HANDOUTS

Understanding and Treating
Obsessive-Compulsive Disorder and Perfectionism

Presented By

Martin M. Antony, Ph.D., ABPP

AGENDA

Thursday

9:00 **Overview of OCD**
- OCD in the anxiety disorders spectrum
- Etiology of OCD
- Diagnostic challenges and proposed changes for DSM-5

10:20 ***Break*** (coffee and tea)

10:35 **Assessment of OCD**
- Clinical interview
- Questionnaire measures
- Behavioral measures
- Assessing OCD in children

Biological Treatments for OCD
- Medication treatments
- Other biological approaches
- Alternative and complementary treatments
- Combining psychological and biological treatments

12:00 p.m. ***Lunch*** *(on your own)*

1:15 **Behavioral Treatments for OCD**
- Exposure
- Ritual prevention

2:35 ***Break*** *(coffee, tea, soda, snack)*

2:50 **OCD Treatment**
- Video Demonstration

4:15 Adjournment

Friday

8:30 **Cognitive Strategies for OCD**
- Cognitive restructuring
- Behavioral experiments
- Treating OCD in Groups
- Treating OCD in Children

9:50 ***Break*** *(coffee and tea)*

10:05 **Treating Compulsive Hoarding**

Challenges in the Treatment of OCD

Strategies for Enhancing Motivation
- Motivational interviewing

11:30 ***Lunch*** *(on your own)*

12:45 p.m. **Introduction to Perfectionism**
- Cognitive and behavioral features
- Assessment of perfectionism
- Cognitive behavioral treatment of perfectionism

2:05 ***Break*** *(coffee, tea, soda, snack)*

2:20 **Perfectionism Treatment**

Video Demonstration

Mindfulness and Acceptance-Based Strategies

3:45 Adjournment (Pick up certificates)

Sponsored by
J&K Seminars, *LLC*
1861 Wickersham Lane
Lancaster, PA 17603-2327
(800) 801-5415
jk@jkseminars.com
www.jkseminars.com

Martin M. Antony, Ph.D.
Department of Psychology
Ryerson University
350 Victoria Street
Toronto, ON M5B 2K3
Canada
Tel: 416-979-5000, ext. 2631
mantony@psych.ryerson.ca
www.martinantony.com

J&K Seminars

Understanding and Treating Obsessive-Compulsive Disorder and Perfectionism

April 15 and 16, 2010

Martin M. Antony, Ph.D., ABPP
Department of Psychology, Ryerson University
Anxiety Treatment and Research Centre, St. Joseph's Healthcare

www.martinantony.com

Martin M. Antony, Ph.D.
President (2009-2010), Canadian Psychological Association
Professor and Director of Graduate Program, Department of Psychology, Ryerson University
Director of Research, Anxiety Treatment and Research Centre, St. Joseph's Healthcare

Department of Psychology
Ryerson University
350 Victoria Street
Toronto, ON M5B 2K3
Canada

Tel: 416-979-5000, ext. 2631
Fax: 416-599-5660
E-mail: mantony@psych.ryerson.ca

Outline 1

- Recommended Books and Videos
- Overview of OCD
- Etiology of OCD
- Assessment of OCD
- Overview of Effective Treatments
- Pharmacological Treatments
- Complementary Treatments
- Other Biological Treatments

Outline 2

- Combination Treatments
- Exposure and Ritual Prevention
- Cognitive Strategies
- Treating OCD in Groups
- OCD and the Family
- Treating OCD in Children
- Treating Compulsive Hoarding
- Concerns about Treatment
- Enhancing Motivation

Outline 3

- Overview of Perfectionism
- Assessing Perfectionism
- Treating Perfectionism
- Mindfulness and Acceptance-Based Strategies
- Research on Perfectionism Treatment

Recommended Books and Videos on OCD

Recommended Readings

- Antony, M.M., & Norton, P.J. (2009). *The anti-anxiety workbook: Proven strategies to overcome worry, panic, phobias, and obsessions*. New York: Guilford Press.
- Antony, M.M., & Stein, M.B. (Eds.) (2009). *Oxford handbook of anxiety and related disorders*. New York: Oxford University Press.

Recommended Readings

- Antony, M.M., Purdon, C., & Summerfeldt, L.J. (Eds.) (2007). *Psychological treatment of OCD: Fundamentals and beyond*. Washington, DC: American Psychological Association.
- Clark, D.A. (2004). *Cognitive-behavioral therapy for OCD*. New York: Guilford.
- Wilhelm, S., & Steketee, G.S. (2006). *Cognitive therapy for obsessive-compulsive disorder: A guide for professionals*. Oakland, CA: New Harbinger.

Recommended Readings

- Abramowitz, J.S. (2006): *Obsessive-compulsive disorder*. Cambridge, MA: Hogrefe & Huber.
- Abramowitz, J.S. (2006): *Understanding and treating obsessive-compulsive disorder: A cognitive behavioral approach*. Mahwah, NJ: Erlbaum.
- Rachman, S. (2003). *The treatment of obsessions*. New York: Oxford.

OCD Workbooks

- Abramowitz, J.S. (2009). *Getting over OCD: A 10-step workbook for taking back your life*. New York: Guilford Press.
- Hyman, B.M., & Pedrick, C. (2005). *The OCD workbook: Your guide to breaking free from obsessive-compulsive disorder (2nd edition)*. Oakland, CA: New Harbinger.

Other OCD Self-Help

- Carmin, C. (2009). *Obsessive-compulsive disorder demystified: An essential guide for understanding and living with OCD*. Cambridge, MA: Lifelong Books.
- Grayson, J. (2004). *Freedom from obsessive-compulsive disorder: A personalized recovery program for living with uncertainty*. New York: Berkley Publishing Group.
- Purdon, C., & Clark, D.A. (2005). *Overcoming obsessive thoughts: How to gain control of your OCD*. Oakland, CA: New Harbinger.

Recommended Videos

- Antony, M.M. (2007). *Obsessive-Compulsive Behavior* (DVD Video). Washington, DC: American Psychological Association.
- Antony, M.M. (2009). *Behavioral therapy over time* (DVD Video on Compulsive Hoarding). Washington, DC: American Psychological Association.
- Wilson, R.R. (2005). *Obsessive-compulsive disorder* (DVD or VHS). Washington, DC: American Psychological Association.

OVERVIEW OF OCD

Obsessive Compulsive Disorder (OCD)

- Unwanted, repetitive thoughts, images or urges (obsessions)
- Repetitive behaviors that occur in response to an obsession, in order to reduce anxiety (compulsions)
- Significant distress or impairment

Examples of Obsessions

- **Contamination Obsessions**
  (e.g., germs, bleach, H1N1, HIV, cancer, colors)
- **Doubting Obsessions**
  (e.g., appliances, locks, written work, running over pedestrians)
- **Aggressive Obsessions**
  (e.g., stab children, push loved ones into traffic)
- **Obsessions about Accidentally Harming Others**
  (e.g., contamination, poisoning, starting fires)
- **Religious Obsessions**
  (e.g., satanic thoughts, blasphemous thoughts)
- **Sexual Obsessions**
  (e.g., thoughts of sex with children)

Examples of Compulsions

- Washing and Cleaning
- Checking
- Repeating Actions
- Repeating Words, Phrases, or Prayers to Oneself
- Counting
- Symmetry and Exactness
- Hoarding

Other Features of OCD

- Avoidance of feared situations
- Varying levels of insight (including poor insight or overvalued ideation)
- Thought-action fusion
- Magical thinking
- Inflated Responsibility

Magical Thinking

- "My boyfriend will be in a car accident if I don't finish my term paper by midnight."
- "If I do everything seven times, I can prevent bad things from happening."
- "If I step on a sidewalk crack, I'll break my mother's back."

Inflated Responsibility

- A child checks excessively when leaving a room to make sure that nothing was left behind.
- A man repeatedly asks for reassurance that others aren't offended by something he said.
- A lawyer spends hours reviewing reports and letters to ensure that everything is accurate, so harm will not come to her clients.
- A new mother avoids spending time with her baby for fear of acting on intrusive sexual obsessions.

Proposed Changes for DSM-5

- Relatively minor changes proposed for OCD in DSM-5 (comments accepted until April 20, 2010)
- Included in a new category of disorders called *Anxiety and Obsessive-Compulsive Spectrum Disorders*
- Specify whether OCD beliefs are currently characterized by (1) good or fair insight, (2) poor insight, or (3) delusional beliefs
- Specify if "tic-related OCD"

www.dsm5.org

Frequency of Obsessions

Type of Obsession	% of Sample
Aggressive	68.7
Contamination	57.7
Symmetry/Exactness	53.2
Somatic	34.1
Hoarding/Saving	30.2
Religious	24.2
Sexual	19.8
Miscellaneous	55.5

Current symptoms as reported by 182 adults with OCD on the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) Symptom Checklist. From Antony, Downie, & Swinson, 1998

Frequency of Compulsions

Type of Compulsion	% of Sample
Checking	80.7
Washing	63.7
Repeating	55.5
Ordering/Arranging	40.1
Counting	35.2
Hoarding	28.0
Miscellaneous	59.3

Current symptoms as reported by 182 adults with OCD on the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) Symptom Checklist. From Antony, Downie, & Swinson, 1998

Patterns of Comorbidity

- 36% of patients diagnosed with OCD only
- 28.7% had 1 additional diagnosis
- 17.2% had 2 additional diagnoses
- 18.4% had 3 or more diagnoses

- Data from Anxiety Disorders Clinic patients with a principal diagnosis of OCD (Antony, Downie, & Swinson, 1998)
- Patients with a psychotic disorder, bipolar disorder, or substance abuse/dependence, were excluded from the sample

Patterns of Comorbidity

- 41.4% had social phobia
- 24.1% had major depressive disorder
- 20.7% had a specific phobia
- 13.8% had dysthymic disorder
- 11.5% had panic disorder
- 11.5% had generalized anxiety disorder
- 8.0% had a tic disorder
- 4.6% had trichotillomania

- Data from Anxiety Disorders Clinic patients with a principal diagnosis of OCD (Antony, Downie, & Swinson, 1998)
- Patients with a psychotic disorder, bipolar disorder, or substance abuse/dependence, were excluded from the sample

ETIOLOGY OF OCD

Learning and Anxiety Disorders

Rachman's Pathways to Fear

- Direct Conditioning
- Vicarious Acquisition
- Informational/Instructional Learning

Cognitive Model of OCD

- Everyone experiences intrusive thoughts.
- Normal intrusive thoughts and obsessions differ only in the way they are interpreted by the individual
- Individuals with OCD interpret intrusive thoughts as indicating that they are responsible for the occurrence or prevention of harm to self and others (e.g., "I will kill my baby" equals an increased risk of doing so, unless I take steps to prevent it).
- Thought suppression and compulsive rituals help to maintain the problem.

(Salkovskis, 1998)

Normal Intrusive Thoughts

- Thoughts of intentionally harming oneself
- Intentionally harming others
- Thoughts of causing nonintentional harm to oneself or others
- Thoughts of physical harm or death to others
- Thoughts of physical harm or death to self
- Thoughts of being contaminated
- Thoughts of causing social difficulties through impulsive actions

Normal Intrusive Thoughts

- Doubts about safety at home or in the car
- Thoughts involving deviation from one's moral code
- Thoughts of losing control or acting out of character
- Doubts about memory
- Impulses to leave everything (e.g., run away and live in the mountains)
- Sexual thoughts
- Symmetry, exactness, or "just right" thoughts

(Wilhelm & Steketee, 2006)

Biological Factors in OCD

Increased Cerebral Blood Flow in Prefrontal Cortex and Basal Ganglia of OCD Patients

- Based on PET studies; appears to be corrected by pharmacological or cognitive behavioral treatments

Genetic Factors

- Based on family, twin, and molecular genetics studies

Altered Neurotransmitter Functioning

- Serotonin
- Glutamate

PANDAS

Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infection (PANDAS)

- Caused when the immune system attacks the basal ganglia (triggered by a strep infection, and often associated with a genetic predisposition for OCD or tics).
- Rapid onset (usually between 3 years of age and puberty); often with involuntary movements of legs, face, arms.
- Diagnosis is controversial. Experts don't agree whether it even exists.

PANDAS

Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infection (PANDAS)

- Unknown whether treatment with antibiotics is useful.
- If OCD symptoms remain after treatment with antibiotics, then treatment with medication or CBT is typically recommended.
- Plasma exchange may be useful in severe cases, but side effects can be problematic.
- Preliminary data from 7 children with related OCD suggest that CBT may be effective (Storch et al., 2006)

ASSESSMENT OF OCD

Assessment Modalities

- Clinical Interview
- Monitoring Diaries
- Behavioral Approach Test
- Questionnaire Measures

Clinical Interview

- Diagnostic features
- Current pattern of symptoms
- Impact on functioning
- OCD triggers
- Variables influencing level of fear
- Physiological responses (e.g., panic, nausea)
- Cognitions, beliefs, predictions, cognitive biases
- Patterns of avoidance
- Compulsions and safety behaviors

Clinical Interview

- Alcohol, drug, and medication use
- Development and course of problem
- Treatment history
- Role of family (e.g., family accommodation)
- Potential for family members to help with treatment
- Family history of the problem
- Medical history

Monitoring Diaries

- Frequency of Obsessions
- Frequency of Encounters with Feared Situations
- Subjective Fear Ratings during Encounters
- Anxious Thoughts and Predictions
- Escape and Avoidance Behaviors
- Urges to Complete Rituals
- Compulsions and Safety Behaviors
- Physiological Reactions and Symptoms

Behavioral Approach Test

- Closest Distance of Approach
- Subjective Fear Ratings
- Anxious Thoughts and Predictions
- Physiological Reactions and Symptoms
- Subjective Fear Ratings during Encounters
- Escape and Avoidance Behaviors
- Urges to Complete Rituals
- Compulsions and Safety Behaviors

Scales for OCD

- Yale-Brown Obsessive-Compulsive Scale (YBOCS; Goodman et al., 1989)
- Clark-Beck Obsessive-Compulsive Inventory (CBOCI; Clark & Beck, 2002)
- Florida Obsessive-Compulsive Inventory (Storch et al., 2007)
- Obsessive Beliefs Questionnaire (OBQ; OCCWG, 1997)

Scales for OCD

- Obsessive Compulsive Inventory - Revised (OCI; Foa et al., 2002)
- Padua Inventory-Washington State University Revision (PI-WSUR; Burns et al., 1996)
- Vancouver Obsessional Compulsive Inventory (VOCI; Thordarson et al., 2004)

OCD Measures for Children

- Children's Yale-Brown Obsessive-Compulsive Scale (Riddle, Scahill, King, et al., 1992)
- Leyton Obsessional Inventory – Child Version (Berg, Witaker, Davies et al., 1988)
- Child Obsessive-Complusive Impact Scale (COIS; Piacentini & Jaffer, 1999)
- Children's Florida Obsessive-Compulsive Inventory (C-FOCI; Storch et al., 2009)
- OCD Disturbance Scale (Geffken et al., 2005)

Recommended Readings

- Antony, M.M., & Barlow, D.H. (Eds.) (2010). *Handbook of assessment and treatment planning for psychological disorders, 2nd ed*. New York, NY: Guilford Press.
- Antony, M.M., Orsillo, S.M., & Roemer, L. (Eds.) (2001). *Practitioner's guide to empirically-based measures of anxiety*. New York, NY: Springer.

OVERVIEW OF EFFECTIVE TREATMENTS

Treatment Strategies

Exposure Strategies

- Exposure to feared objects, thoughts, situations

Ritual (Response) Prevention

- Preventing compulsive rituals

Cognitive Strategies

- Correcting unrealistic beliefs and interpretations

Medications

- SSRIs, clomipramine, augmentation strategies (e.g., antipsychotic drugs)

Combination Treatments

- CBT plus medications (e.g., SSRIs)

PHARMACOLOGICAL TREATMENTS

Selective Serotonin Re-Uptake Inhibitors (SSRIs)

- Paroxetine (Paxil)
- Sertraline (Zoloft)
- Fluvoxamine (Luvox)
- Fluoxetine (Prozac; Sarafem)
- Citalopram (Celexa)
- Escitalopram (Lexapro; Cipralex)

Selective Serotonin Re-Uptake Inhibitors (SSRIs)

- Dosages
- Duration of Treatment
- Discontinuing Treatment

Side Effects for SSRIs

Gastro-Intestinal*:* nausea, intestinal cramping, diarrhea, vomiting, dry mouth, weight gain

Central Nervous System: nervousness, headache, tremulousness, insomnia, hypersomnia, sedation, anxiety

Sexual Symptoms: delayed orgasm, difficulty becoming aroused, reduced interest

Skin: allergic reactions, rashes

Other Antidepressants

- **Clomipramine (Anafranil)**: Support in numerous placebo-controlled trials.
- **Venlafaxine XR (Effexor XR):** Comparable to Paroxetine for OCD (Denys et al., 2003)
- **Mirtazapine (Remeron)**: Support in open trials only (e.g., Koran et al., 2005).

Ineffective Medications

- Other antidepressants (e.g., bupropion, imipramine)
- Benzodiazepines
- Beta-blockers
- Lithium
- Buspirone

Adjunctive Antipsychotics

- Support for adjunctive risperidone (Risperdal) and adjunctive haloperidol (Haldol)
- Mixed evidence for adjunctive olanzaline (Zyprexa) and adjunctive quetiapine (Seroquil)
- Only open trials with aripiprazole (Abilify) (e.g., Pessina et al., 2009)
- **Long Term Study**: A long term trial examining 1 year of treatment with SSRI plus olanzapine, quetiapine, or risperidone in SSRI-nonresponders did not support the use of these medications in OCD (Matsunaga et al., 2009)

Glutamatergic Agents

- Evidence is emerging that elevated glutamate levels may be involved in OCD and related problems (e.g., Chakrabarty et al., 2005).
- Studies are beginning to investigate the use of glutamatergic agents (e.g., memantine) as a treatment for OCD. Preliminary evidence is promising (e.g., Stewart et al., 2010), but no placebo controlled trials in OCD.
- Controlled study (Grant et al., 2009) supports the use of *N*-acetylcysteine (a glutamate modulator) in the treatment of trichotillomania.

Medication Treatments for Children

- Children tend to have a high placebo response
- Medication dosages must be adjusted, depending on the weight of the child.
- Several controlled studies support SSRIs for OCD, though some studies suggest that it may take more than two months for medication to be more effective than placebo.
- Fluvoxamine and sertraline have FDA approval for OCD, down to ages 8 and 6, respectively. Controlled trials for fluoxetine exist as well.

Criteria for Determining Strength of Evidence and Clinical Recommendations

Levels of Evidence	
Level 1	Meta-analysis or replicated randomized controlled trial (RCT) that includes a placebo condition
Level 2	At least 1 RCT with placebo or active comparison condition
Level 3	Uncontrolled trial with at least 10 or more subjects
Level 4	Anecdotal reports or expert opinion

Treatment Recommendation Summary	
First line	Level 1 or 2 evidence + clinical support for efficacy & safety
Second line	Level 3 evidence or higher + clinical support for efficacy & safety
Third line	Level 4 evidence or higher + clinical support for efficacy & safety
Not recommended	Level 1 or 2 evidence for lack of efficacy

Canadian Anxiety Disorders Treatment Guidelines, Published July 2006

Obsessive-Compulsive Disorder: Recommendations for Initial Therapy

First line	Fluvoxamine, fluoxetine, paroxetine, sertraline
Second line	Clomipramine, venlafaxine, citalopram,, adjunctive risperidone, adjunctive mirtazapine
Third line	IV clomipramine, escitalopram, phenelzine, tranylcypromine Adjunctive: olanzapine, quetiapine, haloperidol, gabapentin, topiramate, tramadol, riluzole, St. John's wort, pindolol
Not recommended	Clonazepam, desipramine, clonidine, buspirone, lithium, morphine, naltrexone

Canadian Anxiety Disorders Treatment Guidelines, Published July 2006

Choosing Among Medications

- Empirical support
- Side effect profile
- Cost
- Interactions with other medications and medical conditions
- Half life and discontinuation issues
- Previous response to medications
- Previous response of a family member

Recommended Readings

- Virani, A.S., Bezchlibnyk-Butler, K.Z. & Jeffries, J.J. (Eds.) (2009). Clinical handbook of psychotropic drugs, 18th edition. Cambridge, MA: Hogrefe & Huber.
- Bezchlibnyk-Butler, K.Z., & Virani, A.S (2007). Clinical handbook of psychotropic drugs for children and adolescents, 2nd edition. Cambridge, MA: Hogrefe & Huber.

COMPLEMENTARY AND ALTERNATIVE TREATMENTS

Complementary and Alternative Treatments

- In a 2002 survey, 62% of adults in the US had used these treatments in the past year for a health concern (Barnes et al., 2002).
- According to www.holisticonline.com, the following treatments are "helpful both for relieving the anxiety of OCD and for diminishing the compulsions themselves…."

Complementary and Alternative Treatments

- Acupressure
- Aromatherapy
- Autosuggestion
- Bach Flower Remedies (Wild Chestnut)
- Biofeedback
- Color Therapy
- Diet Therapy
- Exercise
- Herbal Medicine

Complementary and Alternative Treatments

- Homeopathy
- Massage
- Mind/Body Medicine
- Nutritional Supplements
- Prayer and Spirituality
- Reflexology
- Schuessler Tissue Salts
- Yoga

Research Findings

- ***Inositol***: Superior to placebo in one study of OCD (Fux et al., 1999)
- ***Mindfulness Meditation***: Mindfulness superior to waitlist in one OCD study (Hanstede et al., 2008)
- ***Aerobic Exercise***: Support in two open trials for OCD (Abrantes et al., 2009; Brown et al., 2007)
- ***Omega-3 Fatty Acids***: Not supported in a controlled study for OCD (Fux et al., 2004).
- ***St. John's Wort***: No difference from placebo for OCD (Kobak et al., 2005)

Research Findings

- *No OCD studies with kava,* ginkgo biloba, SAM-e, galphimia glauca, valerian root, homeopathy, Bach flower remedies, aromatherapy, yoga

OTHER BIOLOGICAL TREATMENTS

Psychosurgery (Cingulotomy)

- Involves severing of the supracallosal fibres of the cingulum bundle, which pass through the anterior cingulate gyrus (in limbic system)
- At a mean of 32 months post-surgery, 45% of individuals with severe OCD who were nonresponsive to medications and behavior therapy obtained responded at least partially to cingulotomy, with relatively few adverse effects (Dougherty et al., 2002).

Deep Brain Stimulation

- Greenberg et al. (2006) followed 8 highly treatment resistant patients for 3 years after deep brain stimulation (DBS) of the ventral capsule / ventral striatum (part of the basal ganglia). 4 patients had a >35% reduction in YBOCS scores; 2 had between 25 and 35% reduction.
- Depression and anxiety also improved, as did self-care, independent living, and work, school, and social functioning.
- Adverse effects included an asymptomatic hemorrage, a single seizure, a superficial infection, transient hypomanic symptoms, and worsened depression and OCD when DBS was interrupted by battery problem.

Deep Brain Stimulation

- In a double blind, controlled study, Mallet et al. (2008) had 8 treatment refractory patients with OCD undergo stimulation of the subthalamic nucleus (part of the basal ganglia) for 3 months, followed by sham stimulation for 3 months. Eight other patients received sham stimulation followed by stimulation of the subthalamic nucleus.
- Changes in OCD symptoms (but not depression or anxiety were greater during stimulation of the subthalamic nucleus than sham stimulation.
- 15 serious adverse events (e.g., 1 hemorrhage, 2 infections) in 11 patients.

COMBINING MEDICATIONS AND PSYCHOLOGICAL TREATMENTS

CBT vs. Medications

- Averaging across studies, CBT and medications tend to be equally effective in the short term for OCD.
- For many patients there is not much benefit of combining CBT and medication over either approach alone.
- Recent findings (Simpson et al., 2008; Tundo et al., 2007) suggest that ERP may improve outcomes for individuals who still have OCD despite taking medications, compared to stress management therapy.

D-Cycloserine (DCS)

- A partial agonist at the N-methyl-D-aspartate (NMDA) glutamatergic receptor
- Best known as a treatment for tuberculosis (500-1000 mg per day)
- NMDA antagonists seem to prevent fear learning and extinction
- DCS is a cognitive enhancer – it improves extinction learning (fear reduction during exposure) in rodents
- DCS enhances memory in some human studies
- Question - Does DCS improve outcomes in exposure-based treatments for anxiety?

D-Cycloserine (DCS) and Anxiety

- D-cycloserine enhances exposure-based treatment for social phobia (Hofmann et al., 2006; Guastella et al., 2008) and specific phobia (Ressler et al., 2004)
- D-cycloserine is supported in a meta-analytic study (Norberg et al., 2008)
- D-cycloserine reduces some forms of relapse, based on animal studies (Vervliet, 2008)

D-Cycloserine (DCS) and OCD

- Wilhelm et al. (2008) found that DCS (100 mg) was more effective than placebo when administered 1 hr before each of 10 behavior therapy sessions (twice per week). Differences found for OC symptoms at mid-treatment and for depression and post-treatment. No differences at 1-month follow up.
- Kushner et al. (2007 found short term benefits for DCS (125 mg) for OCD at session 4, but over time the placebo condition caught up (no differences at post-treatment and 3-month follow up. DCS was taken 2 hrs before each of 10 sessions (conducted twice per week).
- Storch et al. (2007) found no effects of DCS (250 mg), relative to placebo. DCS was taken 4 hours before each of 12 weekly sessions. Just looked at pre-treatment, post-treatment, and 2-month follow up.

EXPOSURE AND RITUAL PREVENTION

Behavioral Features of OCD

- Compulsive rituals
- Avoidance of feared situations
- Cognitive Avoidance and Thought Suppression
- Compulsions and safety behaviors
- Requests for Reassurance
- Alcohol or Drug Use

Exposure and Ritual Prevention

- Exposure and Ritual Prevention (ERP) is the "gold standard" psychological treatment for OCD.
- Between 63% and 83% of participants who complete ERP tend to obtain some benefit.
- Benefits are often maintained over the long term.

Variations in Format

- Combining ERP with cognitive strategies
- Inpatient vs. outpatient treatments
- Home-based vs. office-based treatment
- Group vs. individual therapy
- Including family members

Variations in Intensity

- Therapist-assisted vs. self-guided exposure
- Outpatient vs. day treatment or inpatient
- In-person vs. telephone treatment
- Intensive vs. twice weekly sessions

Presenting the Treatment Rationale

- Defining OCD, obsessions, compulsions
- Develop model of OCD
- "Fuel for the car" metaphor
- "Candy from a baby" metaphor
- Discussing treatment procedures
- Making sure that supports are in place

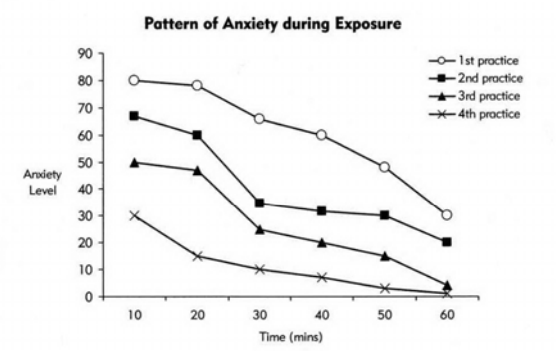
Exposure-Based Treatments

Modalities

- In-Vivo Exposure
- Imaginal Exposure
- Interoceptive Exposure
- Virtual Reality Exposure
  - Recent evidence suggests that OCD-related stimuli presented in VR can trigger anxiety symptoms (Kim et al., 2008)

Principles of Effective Exposure

- Predictability and perceived control
- Graduated exposure versus flooding
- Longer exposure practices work best
- Exposures should be spaced closely
- Eliminate compulsions and safety behaviors
- Vary the context of the exposure practices
- Do not fight the fear
- Measure success by what one does – not how one feels



Abramowitz (2009)

Obsessive-Compulsive Disorder Sample Exposure Hierarchy

Item	Fear
Visit a cancer ward in a hospital	100
Shake hands with a person who has cancer	90
Talk to someone with cancer	75
Eat in a hospital cafeteria	70
Walk through the halls of a hospital	60
Stand in front of a hospital	50
Read a library book about cancer	40
Talk to someone about cancer	25

Practical Issues

- Setting of session
- Where to start on the hierarchy
- When to move on to the next item
- When to end the session
- Role of modeling by the therapist
- Assessment of danger during exposure
- Using helpers (e.g., family members)

Managing Overwhelming Urges

- Engage in other activities (e.g., going for a walk)
- Seek social support (e.g., calling a friend)
- Contact therapist
- Distraction (e.g., watch TV)
- Breathing retraining or relaxation exercises

Principles of Ritual Prevention

- Eliminating Cognitive Rituals
- Undoing the Effects of Rituals (e.g., with additional exposure)
- Soliciting Help from Others
- Complete vs. Gradual Ritual Prevention

If Preventing Rituals is Impossible

- Eliminate certain rituals first (based on location, time of day, ritual content)
- Delay the ritual
- Shorten the ritual
- Do the ritual differently
- Do the ritual more slowly

Predictors of Positive Outcome

- Inclusion of therapist-assisted exposure (vs. just self-exposure)
- Stricter ritual prevention (vs. gradual or partial ritual prevention)
- Including both imaginal and situational exposure (vs. just situational exposure)

Sample Treatment Plans

- Contamination obsessions and washing
- Fear of particular words or images
  - e.g., religious symbols, colors, numbers
- Fear of running over pedestrians
- Fear of stabbing children
- Need to repeat actions
- Need to check one's work (e.g., writing)

Exposure Trouble Shooting

- Fear doesn't decrease during the practice
- Fear returns between practices
- Fear fluctuates during the practice
- Patient asks to end the exposure practice due to elevated fear
- Patient refuses to do a practice

Exposure Trouble Shooting

- An unexpected negative event occurs (e.g., patient becomes ill during treatment)
- Therapist is frightened of the situation
- Patient is *not* fearful of the practice

Reasons for Non-Compliance

- Patient doesn't understand the task
- Task not relevant to the patient
- Task too frightening
- Interpersonal issues (e.g., rapport)
- Other demands (e.g., family, work)
- Therapist doesn't ask about homework
- Ambivalence about treatment

Improving Compliance

- Simplify the task
- Try homework task in session before leaving
- Schedule more frequent sessions
- Do homework at the therapist's office
- Schedule telephone contacts
- Reinforcement for completed homework
- Deal with scheduling conflicts, other demands
- Motivational enhancement strategies

COGNITIVE STRATEGIES

Cognitive Models of Anxiety

- Cognitive models of anxiety disorders assume that an individual's beliefs determine whether he or she experiences anxiety or fear in a given situation.

Developing the Cognitive Model

- Typical circumstances for OCD symptoms
- Maladaptive thoughts, images, impulses
- Interpretations of obsessive intrusions
- Rituals and avoidance strategies
- Underlying beliefs that contribute to symptoms
- Probable core beliefs
- Personal experiences that contributed to OCD
- Current and recent stressors, mood

(Wilhelm & Steketee, 2006)

Cognitive Features of OCD

(Obsessive Beliefs Questionnaire (OBQ; OCCWG, 1997)

- Beliefs about responsibility
- Overestimating the probability and severity of danger
- Overimportance of thoughts
- Control of thoughts
- Desire for certainty
- Consequences of anxiety
- Fear of positive experiences
- Perfectionism

Structure of a Typical Cognitive Therapy Session

1. Set the agenda for the session
2. Catch up from the previous week
3. Review the patient's homework for the previous week (e.g., thought records, behavioral experiments)
4. Psychoeducation (e.g., learn a new strategy)
5. Apply cognitive therapy techniques throughout the session
6. Assign new homework

Cognitive Strategies for OCD

- Focus on challenging beliefs and interpretations, including meta-cognitions.
- Avoid challenging intrusive thoughts directly, providing excessive reassurance, etc.

Socratic Questioning to Challenge Anxiety-Provoking Beliefs

- Are my thoughts necessarily true?
- Are my thoughts consistent with the evidence?
- Are there other ways of thinking about the situation?
- What if my thought were to come true?

Thought Records

- Used to identify and evaluate beliefs

Challenging Catastrophic Thinking

- Catastrophic thinking refers to overestimating how bad a particular outcome would be or underestimating one's ability to cope.
- Examples:
  - It would be unmanageable if my books were not organized in order of size
  - I could not handle losing an important receipt.

Countering Catastrophic Thinking

- Ask "What is the worst thing that can happen?"

Pie Chart Technique

- Why I got sick with a cold
- Why my friend was in a car accident

Challenging Meta-Cognitions

Beliefs about Obsessions

- Thinking that I will stab my child means that I will do it.
- Thinking about sex means that I am a bad person
- If I think that I have run over a pedestrian, that means I have done it.

Collecting New Data

- Thought suppression experiment
- Testing out specific predictions using behavioral experiments
- Consulting with experts (e.g., religious leaders, doctors).
- Conducting surveys

(Wilhelm & Steketee, 2006)

Collecting New Data – What is Normal? –

- Recommended time to wash hands (Toronto Public Health recommends 15 seconds)
- Number of squares of toilet paper used
- Sitting on toilet seats
- Eating off the floor
- Washing hands when coming home
- Touching taps, elevator buttons, etc.
- Intrusive aggressive, sexual, or religious thoughts
- Checking locks
- Checking stoves

Overimportance of Thoughts

- Having a thought means it is important
- Having a thought can cause it to happen
- Thinking something is as bad as doing it

Challenging These Assumptions

- Wise mind = rational and emotional thinking
- Psychoeducation (e.g., to combat fear of sexual thoughts)
- Socratic questioning / evaluating the evidence
- Behavioral experiments

Metaphors and Analogies

- Patient: "I have sore on my face. I am worried that I have cancer."
- Therapist: "If I cough, does that mean I have tuberculosis?" "If I feel tired, does that mean I have AIDS?"

(Wilhelm & Steketee, 2006)

Perspective Shifting

- Consider the event from a different perspective.
- What would your friend think in this situation?
- What would you tell a loved one who was having the same thought as you?

Coping Statements

- Coping statements are useful in moments of high distress, when it may be difficult to step back from thoughts and use countering strategies.
- Examples:
  - It's not dangerous to feel anxious
  - This feeling will pass

Other Cognitive Strategies

- Continuum technique (e.g., importance of certainty)
- Cost-benefit analysis
- Highlighting double standards
- Retrospective review of the evidence
- Reversing therapist/client roles
- Calculating probabilities

(Wilhelm & Steketee, 2006)

Germs and the Immune System

"What d'ya think you have an immune system for? It's for killing germs! But it needs practice, it needs germs to practice on. So if you kill all the germs around you, and live a completely sterile life, then when germs do come along, you're not gonna be prepared."

George Carlin
Brain Droppings
1997

Germs and the Immune System

"When I was a little boy in New York city in the nineteen-forties, we swam in the Hudson river. And it was filled with raw sewage! OK? We swam in raw sewage, you know, to cool off. And at that time the big fear was polio. Thousands of kids died from polio every year. But you know something? In my neighborhood no one ever got polio. No one! EVER! You know why? Cause WE SWAM IN RAW SEWAGE! It strengthened our immune system, the polio never had a prayer."

George Carlin, *Brain Droppings,* 1997

Troubleshooting

- Cannot identify thoughts
- Strategies are too intellectually challenging for the client
- Patient is too anxious to think clearly
- Patient does not complete cognitive monitoring forms
- Completing the forms increases the patient's anxiety

TREATING COMPULSIVE HOARDING

Difficulty Discarding

- Possessions may be viewed as having sentimental (emotional), instrumental (useful), or intrinsic (aesthetic) value.
- Clients may be able to discard some items, but the process is difficult, and items are often acquired faster than they are discarded.

Compulsive Acquiring

- Acquiring free things (e.g., extra newspapers, magazines, coupons, discarded garbage)
- Compulsive shopping
- Compulsive stealing
- Positive feelings or euphoria may be associated with acquiring.

Other Features of Hoarding

- Severity appears to increase with age
- Mean age for seeking treatment is 50
- Course is often chronic
- Appears to run in families
- Often associated with a low rate of marrying
- May pose a public health risk (e.g., animal hoarding)

Other Features of Hoarding

- Currently often diagnosed as OCD, though relationship between OCD and hoarding is controversial.
- About 25% of people with OCD have hoarding problems.
- About half of hoarders have no other OCD symptoms.

Hoarding Disorder

- Proposed for DSM-5
- Difficulty discarding or parting with personal possessions due to strong urges to save items, distress, or indecision associated with discarding
- Accumulation of clutter in living spaces
- Significant distress or impairment
- Not due to a general medical condition
- Not restricted to the symptoms of another disorder (e.g., due to obsessions in OCD, lack of motivation in depression, etc.).

Hoarding Disorder

- Specify if:
  - *With Excessive Acquisition:* If symptoms are accompanied by excessive collecting or buying or stealing of items that are not needed or for which there is no available space.
- Specify if:
  - Good or fair insight
  - Poor insight
  - Delusional

Assessment of Hoarding

- *Home visit (with photos)*
- *Hoarding Interview* (Steketee & Frost, 2007)
- *Saving Inventory-Revised* (Frost et al., 2003)
- *Saving Cognitions Inventory* (Steketee et al., 2003)
- *Clutter Image Rating Scale* (Frost et al., 2008)

All scales are reproduced in Steketee & Frost (2007)

CBT Model of Hoarding

1. ***Personal and family vulnerabilities*** (e.g., past experiences, parental values, negative mood, information processing deficits)
2. ***Cognitive appraisals*** (e.g., about possessions, vulnerabilities, etc.)
3. ***Positive and negative emotional responses***
4. ***Hoarding behaviors*** (clutter, acquiring, difficulty discarding)

Steketee & Frost (2007)

Vulnerabilities

- Family history of hoarding
- Comorbidity
- Parental values toward acquiring, discarding, clutter, waste, etc.
- Physical constraints (health, time, space)
- Traumatic events (e.g., loss of parent, assault, moving, deprivation)

Steketee & Frost (2007)

Cognitive Appraisals

- Finding beauty in unusual objects
- Fear that memories will be lost if objects are discarded.
- Seeing the usefulness of virtually anything
- Attaching emotional significance to objects
- Seeing objects or activities (e.g., shopping) as emotionally comforting
- Viewing objects as a source of safety

Steketee & Frost (2007)

Cognitive Appraisals

- Concern about others controlling one's possessions
- Strong beliefs about wasting possessions, using possessions responsibly, protecting the environment
- Concern about making mistakes
- Need for completeness or feeling "just right"
- Belief that objects validate self-worth
- Buying or collecting as a source of social contact

Steketee & Frost (2007)

Exposure

- Feared tasks (e.g., sorting, discarding) can be treated as exposure practices, beginning in areas and with objects that are less frightening, and gradually moving to areas that are more frightening.
- Eliminate rituals (e.g., checking, reassurance seeking)
- Consider imaginal exposure (e.g., imagined loss of possessions, loss of information)

CBT Hoarding Treatment Rules

- Therapist may not touch or remove any items without permission
- Clients make all decisions about possessions
- Treatment proceeds systematically
- Establish an organizing plan before sorting possessions.

Reducing Acquiring

- Avoiding triggers for acquiring, at least in the short term (e.g., to avoid yard sales, don't go out on Saturday morning)
- Enhance motivation to reduce acquiring
- Consider advantages and disadvantages
- Establish rules for acquiring
- Exposure to cues, without acquiring (e.g., go to mall and not buy anything)
- Introduce alternative sources of enjoyment
- Cognitive strategies

Clutter Visualization Exercises

- Imagine room with all of its current clutter, and evaluate discomfort, feelings, thoughts
- Visualize room with all the clutter gone (without thinking about where the clutter has gone). Again, evaluate level of discomfort, emotional responses, and thoughts. Also, imagine what could be done in the room now that it is not cluttered.

Targets for Cognitive Strategies

- Value of objects
- Objects representing personal identity
- Objects representing safety
- Need for objects
- Ability to tolerate discomfort
- Perfectionism
- Responsibility for objects
- Usefulness, avoiding waste
- Confidence in memory
- Need for control over objects

Problem Solving Steps

1. Define problem and contributing factors
2. Brainstorm solutions
3. Evaluate solutions and select one or two
4. Break solutions into manageable steps
5. Implement the steps
6. Evaluate the outcome
7. Repeat the process until a good solution is found

Categorizing Unwanted Items

- Trash
- Recycle
- Donate
- Sell
- Undecided

Treating Hoarding

- Presence of hoarding may decrease the effectiveness of standard OCD treatment.
- Hoarding-specific CBT is promising, based on preliminary studies.
- Some research supporting SSRIs as well.

Tolin et al. (2007) study

- Tolin et al. (2007) published an open trial of a 26-session treatment for hoarding, occurring over 7-12 months, with frequent home visits. 10 out of 14 participants completed treatment. Medications were excluded.
- Treatment targeted motivation, organization, acquiring, removing clutter.
- 50% of completers were much improved or very much improved at posttreatment.
- Compliance with homework was significantly related to outcome.

Treating Hoarding

- Steketee, G., & Frost, R.O. (2007). *Compulsive hoarding and acquiring (therapist guide)*. New York: Oxford.
- Steketee, G., & Frost, R.O. (2007). *Compulsive hoarding and acquiring (workbook)*. New York: Oxford.
- Tolin, D., & Frost, R.O., Steketee, G. (2007). *Buried in treasures: Help for compulsive acquiring, saving, and hoarding*. New York: Oxford.
- Tompkins, M.A., & Hartl, T.L. (2009). *Digging out: Helping your loved one manage clutter, hoarding, and compulsive acquiring*. Oakland, CA: New Harbinger.

OCD
AND THE FAMILY

Family Accommodation and OCD
(Calvocoressi et al., 1995)

Examples of Accommodation

- Participation in OC compulsions
- Providing items for OC rituals
- Assisting with or participating in patient avoidance
- Modifying family routine
- Doing things for the patient
- Modifying work or leisure schedule

Family Accommodation and OCD
(Calvocoressi et al., 1995)

Percent of Family Members Reporting:

No Accommodation	11.8%
Mild Accommodation	50%
Moderate Accommodation	29.4%
Severe Accommodation	8.8%

OCD and Expressed Emotion
(Hibbs et al., 1991)

Critical Comments

- Based on content (e.g., "*It's annoying when he leaves his shoes lying around*.") and tone of voice (e.g., speed, inflection, pitch, etc.) (e.g., *EVERY morning he goes out to get the paper*).

Emotional Overinvolvement

- *e.g., "I quit my job and went into debt so I could take care of him. I think I may end up in the hospital from all the stress I've been under."*

OCD and Expressed Emotion
(Hibbs et al., 1991)

Results:

	OCD	No Diagnosis
Low EE	18.4%	58.5%
High EE	81.6%	41.5%

Proposed Family Predictors of Poor Response to CBT

- Critical interactions with significant other
- Negative feelings in the household
- Pressure to confront feared situations
- Anger toward the OCD symptoms
- Belief that the OCD symptoms can be controlled
- Lack of empathy
- Accommodation

Proposed Family Predictors of Good Response to CBT

- Decreased participation in the patient's rituals
- Tendency to ignore the patient's rituals
- Increased expression of concern and support
- Increased logical discussion of the problem

TREATING OCD IN CHILDREN

Prevalence and Onset

- Prevalence of OCD in children is about 1 in 200.
- Up to ½ of adults with OCD have an onset in childhood.
- Boys have an earlier OCD onset than girls.

Developmental Issues

- Treatments need to be adapted, depending on the age of the child.
- Younger children may require more activities and redirection than older children.
- Adolescents are more sensitive than younger children to the effects of OCD on peer relationships.

March & Mulle (1998)

Treating Children

- Source: March, J.S., & Mulle, K. (1998). *OCD in children and adolescents*. New York, NY: Guilford Press.

Structure of Treatment

- Four stages (12 to 20 sessions, each lasting 50 – 60 minutes)

  Stage 1: Psychoeduction
  Stage 2: Cognitive Training
  Stage 3: Mapping OCD
  Stage 4: Exposure and Ritual Prevention

- Children are given home and work phone numbers for the therapist, and a mid-week phone check-in is typically scheduled.

Treatment Assumptions

- Most of the treatment (e.g., 75% of sessions) is focused on ERP
- As with adults, children are not forced to do anything they are not ready and willing to do.

Session 1

- Define "obsessions," "compulsions," and other key terms
- Define OCD within a neurobehavioral framework (to help reduce self-blame)
- Medications may be explained using a metaphor of "water wings" (or "training wheels") that can be removed when no longer needed.

Session 2

- Begin mapping OCD
  - Introduce "fear thermometer"
- Introduce ERP concepts
- Make OCD the problem (e.g., "How has OCD bossed you around this week?" "How did you beat up on OCD this week?")

Distancing the Child from OCD

- Children are encouraged to distance themselves from their OCD.
- Chasing OCD off my land; bossing back OCD
- OCD is conceptualized as an adversary and everyone must have a common goal of defeating OCD.
- Helps the child to see that he/she is not his/her OCD, and is not to blame for the OCD.
- Younger children (but not adolescents) may be encouraged to give their OCD a nickname.

March & Mulle (1998)

Distancing the Child from OCD

Instead of: "Are you sure that glass is clean?"
Say: "*OCD* is telling me there are lots of germs in that glass."
Instead of: "I am always thinking bad things."
Say: "*Mr. Nag* is scolding me again, but those ideas are his…not mine."
Instead of: "I have to line up my shoes before I can go to school."
Say: "*Mr. Neat Freak"* wants me to hang around the closet all morning."

March & Benton (2007)

Session 3

- Continue mapping OCD
  - Develop a symptom hierarchy
- Begin cognitive training
  - Constructive self-talk (e.g., “Can’t catch me this time, OCD”)
  - Coping statements
  - Cognitive restructuring
  - Cultivating detachment (e.g., assign nickname for OCD; view OCD as a brain hiccup)

Session 4

- Preparing for treatment
  - Finalizing the toolkit (e.g., cognitive strategies, fear thermometer, distancing from OCD, identifying triggers, etc.)
- Begin trial exposure practice

Sessions 5 - 18

- Therapist-assisted imaginal and in vivo ERP, and homework assignments
- Identify OCD’s influence onfamily members
- Troubleshooting (e.g., dealing with comorbidity)
- Parental check-in at each session, and full family meetings at sessions 7 and 12
- Occasional *rewards*, *ceremonies* (e.g., going out for pizza to celebrate a success) and *notifications* (e.g., calling Grandma to tell her about successes) should be planned from time to time.

Sessions 19 - 21

- Relapse prevention (session 19)
- Graduation (session 20)
- Booster session (session 21)

Possible Roles for Parents

- Helper of OCD (needs to change)
- Cheerleader for the child
- Co-therapist or coach (with the child’s permission)

Teaching Parents to Communicate Supportively

- Parents should be taught not to harass, punish or try to reason with a child who stuck in an OCD attack, any more than they would instruct a child to stop coughing if he or she had a cold.
- Instead, try..”I’m so sorry you’re hurting. This one is pretty hard. Just do the best you can and we’ll get there.”

March & Benton (2007)

Metaphors

- "Giving OCD what it wants makes it come back for more."

Books for Children and Parents

- March, J.S., & Benton, C.M. (2007). *Talking back to OCD: The program that helps kids and teens say "no way" – and parents say "way to go."* New York, NY: Guilford Press.
- Wagner, A.P. (2002). *What to do when your child has obsessive-compulsive disorder: Strategies and solutions*. Rochester, NY: Lighthouse Press.
- Wagner, A.P. (2000). *Up and down the worry hill: A children's book about obsessive-compulsive disorder and its treatment*. Rochester, NY: Lighthouse Press.

Child OCD Manuals

- *Freeman, J.B., & Garcia, A.M. (2009). Family-based treatment for young children with OCD (therapist guide). New York, NY: Oxford University Press.*
- *Freeman, J.B., & Garcia, A.M. (2009). Family-based treatment for young children with OCD (workbook). New York, NY: Oxford University Press.*
- Piacentini, J., Langley, A., & Roblek, T. (2007). *Cognitive-behavioral treatment of childhood OCD: It's only a false alarm (therapist guide)*. New York, NY: Oxford University Press.
- Piacentini, J., Langley, A., & Roblek, T. (2007). *It's only a false alarm (workbook)*. New York, NY: Oxford University Press.

OVERVIEW OF PERFECTIONISM

Definition of Perfectionism

Perfectionism is a disposition to regard anything short of perfection as unacceptable

Merriam Webster Dictionary

Definition of Perfectionism

A perfectionist is someone "whose standards are high beyond reach or reason" and "who strain compulsively and unremittingly toward impossible goals and who measure their own worth entirely in terms of productivity and accomplishment."

David Burns (1980)

OC Personality Disorder

- Preoccupied with details, rules, lists, order, organization, schedules
- Perfectionism that interferes with task completion
- Excessively devoted to work and productivity
- Overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values
- Unable to discard worn-out or worthless objects
- Reluctant to delegate tasks or to work with others
- Miserly spending style toward both self and others
- Rigidity and stubbornness

Domains of Perfectionism

- Performance at work or school
- Relationships, friendships and family life
- Leisure and recreation
- Neatness and aesthetics
- Organization and ordering
- Writing
- Speaking
- Physical appearance
- Health and personal cleanliness

Perfectionism and Psychological Functioning

- Social and performance anxiety
- Worry and generalized anxiety disorder
- Obsessive compulsive disorder
- Obsessive compulsive personality disorder
- Eating disorders
- Body dysmorphic disorder
- Anger
- Depression

TREATING PERFECTIONISM

Cognitive Features

- All-or-nothing thinking / should statements
- Excessively high and inflexible standards
- Probability overestimations
- Being overly focused on details
- Catastrophic thinking
- Over-responsibility and an excessive need for control
- Biases in attention and memory

Changing Perfectionistic Thinking

- Examining the evidence
- Education
- Perspective shifting
- Compromising with self and others
- Hypothesis testing
- Changing social comparison habits
- Looking at the big picture
- Tolerating uncertainty and ambiguity

Changing Perfectionistic Thinking

Perfectionistic Statement

- It's terrible that I got "B" on my first midterm exam

Rational Response

- It is unlikely that my grade on this exam will have any impact on what I am doing a year from now (e.g., my career, income, relationships, etc.)

Changing Perfectionistic Thinking

Perfectionistic Statement

- My haircut looks terrible and I am terrified of being seen in public

Rational Response

- People on the street are much less interested in my hair than I am and they probably won't even notice

Changing Perfectionistic Thinking

Perfectionistic Statement

- I feel bad that the cake that I made for my daughter's birthday party did not turn out the way I hoped it would

Rational Response

- The children will probably still enjoy the cake and even if they don't, it won't matter a week from now

Changing Perfectionistic Thinking

Perfectionistic Statement

- It drives me crazy when my husband leaves his jacket lying on the floor

Rational Response

- I guess he only leaves his jacket lying around once per week. That is a small price to pay for an otherwise great relationship

Changing Perfectionistic Thinking

Perfectionistic Statement

- I am very upset because my new car has a small scratch on the fender

Rational Response

- *It is normal for cars to have small scratches. If it didn't happen today, it would have happened sooner or later*

Behavioral Features

- Overcompensating
- Excessive checking and reassurance seeking
- Repeating and correcting
- Excessive organizing and list making
- Difficulty making decisions
- Procrastination

Behavioral Features

- Not knowing when to quit
- Giving up too soon
- Failure to delegate
- Hoarding
- Avoidance
- Attempts to change the behavior of others

Changing Perfectionistic Behaviour Exposure-Based Strategies

- Design practices that are predictable, structured and planned in advance
- Continue the practice until anxious predictions are challenged or until discomfort has decreased
- Practice frequently and schedule practices close together
- Expect to feel uncomfortable
- Don't use subtle avoidance strategies
- Use cognitive strategies to cope with discomfort following practices

Sample Exposure Hierarchy
Fear of Making Mistakes in Front of Others

Item	Anxiety (0-100)
Give a formal presentation about unfamiliar material in front of people I don't know well	99
Throw a party for people from work and prepare an unfamiliar dish	85
Purposely forget my wallet when in line at the store	85
Ask someone to repeat themselves at a meeting	75
Show up for a haircut on the wrong day	60
Have lunch with a co-worker and allow uncomfortable silences	50
Answer a question in my night class	45
Forget my ticket when I pick up my dry cleaning	40

Other Strategies for Changing Perfectionistic Behavior

- Response prevention
- Prioritizing
- Overcoming procrastination
- Communication training
  - Assertiveness training
  - Learning to listen
  - Learning to pay attention to non-verbal communication

DOES PERFECTIONISM RESPOND TO TREATMENT?

Does Treatment Work? - Study 1

- *N* = 107
- Diagnosis = Social Anxiety Disorder
- Treatment = 12 sessions of group CBT for social phobia
- Ashbaugh, A., Antony, M.M., Liss, A., Summerfeldt, L.J., McCabe, R.E., & Swinson, R.P. (2007). Changes in perfe ctionism following cognitive-behavioral therapy of social phobia. *Depression and Anxiety, 24,* 169-177.

Does Treatment Work? - Study 1

Measure	Pre	Post	*p*
SPS	39.08	25.51	< .0001
SIAS	51.95	38.05	< .0001
DASS-Depression	17.07	13.27	< .0001
DASS-Anxiety	13.51	10.17	< .0001
DASS-Stress	19.72	15.88	< .0001

From: Ashbaugh, A., Antony, M.M., Liss, A., Summerfeldt, L.J., McCabe, R.E., & Swinson, R.P. (2007). Changes in perfectionism following cognitive-behavioral therapy of social phobia. *Depression and Anxiety, 24,* 169-177.

Does Treatment Work? - Study 1

Measure	Pre	Post	*p*
Concern over Mistakes	29.13	26.40	< .0001
Doubts about Actions	13.65	12.70	< .05
Personal Standards	22.41	22.03	n.s.
Parental Expectations	13.71	13.71	n.s.
Parental Criticism	11.43	11.16	n.s.
Organization	21.94	20.01	< .01
FMPS Total	90.32	85.90	< .01

From: Ashbaugh, A., Antony, M.M., Liss, A., Summerfeldt, L.J., McCabe, R.E., & Swinson, R.P. (2007). Changes in perfectionism following cognitive-behavioral therapy of social phobia. *Depression and Anxiety, 24,* 169-177.

Does Treatment Work? - Study 2

- *N* = 20
- Participants – high scorers on the *Clinical Perfectionism Examination* and the *Clinical Perfectionism Questionnaire* (Fairburn, Cooper, and Shafran).
- CBT treatment vs. a wait-list control condition
- Treatment = 10 sessions of individual CBT over 8 wks.
- Riley, C., Lee, M., Cooper, Z., Fairburn, C.G., & Shafran, R. (2007). A randomised controlled trial of cognitive-behaviour therapy for clinical perfectionism: A preliminary study. *Behaviour Research and Therapy, 45,* 2221-2231.

Does Treatment Work? - Study 3

- *N* = 49
- Participants – high scorers (84 or higher) on *Frost Multidimensional Perfectionism Scale*
- Guided self-help (eight 50-minute sessions) vs. pure self-help (no therapist)
- Treatment based on first edition of *When Perfect Isn't Good Enough* (Antony & Swinson, 1998).
- Pleva, J., & Wade, T.D. (2006). Guided self-help versus pure self-help for perfectionism: A randomised controlled trial. *Behaviour Research and Therapy, 45,* 849-861.

Does Treatment Work? - Study 3

Results

- Generally, participants in both groups showed improvement on measures of depression, OCD symptoms, depression, and anxiety.
- Overall, improvement was greater in the GSH condition than the PSH condition
- Generally, gains were maintained at 3 month follow-up.

Recommended Readings

- Antony, M.M., & Swinson, R.P. (2009). *When perfect isn't good enough: Strategies for coping with perfectionism, second edition.* Oakland, CA: New Harbinger Publications.
- Burns, E.F. (2008). Nobody's perfect: A story for children about perfectionism. Washington, DC: Magination press.
- Shafran, R., Egan, S., & Wade, T. (2010). Overcoming perfectionism: A self-help guide using cognitive behavioral techniques. London, UK: Constable & Robinson.

Recommended Readings

- Flett, G.L., & Hewitt, P.L. (2002). *Perfectionism: Theory, research, and treatment.* Washington, DC: American Psychological Association.

Recommended Video

- Antony, M.M. (2008). *Cognitive behavioral therapy for perfectionism over time* (DVD Video). Washington, DC: American Psychological Association.

TREATMENT CHALLENGES

Limitations of Standard Treatment

"…one-quarter to one-third of individuals with OCD do not benefit from ERP"

(Clark, 2005)

Why?

- Treatment refusal
- Treatment drop out
- Lack of treatment response
- Poor maintenance of treatment gains
- Inability to generalize treatment gains to their day-to-day environments

Challenges in the Treatment of Obsessive-Compulsive Disorder

- Breadth of symptoms
- Transfer of responsibility
- Symptom shift
- Competing demands of real life (e.g., needing to wash at work)
- Presence of realistic risk (e.g., possible pedophilia, risk of disease)

Challenges in the Treatment of Obsessive-Compulsive Disorder

- Predominantly mental rituals
- Poor insight
- Moral or ethical values that conflict with treatment (e.g., religious obsessions)
- Requests for reassurance
- Family issues (e.g., accommodation)
- Severe functional impairment at work, in relationships, and in other life domains

Treatment Interfering Behaviors

Pollard (2007)

- Does not acknowledge having a problem
- Underestimates problem severity
- Does not identify clear treatment goals
- Dismisses the therapist's view of the problem or the suggested treatment
- Attempts to change the focus of sessions to issues not related to the treatment
- Has difficulty explaining the treatment plan or the rationale behind it

Treatment Interfering Behaviors

Pollard (2007)

- Difficulty answering questions (e.g., too much detail, irrelevant responses
- Frequently late or misses sessions
- Difficulty following the treatment plan
- Provides information that is inaccurate, misleading or inconsistent
- Engages in or threatens self-destructive acts
- Makes others feel physically threatened

Dealing with Treatment Interfering Behaviors

- Patient and therapist collaboratively identify TIBs that may be interfering with treatment
- Select one TIB at a time to work on
- Identify readiness goals (e.g., for 5 sessions, Jack will agree not to call the therapy stupid)
- Identify factors contributing to the TIB
- Implement strategies to target TIB
- Resume treatment of the OCD

MOTIVATIONAL ENHANCEMENT FOR OCD

Motivational Interviewing

- Developed by William R. Miller and Stephen Rollnick
- www.motivationalinterview.org

Motivational Interviewing

- Arkowitz, H., Westra, H.A., Miller, W.R., & Rollnick, S. (2008). *Motivational interviewing in the treatment of psychological problems*. New York: Guilford.
- Miller, W.R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change, 2nd Ed.* New York: Guilford.
- Rosengren, D.B. (2009). Building motivational interviewing skills: A practitioner workbook. New York: Guilford.

Definition

- Motivational Interviewing – "*A client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence*."

  Miller & Rollnick, 2002

Transtheoretical Model of Change

- *Precontemplation* – Person is unaware of the problem, or is unwilling to change, or feels discouraged
- *Contemplation* – Person is aware of the problem and is thinking seriously about changing.
- *Preparation* – Person is ready to change in the near future.
- *Action* – Person takes steps to change.

Is the Patient Willing, Ready, and Able?

- ***Willing*** – is change important to the patient?
- ***Able*** – is the patient confident in his or her ability to change?
- ***Ready*** – Is change a high priority for the patient at this time?

Assumptions

- People are ambivalent about change (e.g., in OCD – "my OCD rituals protect me from getting sick" vs. "my OCD keeps me up at night)"
- Motivation occurs in an interpersonal context, rather than residing in the individual.

Assumptions

- MI is viewed as an approach to preparing the patient for treatment, and is therefore complementary to CBT.
- Focus is on intrinsic reasons for change, rather than extrinsic reasons (e.g., financial gains, social pressure, punishment, etc.)
- Emphasis is on change that is consistent with the individual's own values.

Spirit of Motivational Interviewing

- Collaborative – honors the client's perspectives and expertise (vs. confrontational)
- Evocation – draws on the client's own perceptions, goals, and values (vs. education)
- Autonomy – therapist affirms the client's right and capacity for self-direction (vs. authority)

Four General Principles

1. Express empathy
2. Develop discrepancy
3. Roll with resistance
4. Support self-efficacy

Expressing Empathy

- Communicating acceptance
- Skillful reflective listening, without judging, criticizing or blaming
- Acceptance of the client's ambivalence (ambivalence is normal)

Four General Principles

1. Express empathy
2. Develop discrepancy
3. Roll with resistance
4. Support self-efficacy

Developing Discrepancy

- Highlight and amplify (from the client's perspective) the discrepancy between present behavior and the client's broader goals and values.
- The focus is on intrinsic motivators (e.g., personal values) rather than extrinsic ones (e.g., pressure from spouse, threat of job loss).
- The client (not the therapist) generates the arguments for change.

Four General Principles

1. Express empathy
2. Develop discrepancy
3. Roll with resistance
4. Support self-efficacy

Categories of Resistance

- ***Arguing*** (e.g., challenging, discounting, hostility toward therapist)
- ***Interrupting*** (e.g., talking over, cutting off)
- ***Negating*** (e.g., disagreeing, excusing, minimizing, unwillingness to change)
- ***Ignoring*** (e.g., inattention, no response, non-answer to the question)

Other Signs of Resistance

- Complaining
- Changing the subject
- Nonverbal signs (e.g., sighing, turning away)
- Arriving late, cancelling or forgetting appointments
- Not completing homework
- Feeling discouraged despite improvements

Resistance

- Resistance is considered to be a product of ambivalence.
- Resistance occurs in the context of the interaction between the client and therapist. It is a signal of dissonance in the relationship (rather than just the client being non-cooperative)

Therapist Behaviors That Increase Client Resistance

- Arguing for change
- Assuming the expert role
- Criticizing, shaming, or blaming the client
- Labeling (e.g., accepting diagnostic label as an explanation of the client's behavior)
- Being in a hurry
- Claiming preeminence ("I know what's best for you")

Resistance

- Arguing the reasons why the patient should change sets up the patient to argue the opposite, essentially playing out the patient's ambivalence.
- Instead, the therapist sides with resistance, reflects it, and even amplifies it, rather than confronting it directly.

Rolling with Resistance

- Therapist does not advocate for change (doing so may strengthen the opposite position that the client is forced to defend.
- Resistance is not directly opposed. Rather, the therapist rolls with or flows with resistance.
- Client is the main resource for finding answers and solutions.
- Resistance is a signal to respond differently.

Dealing with Resistance

Simple Reflection

- Client - If I could do exposure, I wouldn't be coming to you for help.
- Therapist - It's hard for you to imagine being able to do the exposure practices.

Amplified Reflection

- Client - If I could do exposure, I wouldn't be coming to you for help.
- Therapist – At this point, the idea of doing exposure seems out of the question.

Dealing with Resistance

Shifting Focus

- Client – Your probably going to make me throw away all the stuff I have been hoarding. I can't even imagine that.
- Therapist – How we proceed will be up to you. For now, I just want to understand how the hoarding affects your life. Can you tell me more about that?

Dealing with Resistance

Reframing

- Client – My husband keeps nagging me to stop my hand washing. It upsets him when my hands are bleeding
- Therapist – It sounds like he really cares about you. I guess he expresses his concern in a way that makes you angry. Maybe we can help him find a better way to let you know that he is worried about you.

Four General Principles

1. Express empathy
2. Develop discrepancy
3. Roll with resistance
4. Support self-efficacy

Supporting Self-Efficacy

- A person's belief in his or her ability to change is an important motivator
- A therapist's belief in a person's ability to change can be a self-fulfilling prophecy.

Two Phases of Motivational Interviewing

- Phase 1 – Resolving ambivalence and building intrinsic motivation for change
- Phase 2 – Strengthening commitment for change and developing a plan

Building Intrinsic Motivation

Assessing Importance and Confidence:

- How **important** is it for you to…..?
- How **confident** you that if you decided to…, you could do it?
- Importance and confidence are rated on a 0-10 point scale.

Building Intrinsic Motivation

- **Open Questions**
  - "Tell me what you have noticed about how your anxiety has affected your life over the past few years?"
  - "What sorts of things do you miss about your life before your OCD?"

Building Intrinsic Motivation

- **Reflective Listening**
  - Respond with statements that show understanding, clarify meaning, and move the conversation forward)
  - Beware of overstating or understating

Building Intrinsic Motivation

- ***Overstating***
  - *Client* – I didn't like when my husband forgot to wash his hands.
  - *Therapist* – you were *very angry* with him.
  - *Client* – no, not really angry. I just felt a bit upset

Building Intrinsic Motivation

- ***Understating***
  - *Client* – I didn't like when my husband forgot to wash his hands.
  - *Therapist* – you were a *bit upset* with him.
  - *Client* – You bet I was upset! He does that all the time.

Building Intrinsic Motivation

- **Affirm and Support the Client**
  - "I appreciate that you took a big step in coming here today"
  - "I enjoyed getting to know you today"
  - "I would find it very stressful to be dealing with what you are dealing with right now"

Two Phases of Motivational Interviewing

- Phase 1 – Resolving ambivalence and building intrinsic motivation for change
- Phase 2 – Strengthening commitment for change and developing a plan

Discussing Change

- Conversation initially focuses on reasons for change
  - Disadvantages of the status quo
  - Advantages of change
  - Optimism for change
  - Intention to change

Examples of Change Talk

- *Recognizing disadvantages of the status quo*
  - "This is more of a problem than I recognized"
- *Recognizing advantages of change*
  - "I would be able to enjoy time with my family much more than I can now"
- *Expressing optimism about change*
  - "I think I could stop my rituals if I really tried"
- *Expressing intention to change*
  - "I need to stop avoiding doing things"

Evoking Change Talk

- Use the importance scale (e.g., "why are you at a 5 and not a 0 on the importance scale")?
- Ask clients to elaborate on responses
- Look back at the past, before a problem developed
- Look forward to a future after the change has been made
- Explore the clients goals and values
- Ask evoking questions

Questions to Evoke Change

Disadvantages of the Status Quo

- What is the problem with your current situation?
- How has your anxiety stopped you from doing what you want to do in life?
- What would happen if you don't change anything?

Questions to Evoke Change

Advantages of Change

- How would you like your life to be in five years?
- What would be better about your life if you spent less time cleaning?
- How would things be better if you could drive anywhere you want to?

Questions to Evoke Change

Optimism About Change

- What makes you think that you can get rid of your OCD?
- How confident are you that you will be able to conquer your hand washing?
- What personal strengths do you have that will make it possible for you to stop your checking?

Questions to Evoke Change

Intention to Change

- How are you feeling about going forward with the treatment at this point?
- What do you think you might do?
- What would you be willing to try?

Research on MI

- Related to increased treatment adherence and reduced drop out in other treatment areas.
- Evidence supporting MI for improving GAD treatment outcomes.
- Preliminary evidence MI can increase rates of acceptance of ERP in OCD (Maltby & Tolin, 2005).

Study on Motivational Enhancement for OCD

Collaborators

- Randi E. McCabe, Ph.D.
  St. Joseph's Healthcare, Hamilton and McMaster University
- Karen Rowa, Ph.D.
  St. Joseph's Healthcare, Hamilton and McMaster University
- Richard Swinson, M.D.
  St. Joseph's Healthcare, Hamilton and McMaster University
- Lisa Young, B.A.
  St. Joseph's Healthcare, Hamilton and McMaster University

Acknowledgements

- This study was funded by a research award from the Obsessive Compulsive Foundation to Dr. Randi McCabe and colleagues.

Motivational Enhancement (ME)

- 3-session intervention using ME techniques

Goals:

- resolve ambivalence
- increase awareness of impact of OCD in the client's life
- address concerns about ERP
- examine costs/benefits of life with and without OCD
- enhance readiness for change and establish realistic and positive treatment expectations

Study Design

- Random assignment to 3 sessions of ME or 3 sessions of relaxation therapy (control condition) prior to a standard 15- session course of ERP
- *N* = 32 (so far), of which 25 have completed treatment
- Main outcome measure: *Yale-Brown Obsessive Compulsive Scale* (YBOCS)

Study Hypotheses

- Relative to those receiving relaxation, participants receiving ME are expected to have greater improvements in OCD symptoms, lower rates of relapse during follow up, and fewer dropouts.

Conclusion

- Initial findings suggest that the ME intervention may augment ERP treatment outcome as reflected in reduced severity of OCD symptoms. Increased power is needed for findings to reach significance on some measures

MINDFULNESS AND ACCEPTANCE-BASED STRATEGIES

Origins of Mindfulness

- Mindfulness is an acceptance-oriented process that can be traced back 2500 years to the earliest forms of Buddhist philosophy.
- Mindfulness involves deliberately paying attention to experiences as they are, in the present and without evaluation.
- Meditation is one strategy for becoming mindful, though there are others.

Assumptions of Mindfulness

- Mindfulness should not be used as a strategy for *controlling* anxiety.
- Rather, mindfulness is used to foster a nonevaluative approach to experience.
- Anxiety reduction may be a by-product of mindfulness, but it is not the goal.

Acceptance and Commitment Therapy for Anxiety Disorders

- www.acceptanceandcommittmenttherapy.com
- www.act-for-anxiety-disorders.com

Primary Goals of ACT

- To foster acceptance of unwanted thoughts and feelings – especially those that cannot be controlled by the individual.
- To foster commitment and action toward living a rich, fulfilling life, consistent with one's core values.

Control-Oriented Strategies

- Avoidance of feared people, situations, places, activities, thoughts, and emotions
- Overcompensating
- Checking and reassurance seeking
- Repeating and correcting
- Excessive organizing and list making
- Putting off decisions
- Distracting yourself from uncomfortable feelings

Evaluating an Experience

Situation – "I can't fall asleep."

- "This is very frustrating"
- "I won't be able to function tomorrow"
- "Why does this keep happening to me"
- "Why does my partner have to snore so loudly"

Strategies for Becoming Mindful

- Raisin exercise
- Mindful breathing
- Body scan exercise

Strategies for Developing Acceptance

Therapist helps patient to develop an observer self

- Teach client to notice events without evaluating content
- Separate self-evaluations from the self that evaluates (e.g., thank your mind for that thought, label thoughts and sensations)
- Point out tendency to drift to past and future, and to bring client back to the present

Strategies for Developing Acceptance

Therapist undermines cognitive fusion (i.e., the fusion of experience with evaluations)

- Direct client's attention to the present moment.
- Contrast what the client's mind says will work with what the client's experience says
- Use metaphors and experiential exercises to illustrate differences between actual experience and conceptualized experience.

Strategies for Taking Action

- Build an action plan based on identified life values
- Help client to reveal hidden sources of interference or barriers to action
- Encourage clients to keep commitments

Exercises and Metaphors

- Chinese Finger Trap Exercise
- Epitaph Exercise

From

- Eifert, G.H., & Forsyth, J.P. (2005). *Acceptance & commitment therapy for anxiety disorders: A practitioner's treatment guide to using mindfulness, acceptance, and values-based behavior change strategies*. Oakland, CA: New Harbinger.
- Forsyth, J.P., & Eifert, G.H. (2007). *The mindfulness and acceptance workbook for anxiety: A guide to breaking free from anxiety, phobias, and worry using acceptance and commitment therapy*. Oakland, CA: New Harbinger.

Epitaph Exercise
Tom's Perfectionist Epitaph

Here Lie's Tom – A Man who Sought Perfection at All Cost

Tom's goal in life was to do everything as perfectly as possible and to make sure that others also lived up to his high standards. He spent much of his life correcting the behavior of his friends, family, and co-workers. Although his two marriages both ended in painful divorce and his children found him difficult to be around, Tom could take comfort in the fact that he did everything he could to help others to think about things in the same way as he did. Tom was also very devoted to his job in retail management. He put in many long hours, and never settled for anything less than perfection in his work or the work of his staff. He always checked and double checked everything to make sure there were no errors. For Tom, work always came before vacations, spending time with friends and family, exercising, and eating well. His goal was to make the world a more perfect place, though he left this earth feeling alone and unfulfilled.

Is Acceptance Anything New?

"Accepting the presence of anxiety is crucial. The patient usually wants to avoid or fight anxiety symptoms. In _____ therapy, he is encouraged instead to accept his symptoms. This strategy is based on the rationale that once anxiety reaches a certain level, the patient can no longer control the symptoms. Paradoxically, by giving up the idea of control, the patient can be taught to control his anxiety...The therapist can stress that one has to accept reality to deal effectively with it. The therapist should thus make it clear that acceptance is allowing what exists at the moment to be as it is. Acceptance is acknowledging the existence of an event without placing a judgment or label on it (right/wrong, good/bad, safe/dangerous). The negative judgments and evaluations the patient places on his anxiety only deepen his distress. For this reason, the patient is encouraged to stop "value-judging" his anxiety."

Is Acceptance Anything New?

"Accepting the presence of anxiety is crucial. The patient usually wants to avoid or fight anxiety symptoms. In cognitive therapy, he is encouraged instead to accept his symptoms. This strategy is based on the rationale that once anxiety reaches a certain level, the patient can no longer control the symptoms. Paradoxically, by giving up the idea of control, the patient can be taught to control his anxiety...The therapist can stress that one has to accept reality to deal effectively with it. The therapist should thus make it clear that acceptance is allowing what exists at the moment to be as it is. Acceptance is acknowledging the existence of an event without placing a judgment or label on it (right/wrong, good/bad, safe/dangerous). The negative judgments and evaluations the patient places on his anxiety only deepen his distress. For this reason, the patient is encouraged to stop "value-judging" his anxiety."

Beck & Emery (1985)

Recommended Readings

- Eifert, G.H., & Forsyth, J.P. (2005). *Acceptance & commitment therapy for anxiety disorders: A practitioner's treatment guide to using mindfulness, acceptance, and values-based behavior change strategies*. Oakland, CA: New Harbinger.
- Forsyth, J.P., & Eifert, G.H. (2007). *The mindfulness and acceptance workbook for anxiety: A guide to breaking free from anxiety, phobias, and worry using acceptance and commitment therapy*. Oakland, CA: New Harbinger.

form 4.1

Anxiety Thought Record

Day and time	Situation	Anxiety-provoking thoughts and predictions	Anxiety before (0–100)	Alternative thoughts and predictions	Evidence and realistic conclusions	Anxiety after (0–100)

Books by the Presenter

1. Antony, M.M., & Norton, P.J. (2009). *The anti-anxiety workbook: Proven strategies to overcome worry, phobias, panic, and obsessions*. New York: Guilford Press. ISBN-13: 978-1593859930
2. Antony, M.M., & Stein, M.B. (2009). *Oxford handbook of anxiety and related disorders*. New York: Oxford University Press. ISBN-13: 978-0195307030.
3. Antony, M.M., & Swinson, R.P. (2009). *When perfect isn't good enough: Strategies for coping with perfectionism, 2nd edition.* Oakland, CA: New Harbinger Publications. ISBN-13: 978-1572245594
4. Antony, M.M., & Rowa, K. (2008). *Social anxiety disorder: Psychological approaches to assessment and treatment*. Cambridge, MA: Hogrefe. ISBN-13: 978-0889373112.
5. Antony, M.M., & Swinson, R.P. (2008). *Shyness and social anxiety workbook: Proven, step-by-step techniques for overcoming your fear,* 2nd edition. Oakland, CA: New Harbinger Publications. ISBN-13: 978-1572245532.
6. Antony, M.M., Purdon, C., & Summerfeldt, L.J. (2007). *Psychological treatment of OCD: Fundamentals and beyond*. Washington, DC: American Psychological Association. ISBN-13: 978-1591474845.
7. Antony, M.M., & Rowa, K. (2007). *Overcoming fear of heights: How to conquer acrophobia and live a life without limits*. Oakland, CA: New Harbinger Publications. ISBN-13: 978-1572244566
8. Antony, M.M., Craske, M.G., & Barlow, D.H. (2006). *Mastering your Fears and Phobias (client workbook*), second edition. New York: Oxford University Press. ISBN: 0-19-518918-3
9. Antony, M.M., & Watling, M. (2006). *Overcoming medical phobias: How to conquer fear of blood, needles, doctors, and dentists*. Oakland, CA: New Harbinger Publications. ISBN: 1-57224-387-2.
10. Bieling, P.J., McCabe, R.E., & Antony, M.M. (2006). *Cognitive behavioral therapy in groups*. New York: Guilford Press. ISBN: 1-59385-325-4.
11. Craske, M.G., Antony, M.M., & Barlow, D.H. (2006). *Mastering your Fears and Phobias (therapist guide),* second edition. New York: Oxford University Press. ISBN: 0-19518-917-5.
12. Antony, M.M., Ledley, D.R., & Heimberg, R.G. (2005). *Improving outcomes and preventing relapse in cognitive behavioral therapy.* New York: Guilford Press. ISBN: 1-59385-197-9.
13. Antony, M.M., & McCabe, R.E. (2005). *Overcoming animal & insect phobias: How to conquer fear of dogs, snakes, rodents, bees, spiders & more*. Oakland, CA: New Harbinger Publications. ISBN: 1-57224-388-0.
14. Antony, M.M., & McCabe, R.E. (2004). *10 simple solutions to panic: How to overcome panic attacks, calm physical symptoms, and reclaim your life*. Oakland, CA: New Harbinger Publications. ISBN: 1-57224-325-2.
15. Antony, M.M. (2004). *10 simple solutions to shyness: How to overcome shyness, social anxiety, and fear of public speaking*. Oakland, CA: New Harbinger Publications. ISBN: 1-57224-348-1
16. Bieling, P.J., & Antony, M.M. (2003). *Ending the depression cycle: A step-by-step guide for preventing relapse.* Oakland, CA: New Harbinger Publications. ISBN: 1-57224-333-3
17. Antony, M.M., & Barlow, D.H. (Eds.) (2002; paperback 2004). *Handbook of assessment and treatment planning for psychological disorders*. New York: Guilford Press. ISBN (paperback): 1-59385-013-1; ISBN (hardcover): 1-57230-703-X
18. Antony, M.M., Orsillo, S.M., & Roemer, L. (Eds.) (2001). *Practitioner's guide to empirically-based measures of anxiety*. New York: Springer. ISBN: 0-306-46582-5
19. Antony, M.M., & Swinson, R.P. (2000). *Phobic disorders and panic in adults: A guide to assessment and treatment*. Washington, DC: American Psychological Association. ISBN: 1-55798-696-7
20. Swinson, R.P., Antony, M.M., Rachman, S., & Richter, M.A. (Eds.) (1998; paperback 2001). *Obsessive compulsive disorder: Theory, research, and treatment*. New York: Guilford Press. ISBN (paperback): 1-57230-732-3; ISBN (hardcover): 1-57230-335-2

Video Resources

Panic Disorder With and Without Agoraphobia

Clark, D.M. (1998). *Cognitive therapy for panic disorder (DVD)*. APA Psychotherapy Videotape Series. Washington, DC: American Psychological Association.

Rapee, R.M. (1999). *Fight or flight? Overcoming panic and agoraphobia (DVD)*. New York: Guilford Publications.

Social Phobia

Albano, A.M. (2006). *Shyness and social phobia*. (DVD). Washington, DC: American Psychological Association.

Rapee, R.M. (1999). *I think they think…Overcoming social phobia* (DVD). New York: Guilford.

Obsessive-Compulsive Disorder and Related Problems

Antony, M.M. (2009). *Behavior therapy over time* (DVD Video on Compulsive Hoarding). Washington, DC: American Psychological Association.

Antony, M.M. (2007). *Obsessive-Compulsive Behavior* (DVD). Washington, DC: American Psychological Association.

Wilson, R.R. (2005). *Obsessive-compulsive disorder* (DVD). Washington, DC: American Psychological Association.

Perfectionism

Antony, M.M. (2008). *Cognitive behavioral therapy for perfectionism over time* (DVD). Washington, DC: American Psychological Association.

Anxiety Disorders and Cognitive Behavior Therapy

Padesky, C. *Guided discovery using Socratic dialog (DVD)*. May be ordered from www.padesky.com.

Padesky, C. *Testing automatic thoughts with thought records (DVD)*. May be ordered from www.padesky.com.

Relevant Associations

Association for Behavioral and Cognitive Therapies (ABCT)
305 Seventh Avenue, 16th Floor, New York, NY 10001-6008, USA
Tel: 212-647-1890 or 800-685-2228; Fax: 212-647-1865; Web Page: www.abct.org

Anxiety Disorders Association of America (ADAA)
8730 Georgia Avenue, Suite 600, Silver Spring, MD 20910, USA
Tel: 240-485-1001; Fax: 240-487-1020; Web Page: www.adaa.org

Obsessive-Compulsive Foundation
112 Water Street, Suite 501, Boston, MA 02119 USA
Tel: 617-973-5801; Fax: 617-973-5803; Web Page: www.ocfoundation.org

Anxiety Disorders Association of Canada (ADAC)
P.O. Box 117, Station Cote St. Luc, Montreal, QC H4V 2Y3
Tel: 514-484-0504 or 888-223-2252; Fax: 514-484-7892; Web Page: www.anxietycanada.ca

Recommended Readings

Obsessive-Compulsive Disorder

Professional Readings

Abramowitz, J.S. (2006): *Obsessive-compulsive disorder*. Cambridge, MA: Hogrefe.

Abramowitz, J.S. (2006): *Understanding and treating obsessive-compulsive disorder: A cognitive behavioral approach*. Mahwah, NJ: Lawrence Erlbaum Associates.

Antony, M.M., Purdon, C., & Summerfeldt, L.J. (2007). *Psychological treatment of obsessive-compulsive disorder: Fundamentals and beyond*. Washington, DC: American Psychological Association.

Clark, D.A. (2004). *Cognitive-behavioral therapy for OCD*. New York: Guilford.

March, J.S., & Mulle, K. (1998). *OCD in children and adolescents*. New York, NY: Guilford Press.

Rachman, S. (2003). *The treatment of obsessions*. New York: Oxford University Press.

Steketee, G., & Frost, R.O. (2007). *Compulsive hoarding and acquiring (therapist guide)*. New York: Oxford.

Wilhelm, S., & Steketee, G.S. (2006). *Cognitive therapy for obsessive-compulsive disorder: A guide for professionals*. Oakland, CA: New Harbinger Publications.

Self-Help Readings

Abramowitz, J.S. (2009). *Getting over OCD: A 10-step workbook for taking back your life*. New York: Guilford Press.

Carmin, C. (2009). *Obsessive-compulsive disorder demystified: An essential guide for understanding and living with OCD*. Cambridge, MA: Lifelong Books.

Foa, E.B. & Wilson, R. (2001). *Stop obsessing! How to overcome your obsessions and compulsions, revised edition.* New York: Bantam.

Grayson, J. (2004). *Freedom from obsessive-compulsive disorder: A personalized recovery program for living with uncertainty*. New York: Berkley Publishing Group.

Hyman, B.M., & Pedrick, C. (2005). *The OCD workbook: Your guide to breaking free from obsessive-compulsive disorder (2nd edition)*. Oakland, CA: New Harbinger.

Purdon, C., & Clark, D.A. (2005). *Overcoming obsessive thoughts: How to gain control of your OCD*. Oakland, CA: New Harbinger.

Steketee, G., & Frost, R.O. (2007). *Compulsive hoarding and acquiring (workbook)*. New York: Oxford.

Tolin, D., & Frost, R.O., Steketee, G. (2007). *Buried in treasures: Help for compulsive acquiring, saving, and hoarding*. New York: Oxford.

Tompkins, M.A., & Hartl, T.L. (2009). *Digging out: Helping your loved one manage clutter, hoarding, and compulsive acquiring*. Oakland, CA: New Harbinger.

Readings for Children

Wagner, A.P. (2000). *Up and down the worry hill: A children's book about obsessive-compulsive disorder and its treatment*. Rochester, NY: Lighthouse Press

Readings for Parents

Fitzgibbons, L., & Pedrick, C. (2003). *Helping your child with OCD*. Oakland, CA: New Harbinger.

March, J.S., & Benton, C.M. (2007). *Talking back to OCD: The program that helps kids and teens say "no way" – and parents say "way to go."* New York, NY: Guilford Press.

Wagner, A.P. (2002). *What to do when your child has obsessive-compulsive disorder: Strategies and solutions*. Rochester, NY: Lighthouse Press.

Manuals and Workbooks for Treating Children

Freeman, J.B., & Garcia, A.M. (2009). Family-based treatment for young children with OCD (therapist guide). New York, NY: Oxford University Press.

Freeman, J.B., & Garcia, A.M. (2009). Family-based treatment for young children with OCD (workbook). New York, NY: Oxford University Press.

Piacentini, J., Langley, A., & Roblek, T. (2007). *Cognitive-behavioral treatment of childhood OCD: It's only a false alarm (therapist guide)*. New York, NY: Oxford University Press.

Piacentini, J., Langley, A., & Roblek, T. (2007). *It's only a false alarm (workbook)*. New York, NY: Oxford University Press.

Perfectionism

Antony, M.M., & Swinson, R.P. (2009). *When perfect isn't good enough: Strategies for coping with perfectionism, second edition.* Oakland, CA: New Harbinger Publications.

Shafran, R., Egan, S., & Wade, T. (2010). Overcoming perfectionism: A self-help guide using cognitive behavioral techniques. London, UK: Constable & Robinson.

Burns, E.F. (2008). Nobody's perfect: A story for children about perfectionism. Washington, DC: magination press.

Flett, G.L., & Hewitt, P.L. (2002). *Perfectionism: Theory, research, and treatment.* Washington, DC: American Psychological Association.

General Assessment and Treatment Books

Assessment

Antony, M.M., & Barlow, D.H. (Eds.) (2010). *Handbook of assessment and treatment planning for psychological disorders, 2nd ed*. New York, NY: Guilford.

Antony, M.M., Orsillo, S.M., & Roemer, L. (Eds.) (2001). *Practitioner's guide to empirically-based measures of anxiety*. New York: Springer.

Motivational Interviewing

Arkowitz, H., Westra, H.A., Miller, W.R., & Rollnick, S. (2008). *Motivational interviewing in the treatment of psychological problems*. New York: Guilford.

Miller, W.R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change, 2nd Ed.* New York: Guilford.

Rosengren, D.B. (2009). Building motivational interviewing skills: A practitioner workbook. New York: Guilford

Cognitive-Behavioral Therapy

Antony, M.M., Ledley, D.R., & Heimberg, R.G. (Eds.) (2005). *Improving outcomes and preventing relapse in cognitive behavioral therapy.* New York: Guilford.

Barlow, D.H. (Ed.) (2008). *Clinical handbook of psychological disorders, 4th edition.* New York: Guilford.

Bieling, P.J., McCabe, R.E., & Antony, M.M. (2006). *Cognitive behavioral therapy in groups*. New York: Guilford.

Wright, J.H., Basco, M.R., & Thase, M.E. (2006). *Learning cognitive-behavior therapy: An illustrated guide.* Washington, DC: American Psychiatric Press.

Acceptance and Mindfulness-Based Therapies

Eifert, G.H., & Forsyth, J.P. (2005). *Acceptance & commitment therapy for anxiety disorders: A practitioner's treatment guide to using mindfulness, acceptance, and values-based behavior change strategies*. Oakland, CA: New Harbinger.

Forsyth, J.P., & Eifert, G.H. (2007). *The mindfulness and acceptance workbook for anxiety: A guide to breaking free from anxiety, phobias, and worry using acceptance and commitment therapy*. Oakland, CA: New Harbinger.

Medication Treatments

Virani, A.S., Bezchlibnyk-Butler, K.Z. & Jeffries, J.J. (Eds.) (2009). Clinical handbook of psychotropic drugs, 18th edition. Cambridge, MA: Hogrefe & Huber.

Bezchlibnyk-Butler, K.Z., & Virani, A.S (2007). Clinical handbook of psychotropic drugs for children and adolescents, 2nd edition. Cambridge, MA: Hogrefe & Huber.

Other Anxiety Disorders and Related Topics

Professional Readings

Antony, M.M., & Rowa, K. (2008). *Social anxiety disorder: Psychological approaches to assessment and treatment*. Cambridge, MA: Hogrefe.

Antony, M.M., & Stein, M.B. (2009). *Oxford handbook of anxiety and related disorders*. New York: Oxford.

Antony, M.M., & Swinson, R.P. (2000). *Phobic disorders and panic in adults: A guide to assessment and treatment*. Washington, DC: American Psychological Association.

Barlow, D.H. (Ed.) (2002). *Anxiety and its disorders: The nature and treatment of anxiety and panic* (2nd ed.). New York: Guilford.

Bernstein, D.A., Borkovec, T.D., & Hazlett-Stevens, H. (2000). *New directions in progressive relaxation training: A guidebook for helping professionals*. Westport, CT: Praeger.

Craske, M.G., Antony, M.M., & Barlow, D.H. (2006). *Mastering your Fears and Phobias (therapist guide),* second edition. New York: Oxford.

Craske, M.G., & Barlow, D.H. (2007). *Mastery of your anxiety and panic, 4th ed. therapist guide)*. New York: Oxford.

Dugas, M.J., & Robichaud, M. (2007). *Cognitive-behavioral treatment for generalized anxiety disorder*. New York: Routledge.

Foa, E.B., & Rothbaum, B.O. (1998). *Treating the trauma of rape: Cognitive behavioral therapy for PTSD*. New York: Guilford.

Foa, E.B., Hembree, E.A., & Rothbaum, B.O. (2007). *Prolonged exposure therapy for PTSD: emotional processing of traumatic experiences (therapist guide)*. New York: Oxford.

Foa, E.B., Keane, T.M., Friedman, M.J., & Cohen, J.A. (2009). *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies, 2nd ed*. New York: Guilford.

Furer, P., Walker, J.R., & Stein, M.B. (2007). *Treating health anxiety and fear of death: A practitioner's guide*. New York: Springer.

Heimberg, R.G., Turk, C.L., & Mennin, D.S. (Eds.) (2004). Generalized anxiety disorder: Advances in research and practice. New York: Guilford.

Hickling, E.J., & Blanchard, E.B. (2006). *Overcoming the trauma of your motor vehicle accident: A cognitive-behavioral treatment program (therapist guide)*. New York: Oxford.

Hofmann, S., & Otto, M.W. (2008). *Cognitive-behavior therapy of social phobia: Evidence-based and disorder specific treatment techniques*. New York: Routledge.

Hope, D.A., Heimberg, R.G., & Turk, C.L. (2006). *Managing social anxiety: A cognitive behavioral therapy approach (therapist guide)*. New York: Oxford.

Rygh, J.L., & Sanderson, W.C. (2004). Treating generalized anxiety disorder: Evidence-based strategies, tool, and techniques. New York: Guilford.

Taylor, S. (2000). *Understanding and treating panic disorder: Cognitive and behavioral approaches*. New York: Wiley.

Taylor, S. (2006). *Clinician's guide to treating PTSD: A cognitive-behavioral approach*. New York: Guilford.

Zuercher-White, E. (1997). *An end to panic: Breakthrough techniques for overcoming panic disorder, 2nd Edition*. Oakland, CA: New Harbinger.

Self-Help Readings

Antony, M.M. (2004). *10 simple solutions to shyness: How to overcome shyness, social anxiety, and fear of public speaking*. Oakland, CA: New Harbinger.

Antony, M.M., Craske, M.G., & Barlow, D.H. (2006). *Mastering your Fears and Phobias (client workbook*), second edition. New York: Oxford.

Antony, M.M., & McCabe, R.E. (2004). *10 simple solutions to panic: How to overcome panic attacks, calm physical symptoms, and reclaim your life*. Oakland, CA: New Harbinger.

Antony, M.M., & Norton, P.J. (2009). *The anti-anxiety workbook: Proven strategies to overcome worry, phobias, and obsessions*. New York: Guilford.

Antony, M.M., & Swinson, R.P. (2008). *The shyness and social anxiety workbook: Proven, step-by-step techniques for overcoming your fear, second edition*. Oakland, CA: New Harbinger.

Asmundson, G.J.G., & Taylor, S.. (2005). *It's not all in your head: How worrying could be making you sick – and what to do about it.* New York: Guilford.

Barlow, D.H., & Craske, M.G. (2007). *Mastery of your anxiety and panic, 4th ed. workbook)*. New York: Oxford.

Burns, D.D. (1999). *The feeling good handbook, Revised Edition*. New York: Plume.

Follette, V.M., & Pistorello, J. (2007). *Finding life beyond trauma: Using acceptance and commitment therapy to heal from post-traumatic stress and trauma-related problems*. Oakland, CA: New Harbinger.

Greenberger, D., & Padesky, C.A. (1995). *Mind over mood: Change how you feel by changing the way you think*. New York: Guilford.

Gyoerkoe, K.L., & Wiegartz, P.S. (2006). *10 simple solutions to worry: How to calm your mind, relax your body, & reclaim your life*. Oakland, CA: New Harbinger.

Hickling, E.J., & Blanchard, E.B. (2006). *Overcoming the trauma of your motor vehicle accident: A cognitive-behavioral treatment program (workbook)*. New York: Oxford.

Hope, D.A., Heimberg, R.G., Juster, H.R., & Turk, C.L. (2000). *Managing social anxiety*. New York: Oxford.

Meares, K., & Freeston, M. (2008). *Overcoming worry: A self-help guide using cognitive behavioral techniques*. New York: Basic Books.

Monarth, H., & Kase, L. (2007). *The confident speaker: Beat your nerves and communicate at your best in any situation*. New York: McGraw-Hill.

Rothbaum, B.O., Foa, E.B., & Hembree, E.A. (2007). *Reclaiming your life from a traumatic experience (Workbook)*. New York: Oxford.

Wilhelm, S. (2006). *Feeling good about the way you look: A program for overcoming body image problems*. New York: Guilford.

Wilson, R. (2009). Don't panic: Taking control of anxiety attacks, 3rd ed. New York: HarperCollins

Child Anxiety Disorders

Professional Readings

Chorpita, B.F. (2007). *Modular cognitive-behavioral therapy for childhood anxiety disorders*. New York: Guilford.

Kearney, C.A. (2005). *Social anxiety and social phobia in youth: Characteristics, assessment, and psychological treatment*. New York: Springer.

Rapee, R.M., Wignall, A., Hudson, J.L., & Schniering, C.A. (2000*). Treating anxious children and adolescents: An evidence-based approach*. Oakland, CA: New Harbinger.

Self-Help Readings / Readings for Parents

Eisen, A.R., & Engler, L.B. (2006). *Helping your child with separation anxiety: A step-by-step guide for parents*. Oakland, CA: New Harbinger.

Foa, E.B., & Andrews, L.W. (2006). *If your adolescent has an anxiety disorder: An essential resource for parents*. New York: Oxford.

Last, C.G. (2006). *Help for worried kids: How your child can conquer anxiety and fear*. New York: Guilford.

McHolm, A.E., Cunningham, C.E., & Vanier, M.K. (2005). *Helping your child with selective mutism: Practical steps to overcome a fear of speaking*. Oakland, CA: New Harbinger.

Rapee, R.M., Spence, S.H., Cobham, V., & Wignall, A. (2008). *Helping your anxious child: A step-by-step guide for parents* (2nd ed.). Oakland, CA: New Harbinger.