Aggressive Obsessions

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Obsessive compulsive disorder (OCD) is characterized by the presence of unwanted or intrusive thoughts (e.g., obsessions) and behaviours or rituals (e.g., compulsions), that are performed in order to reduce distress or prevent a feared outcome (American Psychiatric Association, 2013). OCD is highly heterogeneous in nature with sufferers typically presenting with an array of symptoms. Both children and adults with OCD commonly report experiencing aggressive obsessions. Aggressive obsessions include unwanted thoughts, images or impulses related to harming oneself or defenseless others (e.g., Stabbing oneself or a family member, smothering a baby or beloved pet, poisoning a family member and throwing themself off a balcony)(Moulding, Aardema, & O'Connor, In Press; Purdon, 2004) Moreover, they are often associated with a range of overt (e.g., checking, seeking reassurance) and covert (e.g., thought neutralizing, praying) compulsions. For example, checking online newspapers for reports of hit and run accidents, ensuring knives are locked away and seeking reassurance by repetitively asking loved ones if they are feeling ok. Covert mental rituals may include thinking 'safe' words, phrases or prayers in order to neutralize unacceptable or dangerous thoughts (Abramowitz, Franklin, Schwartz, & Furr, 2003), or mentally reviewing ones own behaviour to manage obsessional doubt related to mistakenly hurting. Aggressive obsessions are typically associated with significant avoidance of triggers of intrusive thoughts, such as avoiding using knives or driving, spending time with loved ones, or even certain colours (black because it is associated with death), places (e.g., hotels with balconies, or cemeteries), or numbers (e.g., number 6).

Within the current OCD literature a number of studies have examined whether OCD can be categorized into different subtypes/dimensions based on patient symptom content. Factor analytic studies of the Yale Brown Obsessive Compulsive Scale (YBOCS; Goodman et al. (1989)) have produced generally consistent results with four and five solutions including the following dimensions – (1) symmetry and ordering, (2) contamination and cleaning, (3)

sexual/religious obsessions, (4) aggressive and checking and (5) hoarding dimensions (Mataix-Cols, Rosario-Campos, & Leckman, 2005; Storch et al., 2008). Notably, across research groups aggressive or harm related OCD symptoms have been conceptualized differently. It is currently unclear whether sexual/religious obsessions and aggressive/checking symptoms load onto a single factor (e.g., repugnant obsessions,'forbidden thoughts' 'taboo thoughts') or two separate factors (harming and 'unacceptable thoughts'). Similar symptom dimensions have been found in children, with the exception of checking which, in adult studies, tends to load on the aggressive dimension however in children on the symmetry OCD subtype (Bloch, Landeros-Weisenberger, Rosario, Pittenger, & Leckman, 2008).

Aggressive obsessions are both highly prevalent and disturbing for sufferers. Estimates suggest approximately 45% to 50% of adult OCD sufferers (Pinto et al., 2008; Rasmussen & Tsuang, 1986) and 30% to 70% of children and adolescents experience aggressive obsessions (Geller et al., 2001; Storch et al., 2008). Moreover, research suggests that 20% to 30% of OCD patients report that 'forbidden' obsessions (e.g. aggressive, sexual or religious obsessions) are their primary concern (Freeston et al., 1997; Stein, Forde, Anderson, & Walker, 1997). Indeed, those who report experiencing harm related or unacceptable obsessions have been found to have greater obsessional symptom severity in comparison to those who have contamination, symmetry or hoarding related OCD (Abramowitz et al., 2003). Some research suggests that the 'forbidden thoughts' OCD subtype is associated with a unique demographic and comorbidity pattern. In adult samples, a number of studies have found that the aggressive, sexual and religious, somatic obsessions and checking compulsions subtype is more likely associated with being male, having early onset OCD (<16yrs) and comorbid anxiety (in particular social phobia), depression, alcohol and substance use disorders and body dysmorphic disorder (Denys, de Geus, van Megen, &

Westenberg, 2004; Hasler et al., 2005). In a recent study Brakoulias et al. (2013) found that 'unacceptable/taboo thoughts' were associated with higher scores on the YBOCS obsession scale, being male, having a past history of substance dependence (non alcoholic) and previously received OCD treatment (either medication or behavioural intervention).

The cognitive behavioural theory of OCD proposes that cognitive content and processes, such as beliefs related to inflated responsibility, overestimating threat, need for perfectionism and certainty, over importance and the need to control thoughts, are related to the development and maintenance of OCD (Obsessive Compulsive Cognitions Working Group, 2005). To date several studies have examined the specific relationships between obsessional beliefs and OCD symptom dimensions. In large samples of adult OCD sufferers (n =135) Wheaton, Abramowitz, Berman, Riemann, and Hale (2010) found that responsibility and threat overestimation beliefs predicted 'responsibility for harm' symptoms. Whereas importance/control of thoughts beliefs were associated with the 'unacceptable thoughts' dimension of OCD. In a more recent study of 154 adult OCD sufferers, Brakoulias et al. (2014) found that responsibility and threat overestimation had a strong association with the OCD symptom dimension of doubting or checking. Consistent with Wheaton et al. (2010), the importance/control of thoughts obsessive belief was related to the unacceptable/taboo thoughts symptom dimension. These studies suggest that OC beliefs, specifically those related to the importance/control of thoughts and responsibility/ threat estimation, are particularly salient for patients with aggressive obsessions and are likely to be important targets in treatment.

Cognitive behavioural therapy (CBT), which includes exposure and response prevention (ERP), either alone or in combination with a serotonergic (SRI) medication has strong empirical support for the treatment of adult and pediatric OCD (Eddy, Dutra, Bradley, & Westen, 2004; The Pediatric OCD Treatment Study (POTS) Team, 2004). Several studies

have examined differential responding to CBT as a function of OCD subtype. Early research in this area proposed that OCD sufferers who engaged in covert rituals such as mental ritualizing, would respond less favorably to CBT (Baer, 1994; Lee & Kwon, 2003). However, this does not appear to be the case with multiple studies in adults and children finding no differences in treatment responding in relation this OCD symptom. Abramowitz et al. (2003) examined response to ERP in a sample of 123 adults with a primary diagnosis of OCD. Patients were categorized on the basis of their symptom presentation with five patient clusters identified (e.g., harming, contamination, hoarding, unacceptable thoughts and symmetry). Mental compulsions were found to have the greatest prevalence among patients within the unacceptable thoughts group, whom experienced intrusive and distressing religious, violent or sexual thoughts. The results revealed that across the OCD subtypes only those with hoarding symptoms responded less favourably to ERP in comparison to the other OCD subtypes. Similarly Rufer, Fricke, Moritz, Kloss, and Hand (2006) found that those who presented with primarily hoarding symptoms were significantly less likely to be treatment responders than those with other obsessions (e.g., symmetry/ordering, contamination/cleaning, aggressive/checking, sexual religious obsessions). In a pediatric sample (n = 92) Storch et al. (2008) found trends consistent with the adult literature with youth whom presented primarily with symptoms of hoarding displaying the poorest treatment response; however, due to limited power significant differences were not observed between the groups. Interestingly, the results also showed that youth presenting with aggressive/checking symptoms were significantly more likely than other symptoms (e.g., symmetry/ordering, contamination/cleaning, sexual/religious and hoarding) to respond positively to treatment, with children and adolescents in aggressive/checking group exhibiting greater pre/post treatment change on a clinical impression of severity rating. In summary, research suggests that patients with aggressive obsessions appear to have a similar treatment response to other

OCD subtypes despite the use of mental compulsions. In fact, it appears that aggressive/checking symptoms in children and adolescents may be associated with an improved treatment outcome. The following case example describes the assessment and treatment of a youth who presented with aggressive obsessions and associated compulsions.

Presenting Problem (1 pg)

Daniel, a 16-year-old caucasian male, in his final year of high school (grade 12), was referred to the Griffith University OCD Program by his general practitioner for treatment of obsessive compulsive symptoms.

During his initial assessment, Daniel reported that he was plagued by thoughts that he would hurt himself. He feared that he would walk in front of cars and buses on his way to and from school, that he would hurt himself if he was at home alone (either by taking a knife to wrist or by jumping out of the window), and that he would drown himself when out surfing with his friends. Daniel was also learning to drive and worried that he would drive his car off the road or into oncoming traffic. Daniel's most pressing concern was how he would cope at his upcoming schoolies week (a rite of passage held on the Gold Coast where year 12 students from across Australia come to celebrate the end of their schooling) where he feared that he would throw himself off the balcony of a hotel. Daniel had seen a news story the previous year about a school leaver who had died after falling from a balcony while partying with friends at schoolies week.

Daniel's thoughts about hurting himself caused him significant distress and he reported having to engage in various rituals to neutralise the anxiety they caused, such as repeating 'safe' thoughts (i.e., I am safe and alive, and my family protects me); engaging in lengthy checking routines (including checking for reassurance that he will not hurt himself or anyone else); avoiding being home alone; and avoiding drinking at parties incase alcohol caused him to act on his aggressive thoughts. Daniel's fear of hurting himself was starting to

cause some difficulties with his peers as he was frequently avoiding social activities such as surfing and going to parties, as well as asking them annoying questions to seek reassurance.

In addition to fears of hurting himself, Daniel also worried about harm coming to others, especially to loved ones. He worried about being responsible for his families' wellbeing, for example he would worry that if he didn't check the front door was locked then he'd be responsible for an intruder breaking into the house and violently attacking his mother. He also had a belief that his favourite past time, fishing, might lead to "bad karma" (for killing fish), which would cause something terrible to happen to his parents. Daniel had recently stopped fishing because of this, which upset him considerably and led to more social avoidance. Daniel was worried about hitting people with his car and was avoiding taking lessons to get his license. He was also fearful of having a bad thought about a loved one in case it came true, and he'd spend much time suppressing these thoughts throughout the day. Daniel also had a fear that he would hurt the family pet – a budgie named Kai. Daniel reported having intrusive thoughts that he would strangle the bird to death and had therefore asked his mother to move the bird cage to the laundry to avoid seeing it.

Daniel involved his family in several of his rituals, such as asking them to repeat certain sentences before bed to ensure their safety and asking his mother to lock the windows so that he wouldn't be able to jump from them. He also sought excessive reassurance from that nothing bad would happen.

Table 1. Summary of Daniel's presenting Obsessive Compulsive Symptoms

	Obsessions	Compulsions
Harm to Self	Driving into oncoming traffic	• Gripping steering wheel and tensing arms • Checking car mirrors • Driving in lane furthest from oncoming traffic
	Walking in front of oncoming traffic	• Walking on the inside of the

		footpath • Asking his mother to drive him to school
	Jumping off a balcony or out of windows	• Checking windows and balcony doors locked • Family accommodation – Parents checking locks • Avoiding standing on balconies • Avoiding attending parties or drinking alcohol
	Slashing wrists when using knife or scissors	• Avoiding using a knife • Checking knives are put away in lockable kitchen draws • Avoiding being home alone
	Drowning himself	• Avoiding surfing & fishing
Harm to Others	Family member being hurt – e.g., mother violently attacked by an intruder or dying in a car accident	• Check house is locked • Neutralizing thoughts • Stopped fishing • Parents repeating sentences before bed
	Strangling his pet budgie	• Moving budgy cage to laundry • Not interacting with budgy – feeding and cleaning cage
	Bad Karma	• Avoid fishing and killing fish

Case Information (2 – 4pg)

Background

Daniel was born on the Gold Coast, Australia, and he and his older sister Maggie (19 years) lived with their mother in a middle class beachside suburb. Daniel's father had moved away from the Gold Coast 8 years earlier, after he and Daniel's mother separated. Daniels stayed with his dad mostly during the school holidays and some weekends. Daniel described his family relationships as close and explained that his parents had always been very supportive of him. Daniel attended a private school and performed well academically. He

particularly enjoyed physical education and hoped to be a Physical Education teacher after leaving school. Daniel had a good group of friends from school, but described himself as one of the quieter ones in the group.

History

Daniel first experienced OCD-like symptoms when he was in primary school at 9-years of age. He would ask his mother to repeat saying certain things, like “have a good day” and “love you”, when she dropped him off at school. He also remembered having to get into bed at night a certain way to avoid bad things from happening, and retracing his steps until he felt just right. These behaviours caused him only minimal distress and did not impact significantly on his daily life.

According to his mother, Daniel suffered from separation anxiety at 5 years of age when he first started school, however, this resolved within the first 12 months of his schooling. When Daniel was 8 years old, his parents separated and although Daniel was upset he generally coped well with the situation.

The onset of his current OCD symptoms was at 15 years of age (one year prior to presenting). The onset coincided with the tragic accident of family friend (sisters best friend) who was involved in a car accident where she was killed and another passenger (the friend’s father) severely injured. Daniel’s mother recalled that Daniel would ask for reassurance that she would drive safely following this incident. Daniel’s symptoms had progressively worsened over the year before seeking treatment. He identified his senior school exams and the pressure to get his license as ongoing stressors that exacerbated his symptoms and in the few months prior to starting treatment Daniel noticed a dramatic increase in symptoms triggered by him and his friends starting to organise their schoolies week accommodation in Surfers Paradise.

Daniel's mother reported that she also suffers from anxiety (likely GAD). She worries about the future, performing at work, her children and health and finds it difficult to control these worries. She was concerned that her worries about her family may have led her to be overprotective of her children.

Treatment History

Daniel had never received treatment for OCD and was first diagnosed at our initial assessment at 16 years of age. He was very reluctant to consider taking medication for OCD due to concerns that it might cause him to commit suicide by over-dosing. He had never received any psychological or medical treatment previously for any mental health problem.

Case Conceptualization and Assessment (2 – 3pg)

Conceptualisation

Daniel may have a biological vulnerability to developing OCD given that his mother has a history of persistent anxiety. Furthermore, Daniel appears to have an anxious temperament, as a young child he experienced separation anxiety and engaged in ritualized behaviours when feeling anxious about separating from his mother and at bedtime. In combination with a biological vulnerability, stressful life events such as the separation of his parents may have predisposed Daniel to developing psychopathology. Despite some sub-clinical OC symptoms during middle childhood, Daniel appears to have had an abrupt onset of clinical OCD following the death of his sister's friend. His symptoms appear to have been exacerbated by the stressors of finishing his schooling, planning for his upcoming schoolies week, and not surprisingly, his experience of learning to drive was a salient trigger for his current episode.

Daniel held numerous dysfunctional beliefs in regards to the experience of intrusions, as well as in relation to the content of his intrusions. Given the relentless nature of obsessions, coupled with poor inhibitory control associated with OCD, it is proposed that appraisals about

the occurrence and meaning of intrusions develop and sever to perpetuate the experience of these intrusions, such that they become obsessional in nature and therefore associated with escalating distress, and attempts to neutralize through overt and covert avoidance, and ritualizing.

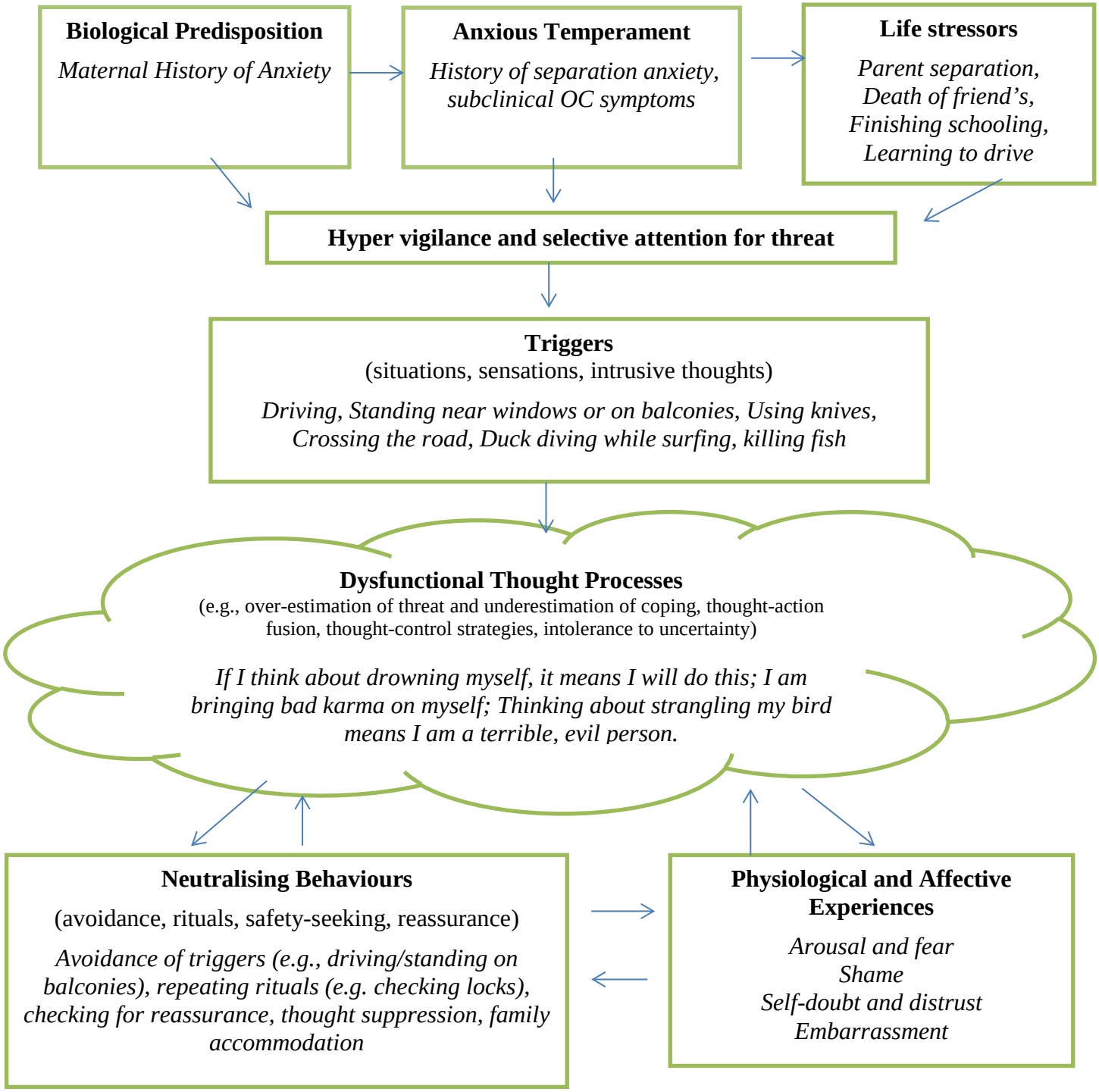
It hypothesized that Daniel's fear associated with his obsessions resulted from his dysfunctional beliefs regarding the presence and significance of his aggressive thoughts, and following this, his efforts to control these thoughts. Daniel believed that he was responsible for his own and mother's safety (i.e., inflated responsibility bias). Moreover, he believed that simply thinking about harming himself (e.g., cutting his wrist, jumping off the balcony) would increase the probability that he would indeed harm himself (i.e., thought-action fusion beliefs). Because of this, Daniel tried to suppress his aggressive obsessions (ie., control of thoughts), exerting mental control and ineffective suppression techniques, which in turn served to maintain these dysfunctional beliefs about harm and responsibility for preventing harm, which led to Daniel experiencing his intrusive thoughts more often and with heightened anxiety and intensity.

Daniel avoided external fear triggers (e.g., surfing, driving, patting his bird) to prevent himself from having to experience his aggressive thoughts and the related distress they caused. Moreover, Daniel engaged in rituals, such as repeating neutral thoughts, checking locks, his car and seeking reassurance from his parents, in order to decrease the anxiety associated with these situations and the experience of intrusions. In the short term Daniel's distress was reduced when he could avoid his triggers or engage in rituals. However, these strategies prevented him from acquiring corrective evidence that he could indeed tolerate uncertainty, and discovering that his obsessions, although unpleasant, were inaccurate. Hence, Daniel's avoidance and ritualizing served to maintain his fear of these disturbing intrusive thoughts.

Furthermore, the anxiety associated with these thoughts was continuing to worsen given the significant attention and preoccupation Daniel had with trying to "not" think about them.

Despite the vicious cycle of obsessions and fear that Daniel was caught up in, he had numerous protective factors present in his life, including a supportive mother and sister and a close group of friends. He was also achieving well at school, and is of at least average intelligence.

Figure 1. **A Cognitive-behavioural formulation of Daniel's OCD**



Assessment

Diagnostic Interviews. Daniel was administered the Children's Yale Brown Obsessive Compulsive Scale (CYBOCS; Scahill et al., 1997) and his score (30) fell within the severe range of OCD symptomology. He scored a 17 on the obsessions subscale, and 13 on the compulsions subscale. Additionally, Daniel and his mother were interviewed using the Anxiety Disorder Interview Schedule for Children (ADIS-IV-C/P; Silverman & Albano, 1996). Based on Daniel's report and that of his mother's during the diagnostic interviews, Daniel was diagnosed with a primary diagnosis of OCD, with a clinician severity rating (CSR) of 7 (on a scale of 0 to 8) and Major Depressive Disorder with a CSR of 4 (on a scale of 0 to 8).

Behavioural Approach Task (BAT). BATs are standardized and controlled tasks designed to assess how someone responds when exposed to feared stimulus. In particular, when avoidance is pathological, a BAT provides a valid assessment of both fear and avoidance behaviors in a standardized and systematic way. Moreover, once exposed to the stimuli that elicits fear and avoidance, a child is more accurately able to gage their degree of distress, along with any dysfunctional beliefs that they may experience in the context of arousal. A BAT task for OCD can be set up a series of steps to measure approach / avoidance, or an exposure task whereby the child is instructed to withhold ritualizing for a period of time to measure resistance and control, as well as fear and fear-related beliefs.

A number of potential BATs were considered for Daniel. For example; (1) Taking Kai (Daniel's pet Budgie) out of his cage and holding him with two hands around his body for 5 minutes; (2) Holding a knife against his wrist for a period of 5 minutes; (3) Leaning over a three-story balcony, dangling his arms over the edge. As during the diagnostic interview Daniel indicated that jumping off a balcony at schoolies week was his most worrying OCD symptom at the time, it was determined that he complete a BAT related to this. During the

BAT Daniel was asked to enter a room (by himself), walk toward a balcony door, open the door, walk over to the railing of the 7th floor balcony, dangle his arms and lean over the side of the balcony for 5 minutes, and say out loud "I might jump off". Prior to commencing the BAT, Daniel's obsessional beliefs and fear level were assessed. Daniel reported that he was afraid that if he lent over the balcony, he would experience a strong urge to climb over the balcony railing and end his life. Belief ratings were assessed, using a 9 point likert scale to measure intensity (i.e., 0 – 10). Following identification of Daniel's belief, he was asked to rate the strength of his belief (truth), the chance their belief will occur (probability), how bad it would be for him if he did actually have the urge to jump off the balcony (severity) and how sure he was that he could cope if he did have the urge to jump off the balcony (estimation of coping). Folliwng thes ratings, Daniel was asked to enter the room and try his best to compete as many stpes as possible without seeking reassurance. Daniel was able to enter the room and approach the balcony door; however, he was not able to open the door. He rated his subjective anxiety at an 8 (on a scale ranging from 0 – 10).

Self-Report Questionnaires. In addition to diagnostic interviews and a behavioural approach task Daniel completed a number of self-report measures (refer to Table x for a summary of self report measure findings) including the Multidimensional Anxiety Scale for Children (MASC; March, 1997), Children's Depression Inventory (CDI; Kovacs, 1992) and the Obsessive Beliefs Questionnaire – Child Version (OBQ-CV; Coles et al., 2010).

Table

Self report measure	Score	Range
MASC	84	Very elevated
CDI	82	Very elevated
OBQ-CV	134	
Responsibility/ Threat Estimation	62	
Perfectionism/ Uncertainty	36	
Importance/ Control of Thoughts	36	

Risk Assessment. Given that Daniel presented with thoughts of harming himself and others a brief risk assessment was conducted with Daniel. As previously discussed a large proportion of people who suffer from OCD report having intrusive violent, sexual and death related thoughts. It is of essential for clinicians to have a sound knowledge of OCD phenomenology to allow them to be able to differentiate between thoughts and urges in people with OCD in comparison to the thoughts experienced by those of are sexual or violent offenders or people whom are actively suicidal (Veale, Freeston, Krebs, Heyman, & Salkovskis, 2009). If a child or adult is presenting with OCD there is almost a negligible risk that they will carry out their obsession. Obsessions by definition are intrusive and *unwanted* thoughts, which are *ego dystonic* to the person. Moreover, an obsession represents a fear that the person wishes to avoid at all costs and does not wish to happen (Veale et al., 2009). To further assist in differential diagnosis when assessing someone who has self and other harm related thoughts the following factors should be considered (adapted from Veale et al., 2009) – (1) Are the thoughts ego dystonic? (2) Does the person avoid situations that trigger the thoughts? (3) Does the person attempt to suppress or neutralise the thoughts? (4) What is the dominant emotion the person experiences when they have the thoughts (e.g., anxiety, distress or guilt vs. pleasure)? (5) Does the person have other symptoms of obsessive compulsive disorder, (6) What other comorbid diagnoses does the person have? (7) What is the persons

motivation for seeking help? and (8) Does the person have a history of harming themself or others?

Daniel reported feeling extremely distressed by thoughts of harming himself and others and went to great lengths to avoid situations which triggered his intrusive thoughts (e.g., stopping surfing, not driving and no longer caring for or spending time with the family pet). Moreover, Daniel engaged in mental rituals in an attempt to neutralize his thoughts. Daniel also reported other OCD symptoms including feeling 'just not right' when waxing his surfboard and checking related to health and illness concerns. Daniel presented with comorbid depression. Daniel's risk of suicide was further assessed. He reported having a low mood most of the day, anehedonia and lacking energy these symptoms developed after his OCD started to worsen. Again he reported that he did not wish to end his life. He indicated that he felt his mood would improve if he no longer had OCD symptoms. Daniel has no history of depression, suicide attempts or harming others.

Treatment (10-12pg)

Daniel attended the Griffith University OCD clinic for 14 x 1 hour weekly sessions of cognitive behavioural therapy (see **table** for summary).

Session Number	Session Content
1 - 2	Psychoeducation Cycle of OCD, fear thermometer, bodily symptoms associated with anxiety & role of family accommodation in the maintenance of OCD
3	Introduction to ERP ERP hierarchy development Rationale for treatment
4	ERP – Harm to self and others Thinking Traps of OCD – Thought Action Fusion - Morality
	ERP – Harm to self and others Thinking Traps of OCD – Thought Action Fusion - Likelihood

	ERP – Harm to self and others Thinking Traps of OCD – Inflated estimate of the probability of danger
	ERP – Harm to self and others Hierarchy Thinking Traps of OCD – Inflated estimate of the sense of responsibility
	ERP – Obsessions Hierarchy Thinking Traps of OCD – Control of thoughts
	ERP – Harm to self and others and obsessions
14	Relapse prevention and life without OCD

Treatment Modules

Psychoeducation

Daniel's treatment commenced with psychoeducation. Both Daniel and his mother attended these initial appointments during which they were provided with education regarding (1) obsessions and compulsions and the cycle of OCD, (2) externalizing OCD (3) how to use a fear thermometer (0 – 10) to rate Daniel's level of anxiety (4) bodily symptoms associated with anxiety and the fight or flight response and (5) the role of family accommodation in the maintenance of OCD. Daniel was given monitoring forms to record the different faces of his OCD symptoms for home practice (refer to **table _** for an example of Daniel's monitoring).

It was important from the outset to begin externalising OCD from Daniel by encouraging him and his family to explicitly label symptom behaviours as OCD. Daniel found it helpful to separate OCD from himself so that he could better view it as a problem that he could actively fight. Daniel and his mother also agreed that this allowed her to be more understanding and patient of Daniel's behaviour at home.

Having Daniel's mother involved in the psychoeducation session helped her to better differentiate between OCD and normal teenage behavior. It also made her aware of how she was accommodating OCD at home and the role of this in maintaining Daniel's OCD.

Exposure and Response Prevention (ERP)

The majority of Daniel's treatment consisted of ERP, which was graded and completed at a pace that Daniel found acceptable and manageable. Daniel completed most ERP sessions on his own but on occasion it was helpful to include his mother in sessions to illustrate the nature of anxiety, specifically that Daniel could cope with and would habituate to the anxiety, reinforcing that she did not need to accommodate OCD and protect him from this feeling. Some sessions also involved his mother as part of the ERP, for example when working on thought action fusion which is discussed in detail below.

We also had Daniel's mother model an ERP task for Daniel that she found challenging during treatment. Not only did this show to Daniel that it was ok to complete a particular task and a positive way of managing anxiety when doing so, but it also gave Daniel an opportunity to act as the therapist and to support his mother to complete something that she found anxiety-provoking. Acting as therapist allowed Daniel to consolidate what he had learnt about how to manage anxiety.

From Daniel's monitoring and the information elicited from the CYBOCS, we formed exposure hierarchies for each face of OCD and broke down steps as necessary. Daniel's fear of harming was broken into two hierarchies: on for self and one for others. These are detailed below.

Daniel was encouraged to address the least distressing symptom from each hierarchy to begin with. These behaviours were broken down into smaller steps where required so that steps were manageable and achievable. Once Daniel chose a symptom that he wanted to work on, we discussed how he could fight back to this through ERP and he agreed on a specific task to practice. ERP tasks could involve changing the compulsion in some way, reducing the number of repetitions of the compulsion, or delaying the compulsion. Behavioural experiments were carried out with during which he was asked to give his predictions about

the task, including what the OCD said would happen and how anxious he expected to become. Before completing the ERP Daniel was asked to consider what he would need to do to be able to complete the task successfully (e.g. using cognitive strategies, staying in the situation until he habituated, therapist support, etc). SUDs ratings were taken immediately after the ERP and at regular time intervals over the subsequent hour. If Daniel's anxiety had not reduced by at least half by the end of the session he was asked to wait in the clinic wait room until it had or to continue to monitor his anxiety on the way home. Through ERP, Daniel was able to gain evidence that the feared outcome did not occur and that he was able to habituate to the anxiety, which usually peaked lower and reduced much faster than expected.

For Daniel's fear of hurting himself an exposure hierarchy was developed. Steps from this hierarchy were started with the therapist in session, which was completed at a nearby hotel, and finished with his mother for homework over a period of 3 weeks.

Exposure Hierarchy – Harm to Self

STEP 6
- Attend schoolies stand on balcony and drink 1 beer
- Surf everyday without engaging in any compulsions
- Drive car in busy traffic using both lanes, no gripping steering wheel excessively, no asking mum for reassurance

STEP 5
- Go to schoolies hotel and stand on balcony and hang arms over edge railing for 20 minutes without engaging in compulsions
- When in the surf jump off board and hold breath underwater for as long as possible
- Rest sharp knife against wrist for 20 minutes when home alone
- Drink 1 beer at a party

STEP 4
- Stand on balcony and hang arms over edge railing for 20 minutes without engaging in compulsions
- Drive car in busy street do not check mirrors unless changing lanes (1x only)
- Go surfing alone and duck dive under waves
- Rest sharp knife against wrist for 20 minutes under mum supervision
- Drink 1 beer at home under mum's supervision

STEP 3
- Stand on balcony and lean against railing for 20 minutes without engaging in compulsions
- Go for a walk alongside a busy road. Drive car in busy street only check mirrors 2x
- Go surfing with a friend/ family member and duck dive under waves
- Rest sharp knife against forearm
- Attend a party and do not drink alcohol

STEP 2
- Stand on balcony (2 meters from railing) for 20 minutes without engaging in compulsions
- Go for a walk alongside moderately busy road.
- Drive car along moderately busy street only check mirrors 2x. Do not grip steering wheel tightly. Change lanes regularly.
- Go surfing with a friend/ family member and catch unbroken waves
- Cut up vegetables for mum using sharp knife

STEP 1
- Stand in balcony doorway for 20 minutes without engaging in compulsions
- Go for a walk alongside quiet road. Drive car in quiet street only check mirrors 2x
- Catch white water waves on surfboard at the beach
- Leave sharp knife on kitchen bench without checking it

These steps were repeated for higher levels with his mother for home practice. Daniel also challenged himself by attending a friend's house party where he consumed alcohol and stood on the first story balcony. Daniel's fear of hurting others was similarly addressed through an exposure hierachy.

Exposure Hierarchy – Harm to Others

STEP 6
- Enclose hands completely around the budgie body and head for 2 minutes
- Do not check house is locked and no goodnight sayings with mum
- Go fishing alone and kill and eat any fish caught
- No checking related to harming other when driving

STEP 5
- Pat budgie while it sits on you finger
- Do not check house is locked. Mum to repeat silly goodnight saying ‘ How now brown cow’ 1x per night.
- Go fishing alone. If catch a fish kill it.
- Do not check the internet or car for accidents/ damage

STEP 4
- Budgie to perch on Daniel’s finger
- Do not check house is locked. Mum to repeat goodnight saying ‘ I love you, the family is safe’ 1x per night.
- Go out in a boat with friends who are fishing and fish yourself. If catch a fish have friend kill it
- Do not check the internet for people being hit by cars. Do not check car is damaged after driving
- Drink 1 beer at home under mum’s supervision

STEP 3
- Pat the budgie while mum holds him
- Check house is locked 1x at night. Mum to repeat goodnight saying ‘ I love you, the family is safe’ 1x per night.
- Go out in a boat with friends who are fishing and fish yourself. If catch fish release it without performing any rituals.
- Check the internet 1x a maximum per day for people being hit by cars. Check car for damage 1x maximum after driving

STEP 2
- Feed bird and change water. Clean the bird cage while mum holds the budgie
- Check house is locked 2x at night. Mum to repeat goodnight saying ‘ I love you, the family is safe’ 2x per night.
- Go out in a boat with friends who are fishing and fish yourself. If catch fish release it without performing any rituals.
- Check the internet 2x a maximum per day for people being hit by cars. Check car for damage 2x maximum after driving.

STEP 1
- Move birdcage from laundry to family room
- Check house is locked 3x at night. Mum to repeat goodnight saying ‘ I love you, the family is safe’ 4x per night.
- Go out in a boat with friends who are fishing
- Check the internet 3x a maximum per day for people being hit by cars

After making significant progress with his exposure hierarchies to address his fear of harming himself and others an additional hierarchy was developed to directly expose Daniel to the content of his obsessions and intrusive thoughts. At this point in time Daniel had already been taught a number of cognitive strategies to address his dysfunctional beliefs associated with OCD and additionally he had a good understanding of the rational for exposure therapy and had experienced success following exposure. When working with a patient whom experiences intrusive violent or sexual obsessions it is important to be ensure exposure is gradual and under the control of the patient. By saying a particular word aloud that they client is avoiding (e.g., Funeral) the therapist may inadvertently flood the client and if this were to occur early in therapy may lead to client drop out or treatment refusal. Daniel's hierarchy for this symptom was broken down as detailed below.

Exposure Hierarchy – Intrusive thoughts

STEP 6
- Write intrusive thoughts on post it notes and leave them around the house
- Set reminders on your smart phone at random times of day so intrusive thoughts pop up onto your smart phone screen

STEP 5
- Record script onto smart phone and listen to repetitively
- Do not engage in any rituals while listening to script

STEP 4
- Write a detailed script of hitting someone when driving
- Write a detailed script about something happening to mum because Daniel did not check the doors at night
- Mum to say to Daniel 'I will die today'

STEP 3
- Daniel to stand on balcony, go surfing, walk alongside busy road or while holding a knife to his wrist repetitively say "suicide, kill myself, I am going to die, do it !"
- Hold budgie and say aloud 'I am going to strangle you repeatedly
- Say aloud repeatedly 'my mum will be in a car accident today'
- Repeat exposure daily for a week.
- Listen to voice recording of sayings on smart daily

STEP 2
- Say aloud suicide, kill myself and I am going to die. Repeat each saying repetitively for 5 minutes
- Say aloud I am going to strangle my budgie. Repeat for 5 minutes.
- Say aloud something bad will happen to my family today. Repeat aloud for 5 minutes
- Make recording on smart phone and listen to self saying above daily for 10 minutes at a time
- Record thoughts on a voice changing application or an application which puts your voice recording into a song and play back (e.g., slow motion or mini mouse voice)

STEP 1
- Write repetitively on paper the words - suicide, kill myself and I am going to die
- Write repetitively on paper I am going to strangle my budgie
- Write repetitively on paper something bad will happen to my family today

To build on this we involved Daniel's mother in session. For example during one session we asked his mother to walk across the road while Daniel remained in the therapy room imagining that she would be hit by a car then being rushed to hospital, and dying (his biggest fear). Although this understandably caused Daniel some distress, it was a stage in treatment where he was able to agree that the likelihood of this tragedy occurring was negligible and that if it did that it would not be due to him having this thought but rather due to a range of other reasons such as driver error.

A home practice task for Daniel's fear that having a bad thought would cause it to happen was set in the later stages of treatment where Daniel was asked to create an audiotaped habituation. This involved Daniel recording himself saying that a family member would die on his smart phone. We randomly scheduled his alarm for various times throughout the week at which point he would be required to listen to the 1 minute recording repeatedly for up to 5 minutes (or until he habituated to his anxiety).

"Mum is driving home from work along the highway. The traffic's building up and she doesn't notice the car in front slowing. She slams her breaks on too late and although she tries to veer to the right, she hits the back of the car in front of her which sends her sliding into the concrete barrier. She is trapped in her car and unconscious. Her head has hit the windscreen and is split open. Blood is poring down her face. Her arm is facing an unnatural angle and her legs are trapped by the dashboard. She's barely breathing. A witness calls the ambulance who arrive as soon as they can. The fire brigade have to free mum from the car. She has lost a lot of blood and the paramedics carefully move her to the ambulance and she's rushed to the emergency department at the Gold Coast Hospital. I'm called at home by a nurse who asks me to come into the hospital immediately. I see mum lying on a hospital bed with her eyes closed and cuts over her face, there's a very deep gash on her forehead. She doesn't know that I'm there and I can't speak to her because she's rushed by the staff into surgery as soon as I arrive. there are lots of noises - machines beeping and people yelling. After an hour the Drs tell me that mum has died due to her extensive injuries. My sister and I no longer have our mum."

Other Cognitive Treatment Approaches

In addition to ERP, cognitive techniques were used to address Daniel's dysfunctional beliefs related to his aggressive thoughts. Daniel was provided with education regarding the 'thinking traps' of OCD (refer Fig??). Over the course of therapy he completed activities and behavioural experiments to challenge his dysfunctional beliefs. Daniel was taught to be aware of OCD trapping him and to use smart thoughts to fight OCD. Throughout therapy Daniel was encouraged to write his 'smart thoughts' onto post it notes and stick them in places where his obsessions were triggered (e.g., window locks, on the edge of his rear view mirror in the car) to remind him fight OCD.

Fig.1 Client Handout from Farrell and Waters (2008)OCD Busters Program

Thought traps of OCD

There are a number of different ways OCD tricks people into "feeling scared" and engaging in rituals due to the way OCD makes people think. These thought traps are "biases" in the way you think. Based on extensive research with adults and children with OCD we know there are common "thinking biases" associated with OCD, that work by making the person with OCD feel increasingly afraid and concerned about their fears. Therefore, this fuels the need to ritualize in an attempt to "neutralize the thought" or to reduce the fear.

Some of the common biases in thinking are:

Thinking Trap	Description	Example thought
Inflated estimates of the probability of danger	People with OCD tend to exaggerate the probability of danger or threat occurring	"Something bad will happen for sure"
Inflated estimates of the responsibility for danger	People with OCD also tend to exaggerate the extent to which they are responsible for preventing danger	"I must do my habit. If something bad happens it will be my fault"
Thought action fusion (TAF) concerning morality	People with OCD tend to interpret the occurrence of a "bad" thought, as meaning that they are a bad person.	"Having a bad thought means that I must be a bad person"

Thought action fusion (TAF) concerning likelihood	People with OCD tend to also believe that having a "bad" thought may increase the chances of something "bad" happening	"Thinking something bad will make something bad happen"
Beliefs about thought control	People with OCD tend to have beliefs associated with an over-importance of controlling thoughts	"I must control my thoughts"

Inflated Estimates of the Probability of Danger. Daniel was informed that OCD tricks you by telling you the chance of something bad happening was very likely. His therapist explained to him however that this was incorrect. To challenge this belief Daniel and his therapist generated a list of all the things that would have to happen for his mother to be violently attacked by an intruder (**refer to figure**). This exercise assisted Daniel to realistically estimate the probability of his mother being attacked. For home practice Daniel was encouraged to use his smart thoughts ("There goes OCD exaggerating again…") and to "check the chances" of his feared outcome actually occurring when he felt anxious.

Fig.1 Client Handout (Farrell & Waters, 2008)

CHECKING THE CHANCES

By staying calm and thinking your worries through, you can **CHECK THE CHANCES** of something bad really happening.

Remember, OCD TRAPS you by making you think something BAD will DEFINITELY happen – when really, the chances of BAD things happening are actually VERY SMALL.

DANIEL'S CHECKING THE CHANCES SHEET

A burglar/ intruder decides to break into a house in your neighbourhood	7/10
X	
A burglar/ intruder decides to break into a house in your	5/10

street	
X	
A burglar/ intruder decides to break into your house	3/10
X	
The burglar decides to break into your house when you are home	1/10
X	
Your budgie and pet dog do not wake up and bark or squawk. Your neighbour does not hear anything.	1/10
X	
Your house is unlocked	5/10
X	
The burglar attacks someone in the house	3/10

TOTAL CHANCE = _____

Each of these things must **DEFINITELY** happen in order for Daniel's mother to be attacked.

This is called **CHECKING THE CHANCES** – the chance (or percent, or number out of 10) of each thing happening can be multiplied together to give the total chance of mum being attacked by an intruder – (remember to work out the total chance you have to move the decimal place back 7 places!)

As you can see, the chance is actually VERY, VERY small – <u>not</u> very, very BIG, like what OCD tells Daniel! You can use CHECKING THE CHANCES to help you BUST OCD.

Inflated estimates of the responsibility for danger. Daniel was informed that OCD traps you by exaggerating your sense of responsibility. OCD led Daniel to believe that he was responsible for protecting his family and had to prevent them harm. He believed 100% that it would be his fault if something bad happened to his mother or sister. Moreover, Daniel believed he needed to keep other drivers and pedestrians safe from himself, as he was a

learner driver and inexperienced. The therapist discussed with Daniel that occasionally bad things do happen however there are multiple reasons for this and many of the reasons are not your fault. Together Daniel and the therapist made a list of reasons that might lead to someone hitting a pedestrian or having a car crash. For example, the therapist highlighted to Daniel that some reasons you may have a car accident may include a pedestrian not looking before crossing the road, a pedestrian being drunk or having taken drugs and falling onto the road, being rear ended by another car, another car merging into your lane without checking and another car running a red light. The therapist pointed out to Daniel that all these reasons for having a car accident would not be the driver's fault. With the therapist's assistance Daniel made a pie chart of all the causes of car accidents that they had identified. Each reason was assigned a proportion of the pie chart. Additionally, Daniel assigned a segment of the chart to his OCD fear (e.g., that he would cause a car accident because he was distracted and did not check his mirrors or was not holding the steering wheel properly). This activity assisted Daniel to understand that there are multiple reasons that may lead to an event occurring which are not under his control or his fault. For home practice, when driving, Daniel was encouraged to use his smart thoughts ('I cannot control everything. Bad things sometimes happen but doing an OCD habit cannot stop them from happening. OCD habits only make OCD stronger') and to consider the 'real reasons' why his feared outcome might actually occur.

Thought Action Fusion – Morality. Daniel learnt that OCD tricks you by making you believe you are a bad person because you are having aggressive thoughts. To challenge this cognitive bias the therapist discussed with Daniel normative information about experiencing violent and repugnant thoughts. Daniel was given a list of aggressive and intrusive sexual thoughts reported by university students who did not have OCD (Clark, 2004; Purdon, 2004). Additionally, Daniel was encouraged to complete a survey of practitioners in our OCD clinic

and trusted others (e.g., mother, sister, close friend) about whether they ever experienced intrusive aggressive thoughts (e.g., jump off a balcony or drown yourself). From this experience Daniel learnt that the content of his thoughts was no different from others. The therapist explained to Daniel that the only difference between himself and others was his appraisal of the thoughts as threatening. Additionally, it was brought to Daniel's attention that his obsessions (particularly those related to strangling his budgie) caused him significant distress and that instead of indicating he was bad, disturbed or dangerous for thinking this way his distress paradoxically highlighted his morality (e.g., if you were a psychopath you would enjoy having these thoughts and would not be distressed when they entered your mind (see Rachman, 2007). For home practice, Daniel was encouraged to use his smart thoughts – 'this is just a trick of OCD. "My thoughts are no different to anyone else, I am not someone who harms animals, I am not paying attention to you OCD" and "that is an odd thought that just popped into my mind". Over the course of therapy the personal meaning behind Daniel's intrusive thoughts changed for Daniel from threatening to benign. At the conclusion of treatment the frequency of Daniel's intrusive thoughts had declined significantly with many even disappearing.

Thought Action Fusion – Likelihood. Daniel was taught that OCD traps you by making you believe that your thoughts can influence external events and make them more likely to happen. For example, OCD led Daniel to believe that if he thought about his mother being in a car accident this increased the chance of her actually having a car accident. The concept of thought action fusion was demonstrated to Daniel by having him picture in his mind leaving the psychology clinic, walking to the car park, picking up a rock and smashing the windscreen of his therapist's brand new car. Following this, a discussion was had with Daniel about whether he would actually do this when he left the session because he had the thought about doing it. Daniel was taught that thoughts are not magical. They are just words

or pictures in our mind and they can't make things happen. As previously discussed behavioural experiments were conducted with Daniel in session and at home to test out whether Daniel's beliefs were correct, that thinking about harm coming to others actually increased the likelihood of this occurring. The latter steps of Daniel's exposure hierarchy to his obsessions specifically involved him writing a 'worry script', which gave a detailed account of his mother being killed in a car accident. Daniel listened to the script on his smartphone daily. This assisted him to learn that thinking about something does not make it more likely to happen. For home practice, Daniel was encouraged to use his smart thoughts 'thoughts are just words or pictures in my mind, they are not magic, they can't make things happen'.

Control of Thoughts. Daniel learnt that OCD tricks you by making you believe you should be able to control your thoughts. Daniel believed that he should be able to stop his intrusive thoughts and that he should be able to rid them from his mind. Because of this Daniel would go to great efforts to suppress his obsessions. Daniel's failure to suppress his obsessions maintained his anxiety and resulted in him placing further emphasis on the importance of these thoughts (e.g., I can't stop thinking about strangling the budgie which means I am bad and I really do want to harm him). The therapist pointed out to Daniel that despite all the energy he was investing into not thinking about his obsessions and blocking and neutralising them the thoughts kept returning. Daniel was provided with education about thought suppression. He was informed that suppressing his unwanted thoughts was actually having the opposite effect with the thoughts becoming more frequent, rather than less frequent. This was demonstrated to Daniel by having him try to not think about a pink elephant for 2 minutes. During the 2 minute period Daniel was required to tally the frequency with which thoughts about a pink elephant entered his mind. Daniel indicated that he found the task very challenging. The therapist highlighted to Daniel that OCD thoughts are just like the pink

elephant thoughts. The more we try to avoid them and push them out of our mind the more frequently they enter our mind. Instead of suppressing, fighting or trying to cancel his thoughts Daniel learnt to respond differently when the obsessions entered his mind. He was encouraged to stay calm, acknowledge the thought, take a deep breath, smile and wait for the thought to pass. When his intrusive thoughts entered his mind over the week Daniel practiced using his smart thoughts and responding differently to his intrusions by telling himself - "An OCD thought just popped into my mind I don't need to do anything. I just have to wait until it goes".

Relapse Prevention

Daniel's final session focused on relapse prevention. To assist in the generalization of his skills the therapist described to Daniel and his mother symptoms of contamination related OCD. Following this Daniel and his mother practiced generating exposure hierarchies for this OCD type and discussed how Daniel could apply the cognitive strategies he had learnt to this type of OCD. Daniel was also encouraged to identify stressful times over the next few months which may be high risk for OCD returning. Daniel indicated that transitioning to university in the New Year would be stressful for him. He was encouraged to be aware of any OCD symptoms returning during this time and if this happened to address this as soon as possible by reviewing his OCD busting strategies, developing new exposure hierarchies with his mother and if necessary contacting his therapist for a booster session. As Daniel had significantly more time available to him as he was no longer spending hours engaging in his compulsions the remainder of the final session was focused on generating ideas with Daniel for new 'healthy habits and rituals' for his OCD free life. Daniel decided that three times a week, even if he was busy with Year 12 school work, he would make a point of going surfing

as this helped reduce his stress. On weekends Daniel also aimed to catch up with his school friends on at least one occasion. Additionally, Daniel and his mum decided once a month to have a family movie night where they would order take away and watch dvd's.

Post Assessment

Following treatment Daniel's OCD symptoms had reduced significantly. His CY-BOCS score was 5 indicating subclinical/normal range for OCD and on the basis of the ADIS-P, Daniel no longer met criteria for OCD (CSR = 2), and his CSR rating for MDD was at a 1 (subclinical level). Daniel completed all steps involved in the post assessment BAT. He walked over to the railing of the 7th floor balcony and dangled his arms and leant over the side of the balcony for 5 minutes. Daniel reported no longer having to avoid surfing or driving. He indicated that he no longer suppressed or neutralized his thoughts. Daniel's mother stated that Daniel did not check locks at home or ask her for reassurance. We received an email from Daniel in December that year. He reported that he had attended "schoolies week" and had the time of his life ! He was able to stand on the balcony of their 16th storey building. He also indicated that he had successfully passed his drivers license test.

Complicating Factors (1-2pg)

Time taken to reveal obsessions – Secretive and therapist push to hard

Risk ax be sensitive and if ocd don’t go over the top

Distressing nature of thoughts. Go slowly or lose client. Client drop out

Conclusions (2 -3pg)

Key Practice Points

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