The Anxiety Clinic

The Anxiety & OCD Clinic Melbourne

MIT-O Manual

2021

www.theanxietyclinic.com

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Introduction

This manual has been prepared by the team at The Anxiety & OCD Clinic Melbourne to provide information about Obsessive Compulsive Disorder (OCD), the structure of the Melbourne Intensive Therapy-O intervention (MIT-O), and a reference to guide those challenging:

1. the attitudes and thinking that underpin OCD
2. the emotional turmoil arising from OCD
3. the compulsive and ineffective strategies that need to be faced down in dealing with OCD and its complexities.

Our very experienced team has a long history of treating Anxiety and OCD including inpatient and outpatient programs at The Melbourne Clinic from 1990-2007 and being part of the establishment team at The Melbourne Clinic Inpatient OCD Program in 2005. Over the past seven years the team have been offering OCD treatment in an Intensive outpatient setting that is more accessible for those whose family and work commitments preclude inpatient work.

Information

Location of clinical rooms for sessions and groups is in the Church Street Consulting Rooms at 140 Church Street Richmond, adjacent to The Melbourne Clinic, a large private psychiatric hospital. Allocation will be made on the days of treatment to specific rooms located mainly in suites 6, 8, 10 and other rooms by arrangement. On arrival, report to reception at suite 6.

Toilets - located in the foyer area on the ground floor and upstairs. Code for the toilets on the ground floor is C2357.

Eating places nearby include The Chocolate House, Winkel, The Grisley Bear Café & Catering, A Thousand Blessings, Ternary Tuck and various places in Bridge Road or Swan Street, Richmond.

Parking - Church Street Consulting Suites carpark - enter via Bromham Place through the boom gates. A token is required to leave the carpark and the cost of a token is $4.00 and can be purchased at Suite 6 Reception. (Please ensure you don't park in The Melbourne Clinic car park that is in Tweedie Place).

Mental Health Online is a free internet-based service funded by the Australian Government that provides information about OCD and introduces you to skills and strategies that you are able to do in your own time and can further assist you with your treatment of OCD – www.mentalhealthonline.org.au. Another rich resource for information into all aspects of Obsessive Compulsive Disorder (and related disorders) is the International OCD Foundation www.iocdf.org.

Program Overview

Assessment phase interview

Completion of assessment forms, reviewing factors like timing, commitments, accessibility, motivation and comorbidities.

Applicants are invited to attend for a clinical interview by our research team. Once an appointment has been scheduled, there are forms you are required to complete prior to the interview. These forms are part of the MIT-O research project and provide data that will measure the effectiveness of the OCD therapy program. As advised in the MIT-O Plain Language Statement, this data is de-identified and your privacy is fully protected. The assessment session is quite long (2-3 hours) but there will be breaks to make it easier to handle. We want those participating to be fully engaged in the process, so they get the best benefit possible therapeutically as well as participate in a research program that is evaluating an important and effective approach to the treatment of Obsessive-Compulsive Disorder.

Intensive phase

Two full days (Tuesday and Friday) of two successive weeks. This entails attendance at the clinic and participation in morning and afternoon sessions with some group psycho-education sessions and 1:1 therapy with a therapist. Your personalized program will be developed from day one in conjunction with your therapist, and various tasks are set for completion in the evenings or during the day in the time break of two days in the middle of weeks one and two. On these gap days (2 day during the intensive weeks and 3-day 'long weekend' between the two intensive weeks), the tasks are designed to maintain continuity of exposure and response prevention therapy to consolidate your learning to overcome OCD.

Supportive phase

In the three weeks (21 successive days) following the ten days of the intensive phase, participants complete self-driven adaptive learning strategies designed to practice and reinforce the change strategies of the intensive phase. Participants are expected to record their ERP practice and provide daily feedback to the treatment team via email. Check-in calls by telephone or voice mail will be made by the therapy team twice a week during this three-week period.

Follow-up phase

Reviews will occur in one-hour interviews conducted at 6 and 12 months. This will include completion of forms that will provide a de-identified data set for the research project.

Background To This Project

This program of treatment for Obsessive Compulsive Disorder is based on Cognitive Behavioural Therapy:

- The application of exposure and response prevention in graded, repeated, intensive and prolonged exposures is designed to bring dimensional anxiety levels to zero through the process of habituation. Repeated exposure to a fearful, threatening or noxious stimulus is predicted to reduce the intensity and effect of anxiety. This is one fundamental principle of Exposure and Response Prevention.
- The repeated association of the trigger or stimulus with a particular response establishes a fixed connection that is permanent, predictable and habitual. Sometimes such a habitual connection is established by a single incident that is reinforced by memory and extreme emotional arousal like terror. For example, exposure to a traumatizing horrible experience outside of normal experience. In other circumstances, a learned response is based on repeating presentations so that the felt anxiety is based on the reinforcing over and over of the fear experience. Such single-incident trauma can be particularly resistant to both habituation (lessening of anxiety) and an unlearning of the fixed response (extinction).
- Real issues for Exposure and Response Prevention therapy (and CBT generally) are the high number of non-responders - around 30%, Hashmani (2016) and the instability of habituation and extinction. These problems drive constant efforts to improve the skills of therapists in applying the principles of behaviour change, broadening the research base to draw on insights from neuroscience, and providing sufferers of OCD with a coherent explanation of the nature of OCD and the strategies that can reverse it.
- Cognitive restructuring to challenge any faulty appraisals that are associated with increased symptoms, affect management to assist in regulating emotional responses.
- Activity scheduling to shift attentional focus from symptomatic to productive and self-enhancing thinking, affect and behaviours.
- Relapse prevention, crisis management, life enhancement, and motivation are critical factors in shaping and maintaining the shift from the OCD lifestyle. Accept that setbacks are expected as part of life, and they are manageable especially if they can be re-framed as another opportunity to practice your self-therapy techniques – face the issue, accept it as a predictable event, float right through it, let time pass and re-connect with your present-moment focus, your day to day life – and don't be bluffed by impulse or thoughts.
- Targeting issues that can lead to setbacks – low motivation, comorbidities, family accommodation, over-sensitivity to anxiety, over-reliance on medication, understanding the working model of ERP and fluctuating motivation, to name some key problems.

Schedule

First Tuesday

The goal is to highlight your features of OCD (cues or triggers, internal cues or triggers, rituals, and avoidances), rating anxiety level for issues in a hierarchy, and examining tasks to model exposure and response prevention.

Time	Activity	Location
0930-1030	*Group: Team* Introduction of The Melbourne Intensive Therapy for OCD (MIT-O) & program overview. Background to OCD, Obsessions & Compulsions.	Room 10
1030-1130	*Group:* Model of OCD treatment used in the MIT-O. Anxiety & habituation, Exposure & Response Prevention.	Room 10
1130-1145	Break	
1145-1315	*Individual:* Review of Y-BOCS and develop a comprehensive list of cues and triggers, rituals and avoidance behaviours.	
1315-1415	Lunch	
1415-1515	*Group:* Review PowerPoint 'OCD Explained'. *Individual:* Complete cues & triggers document, build hierarchy and target task for Exposure Response Prevention (ERP).	Room 10
1515-1615	*Individual:* ERP tasks & homework including familiarising yourself with the manual.	

First Friday

Review of the OCD model and homework, coached exposure and response prevention tasks in the clinic, external coached ERP tasks, preparation of exposure tasks for coming days, and use of various strategies to manage symptoms.

Time	Activity	Location
0930-1030	*Individual:* Review OCD model & homework. Demonstrate understanding of model by using own example.	
1030-1130	ERP - coached sessions inside and outside clinic.	
1130-1145	Break	
1145-1315	*Group:* Symptom management – other interventions.	Room 10
1315-1415	Lunch	
1415-1515	ERP - coached sessions inside and outside clinic.	
1515-1615	Homework tasks	

Second Tuesday

Review of the OCD model and homework, coached exposure and response prevention (ERP) tasks in the clinic, external coached ERP tasks, preparation of exposure tasks for coming days, and use of various strategies to manage symptoms.

Time	Activity	Location
0930-1030	*Individual:* Review OCD model & homework	
1030-1130	ERP - coached sessions inside and outside clinic.	
1130-1145	Break	
1145-1315	ERP – coached sessions inside and outside clinic.	
1315-1415	Lunch	
1415-1515	*Group:* Planning of ERP tasks for the supported phase	Room 10
1515-1615	Homework tasks	

Second Friday

Review of the OCD model & homework, coached exposure and response prevention (ERP) tasks in the clinic, external coached ERP tasks, preparation of exposure tasks for coming days, and use of various strategies to manage symptoms.

Relapse prevention training, detailed instruction on daily ERP practice.

Time	Activity	Location
0930-1030	*Individual:* Review OCD model & homework. Reinforcement of ERP rationale – different forms of ERP.	
1030-1130	ERP	
1130-1145	Break	
1145-1315	ERP	
1315-1415	Lunch	
1415-1515	*Group:* Relapse Prevention	Room 10
1515-1615	Preparation for discharge	

What is OCD?

Obsessive-Compulsive Disorder (OCD) is a psychological condition that is included in *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM–5; American Psychiatric Association, 2013).

A. Presence of obsessions, compulsions, or both:

Obsessions are defined by (1) and (2):

1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralise them with some other thought or action (i.e. by performing a compulsion).

Compulsions are defined by (1) and (2):

1. Repetitive behaviours (e.g. hand washing, ordering, checking) or mental acts (e.g. praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
2. The behaviours or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviours or mental acts are not connected in a realistic way with what they are designed to neutralise or prevent, or are clearly excessive.

   Note: Young children may not be able to articulate the aims of these behaviours or mental acts.

B. The obsessions or compulsions are time-consuming (e.g. take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g. a drug of abuse, a medication) or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder (e.g. excessive worries, as in generalized anxiety disorder; preoccupation with appearance, as in body dysmorphic; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania (hair-pulling disorder); skin picking, as in excoriation (skin picking) disorder; stereotypes, as in stereotypic movement disorder; ritualized eating behaviour, as in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphilic disorders; impulses, as in in disruptive, impulse-control, and conduct disorder; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behaviour, as in autism spectrum disorder).

Psychological Models of Care

Cognitive Behavioural Therapy

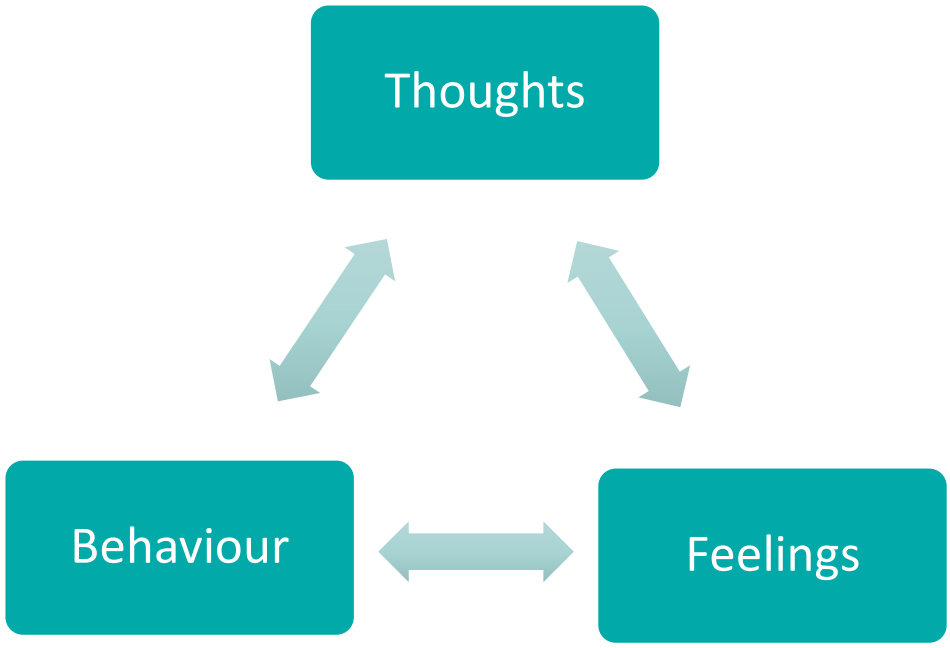


Diagram based on Beck's cognitive triad. (Beck Institute for Cognitive Behavior Therapy, 2019)

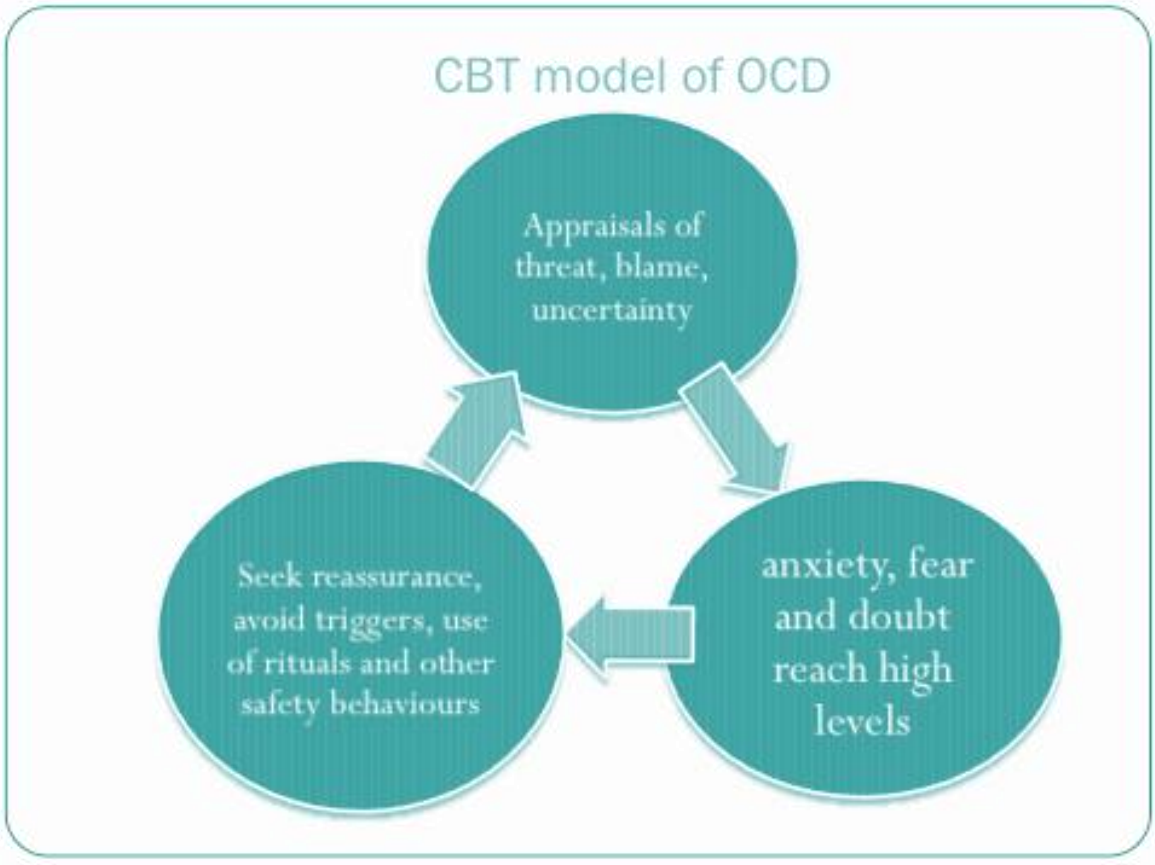


Diagram based on Beck's CBT model. (Beck Institute for Cognitive Behavior Therapy, 2019)

1. Your symptoms are stabilising and open for change.
2. The CBT collaborative model applies for these symptoms.
3. Specific strategies and skills will be outlined.
4. You will learn to think, feel and act adaptively.
5. You will be made aware of relapse prevention.
6. Structured plans for follow-up and crisis intervention.

CBT Model Emphasis

All people have UNWANTED and INTRUSIVE THOUGHTS – just another thought.

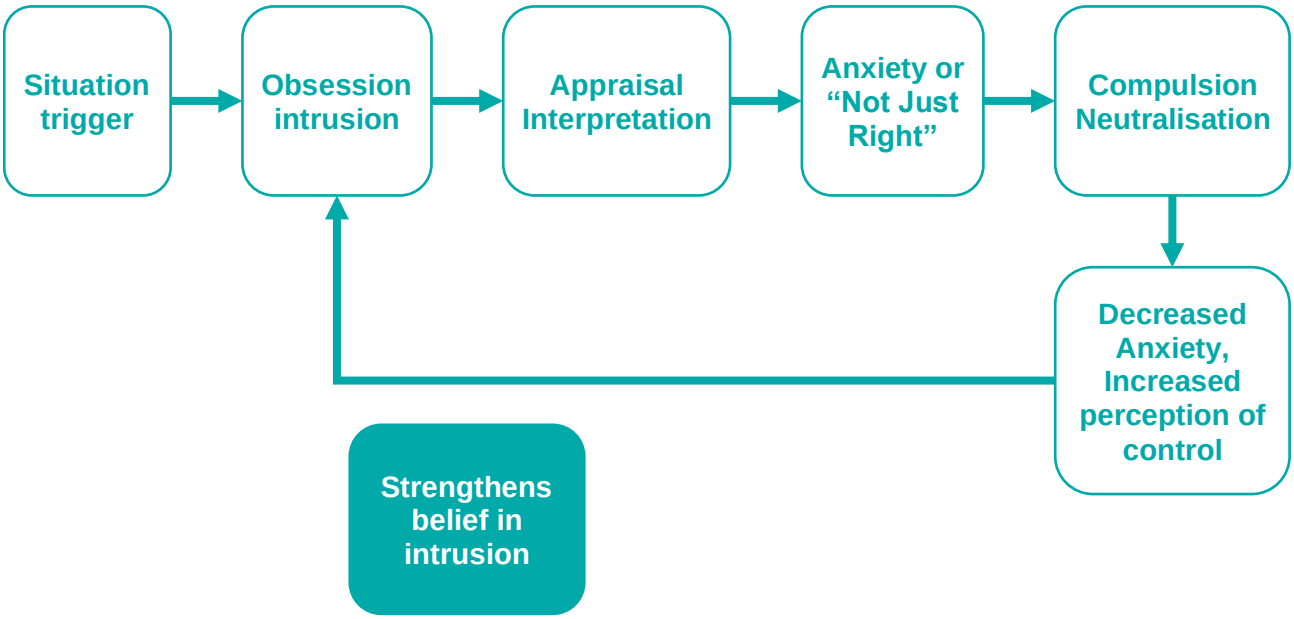
Most can handle them as **not threatening**, easily dismissed.

The power of any thought comes from the **importance** given to it.

Wanting to control thoughts does not work – *try accepting thoughts – whether good or bad – for what they truly are, as just thoughts*.

Obsessive Compulsive Disorder Model

Basic OCD Model



(Adapted from Clark & Purdon, 2002)

Acceptance Commitment Therapy (ACT) Model

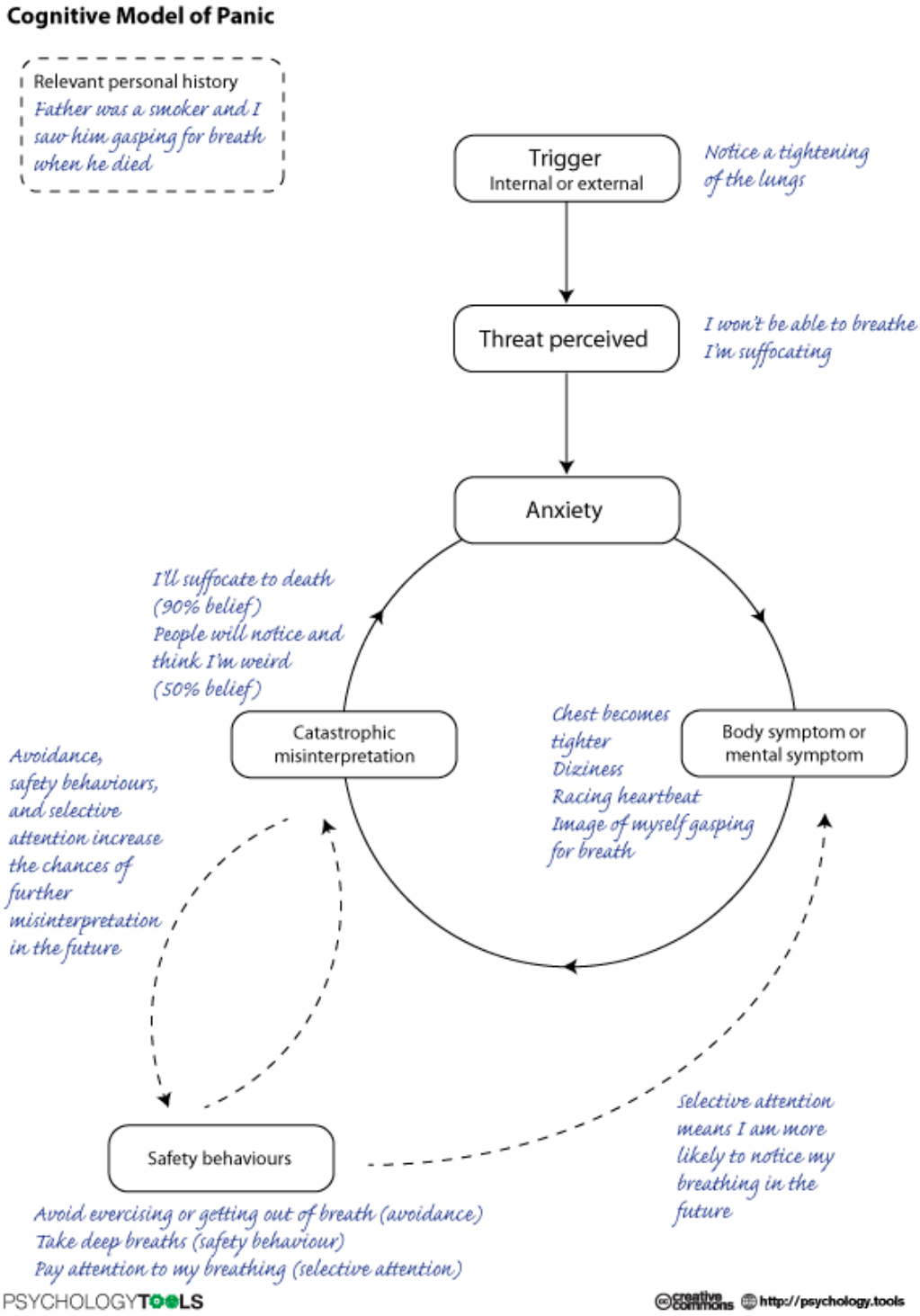
ACT is a variant of Cognitive Behavioural Therapy in the same way that other specific programs have emerged from the Beck's original CBT approach. Examples include Dialectical Behaviour Therapy (Linehan's DBT), Mindfulness-based Cognitive Therapy (MBCT – Teasdale et al) and Schema Therapy (Young). Whilst MIT-O emphasises the CBT model, there are specific elements of these other approaches that are very helpful in assisting with aspects of OCD.

Twohig et al. (2015, p.168.), indicates that the six core ACT processes are:

- Acceptance - embracing unwanted internal events (i.e., thoughts, feelings, memories, physical sensations, and other internal experiences) without attempting to change them. Acceptance is the opposite of experiential avoidance, which is the tendency to avoid such inner events even when doing so interferes with one's values.
- Cognitive defusion - changing how one interacts with internal events by allowing one to experience such events for what they are, rather than what they present themselves to be.
- Awareness of the present moment - the ability to attend non-judgmentally to that which is occurring now, rather than getting lost in thoughts about the past or future.
- Self as context -taking a perspective as the place where inner experiences occur rather than being defined by them.
- Values - statements about areas of life that are meaningful to the individual. Values are life directions that help to guide actions (e.g., "pursuing knowledge") rather than achievable goals.
- Committed action - specific actions taken that produce movement toward values.

Panic model

The presence of panic in OCD is a very common experience. The diagrams below provide an overview of how the personal appraisal made of a particular happening has a large bearing on the overall response. If one feels threatened or terrified, the defensive circuits of the brain will accelerate the physiological and biochemical reactions that are then elaborated by the unique review of any experience that characterises human consciousness. Adaptive learning skills, acceptance and cognitive reappraisals can be utilised to provide a working model that leads to better awareness of these processes.

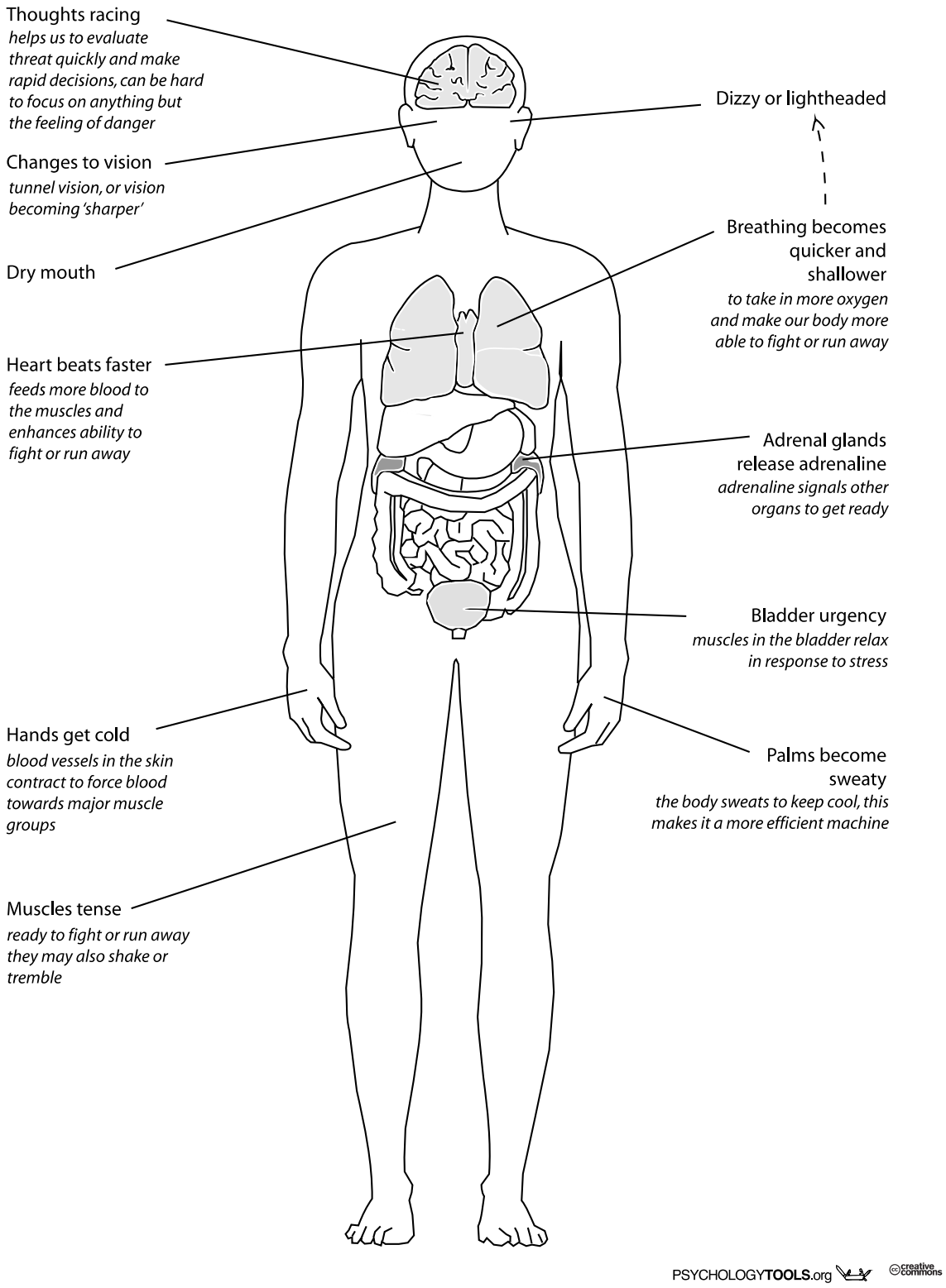


(Psychology Tools, 2020)

Threat system

Threat **System**

The 'fight or flight' response gets the body ready to fight or run away. Once a threat is detected your body responds automatically. All of the changes happen for good reasons, but may be experienced as uncomfortable when they happen in 'safe' situations.



(Psychology Tools, 2020)

Obsessions & Compulsions

Obsessive Compulsive Disorder is a high frequency psychological disorder characterized by intrusive unwanted obsessions (thoughts, images, recollections, flashbacks) that appear so real to the person that they experience reactive anxiety, feelings of threat and blame that force the person to adopt defensive responses that will range from avoidance, reassurance-seeking, and other safety-seeking manoeuvres to compulsive rituals that are repeated, elaborated and shifting that are disabling and disruptive of the life of the sufferer and those close to them. The key to self-management is the insight that this process is self-driven, the obsessions 100% the product of the sufferer's own imaginative mind. We have no control over the workings of our imaginative mind – demonstrably shown in the dreams or nightmares commonly experienced – yet they are all seem so real. Just as the content of dreams and nightmares are easily forgotten and dismissed when we are fully awake, so too the 'pop in' intrusions can be managed better when a coherent explanation of how they occur is presented.

Intrusive thoughts

Intrusive thoughts do not just happen to people who have OCD. There is mounting evidence that these thoughts are quite common in the general population.

Interesting Fact:
Research indicates that the average person has about 4000 distinct thoughts per day. Of these, 13 percent or 520 are spontaneous and intrusive in nature. Many of these thoughts are reported to be quite out of character, even shocking to the person! (Klinger, 1996).

In a landmark study, two OCD researchers Rachman and De Silva (1978), asked people, 1996with and without OCD to write down their intrusive thoughts and they mixed up the list. They then asked professionals such as psychologist with experience in working with OCD to differentiate between abnormal and normal obsessions based on the content of the intrusions. These experts were not able to tell the difference between normal intrusive thoughts and obsessional intrusive thoughts.

Normal intrusive thoughts included:

- Impulse to hurt or harm someone
- Jump on the rails when the train approaches
- Images of loved one dying in a terrorist attack
- Thoughts of acts of violence during sex
- What if I have cancer?
- Feeling contaminated with asbestos
- Impulse to violently attack and kill a dog

This finding has since received a great deal of support by other studies showing that 72-100% of non-clinical individuals in the community experience intrusive thoughts. More recently International studies in 13 countries across six continents show that unwanted mental intrusions, are highly prevalent, regardless of the specific nationality, religion, and/or cultural context (Radmosky et al., 2014). However, people are often surprised to find out that others also experience all sorts of intrusive thoughts such as thoughts of harm coming to people, images of violence, urges to check things, doubts about whether they have done something or impulses to do something unacceptable or out of character.

Research shows that normal and abnormal obsessions differ in several respects, including frequency, duration, intensity and consequences, among others. That is in contrast to the non-clinical population, the obsessions in OCD are experienced more frequently, more intensely, cause more distress and are more difficult to resist (Salkovskis & Harrison, 1984). According to the CBT model

of OCD, there is a number of cognitive processes that turn these so called “normal” intrusions to “abnormal” intrusions and contribute to the development and maintenance of OCD. More detailed description of these maladaptive cognitions is provided later in this manual. During the course of the program, we will be addressing these unhelpful cognitions in order to reverse this process and work towards turning the obsessions back into occasional intrusive thoughts.

Key points to remember:
• Everyone experiences all sorts of bizarre and negative intrusive thoughts • The content of the intrusive thoughts in “normal” vs “abnormal” intrusions are indistinguishable • It is the way the person interprets these intrusions which determines if a disorder develops • By addressing these unhelpful cognitions and interpretations the condition can be reversed

Obsessions - OCD Criteria

- Recurrent, intrusive, unwanted thoughts, impulses or images causing marked anxiety.
- Not simply excessive worries about real life problems.
- Attempts to ignore, suppress or neutralise.
- Recognised as coming from our own mind.

Content of Obsessions

The content of obsessions is extremely variable and will sometimes change during different episodes of OCD. The content can vary so widely that it almost seems like there are different kinds of OCD. What underpins all presentations of OCD is the rapid onset of anxiety accompanied by misappraisals of the threat, danger, uncertainty and doubt that create an endless cycle of threat and anxiety that impairs the persons functioning. The most common types of OCD presentations are:

- Contamination/cleanliness
- Violent/aggressive/disaster
- Relating to symmetry or exactness
- Relating to doubt or “just right” feeling
- Relating to fear of loss of something important
- Fears of blasphemy, sacrilege, immorality, scrupulosity
- Sexual fears
- Superstitious fears

Less common presentations are Relationships OCD, Sensory motor and olfactory (smell) OCD.

Why do Intrusions become Compulsive?

The intensity of the anxiety symptoms can lead the sufferer to try and do something about reducing such anxiety. What then develops is an endless array of gestures, thoughts, actions and reviews that have the object of trying to reduce the intensity of the anxiety. The compulsive element comes from the need to repeat, elaborate further review, change and alter these attempts to control anxiety that establishes a never-ending compulsive loop.

- IDEAS 'stick' because rituals might bring some reduction in anxiety. They could work initially
- Rituals reinforce the thought and guarantee its return. Act as a REMINDER of an intrusion, hence, trigger it (retrieval cues)
- Prevent the feared outcome being disproved
- Make person feel so bad, something has to be done

Appraisals

Why are appraisals so important in OCD?

Contemporary understanding of OCD (the website https://iocdf.org/about-ocd/) provides a comprehensive source of reliable information on OCD has established that everyone has intrusive, unwanted bizarre and disturbing thoughts that have varying impacts depending on the appraisal made by the person. It is not the presence of the thought, it is the appraisal of responsibility, uncertainty, guilt, even horror that a person with OCD that results in crippling anxiety that requires that they do something to reduce it. Those without OCD see such thoughts as fleeting and passing and do not have a reaction of continuous anxiety. Such thoughts simply 'pop in' and 'pop out', in contrast to the inability of the person with OCD to shake free of such thoughts. The appraisals of people with OCD have led to obsessional beliefs that are summarised below:

- These belief domains create threat and intolerable anxiety
- Inflated responsibility/Over-estimation of threat
- Exaggeration of the importance of thoughts and need to control thoughts
- Perfectionism/intolerance of uncertainty

Common Obsessions and Compulsions

The table below presents some common obsessions and compulsions experienced by those with OCD.

Obsessions	Compulsions
Worry about contamination, such as from dirt, germs, radiation and chemicals	Excessive hand washing or cleaning due to the obsessive fear of contamination
Doubts about having remembered to turn the stove off, lock the doors and son on	Checking and rechecking to see that the stove is off, doors are locked and so on
Sexual imagery that causes shame or thought that urge one to behave in a socially unacceptable way	Counting or repeating phrases or prayers to prevent oneself from carrying out shameful acts
Unwanted thoughts of harming someone	Repeating rituals over and over again, such as touching things in a particular sequence
Worries about death, bad luck and catastrophes	Avoiding certain numbers, words and places associated with death and bad luck
Worries that everything must be 'just so'	Arranging items in particular patterns, alphabetically or in some symmetrical order

(Mogan, Elliot; & Smith, 2014)

What are the Features of Your OCD?

Cues or Triggers

Please list the objects, situations, or circumstances that cause you discomfort or anxiety in regards to your OCD. Think about the triggers for your emotional distress. Your clinician will help you rate them in terms of their discomfort evoking abilities.

No.	Cue or Trigger	SUD
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

(Clinical Research Unit for Anxiety and Depression (CRUfAD), 2015)

Internal Cues or Triggers

Please list the internal cues that may cause discomfort. These may be self-talk or thoughts (*my hands are dirty, is the iron off, I will harm my child*), images, feelings, and impulses. Your clinician with help you rate them as regards their anxiety-causing potential.

No.	Internal Cue or Trigger	SUD
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

(Clinical Research Unit for Anxiety and Depression (CRUfAD), 2015)

Rituals/Other behaviours

Please list the type of rituals or other behaviours that you engage in to lessen your discomfort. If you have developed daily routines that are not in response to direct stimuli (e.g. Having a one-hour shower daily, washing or checking in a particular manner), please list them as well.

No.	Rituals	SUD
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

(Clinical Research Unit for Anxiety and Depression (CRUfAD), 2015)

Avoidance

List all situations, objects, etc. that you avoid because they will cause you emotional distress.

No.	Avoidance	SUD
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

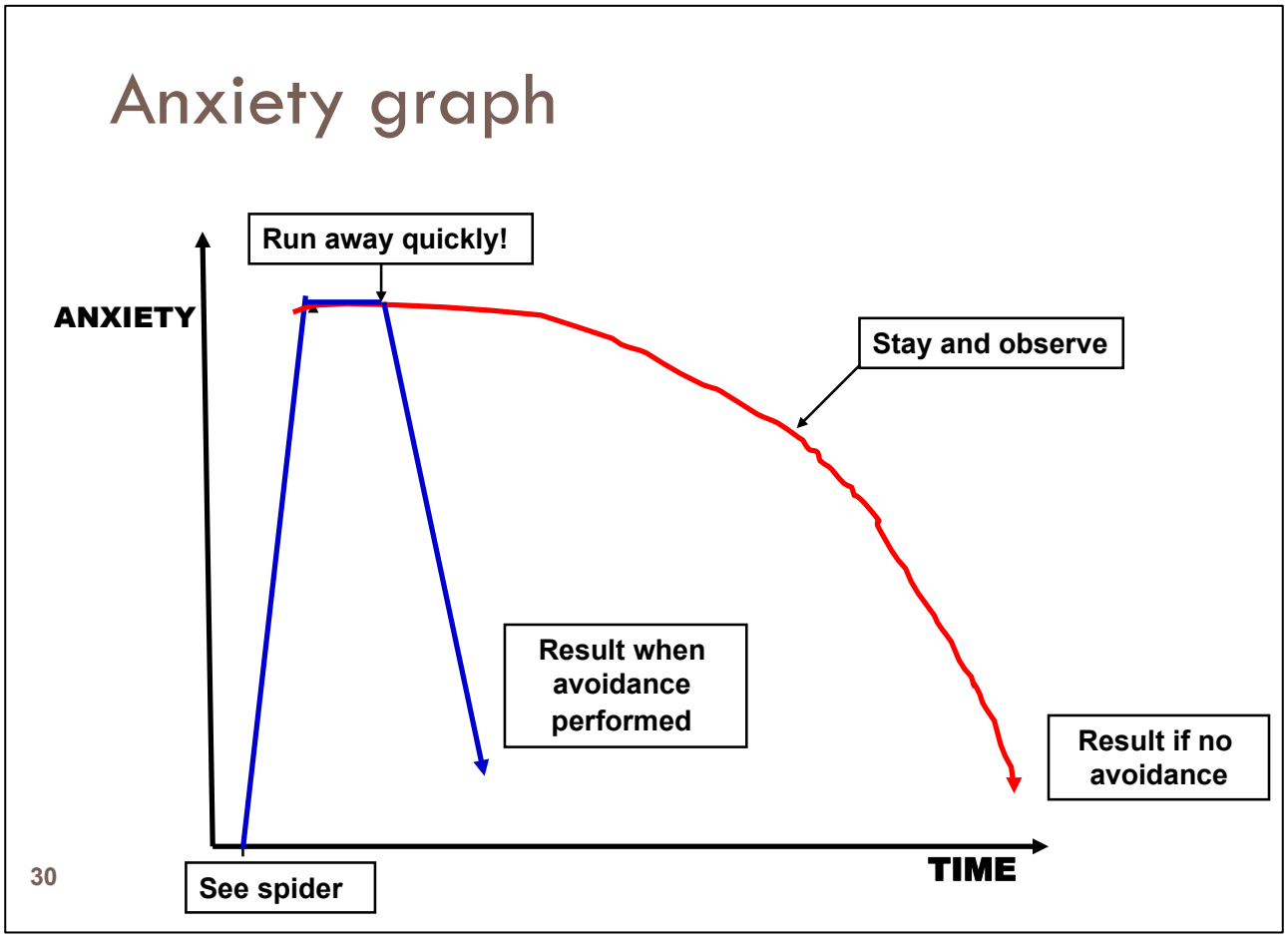
(Clinical Research Unit for Anxiety and Depression (CRUfAD), 2015)

Interventions

Anxiety and Habituation

The Anxiety figure below shows how anxiety peaks when triggered, then lowers quickly when escape or avoidance are used. The anxiety would, over time, spontaneously settle. The difficult thing for the sufferer of the anxiety is to allow the experience of anxiety to be felt without resorting to escape, avoidance or other impulsive responses to curb the anxiety. Accepting the anxiety as part of your experience opens up the possibility that 'sitting with the anxiety' might lead to getting used to the anxiety, then noticing the fading of anxiety. Beginning slowly at first, the exposure or facing of anxiety gradually leads to acceptable levels of felt anxiety (habituation).

You apply this process to the challenge of triggers that bring high levels of anxiety. You continue to face the triggers with aim of developing the skills necessary to handle the increased anxiety. This is done in a step-by-step or graded way. You keep repeating a particular step until you feel okay about it, before moving up the next step in intensity. Again repeating this level over and over until the anxiety settles. The final step is to prolong the time in the anxious situation until it reduces to a manageable and increasingly acceptable level. The goal is not no anxiety, rather it is to tolerate the anxiety so it is not interfering with functioning. Exposure is applied in the process of G-R-I-P: graded, repeated, intensity increasing, and prolonged exposure that bring anxiety to manageable levels.



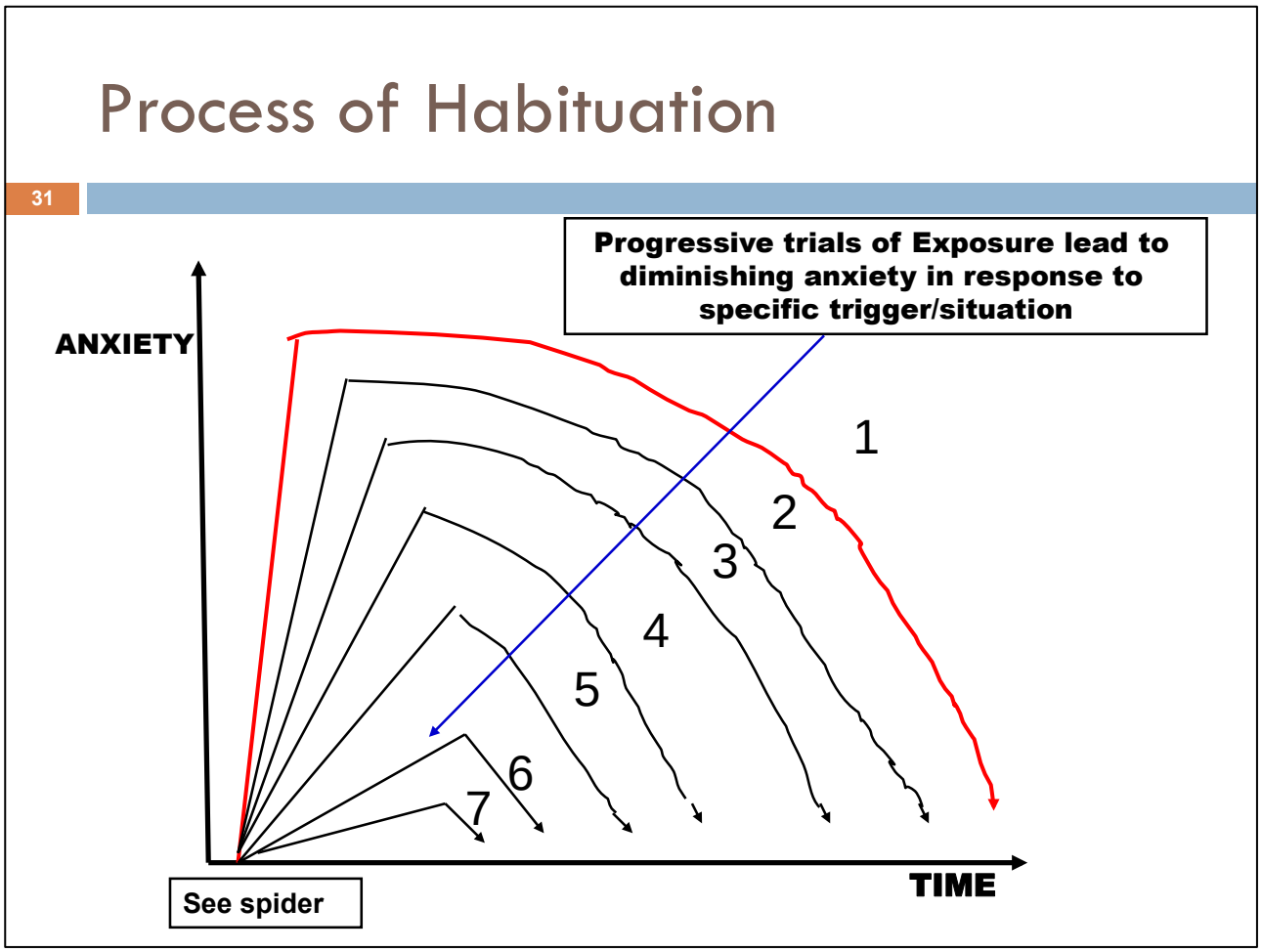
(Adapted from Clinical Research Unit for Anxiety and Depression (CRUfAD), 2015)

When this process of facing the anxiety and developing new skills to deal with it is allowed to develop, avoiding, escaping and neutralizing of anxiety are seen as unnecessary and ineffectual. Anxiety is an emotion like love, humour, fear and anger. Research and experience shows that emotions like anxiety – driven by chemistry and various neurotransmitters (cortisol, adrenalin, norepinephrine, noradrenalin) – settle over time.

If a person can learn to slow down their reactive response, their emotional state will stabilize. Preventing impulsive reactions and the emotional responses that agitate the person does lead to increased skills of being able to experience emotion without being emotionally overwhelmed. Increasing emotional regulation by understanding that under-expressing emotion (denying, suppressing, freezing) and over-expressing of emotion (impulsivity, loss of control) are ineffective in emotional regulation. Emotional regulation is also enhanced by developing self-soothing, mindfulness and exercise skills that lead to reducing anxiety- sensitivity.

Process of habituation leads to diminishing both the anxiety response and the prediction of catastrophe, fear and doubt. Most anxiety appraisals are 'over-the-top' and essentially harmless as the product of the over-reactive mind.

The word habituation means that over time our felt experience of increased anxiety declines to be a non-issue. Habituation occurs in every novel situation when we face something different, and take our time to get used to it. For example, if you live near a tram-line or busy road, you hardly notice the trundling noise of the trams or traffic as time goes by.



(Adapted from Clinical Research Unit for Anxiety and Depression (CRUfAD), 2015)

Exposure and Response Prevention

Applying Exposure and Response Prevention

Exposure and Response Prevention (ERP) is now accepted as a major intervention for Obsessive Compulsive Disorders, Abramowitz (1966) with a long history and variegated presentations dating back to Victor Meyer's apotreptic therapy of the 1960's, Meyer (1966) through various nuances of behavioural and cognitive models to the most recent research from the B4DT Program (iocdf.org) that has provided dramatic outcomes from highly intensive ERP interventions. ERP is an application of Cognitive Behaviour Therapy that aims to teach people to think clearly, to manage feelings, and to engage in life (the how-I-think, how-I-feel, what-I-do rhythm) – that is based on negotiated, paced and 1:1 care.

The MIT-O program endorses such collaborative interventions and as such the ERP therapy is directed to bringing the patient into a self-management role – learning to be your own therapist – so that even the most disruptive symptoms can be managed. Just as being a therapist for others requires training, guidance and supervision, so too becoming your own therapist requires motivation, persistence and openness to change.

In starting to challenge OCD, it is clear that getting a clear picture of the nature of your symptoms. This assessment phase enables the treating mental health professionals to understand how you describe the features of OCD, how much it is affecting your life, work and relationships, and to advise you of the severity of your symptoms. There are so many different ways that OCD symptoms appear ranging from detailed ways of doing things that are compulsive and ritualistic (washing and checking), persistent fears of harming others through contamination, harm or abuse, to overwhelming review past actions or concern about personal health or aspects of your breathing, blinking or physical appearance. The team help participants to get an understanding of how OCD is triggered, what thoughts are associated, the particular ways they have tried to deal with how they feel, and things that they have been avoiding because of OCD. From this negotiation, a treatment plan starts to emerge.

Those suffering from OCD can find it difficult to get appropriate treatment as mental health services are under-funded and resources are applied to what are regarded as more pressing needs. For example, many resources are needed for issues involving suicide, depression, eating disorders and trauma. Exposure and Response Prevention is an effective treatment for OCD (Cochrane reviews) that follows a graded, step-by-step approach to managing anxiety, in particular the anxiety derived from obsessions and compulsions that are persistent, overwhelming, disruptive and frightening at many different levels. Each person has their list of triggers or cues for OCD, and their experience of these cues will result in anxiety. When a person learns that anxiety is a normal emotion that has an adaptive and important role in maintaining human functioning. What can go wrong is anxiety is so distressing that we can become over-sensitive to any anxiety experience at all. To address this, we look at the SUDS scale below: This 0-10 scale enables a person to rate the level of anxiety being experienced in any particular situation, and to summarize the anxiety felt as low (0-3), moderate (4-7) and high (8-10).

Subjective Units of Distress scale (SUDS)

This scale was developed by Wolpe (1969), it is a self-report measure of the experience of distress felt at a particular moment. It is used to monitor shifts in levels of distress or discomfort when reporting individual experience on a 0-10 scale. It is important to build tolerance for the experience of anxiety, to habituate response to anxiety-provoking stimuli.

0-1	Little or no distress being experienced. Generally calm, feeling okay.
2-3	Some distress, mild distress such as an experience of tension, hesitation or nervousness.
4-5	Moderately high distress with definite felt tension, nervousness, reluctance but still able to do things to function personally and socially.
6-7	High distress with the presence of clear symptoms including worrying thoughts, physiological responses - feeling hot and bothered, dry mouth, under pressure, noticeable heart beat, muscles tension, sweating. Definite interference with social and personal functioning, might experience tension, rigidity in neck, shoulders, stomach, jaw.
8-9	Very high - symptoms like sweating, shaking, difficulty swallowing, feeling confused, dizzy, emotionally overwhelmed, unable to concentrate or function, pronounced heaviness in limbs, unable to move, a sense of 'freezing' setting in. Unable to function personally or socially or to complete tasks.
10	Extreme - equivalent symptoms to your worst experience of anxiety or panic. Agitated and overwhelmed, out of control, racing heart, difficulty breathing, fear of 'passing out', deep sense of threat, even of dying.

ERP can be summarized as follows:

Exposure & Response prevention formula (MIT-O)

1. Constantly face up the things that make you anxious: EXPOSURE

   List your OCD triggers, rate the anxiety level for each one:

   0-3 low anxiety;

   4-7 moderate anxiety;

   8-10 high anxiety.

   Over time, the anxiety set off by each one will lessen. How much is the anxiety interfering with what I do? When it stops interfering you will notice your tolerance for feeling anxious gets stronger, your push-back against the obsessional thoughts increases, and habituation (zero anxiety) is reached for 'over the top' anxiety triggers, one by one.

2. When you think of something you can say, do I think that will ease anxiety - DO NOT DO IT.

   DO THE OPPOSITE: RESPONSE PREVENTION.

   Exposure and Response Prevention (ERP), the No.1 treatment for OCD. Learn it!!

   NO GIMMICKS - counting, repeating, tapping, checking, reviewing, worrying, staring, picking up or holding on to things special words or gestures or the myriad things that your upset mind will come up with. Sit with the anxiety felt, become an expert at RESPONSE PREVENTION by doing it over and over. Nothing takes the place of persistence. Just keep at it. Stop any compulsion becoming worse by saying NO every time. Get help in doing this because sometimes it seems so difficult to do it alone. This is called COACHED ERP.

3. Other things we usually do to lower anxiety are:

   AVOIDANCE – common way to reduce anxiety 'I don't like doing new stuff….this is too hard for me' ..'This won't help me'.

   SEEK REASSURANCE: 'Tell me it's okay to do this'…. 'I'm not sure what to do'

   SAFETY BEHAVIOURS 'I need to read my book ..I have to rest …I'll ask my friend'

   COMPULSIVE RITUALS - 'if you don't do this my way (i.e. OCD way) something bad will happen' Push back OCD by saying firmly to yourself ..MY LIFE, MY RULES, OCD IS NOT MY BOSS! I refuse to be bluffed by OCD thoughts any longer.

4. Start to sit with the anxiety, at low levels first, allowing it to settle naturally. This feeling will pass (as all feelings do). Let it unfold, float with it…in time it will pass … it might happen more quickly if you switch your attention to something you like doing. Repeat ERP every day. Increase the challenge. Prolong your practice.
5. OCD is 100% the product of your upset imagination. It closely resembles the power of a dream or nightmare. It might SEEM SO REAL, but it is NOT REAL.
6. Prevent relapse by understanding that slip-ups and lapses are not full-on relapses (back to square one). Relapse is more likely when MOOD is low, when you are in conflict with self/others, and when old habits strike.
7. Free yourself from OCD by pushing back at OCD constantly (exposure), not avoiding the triggers but refusing to use gimmicks, use response prevention on the gimmicks, and engage in a life free from OCD and all the trouble it causes you.
8. Do Something Daily to keep OCD away. Engage in your activities, look after you.
9. OCD is 100% the product of your own imaginative mind – let it be, let it go.
10. ERP will happen in the way I describe. Never stop practicing ERP.

Guidelines when doing an ERP task

- Do tasks in a planned way, therefore set some time aside.
- Do not do any relaxation exercises or take anxiety medication when doing an ERP task, as you are learning to tolerate the anxiety provoking situation.
- Sit with the anxiety for a designated period of time, or until highest SUDS reduces to 50%.
- Monitor SUDS before, during and after the task using ERP worksheet.
- Remember that habituation is different for each person and may take time.

Preparation for ERP

Timing, attentional focus, sitting with the anxiety felt (float, push back, accepting completely, let it just be there). Each person needs to develop their own acceptance metaphor or image that allows facing, accepting, floating and letting time pass work for them.

Writing down your SUD scores provides essential feedback to you and the treating team. Those who complete the ERP scoring sheets increase the effectiveness of the intervention and the acquiring of the new learning needed to overcome OCD.

Do something every day on your OCD therapy – an ERP sheet, a behavioural experiment, a review of incidental OCD intrusions, avoidance, reassurance seeking or new rituals.

Relapse prevention - mood shifts, conflict, old habits, not doing daily tasks are the major factors contributing to relapse. Other factors like high risk situations, family accommodation, low motivation, and issues around mindfulness and attentional focus also play significant roles.

Thinking styles

Some Unhelpful Core Beliefs

Your response to adverse happenings in your life may be influenced by deep-seated convictions that unchallenged hold considerable influence on your ideas. Young (2012), developed the early eighteen maladaptive schemas.

1. Abandonment…*they will let me down*.
2. Mistrust…*others don't care if I'm hurt*.
3. Emotional Deprivation…*no one is there for me, to guide me, to understand me*.
4. Fatal flaw…*it comes out all the time that I don't measure up with other people*.
5. Alienation…*I'm isolated from and different from other people*.
6. Vulnerability…*something dangerous or awful is coming up for me*.
7. Emotionally immature…*I feel unable to separate as an individual, feel caught up, enmeshed with another*.
8. Helplessness…*I feel helpless and incompetent to run my life*.
9. Failure…*here is another demonstration of how I'm a failure*.
10. Over-controlling…*I want it now, right now, my way*!
11. Low tolerance for frustration…*I cannot stand this another second*!
12. Inadequacy…*always putting aside, subjugating my needs to the needs of others. I don't count*.
13. Victim…*don't worry about me, no one ever has, I'll suffer and be the martyr*.
14. Approval seeking…*I have to be seen to be doing good for others*.
15. Be careful, watch out…*the catch cry of the over-cautious who so fear error or mistakes*.
16. Inhibition…*if I follow this set and rigid routine I will not come unstuck*.
17. Unrelenting personal standards…*it has to be exactly right, criticism is not acceptable*.
18. Punitiveness…*people deserve to be punished*.

The logic of these ideas can be reviewed and challenged by you.

Unhelpful **Thinking Styles**

All or nothing thinking

Sometimes called 'black and white thinking'..

If I'm not perfect I have failed

Either I do it right or not at all

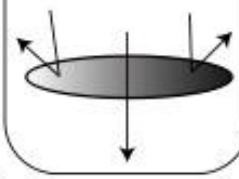
Over-generalising

*"**everything** is **always** rubbish"*

*"**nothing** good **ever** happens"*

Seeing a pattern based upon a single event, or being overly broad in the conclusions we draw

Mental filter



Only paying attention to certain types of evidence.

Noticing our failures but not seeing our successes

Disqualifying the positive

Discounting the good things that have happened or that you have done for some reason or another

That doesn't count

Jumping to conclusions

$2 + 2 = 5$

There are two key types of jumping to conclusions:

- **Mind reading** (imagining we know what others are thinking)
- **Fortune telling** (predicting the future)

Magnification (catastrophising) & minimisation

Blowing things out of proportion (catastrophising), or inappropriately shrinking something to make it seem less important

Emotional reasoning

Assuming that because we feel a certain way what we think must be true.

I feel embarrassed so I must be an idiot

should

must

Using critical words like 'should', 'must', or 'ought' can make us feel guilty, or like we have already failed

If we apply 'shoulds' to other people the result is often frustration

Labelling

Assigning labels to oursleves or other people

I'm a loser
I'm completely useless
They're such an idiot

Personalisation

"this is my fault"

Blaming yourself. Taking responsibility for something that wasn't completely your fault. Conversely, blaming other people for something that was your fault.

PSYCHOLOGYTOOLS.org

(Psychology Tools, 2020)

Cognitive worksheets

Cognitive therapy focuses on teaching you new ways of thinking. People with anxiety often have distortions in the way they perceive events, and this approach helps you correct those distortions.

Examples below include:

- Testing your thoughts
- Behavioural experiment with example
- Downward arrow technique

Testing your thoughts

Testing your thoughts worksheet was devised by the Beck Institute for Cognitive Behavior Therapy (2019).

What is the situation?_____

_____

What am I thinking or imagining?_____

_____

How much do I believe it? A little Medium A lot
(or rate 0-100 _____)

How does that thought make me feel? Mad Sad Nervous Angry Other:_____

How strong is the feeling? A little Medium Very Strong
(or rate 0-100 _____)

What makes me think the thought is true?_____

_____

What makes me think the thought is not true or not completely true?_____

_____

What's another way to look at this?_____

_____

What's the worst that could happen? Would I still live through it?_____

_____

What's the best that could happen?_____

_____

What will probably happen?_____

_____

What could happen if I changed my thinking?_____

_____

What would I tell my friend if this happened to him or her?_____

_____

What should I do now?_____

_____

How much do I believe the negative thought now? A little Medium A lot (or rate 0-100 ____)

How strong is my negative feeling now? A little Medium Very Strong (or rate 0-100__)

Behavioural experiment record form with example

DATE	SITUATION	PREDICTION What do you think would happen? How would you know?	EXPERIMENT What did you do to test the prediction?	OUTCOME What actually happened? Was the prediction correct?	WHAT I LEARNED More balanced view? How likely is what you predicted will happen in the future?
e.g. Monday 16 April	Driving to school	- I won't be able to do this, I will feel really sick. - I know I always get sick when I feel anxious or too stressed - Anxiety makes the task harder that it really will be - I will go into an avoidance state and say I can't do this today	I expected to be anxious and I stuck to the plan. I did xxxxxxxx	I did keep to the plan most of the time My prediction of anxiety was only partly true and I was able to keep to the plan Anxiety was better when the task goal seemed reachable	Part of the problem was worrying beforehand What I predicted was not 100% true Taking one step at a time was a good strategy for me

Behavioural record form

DATE	SITUATION	PREDICTION What do you think would happen? How would you know?	EXPERIMENT What did you do to test the prediction?	OUTCOME What actually happened? Was the prediction correct?	WHAT I LEARNED More balanced view? How likely is what you predicted will happen in the future?

Downward Arrow Technique

SITUATION	I cannot stop thinking about shocking sexual thoughts towards my children	MOOD RATING 8-9 (out of 10)
FEELINGS	1. Anxious 2. Dread	**REBUTTAL**
THOUGHTS Immediate Thoughts **Dig Deeper** **Core Beliefs**	**'I am a disgrace as a person. I deserve to be punished, my children taken from my care'** **WHAT DOES THAT SAY ABOUT ME IF THAT HAPPENED THEN…** That I don't deserve them, and the happiness they bring me. I am worthless, a waste of space. If people only knew **WHAT WOULD THAT MEAN?** **I am doomed to a life of misery, uncertainty,** **Having to watch my every thought and interaction with my child** **WHAT DOES IT SAY ABOUT ME?** I've always thought that I was deep down no good and one day I would be shown up as the opposite to what I appear	I know I am confused, disturbed and overwhelmed because thoughts like this are not me. How can I have such thoughts and not be a fraud and a monster. OCD presses disturbing buttons and tries to undermine me. They are just thoughts that make me worry myself sick. They are not real – flowing from my distressed imagination. So much conflict, criticism and negativity is exhausting. When anxious people are too highly self-critical, it creates a sensitive/reactive feeling in them. Rather take a learning stance…it is your deep love for your children that triggers the very opposite idea that you would actually harm them. Such a thought is more common than you think and really flabbergasts everyone. It just "pops in and pops out" for most people. It is OCD that makes it stick and torment. Face the thought, accept it as just that, a thought, and float through it over time. Your values-base of caring about others, being good to be around, and getting done what you say you will do. You base your life on values and principles not just by over-reacting to thought that are 'over the top' and the opposite of who you are.

(Adapted from Greenberger & Padesky, 1995)

Your OCD Therapy at a Glance

The context of your OCD

Each person has specific features of intrusive and unwanted images or thoughts that create the anxiety based responses of compulsions, reassurance seeking and avoidance. For those who have had OCD over a long period, there can be clear shifts of focus of their obsessions and compulsions. In this treatment program your focus will be on the present moment symptoms that are interfering in your functioning in your personal life, work life and your home life. These symptoms are the targets of your ongoing exposure and response prevention. Repeated practice will assist you in overcoming any ideas, images, actions or thoughts that you could think of to help you reduce your anxiety – because such gimmicks will not work in learning to overcome your OCD. Apply OCD principles of exposure and response prevention every day as a life-style change.

Maintaining ERP as a daily practice will strengthen your sense of self, your commitment to the things that are really important in your life, and help you to maintain clear thinking, balanced emotions and fully engaging in life.

One take home message from this program that will give you stability and resilience, whatever happens, is doing something daily about ERP.

What can go wrong?

The single factor in acquiring new learning is motivation, the driving force for all change. When coupled with persistence, there are few behaviours that cannot be altered. For this reason, the skills and strategies of relapse prevention are a necessary tool in managing OCD.

Relapse is largely influenced by shifts in mood, conflict or stress with others, and the resurgence of old habits. This program has highlighted your cues and triggers for emotional distress, the high-risk behaviours that make you more vulnerable and the need to maintain focus when striving for your goals. For example, when setting out to practice ERP, it is difficult to be in focus if there are other stressful factors in your life 'in play' like a troubled relationship or unwell relative. Ways of managing is to reduce the intensity of the ERP session so your targets are lower in SUDS ratings. Or you can shorten the length of the planned exposure. The important thing is to maintain the ERP practice – do something daily – to reinforce your commitment to and engagement in changing behaviours.

Treatment interfering behaviours

These are behaviours that actually get in the way of learning what you need to do to overcome any psychological condition.

Treatment interfering behaviours are very common and can be done knowingly or unknowingly. It is the therapist's role to point out if these factors are affecting the treatment. To name a few of these:

Adopting a passive-aggressive stance, missing or late for appointments, not filling out homework tasks, forgetting to bring work material, good understanding of the treatment model but reluctant to apply the principles explained. (VanDyke & Pollard, 2005).

Family accommodation

Can significantly disrupt therapy, family members can unwittingly change their own behaviour to accommodate the demands of the over-anxious patient, this leads to avoidance and safety seeking behaviour and places the accommodating family members in a compromising position of encouraging rituals, reassurance seeking or other safety behaviours.

Crisis plan

Crisis planning needs to be done in conjunction with your treating team, there are services that you can access 24-hour support and we recommend the Beyond Blue app (BeyondNow) to assist you in personalising a crisis plan.

General Anxiety Management Strategies

Relaxation is the voluntary letting go of tension. This tension can be physical tension in the muscles, or it can be mental, or psychological tension. When we physically relax, the impulses arising in the various nerves in the muscles change the nature of signals that are sent to the brain. This change brings about a general feeling of calm, both physically and mentally. Muscle relaxation has a widespread effect on the nervous system and therefore should be seen as a physical treatment, as well as a psychological one.

Progressive Muscle Relaxation

Progressive relaxation involves the muscles being relaxed in a progressive manner, gradually working through different muscle groups in the body, usually starting with the feet and ending with the face and neck muscles.

Slow breathing technique

To be done at first signs of anxiety or panic.

You must learn to recognise the first signs of over-breathing and immediately do the following:

- Stop what you are doing and sit down or lean against something.
- Breathe in and out (through the nose) slowly in a six second cycle. Breathe in for three seconds and out for three seconds. This will produce a breathing rate of 10 per minute. Say the word 'relax' to yourself every time you breathe out.
- Continue breathing in this way until all the symptoms of over-breathing have gone.
- If you do these things as soon as you notice the first signs of over-breathing, the symptoms should subside within a minute or two and you will not experience excessive anxiety. The more you practice this slow breathing technique the better you will become at managing your excessive anxiety.

Mindfulness

Mindfulness is a form of self-awareness adapted from Buddhist mindfulness mediation.

Mindfulness techniques teach you how to maintain attention on a particular focus. As you begin to focus your full attention on the task you are doing, other things can take care of themselves. In order to do this, you will need to start practicing ways of refocusing your attention. There are mindfulness exercises you can do to train your ability to refocus your attention.

Mindfulness exercises

One-Minute Exercise

Sit in front of a clock or watch that you can use to time the passing of one minute. Your task is to focus your entire attention on your breathing, and nothing else, for the minute. Have a go - do it now.

Mindful Eating

This involves sitting down at a table and eating a meal without engaging in any other activities - no newspaper, book, TV, radio, music, or talking. Now eat your meal paying full attention to which piece of food you select to eat, how it looks, how it smells, how you cut the food, the muscles you use to raise it to your mouth, the texture and taste of the food as you chew it slowly.

You may be amazed at how different food tastes when eaten in this way and how filling a meal can be. It is also very good for the digestion.

Mindful Walking

Here the same principle, while walking you concentrate on the feel of the ground under your feet, your breathing while walking. Just observe what is around you as you walk, staying IN THE PRESENT. Let your other thoughts go, just look at the sky, the view, the other walkers; feel the wind, the temperature on your skin; enjoy the moment.

(Black Dog Institute, 2014).

Cue Card

Use of a small card in wallet with words to read to yourself when feeling overwhelmed by stressful thoughts, feelings and reactions. As an example, the word AWARE cues in some coping messages:

A-W-A-R-E

A The A stands for ACCEPT or ACKNOWLEDGE that you are anxious, distressed or sad. Step back and see this as ONLY PART of you. When feelings are overwhelming, you can use this to put them in perspective. You're not always like this.

W Watch the LEVEL. Rate your feelings on the 0-10 scale from 0/1 being little or no distress through to moderate distress at 4 or 5, to overwhelming distressing at 8 or 9. The 10 rating is the worst experience of distress you have had.

A Act AS IF you are not distressed. This is a commonly used technique for people to stay in control when really upset by something. For example, if someone telephones when you are arguing over something, you do not transfer your anger to yell at the caller, more likely you will act AS IF you are quite calm. This is not meant to be the only way to deal with distress- by acting as if it does not exist - it is part of your response package, to be used sometimes whilst you are developing more stable and effective emotional regulation skills.

R Cues in the repeating of the first three points - Accept feelings as part of you, watch the level, and try to act calmly. It also triggers the idea of RELAXING yourself to tolerate the distress present. The R has a third meaning…trying to shift attention to other experiences – recreate the present moment.

E Expect this to happen again, simply because anxiety is a part of you. You are learning to handle anxiety better by keeping it in perspective, planning for your high risk situations, and understanding that anxiety can bring stressful reactions when this approach is more strategic.

(Adapted from Kidman & Biochemical & General Services, 2001)

Dealing with emotional distress

1. Intrusive negative thoughts and feelings are a feature of anxiety and depression, and of normal experience. This is expected to happen. We have to learn to accept that thoughts of all kinds come into our mind.
2. Step back metaphorically from these thoughts and feelings. This is not easy as thoughts create reactions within us - emotional and critical reactions. Some ways of 'stepping back' include:
   (a) using cue cards to read some key ideas to yourself…for example, I am not my thoughts, I am separate from my thoughts
   (b) using a breathing exercise whether counting breaths or watching the rise and fall of the diaphragm
   (c) Create a space that slows down your immediate reaction, and gives a chance that you can focus on what you are doing at that moment and not be overwhelmed by your thoughts.
   (d) Such a space also creates the opportunity for your emotional mind to process the upsetting thoughts.
3. Even a brief pause connects you back to longer moments when you have had more time to take a broader perspective. It is at that time that we notice things like how worrying thoughts and feelings cause tension in particular parts of the body. Becoming more aware of such tension enables us to become more aware of the thoughts or feelings that can trigger this reactive tension. How long do they last? Do they stay the same or do they shift over time? Can I 'soften' that impact by shifting my attention back to the present moment or breathing into the tension or blockage to create 'space' for a better response, even a healing response. Self-soothing is a very useful skill to develop. "I don't like this, but I can handle it, let it pass, it will fade over time"
4. Be open to experiences - negative and positive. It is the continual connection with unresolved issues that bring the unhelpful thought and feelings that destabilize. Find your inner peace, get in touch with the things that engage your attention, get you in the 'flow" and bring genuine feelings of satisfaction
5. CBT has an emphasis on TAKING ACTION. In response to intrusive thoughts or feelings, the first action step is to **create this pause** or space to enable you to sense what is happening. Am I more irritable? Do I not want to see people? Am I not eating or sleeping sensibly? Am I giving up on my curiosity about trying things - exercise, hobbies, new experiences? Am I not opening mail, using the telephone or checking emails?
6. These may be your relapse signature or fingerprint. These feelings will pass, just sit with the anxiety and it will gradually fade.
7. You know that rumination, negative thoughts and criticism don't help…try and move away from those reactions, and shift attention to things that do help …stay close to those who care, do something kind for yourself, complete something however small that really needs doing - you'll feel you've done something to help.

Reducing Your Sensitivity To Anxiety

Hyperventilation exercise

When you just can't stand feeling anxious at all, you avoid, escape from or mask feelings of anxiety in every situation. Anxiety can stop you from thinking clearly, so too much anxiety may lead to oversensitivity, catastrophic thinking and habitual avoidance.

One of the signs of anxiety is uncontrolled breathing or hyperventilation. This can be very distressing to experience, and anxiety about experiencing these symptoms and not being able to handle them adds to overall anxiety.

A specific strategy is the hyperventilation exercise – to lower sensitivity to anxious feelings. This strategy asks you to deliberately bring on hyperventilation to help realise that anxiety sensitivity can be lowered and symptoms like feeling puffed, hot and sweaty or dizzy actually pass.

You can create the symptoms of hyperventilation by doing deep chest breathing for just 10 seconds. Understand that you will go red in the face and will feel puffed, but the symptoms will quickly pass. After completing the exercise, rate how anxious you feel on a scale of 0 to 10 (with 10 being the highest).

Your reaction to the hyperventilation exercise will vary according to your own experience of anxiety. If the exercise is too strenuous or causes too much anxiety, only proceed under the supervision of a mental health professional. This exercise is only for those who don't have breathing or respiratory problems. If you have asthma, or other breathing or health issues, always check with your doctor and follow their advice.

If possible, you will make more progress with reducing your sensitivity to anxiety through practicing the hyperventilation exercise daily at home. The important thing is to start with just a short exercise and to practice only once a day. Only move up to higher levels when you measure your anxiety below 5, and only increase the time in 5-second increments. Through this process, you can start to understand that the feelings associated with deep chest breathing are harmless, helping you to reduce your catastrophic thoughts about being anxious and to increase your sense of control in managing anxiety.

Below outlines a program of gradually increasing the rate of breathing during the exercise.

(Adapted from Deacon et al, 2013).

Hyperventilation exercise with gradual increases

Task	Deep chest breathing: puff the air out	Rest	Deep chest breathing: puff the air out	Rest	Deep chest breathing: puff the air out
Level 1	*Trial 1* 10-20 secs	15 secs	*Trial 2* 10-20 secs	15 secs	*Trial 3* 10-20 secs
Level 2	20-40 secs	15 secs	20-40 secs	15 secs	10-20 secs
Level 3	40-60 secs	15 secs	40-60 secs	15 secs	40-60 secs

Producing Panic & Anxiety sensations

Other exercises to try:

The goal is for you to identify any sensations that you feel as a result of each exercise. After performing the exercises set out below, write down all the physical sensations you experience during or after the exercise, as well as any anxiety-provoking thoughts.

Exercise	Level of distress (1 – 10)	Similarity to other anxiety experiences (1 – 10)
Hyperventilation Breathe deeply and quickly, using a lot of force, for 10 - 60 seconds		
Shaking head Moving head from side to side, with eyes open for 30 seconds		
Head between legs Place your head between your legs for 60 seconds, then stand upright quickly		
Step-ups Step up on a step or a box, then step down again, quickly, for 60 seconds		
Holding breath Hold your breath, holding your nose shut at the same time, initially for 30 seconds leading up to as long as you can		
Push Up / Body tension Hold a push up position for 60 seconds		
Spinning Spin for 30 seconds whilst standing. Don't hold on to anything nor sit down immediately afterwards		
Staring at the wall / pattern / vent Stand close (one hand span) to the wall / pattern / vent and star at the wall / pattern / vent for at least 60 seconds, up to 2 minutes		
Staring in a mirror Stand close to the wall (one hand span) and star at the mirror for 60 seconds		
Breathing through straw Breath through a straw for 30 seconds, hold your nose whilst you do this		
Chest breathing		

Fill your lungs with air until your chest feels fully expanded. Take quick, shallow breaths, and breath from your chest for 60 seconds		
Gag reflex Hold your hand to your throat, or put your fingers or a scarf in your mouth, and breathe for 30 seconds		
Nausea Sit in a hot room (eg. a cupboard) or hold a paper bag over your face and breath for 60 seconds		

Please note: The treating team prefer that you discuss these exercises to determine the most suitable ones for you to do. Only do 3 exercises at a time completing the two ratings above.

(Clinical Research Unit for Anxiety and Depression (CRUfAD), 2015)

Worksheets

Daily activity schedule

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7 – 9							
9 -10							
10 - 11							
11 - 12pm							
12 – 1							
1 – 2							
2 – 3							
3 – 4							
4 – 5							
5 – 6							
6 – 7							
7 – 8							
8 – 10							
10 – 12							

Goal setting

When setting your goals, consider what you would like to achieve in the following areas:

- Professional career / work
- Self-development
- Health
- Relationship
- Social life
- Experience
- Recreation
- Hobbies
- Travel
- Any other personal goals

Remember to make your goals specific, measurable, achievable, realistic, and within a time frame.

You may have more than one goal per time frame.

Time frame	My Goal Is
Immediate (1-7 days) For example: *I will commence this program on Friday this week*	
Short term (1 week – 6 weeks) For example: *I will book a social outing to the movies with my friend*	
Medium term (6 weeks – 3 months) For example: *I will start a public speaking course*	
Long term (3 months – 12 months) For example: *I will have a weekend away with my partner*	
Longer term (12 months – 2 years) For example: *I will attend a cooking class at Essential Ingredient*	
Future (2 years – 5 years) For example: *I will renovate my bathroom*	

Exposure & Response prevention worksheet

ERP tasks	B	D 5	D 10	D 15	D 20	D 30	D 35	D 40	D 45	A
1.										
2.										
3.										

B = Rate anxiety level before ERP session.

D = Rate anxiety during task, sit with anxiety and record SUDS every 5 mins until it reduces by 50%.

A = After task is completed

Ratings of anxiety on 0-10 scale: 0-1 little or no distress, 2-3 some distress,
4-5 moderate levels, 6-7 high distress, 8-9 very high,10 extreme distress.

Exposure & Response Prevention worksheet 2

This is an example of an exposure and response prevention exercise.

Trigger for your OCD symptoms - Niece

Exercise - Look at photo of niece or write niece's name down on a small card.

Rate your anxiety prior to looking at photo or writing name of niece down = B

Continue looking at photo or name and rate anxiety every 2 mins for 10 mins = D

After 10 mins put photo away or name away and rate anxiety again = A

Then return to the photo or name written down 1-3 hours afterwards and rate your anxiety again = L

In this exercise you are exploring how the trigger impacts on the anxiety felt. Your anxiety level could stay the same, or it could get worse or go down. It is only doing ERP exercises like this that the effect on the felt anxiety can be measured.

Twice a day for 10 days:	B	D	D	D	D	D	A	L	B	D	D	D	D	D	A	L

Ratings of anxiety on 0-10 scale: 0-1 little or no distress, 2-3 some distress,

4-5 moderate levels, 6-7 high distress, 8-9 very high,10 extreme distress

Homework tasks

Intensive phase	Homework record	Completed
Day 1 Tuesday		
Day 2		
Day 3		
Day 4 Friday		
Day 5		
Day 6		
Day 7		

Intensive phase	Homework record	Completed
Day 8 Tuesday		
Day 9		
Day 10		
Day 11 Friday		
Day 12		
Day 13		
Day 14		

Generic exposure & response prevention tasks

Exposures review

Day	Measure	
1	# Exposures	
	Highest SUDS	
	Lowest SUDS	
	# Rituals/Other behaviours	
	Motivation	
2	# Exposures	
	Highest SUDS	
	Lowest SUDS	
	# Rituals/Other behaviours	
	Motivation	
3	# Exposures	
	Highest SUDS	
	Lowest SUDS	
	# Rituals/Other behaviours	
	Motivation	
4	# Exposures	
	Highest SUDS	
	Lowest SUDS	
	# Rituals/Other behaviours	
	Motivation	
5	# Exposures	
	Highest SUDS	
	Lowest SUDS	
	# Rituals/Other behaviours	
	Motivation	
6	# Exposures	
	Highest SUDS	
	Lowest SUDS	
	# Rituals/Other behaviours	
	Motivation	
7	# Exposures	
	Highest SUDS	
	Lowest SUDS	
	# Rituals/Other behaviours	
	Motivation	

Notes

Reference List

- Abramowitz, J. S. (1996). Variants of exposure and response prevention in the treatment of obsessive-compulsive disorder: A meta-analysis. *Behavior Therapy*, 27(4), 583-600. https://doi.org/10.1016/S0005-7894(96)80045-1
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Beck Institute for Cognitive Behavior Therapy. (2019). Cognitive model. Retrieved from https://beckinstitute.org/cognitive-model/
- Beck Institute for Cognitive Behavior Therapy. (2019). What is cognitive behavior therapy (CBT)? Retrieved from https://beckinstitute.org/get-informed/what-is-cognitive-therapy/
- Beck Institute for Cognitive Behavior Therapy. (2019). CBT basics and beyond worksheets. Retrieved from https://beckinstitute.org/get-informed/tools-and-resources/professionals/cbt-basics-and-beyond-patient-worksheets/
- Black Dog Institute. (2014). Fact sheets: Staying well techniques: Mindfulness in everyday life. Retrieved from http://www.blackdoginstitute.org.au/docs/10.MindfulnessinEverydayLife.pdf
- Clinical Research Unit for Anxiety and Depression (CRUfAD). (2015). Treatment manuals. Retrieved from https://crufad.org/index.php/treatment-support/treatment-manuals
- Deacon, B., Kemp, J. J., Dixon, L. J., Sy, J. T., Farrell, N. R., & Zhang, A. R. (2013). Maximizing the efficacy of interoceptive exposure by optimizing inhibitory training: a random controlled trial. *Behaviour Research and Therapy*, 51(9), 588-596.
- Greenberger, D., & Padesky, C. A. (1995). Mind over mood: *Change how you feel by changing the way you think*. New York., NY: Guilford Press.
- Hashmani, T. (2016). Defining treatment responders and non-responders in CBT. Disordered eating among female athletes: *A review of potential sports-related predictors*, 16. Retrieved from https://www.researchgate.net/publication/325644365_Defining_Treatment_Responders_and_Non-Responders_in_CBT
- Kidman, A. D., & Biochemical &General Services. (2001). *From thought to action: A self help manual* (2nd ed.). Sydney: Biochemical & General Services.
- Klinger, E. (1996). The content of thoughts: Interference as the downside of adaptive normal mechanism in thought flow. In I. G. Sarason, G. R. Pierce, & B. R. Sarason (Eds.), *Cognitive interference: Theories, methods, and findings* (pp. 3-23). N.J.: Lawerence Erlbaum Associates.
- Meyer, V. (1966). Modification of expectations in cases with obsessional rituals. *Behaviour Research and Therapy*, 4(4), 273-280. https://doi.org/10.1016/0005-7967(66)90023-4
- Mogan, C., Elliott, C. H., & Smith, L. L. (2014). *Overcoming anxiety for dummies* (Australian and New Zealand edition ed.). Milton, Qld Wiley: Publishing Australia Pty Ltd.
- Psychology Tools. (2020). Unhelpful thinking styles. Retrieved from https://www.psychologytools.com/resource/unhelpful-thinking-styles/

- Psychology Tools. (2020). Understanding my panic. Retrieved from https://www.psychologytools.com/resource/understanding-my-panic/
- Psychology Tools. (2020). Fight or flight response. Retrieved from https://www.psychologytools.com/resource/fight-or-flight-response/
- Purdon, C., & Clark, D. A. (2002). The need to control thoughts. In R. Frost, O & G. Steketee (Eds.), *Cognitive approaches to obsessions and compulsions: Theory, assessment, and treatment* (pp. 29–43). New York: Elsevier Science.
- Rachman, S., & de Silva, P. (1978). Abnormal and normal obsessions. *Behaviour Research and Therapy*, 16(4), 233-248.
- Radomsky, A. S., Alcolado, G. M., Abramowitz, J. S., Alonso, P., Belloch, A., Bouvard, M., . . . Fernández-Álvarez, H. (2014). Part 1—You can run but you can't hide: Intrusive thoughts on six continents. *Journal of Obsessive-Compulsive and Related Disorders*, 3(3), 269-279. https://doi.org/10.1016/j.jocrd.2013.09.002
- Salkovskis, P. M., & Harrison, J. (1984). Abnormal and normal obsessions—a replication. *Behaviour Research and Therapy*, 22(5), 549-552.
- Twohig, M. P., Abramowitz, J. S., Bluett, E. J., Fabricant, L. E., Jacoby, R. J., Morrison, K. L., . . . Smith, B. M. (2015). Exposure therapy for OCD from an acceptance and commitment therapy (ACT) framework. *Journal of Obsessive-Compulsive and Related Disorders*, 6, 167-173. https://doi.org/10.1016/j.jocrd.2014.12.007
- VanDyke, M.M., & Pollard, C.A. (2005). Treatment of refractory obsessive-compulsive disorder: The St. Louis model. *Cognitive and Behavioral Practice*, 12, 30-39. https://doi:10.1016/S1077-7229(05)80037-9
- Wolpe, J. (1969). *The practice of behavior therapy*. Oxford, England: Pergamon.
- Young, J. (2012). Schema therapy: Early maladaptive schemas. Retrieved from http://www.schematherapy.com/id73.htm

