worst case scenarios, sitting with a specific feared thought or outcome, writing uncertainty statements, and more.

Interoceptive Exposure: Interoceptive exposures are often used for individuals with panic disorder. Interoceptive exposures are physical exercises designed to simulate the symptoms of a panic attack. This kind of exposure exercise allows individuals to recreate the feared physical symptoms they experience during a panic attack in a controlled, safe environment. The goal of interoceptive exposure is for the associated fear with these symptoms to decrease over time as well as to create new learning about your ability to tolerate these physical symptoms. Examples of interoceptive exercises may include running in place, spinning, hyperventilating, breathing through a straw, sitting facing a heater, in order to purposely induce common symptoms of panic attacks including shortness of breath, dizziness, chest tightness, or heat flashes. Interoceptive exposures can also be combined with other exposures, particularly when the individual experiences significant physical symptoms of anxiety, with or without the presence of panic disorder.

ERP at Compass and Homework

ERP at Compass involves an individual and their treatment team working collaboratively to determine what would be most helpful in addressing their anxiety. Together, we create a hierarchy of fears, as well as identified safety behaviors, that will function as an outline for our work together. We will then design exposures for Compass as well as daily homework assignments outside of Compass. There are several reasons for this:

1. The more opportunities we have to approach our anxiety and identified fears, the more likely we are to experience habituation and helpful new learning

2. There are some situations that we cannot re-create in program

3. It can be useful to practice coming into contact with anxiety across different contexts.

4. ERP is most helpful to think of as a lifestyle of approaching vs. avoiding the things that cause us distress. This mindset is something you can connect with and practice regularly outside of Compass, and long after you have ended treatment here.

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ERP at Compass also involves de-briefing after exposures to process what you may have learned, what surprised you, and what discrepancies exist between anxiety's predictions and reality. These "take-aways" help generalize the benefits of a given exposure so that it can be applied to other contexts.

We also involve family and loved ones when it is deemed helpful. Family accommodation refers to ways in which family members take part in the performance of rituals, avoidance of anxiety-provoking situations, or modification of daily routines to assist a relative with anxiety. By looking at the ways in which families respond to the individual's anxiety, we are able to not only support the family but also reduce ways in which they might be impacting the individual's progress in ERP.

ERP can be both challenging AND rewarding – we look forward to working together through both.

Guidelines for Conducting Exposure (Abramowitz et al., 2019)

1. **Prepare to feel anxious during exposure.** It is normal to feel uncomfortable when doing exposure therapy. In fact, feeling anxious is a sign that you are doing exposure correctly. Your job is to remain in the situation, despite the anxious feelings, so you can learn that anxiety is safe and tolerable.

2. **Don't fight the anxiety or fear-learn into it.** Think of anxious feelings as the raw materials of change. Instead of fighting or resisting them, notice these feelings and body sensations and let them be there. Better yet, push yourself to bring them on. Remember that anxiety is a natural response to the perception of threat.

3. **Do not use safety behaviors or anxiety reduction strategies before, during or after.** In order to work properly, exposure practices must be completed without safety behaviors, reassurance seeking, distraction, medications, alcohol or other anxiety reduction strategies that make you feel safer or that prevent you from becoming anxious. Even very small or brief safety behaviors can block the benefits of exposure. An important goal of exposure is to learn that you don't need safety behaviors or anxiety reduction strategies.

4. **Use exposure to learn something new.** Before starting each exposure practice, identify what you are afraid will happen when you confront this situation without using safety behaviors. Then think of the exposure as an opportunity to test your predictions. Remain in the situation (or repeat the exposure) until you have learned something new. Afterward, consider what the experience has taught you. Did the feared outcome occur? Was it as awful as you expected? Could you tolerate the fear and anxiety? Did it decrease over time? Have your thoughts about the situation changed?

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5. **Surprise yourself.** The more you are taken aback by what happens during an exposure practice, the more the experience stands out and gets encoded in your memory-and this helps with extinguishing your fear. So don't seek out information to reassure yourself that everything is going to be ok. Let yourself be surprised.

6. **Vary the intensity of exposures.** Although you will start with lower-level exposure items, changing up the degree of anxiety you experience with each exposure helps you learn that you can manage even high levels of anxiety and fear. Try to choose practices that are challenging but not so difficult that you will not complete them.

7. **Practice in different settings.** Confronting your fears in new and different settings helps to solidify your improvement. Practice with your therapist, with friends or family members (if applicable) on your own, and in different places that trigger your fear.

8. **Practice every day.** The more often you practice exposure, the quicker you will learn that your feared situations are safer than you think and that you can manage the feelings of anxiety. Invest the time and effort up front so your fears don't get the best of you in the long run.

Core Fears

Core fears are the underlying feared outcome of coming into contact with our identified triggers during ERP. This may look different from the surface level feared outcomes we can readily identify, such as "my hands will feel dirty, I will be embarrassed, I will get sick," etc. Core fears may not always be readily known even to us, and it can be helpful to start to zoom in and identify what these are.

Understanding your underlying core fears will allow you to target these during ERP, creating for more effective treatment that appropriately addresses your specific concerns. This allows you to build your distress tolerance and ability to accept uncertainty in the areas where this is challenging. For many individuals with OCD or anxiety disorders, they find they are able to accept and tolerate uncertainty in several areas of their life, but struggle with a need for certainty or control in one or more identified spaces. Core fears are often the ultimate reason someone engages in compulsions or safety behaviors-in an attempt to control and prevent the core fear from being true.
Core fears are individual to each person, and it would be impossible to identify all of them. Here are some common core fears often seen in individuals with OCD or anxiety:

Fear of living inauthentically | Fear of being an irresponsible or careless person

Fear of abandonment or rejection | Fear of being a "bad" or immoral person

Fear of losing control | Fear of not truly knowing oneself | Fear of death

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We can identify core fears by asking specific questions about our identified anxiety triggers, obsessive thoughts, and safety behaviors or compulsions. It can also help to further clarify your values, as core fears often are related to what you value most. See below for questions that can help establish core fears. Your therapist may ask you these questions about different triggers or exposures you engage in to help increase your awareness and understanding. Let's take an example below for Matt, who is struggling with OCD.

What if that were true?

If that were true, what would it mean?

Let's say my thoughts were true, why would that bother me?

What would be so bad about that?

If that thought was true, what is the worst thing that would happen?

If that were true, what would that say about me?

If that thought were true, what would that mean about my future?

Matt has obsessive fears about something happening to their home or family, such as a fire starting, someone breaking in, or him or his family getting carbon monoxide poisoning. These obsessive fears lead to increased physical checking behaviors of the stove, smoke and other detectors in the home, door locks, as well as mental checking to attempt to establish certainty that the home is secure. When Matt is asked about the fears associated with these OCD symptoms, it may seem fairly straightforward. Matt shares that his fears are that his home will burn down, that we will be robbed, that my family will be harmed in some way.

We can likely all agree that each of these things would be devastating, undesired events. But for people without these specific OCD symptoms, they are able to live with the uncertainty that exists in these areas, taking basic precautions without excessive rituals. However, for someone with OCD, these specific obsessions may be indicative of a core fear the person experiences, that leads them to try to eliminate any uncertainty in these areas of safety. See below for how we may help Matt to identify his own core fears to further individualize his treatment.

Matt: *"I have to check the stove, doors and detectors in the house each night. Once or twice never feels quite enough. I have to go back and do it more if the doubt comes in, because I can't bear the thought of something happening when I could have prevented it."*

Let's now imagine Matt is assigned exposure HW to lock the front door once without checking it, and to sit with the thought "Maybe I didn't lock it right, someone could break in and robs us." Below, we can see how asking some of these questions may help Matt identify his underlying core fear.

Q: If that thought was true, what is the worst thing that would happen?

A: *That my family or home could be harmed in some way.*

Q: If that were true, what would it mean?

A: *That my family or home was harmed, and I could have prevented it in some way.*

Q: If that were true, what would that say about you?

A: *This is evidence that I am an irresponsible person.*

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Matt can use this understanding of his core fear "being an irresponsible person" to inform the exposures he engages in going forward, ensuring they target this area. Matt can learn to accept uncertainty and tolerate distress around this specific fear, which could show up as various OCD themes throughout his life (contamination concerns, checking behaviors, etc.) While the focus of symptoms may shift over time, if Matt understands the underlying fear, he can build confidence through ERP in his ability to face these fears head on.

Let's practice below. Identify a specific thought you have when coming into contact with one of your anxiety or OCD triggers. For example, your identified trigger might be walking closely by others in a crowded place. The thought or obsessive fear you experience when coming into contact with this might be: "What if I lost control and pushed someone" After identifying these, answer the questions below to better understand your own core fears.

Trigger: _____

Thought: _____

What if that were true?

If that were true, what would it mean?

Let's say my thoughts were true, why would that bother me?

What would be so bad about that?

If that thought was true, what is the worst thing that would happen?

If that were true, what would that say about me?

If that thought were true, what would that mean about my future?

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Safety behaviors, compulsions and avoidance

Safety behaviors are behaviors that are carried out (either overtly or covertly) in specific situations in an effort to prevent feared outcomes and reduce anxiety.

Many safety-seeking behaviors are helpful and adaptive when the concern is real and the behavior can genuinely reduce danger, such as looking both ways before crossing the street, or bringing your inhaler when you go for a run (if you have asthma).

When safety-seeking behaviors concern perceived threats rather than actual dangers, they are often unnecessary, excessive and can serve to exacerbate and maintain anxiety. Some of the main functions of safety behaviors seen with OCD and Anxiety Disorders are to reassure, avoid, control, or distract us in order to reduce anxiety.

When we engage in safety behaviors where there is not an objective threat, we often misattribute the lack of occurrence of the feared outcome to the safety behavior and not to the low probability of the feared outcome. This leads to the perpetuation of the fear and increases our belief in distorted thoughts about needing to perform these behaviors to maintain safety.

For example, take Carrie who has obsessive fears related to contamination and getting her or family sick. Carrie avoids touching the bathroom door handles at work due to her concerns it could lead to her becoming ill. Instead, she engages in a safety behavior of using a paper towel to open these doors. In the short term, Carrie feels decreased anxiety, and assuming she has not been sick recently, is likely to attribute her health and lack of illness to the fact that she is using towels to open the bathroom doors (vs. the reality of good luck, strong immune system, timing, etc.) Carrie may start to think that she should take additional steps to protect herself from illness, such as using towels or other barriers to touch all door handles and public surfaces. We can see where the use of safety behaviors provides an illusion of control and can quickly become unworkable as we add more of these into our daily lives.

An important part of treatment is building awareness of your own safety behaviors, understanding the way they actually maintain your anxiety over time, and beginning to challenge and reduce them. When you are able to disengage from safety behaviors and allow yourself to experience feelings of anxiety as they are, without efforts to control, your life often becomes more manageable and flexible. We also serve to change our relationship with anxiety itself, learning that it is an acceptable experience that will reach a high point and come down on its own over time, and that we do not need to use safety behaviors to attempt to control it.

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For individuals who have OCD, you may find that your safety behaviors are mostly time-consuming compulsions, those physical or mental acts you perform in response to your obsessive fears in order to reduce distress. For others, such as someone who experiences social anxiety, they may find that avoidance is their main safety behavior, avoiding situations, places and events that could involve meeting new people, public speaking, socializing with others and potential judgement. Read the list below for examples of common safety behaviors.

- Excessive research
- Reassurance seeking from self or loved ones
- Substance use
- Compulsions (checking, cleaning, repeating, mental processes etc.)
- Distraction (music, podcasts, humor)
- Rules about how things "have" to be done
- Family Accommodations (loved ones doing things for you or in a certain way to reduce your anxiety)
- Avoidance (i.e. dirt, germs, touching certain things, leaving the house, being put on the spot, spinning, feeling full, etc.)
- Carrying belongings
    - Water bottle
    - Medications (nausea, prn antianxiety meds/home remedies)
    - Mints/gum for fresh breath
    - Deodorant for fears around sweating/smelling
    - Superstitious items

Now see if you can start to identify some of the safety behaviors or compulsions you engage in to try to reduce your experience of anxiety. List any of these below and be as specific as possible. Building awareness of these behaviors or mental acts and gradually reducing them will be an important part of your treatment.

Safety behaviors I engage in:

Cost/benefit decisional balance

Making any kind of behavior change can be challenging, and in treatment, we are asking you to make two significant behavior changes consistently in ERP-to approach what makes you anxious as opposed to avoiding it, and to resist engaging in any of the normal safety behaviors you do to reduce your anxiety.

One helpful tool for exploring motivation for change can be to examine the costs and benefits of making a change vs. staying the same. While we may believe that we know and understand why we behave the way we do, it can be helpful to get this out of our head and onto paper to allow us to take a more objective look. You may hear this referred to as a 2x2 in skill groups at Compass- exploring the pros and cons of both making a change and staying the same.

When we think about this in the context of OCD and anxiety, the changes we are considering making will often be connected to some of these areas:

- **Coming into contact with something you have previously avoided** (a triggering thought, situation, person, place, event, physical sensation, etc).
- **Resisting the use of safety behaviors, you had previously used to reduce anxiety** (Decreasing/eliminating hand washing or other cleaning rituals, decreasing checking behaviors, asking family members not to provide reassurance to you, eliminating googling of symptoms online, etc.)

These are just some examples of the changes you may be considering weighing the costs/benefits of. It may be helpful to do a decisional balance for bigger picture areas, such as what are the pros and cons of disengaging from safety behaviors and avoidance altogether, particularly in the start of treatment. It also may be helpful to zoom in on more specific changes you are looking at making in the treatment process to better understand the potential benefits as well as drawbacks you can expect when making a change.

Let's look at an example for Lucy, who has a diagnosis of panic disorder. Lucy has been having panic attacks 1-2 times a week for the last 8 months and has become increasingly fearful of certain situations that she fears are more likely to trigger another attack. Lucy has stopped driving on the highway due to her concerns she could have a panic attack. She has also stopped exercising at the gym, which was a previous part of her daily routine, as she feels more anxious when her heart rate is increased. Lucy has started to ask her partner to go with her places that she would have previously gone on her own such as the grocery store, library, mall, so that there is a safe person with her if she starts to have a panic attack.

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3 different times in the last 8 months Lucy has taken herself to the emergency room during a panic attack, due to concerns that she was going to die from a heart attack. Let's zoom in one of the changes Lucy is considering making early on in her treatment, and what a decisional balance may look like for her.

The change Lucy is considering is returning to working out at the gym 2-3 times a week. Below, she will use the 2x2 table to examine the pros and cons of making this change, and of not making this change in order to fully examine all of her options.

Pros of Change	**Cons of Change**
Return to something I love to do Physical, mental and emotional health benefits from exercise Get to see my friends at the gym Challenges my anxiety to put me more in the driver's seat	May feel uncomfortable or anxious if I experience increased heart rate while exercising
Pros of staying the same	**Cons of staying the same**
Feel like I am more in control One less situation to be uncertain about-can't have a panic attack while working out, if I am not working out	Continue to miss out on something I love, and I know is good for me May continue to feel frustration, resentment, anger at my partner when he goes to the gym Could lead to avoiding other enjoyable situations in the future

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Completing this decisional balance can allow Lucy to take a closer look at the potential pros and cons of making behavioral changes as it relates to her anxiety. This in turn can allow her to examine and weigh out which of these potential consequences are most in line with her values and help with her decision making about change. Try this exercise for yourself below. Identify one specific change you may be asked to make or are thinking about making as it relates to your OCD/Anxiety treatment. Maybe it is coming into contact with something you have been avoiding or eliminating a specific safety behavior or ritual. Use the 2x2 below to zoom in on some of the potential pros and cons.

Pros of Change	**Cons of Change**
Pros of staying the same	**Cons of staying the same**

Accommodations

Accommodations are a specific safety behavior we will learn more about in treatment. In the context of OCD/Anxiety treatment, accommodations refer to the way people around us may make space for, or change/modify their own behavior to fit the demands of our OCD or Anxiety. Accommodations are a safety behavior or form of avoidance that other people engage in.

Accommodations may help relieve our anxiety or distress in the short term but worsen symptoms in the long run. Accommodations from others rob us of opportunities to practice managing our distress and teach us that we are only able to tolerate certain situations with these accommodations in place. To accommodate literally means to give consideration to, allow for, or make room for (definitions from Meriam and Webster Dictionary). While accommodations are necessary in many areas of life, it is unhelpful when we make excessive accommodations to make room for or fit the needs of our OCD or anxiety. Doing so can not only impact our relationships but can often make our lives more challenging and move us away from our values.

It is important to note the difference between accommodation and healthy support from family and friends. We all adjust in our daily life to support the needs, wishes and desires of those around us. This is often just a matter of being considerate, a good friend, etc. For example, if your friend is coming over for a dinner party and you know she is a vegetarian, it is likely you will accommodate her diet by preparing a vegetarian option to eat. This is an accommodation that feels helpful and supportive. However, if a friend is coming over who struggles with contamination OCD, you may find yourself trying to accommodate by not serving a family style meal although you otherwise would have, putting them next to specific guests who they report feeling are safer/cleaner, or delaying serving dinner until they are complete with handwashing rituals. These behaviors are also accommodations, and in the long run actually increase our anxiety, and our feelings of being unable to cope/manage. Accommodation can take many forms and will look different for each person. However, there are some common ways that those around us may participate in our anxiety or try to keep our distress at bay.

- Getting reassurance from others
- Having others provide items needed because of anxiety
- Having others participate in behaviors related to anxiety (compulsions, rituals or other safety behaviors)
- Letting my reaction to distress hinder someone's ability to go certain places or be with certain people
- Having others change their routine
- Having others do my daily responsibilities for me
- Having others modify their schedule
- Having others modify their leisure activities

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Accommodation is very often a part of the Anxiety cycle for individuals who struggle with OCD or an anxiety disorder. This is because it is normal for those around us who care about us to seek to relieve our distress. If they believe they can do this by modifying their own behaviors, it often not only makes us feel better temporarily, but it also provides them relief as well, at not having to see their loved one uncomfortable in the short term. The problem with these kinds of accommodations for OCD/anxiety are multifold:

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1. We build a tolerance for them, and believe we need more accommodations over time in order to manage.

2. Accommodations reinforce unhelpful behaviors and beliefs, both for the individual accommodating and the person being accommodated. (Ex: “I cannot handle this situation without my partner” AND “My partner would never be able to handle this if I were not there with them.”)

3. Continual accommodation from others creates a collapsed boundary with your loved ones. Your anxiety becomes a shared anxiety and can often increase both conflict and feelings of co-dependence.

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We can work to reduce accommodation by:

- Building awareness – start to notice and track when those around you are engaging in accommodations for your OCD/anxiety.
- Creating a cope ahead plan for you, family/friends, (i.e. how can they be supportive of you without being accommodating of your OCD/Anxiety?)
- Set gradual and specific goals. The accommodations in place now did not happen overnight, so identifying a plan to gradually and mindfully start reducing them will likely be most helpful. How will you track this? Will you decrease a specific accommodation to start?
- Engaging in exposures on my own- challenge beliefs related to ability and uncertainty.

Let's start here! Use the table below to identify some of the specific accommodations that people in your life engage in around your OCD or anxiety symptoms. Identify what the accommodation is, and who provides it (For example: Mom opening doors for me so I don't have to touch them).

Accomadation	Who provides it

Hierarchy building, identifying triggers, SUDS scale

Prior to engaging in ERP, you will create a hierarchy at the onset of treatment. This serves as a guide through treatment of exposures to plan for and engage in. A hierarchy is an individualized list of stimuli (events, objects, people, thoughts, physical symptoms etc.) that provoke anxiety. Your hierarchy will rank these items in order of their Subjective Units of Distress (SUDS a 1-10 scale).

A SUDS scale is used to indicate your level of anxiety, at any given time, and will be used frequently during exposure to monitor where your distress is at. You will be asked to note your SUDS level before starting an exposure, during the exposure, and after an exposure. SUDS is one of the main ways we can measure habituation, reduction of anxiety over time. It is helpful to familiarize yourself with the descriptions of the different levels on the SUDS scale below and start to personalize what this may look like for you.

10	Highest point of anxiety, could be experienced as a panic attack or overwhelming anxious thoughts and feelings
9	Extremely high anxiety, feeling intensely uncomfortable and scared
8	Highly anxious and uncomfortable, mind and body look for ways to escape
7	Moderately high anxiety, starting to feel tense, difficulty focusing, urges to engage in safety behaviors to reduce feelings of anxiety.
6	Moderate to strong anxiety, distress that is becoming more noticeable
5	Moderate anxiety, feeling uncomfortable due to worries or fears
4	Mild to moderate anxiety that you are starting to notice more
3	Mild anxiety, slightly worried, but still able to focus
2	Minimal anxiety, easily able to continue with activities
1	No noticeable anxiety, alert and focused
0	Absence of anxious feelings, calm, connected to the present moment, peaceful

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Hierarchy building involves examining the exact conditions that maintain the fear response. This involves identifying the antecedents (fear cues) in the environment, the feared consequences of the situation/stimuli, as well as the context in which the fear response occurs in, and the responses (e.g. safety seeking behaviors) that the fear elicits. See below for questions that may be helpful for you to consider while you are building out your hierarchy.

- *What are situations that you know the fear/anxiety will rise?*
- *Are there specific thoughts, memories, objects, people, bodily sensations that trigger this specific anxiety?*
- *What are ways that I can approach these situations, thoughts, memories, objects, people, sensations that trigger anxiety, both at Compass and at home?*
- *What are the feared consequences of exposure to these triggers? What is the worst-case scenario in terms of outcomes?*
- *What are the things you avoid in hopes of controlling anxiety or preventing those negative outcomes?*
- *Other than avoidance, what behaviors do you engage in to manage or control anxiety or prevent the negative outcomes from happening?*
- *How do you believe the safety behaviors prevent the feared outcomes from occurring?*
- *What are the feared consequences of not completing those safety behaviors?*

Each item on the hierarchy will also list the corresponding safety behavior the patient previously used, and exposures will target coming into contact with your fears while resisting these normal safety behaviors. The hierarchy also lists the feared outcome for facing each identified trigger. You will identify your feared outcomes prior to engaging in each exposure, in order to ensure we are targeting your core fears, and to get data on how often your feared outcomes occur, and whether or not they are manageable.

As you list triggers on your hierarchy, it will be helpful to also start brainstorming ways you can come into contact with these triggers both at Compass, and at home for homework. This will be through a combination of both in vivo and imaginal exposures as we discussed earlier.
When engaging in ERP, you will ideally aim to start with exposures that fall in the middle of your SUDS scale, somewhere between a 4 and a 6, or anxiety triggers that feel challenging, but manageable to approach. From here, you will focus on staying in contact with those triggers and taking note of the way your anxiety changes over time, and the learning that occurs. A goal for each exposure you engage in, is to stay in contact with your identified anxiety trigger, until you feel your SUDS decrease in half.

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For example, if you start an exposure of sitting with a specific intrusive thought written out about harming a loved one, and your SUDS begins at a 6, you will want to stay in contact with that thought, re-reading it silently or out loud to yourself, until you feel your SUDS decrease to a 3. This means your distress response has decreased significantly, or that you have habituated during this trial of the exposure. It may mean it is time to make the exposure exercise slightly more challenging, or to engage in a different exposure activity from your hierarchy. Looking ahead, it may be helpful to also repeat this same exposure exercise the next ERP session in order to continue practicing coming into contact with this fear and noticing if your SUDS level changes between trials. For example, when repeating this exposure the next day, you may notice that your SUDS is now starting at 4, as opposed to a 6. This is helpful data that you are also habituating to your feelings of anxiety between trials of exposures.

Overtime, you will work your way up to increasingly higher rated items on your hierarchy. You may notice that as you work your way up to items you had initially rated an 8, 9 or 10 on the SUDS scale, these levels may feel lower as you build confidence and create new learning completing lower-level exposures. Much of this safety learning from lower-level exposures will generalize to higher level items. See below for an example of a hierarchy for an individual with OCD, specifically violent intrusive thoughts.

The specific problem I am working on: OCD-Harm Intrusive Thoughts

Triggers (People, places, thoughts, images, and situations that increase anxiety)	**Anxiety Rating** How anxious does this make you feel on a scale of 1-10? (1 = least anxious)	**Fear Rating** Describe what you are fearful of	**Safety Behavior** What do you do to reduce or avoid feeling anxious?	**Willingness** How willing are you to work on this on a scale of 1-10? (1 = least anxious)
Seeing a knife in the kitchen	8	I will lose control, use the knife to hurt someone	Avoid using knives, ask spouse to get rid of knives	4
Driving my car	5	Hitting someone while driving, or being unsure IF I hit someone	Drive back to check route, mentally replay drive	8
Movies about true crime, serial killers	8	I will see myself in these people, ideas or images will get stuck in my head	Avoid movies, identify reasons why I am a good person, argue with thoughts	4
Thoughts about harming a family member	7	Thoughts will never go away, I will snap and act on thoughts	Identify all reasons I love my family member, pray for forgiveness, punish myself for my thoughts	5
Watching the news	4	I might see a story and obsess about if I am capable of doing that	Avoid watching the news	8
Going to church	8	I will have terrible thoughts and God will be able to tell I am a bad person	Leave church if I start to have intrusive thoughts	9

Your therapist will provide you with a blank form of the above hierarchy, so that you can begin to fill this out for yourself. First, you can start to gather some ideas of what each level on the SUDS scale would look like for you. What might be some of the potential triggers or anxiety stimuli at each number to put on your hierarchy? What might be some of the symptoms or sensations you experience at each level on the SUDS scale?

(Continued on next page)

Hierarchy

Date: _____

The specific problem I am working on: _____

Triggers (People, places, thoughts, images, and situations that increase anxiety)	**Anxiety Rating** How anxious does this make you feel on a scale of 1-10? (1 = least anxious)	**Fear Rating** Describe what you are fearful of	**Safety Behavior** What do you do to reduce or avoid feeling anxious?	**Willingness** How willing are you to work on this on a scale of 1-10? (1 = least anxious)

SUDS	Potential triggers, symptoms
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

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Tracking Progress

Monitoring your progress in ERP is helpful for many reasons. Tracking your progress with exposures allows you to adapt and adjust ERP as needed. Having a record of exposures you have engaged in can also help with maintaining motivation when challenges inevitably arise. There are multiple ways that you will track progress with ERP while at Compass.

The first way is by logging and tracking each of the exposures you engage in during program. Below is a picture of the exposure log you will keep in your binder/folder. Each time you complete an exposure, you will first detail your exposure plan, your feared outcome, and your goals and objectives. Then, you will engage in the exposure, and upon completing, note your distress levels and your takeaway learning. These logs will serve as a record of the exposures you have completed during treatment and will be helpful to look back on as a reminder of the progress you are making.

Exposure Plan **Detail your plan here:** What will you do to come into contact with your anxiety? What safety behaviors and compulsions will you remove?	**Feared Outcome** **Name your worries:** What are you worried is going to happen? What do you think you can't tolerate? What does your anxiety tell you will happen as a result?	**Goals and Objectives** **Remember your "why":** How does this exposure support your goals and treatment objectives? Why is this meaningful to you?	**Tune in** **Assess your distress:** Track distress level 1-10: before, during, and after the exposure.	**Reflect** **What's your takeaway?** What did you learn about yourself, your capabilities, and/or your anxieties? How did the actual outcome compare to your feared outcome?
			Before: During: After:	

You will also fill out an exposure homework log each night to document what exposures you will be working on for homework. See below for a picture of the HW logs that you will keep in your binder. You will complete the top half each day in program, documenting the exposure homework you plan to complete that night, and the bottom half at home after completing your assigned homework.

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Exposure Homework

Date: _____

This homework is to be done:

Monday night ☐ Tuesday night ☐ Wednesday night ☐ Thursday night ☐

Exposure to be completed		
What I will do:		
When I will do it:		
Willingness Rating 1-10:	Feared outcome:	Value pursued:

Exposure Takeaways	
Highest SUDS (1-10, 10 being the highest)	Takeaways:
Other insights:	
Future exposure ideas:	

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Another way to track progress in treatment, particularly for individuals with OCD, is to focus on ritual prevention. Your treatment team may first ask you to track how often you are engaging in specific rituals such as handwashing, checking, mental rehearsing, etc. Getting baseline data on how often these compulsions are occurring is helpful in setting goals and targets to reduce these safety behaviors. You might focus on one specific compulsion such as checking multiple times that items in the house are turned off (stove, sinks, oven, etc.). Your treatment team may ask you to track throughout a period of time (an evening, a whole weekend) how many times you have the urge to engage in these checking compulsions. You will also track how many times you are able to "resist" completing the compulsive act, and how many times you "submit" to engaging in the compulsion. This can help with awareness building and allowing more time and intention for you to act, vs. react to these urges. It also allows you to track progress over time as you work through your treatment program, and you notice fewer urges, and more success with resisting engaging in them.

Information on measures and how they support progress

An important part of your treatment at Compass will include completing and reviewing outcome measures with your treatment team. The outcome measures used at Compass are typically self-report, validated assessments that ask questions about specific symptoms you are experiencing, and the level to which they impact you.

Outcome measures are typically given at the onset of treatment, throughout the treatment process, and again at discharge. The measures you complete are one way to ensure that your voice, and perspective is at the forefront of every decision in treatment, such as when to transition to IOP, or when you may be ready for discharge. Outcome measures provide data points to look at symptoms over time, and your progress in treatment. Outcome measures at Compass can be easily completed online via the patient portal, or on pen and paper while on site in program. See below for information on some of the specific outcome measures Compass uses to monitor progress. Please note that you may not complete all of the measures below, as some are diagnosis specific.

Patient Health Questionnaire (PHQ 9): Outcome measure for depressive symptoms. 9 question screener that look at presence of specific problems associated with depression over the last 2 weeks.

Generalized Anxiety Disorder (GAD 7): Outcome measure for anxiety symptoms. 7 question screener that looks at presence of specific problems associated with anxiety over the last 2 weeks. Warwick-Edinburgh Mental Wellbeing Scales (WEMWEBS): Scale developed to measure overall mental wellbeing.

Brief Experiential Avoidance Questionnaire (BEAQ): This measure assesses tendency to avoid or escape uncomfortable internal experiences such as distressing thoughts, feelings, memories or physical sensations.

Yale Brown Obsessive Compulsive Scale (YBOCS): Scale designed to rate the type and severity of symptoms in individuals with obsessive compulsive disorder. The YBOCS is broken down into 2 parts-part 1 is a symptom checklist that will ask you to make note of specific obsession or compulsions you are currently experiencing or have experienced in the past. Part 2 is a severity scale that asks 10 questions about the severity and impact of your identified obsessions and compulsions over the last days. The symptom checklist is completed just one time at the onset of treatment, while the severity scale will be used throughout treatment to monitor progress.

Short Health Anxiety Index (HAI): This is an18 question measure that looks at health anxiety for individuals. The questions on this measure assess worry about health, awareness of bodily sensations and/or changes, and the feared consequences of having an illness.
Panic Disorder Severity Scale (PDSS): This brief 7 question measures looks at the frequency, and severity of panic attacks or panic like symptoms, as well as the corresponding anxiety and impact to functioning.

Liebowitz Social Anxiety Scale: This measure looks at the way social anxiety plays a role in your life across various situations. For each situation you will indicate your level of fear and your level of avoidance. This measure can also be helpful for treatment planning and generating exposure ideas for individuals experiencing social anxiety.

Trouble shooting in ERP

We know that engaging in ERP is a challenging, at times uncomfortable process. It requires a degree of willingness for each individual to intentionally come into contact with anxiety triggers and resist the normal safety behaviors that would reduce these feelings. Like any other treatment, we understand there may be concerns or road bumps along the way in your ERP treatment. W encourage you to first and foremost acknowledge that the work you are doing in treatment is difficult, and to practice showing yourself the grace and understanding you would show a loved one when treatment may not go as planned, or when you feel you may not be progressing in the ways you would like. We would also encourage you to bring up these concerns to your treatment team individually, so that they can support you in addressing them and adjusting your exposure plans as needed. We also think it is helpful to highlight some of the common concerns that may come up in ERP, and ways in which you can combat these issues.

Higher anxiety during exposure: There may be times when you engage in exposures that elicit higher anxiety than anticipated. For example, you may identify a level 4 on your hierarchy to begin with, and find that when you engage in the exposure, you are actually at a SUDS of a 9. In these situations, it is important to talk to your treatment team about your experience, and direction on where to go from here. There may be multiple factors to consider when looking at whether or not to adjust the exposure. Some things to consider may be:

- **Are you finding that your mind is wandering beyond past the intended exposure, to higher level triggers?** For example, if the intended exposure was to touch a door handle and sit with thoughts about becoming sick and throwing up, yet you find yourself sitting with this as well as thoughts about then getting your entire family sick, and them throwing up, the guilt you would experience, and the chaos that would ensue from not being able to take care of your children while they are sick, because you are also sick, we may need to refocus and narrow in the exposure again. While the corresponding thoughts may also be anxiety triggers, and getting at your core fears, they may be higher level, and areas to approach as you progress further in treatment. In these situations, it may be helpful to work with your treatment team to re-engage in the intended exposure, and practice mindfully bringing your attention back to the intended trigger when you find your mind wandering.
- **There may be times where your anxiety level is higher than anticipated, or is not decreasing during your exposure, where it is tolerable and helpful to continue with that exposure exercise.** Particularly if you have had experience successfully engaging in lower-level exposures and are progressing to the mid or end point of your treatment journey, it may be helpful to practice experiencing sustained levels of higher anxiety in order to reinforce learning that these internal experiences are acceptable, safe, do not influence or predict feared outcomes, and still decrease eventually.

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Minimal anxiety during exposure: Sometimes individuals may find that they have difficulty bringing their anxiety up as intended during ERP. If this occurs later in treatment, this may be encouraging, and a sign that fear associations have reduced. However, if this occurs consistently early on in treatment, it will be helpful to troubleshoot this with your treatment team to ensure you are engaging in exposures that allow you to practice feeling the intended anxiety. There are a few areas to consider in this situation.

- **The exposure designed may not match your specific fears/anxiety triggers or be in line with your core fears.** When this is the case, this concern can be mitigated by asking yourself why the exposure was not anxiety provoking, and how you might adjust it to make it more anxiety provoking. Often this may mean more directly approaching your feared triggers or shifting to more in-vivo exposures vs. imaginal exposures.
- **You may be engaging in safety behaviors, that are neutralizing the anxiety you would otherwise experience from the exposure.** Some of these safety behaviors may be more covert, such as touching a feared surface, then immediately washing your hands, while others may be more covert, such as sitting with a violent intrusive thought while silently telling yourself "You would never do this." Identifying safety behaviors present during ERP and challenging yourself to resist these will be crucial for progress in treatment.

Difficulty identifying exposures: There may be times when you find it challenging to identify effective exposes. This may be because you have also had difficulty creating your initial hierarchy of anxiety triggers. It may be necessary to go back to this and ensure that it is a comprehensive list of people, places, thoughts, situations, physical sensations etc. that provoke an anxiety response. It may be helpful to track symptoms throughout an entire day or week, to keep a log of when you notice yourself experiencing anxiety, and document where you are, what you are doing, thoughts and physical sensations you may be having at the time. This can help in increasing insight into anxiety triggers.

Some people may find it challenging to replicate exposures in a treatment setting that they feel need to be done at home or work for example. In these cases, it is important to bring these concerns to your treatment team for their expertise on how to engage effectively in exposures at Compass that will closely replicate the feelings of anxiety in these other environments. This may include but is not limited to bringing in items from home or other settings, use of photos connected with imaginal exposures and more.

Relapse Prevention

Relapse prevention includes making plans to maintain and continue the progress you have made at Compass. An important part of relapse prevention involves understanding the difference between a lapse and a relapse.

A relapse can be defined as a complete and more long-lasting return to clinically severe anxiety and fear, while a lapse can be defined as the occurrence of fear or anxiety, or unexpected difficulty managing a situation one has previously managed adequately.

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The distinction here is important, because they are different, and many times, we can take steps to recognize a lapse and prevent it from turning into a full-blown relapse. By understanding potential setbacks, you may face both during treatment and after, you can be better equipped with skills to manage these, and ways to cope ahead. You can also recognize common thinking errors or cognitive distortions that often accompany lapses or setbacks. By challenging these absolute thoughts, you are more likely to see lapses in a more neutral way and prevent a full-blown rela e.

We understand that with successful treatment for OCD/Anxiety, you may become accustomed to a new, more manageable level of symptoms. This may mean that you are experiencing decreased frequency and intensity of intrusive thoughts, panic attacks, or ruminating worry, increased ability to resist compulsions, increased functioning in social situations, or work, school or home life. However, we also know that these symptoms and experiences are still bound to show up for individuals even when they have had success in treatment. When these symptoms do show up, and individuals are not expecting them or prepared to manage them appropriately, it can result in increased stress and further escalation of symptoms.

For these reasons, two important parts of relapse prevention include following up with outpatient providers who specialize in treating OCD and anxiety and adopting an exposure lifestyle outside of treatment. Following up with specialized providers allows you to continue working on the areas you have targeted in treatment, as well as different OCD/anxiety symptoms that come up with the evidence-based treatments you have become accustomed to at Compass. Adopting an exposure lifestyle involves looking for opportunities in your life to approach vs. avoid areas that may bring up anxiety or distress, and to practice sitting with and accepting these feelings. Read below for more information on how to respond to setbacks, both during and after treatment.

How to Respond to a Setback

1. Practice self-compassion and remember that a setback is not the same thing as a relapse. It is simply a temporary lapse. Occasional setbacks are to be expected, and do not have to be problematic if they are managed appropriately. It can also be helpful to remind yourself here that there are no setbacks without progress, and no progress without setbacks!

2. Look at the situation mindfully. Try to understand what may have caused the lapse without exercising judgement on yourself. Were there distorted thought presents that increased urges to use safety behaviors? Is there a new stressor in your life that may have you searching for an increased sense of control?

3. Engage in ERP! Return to the situation, identify your feared outcome, resist safety behaviors, and practice approaching vs. avoiding through exposure until your fear expectations have been violated, and your anxiety has decreased.

4. Make plans to restrict and contain the lapse. Be mindful about reaching out to your outside providers for increased support in managing a setback. Be prepared to engage in increased exposures to stimuli you find yourself seeking to avoid. Challenge catastrophizing thoughts about what this newly increased anxiety has to mean for you and your future through your behaviors. Focus instead on what you can learn and take away from the experience that may help you continue to grow in your recovery.