

OVERCOMING CONFOUNDING SLEEP AVOIDANCE BEHAVIOR IN COGNITIVE BEHAVIORAL TREATMENT  
FOR OBSESSIVE COMPULSIVE DISORDER: THE CASE OF JACK

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## ABSTRACT

Cognitive Behavioral Therapy (CBT) with Exposure and Response Prevention (ERP) is widely accepted as the gold standard treatment for Obsessive Compulsive Disorder (OCD). Many efficacious treatment manuals have been developed over the years, resulting in clinicians being able to select protocols that best match their patient's developmental stage, and thus helping to facilitate positive outcomes. However, challenges do present themselves when applying CBT treatment protocols with anxious patients. This requires the creation of an individualized case formulation and an associated treatment plan, which is specific to each particular patient. In this context the purpose of this case study is to analyze a particular deleterious confound to the therapy process: an OCD patient falling asleep during in-session ERP tasks. The case study chronicles the process of coming to understand the impact of the patient's sleep behavior on his treatment, and the unfolding of both ineffective and effective interventions aimed at overcoming this obstacle. Importantly, a functional analysis of the sleep behavior determined that this behavior was, in fact, employed in avoidance of the feared stimuli presented during exposure tasks. Once this was established, the patient and I as the therapist worked collaboratively to develop novel interventions to eliminate the sleep avoidance behavior, in order for the established benefits of CBT with ERP to take hold. This proved to be a fluid process requiring frequent adjustments to each intervention, as they no longer proved effective over time. As the treatment process unfolded, the intervention of walking outside during exposure tasks was employed and proved to trump all other interventions in its effectiveness in eliminating the patient's sleep avoidance behavior. This resulted in a complete eradication of the patient's sleeping during therapy sessions and the development of rapid treatment gains from that point forward in the treatment process.

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TABLE OF CONTENTS

	PAGE
ABSTRACT.....	ii
ACKNOWLEDGEMENTS.....	iii
LIST OF TABLES.....	viii
CHAPTERS	
I. CASE CONTEXT AND METHOD .....	1
The Rationale for Selecting this Particular Client for Study .....	1
The Clinical Setting in Which the Case Took Place.....	3
The Methodological Strategies Employed for Enhancing the Rigor of the Study.....	4
Sources of Data Available Concerning the Client .....	5
Confidentiality .....	5
II. THE CLIENT.....	6
III. GUIDING CONCEPTION, WITH RESEARCH AND CLINICAL EXPERIENCE SUPPORT .....	8
Treatment of OCD .....	8
CBT with ERP.....	8
CBT versus pharmacotherapy.....	10
Safety Behaviors within CBT with ERP.....	12
IV. ASSESSMENT OF THE CLIENT’S PRESENTING PROBLEMS, GOALS, STRENGTHS, AND HISTORY.....	18
Presenting Problems .....	18
Quantitative Assessment.....	20
Relevant Personal History .....	21
Presentation at the Beginning of Therapy .....	23
Diagnosis .....	25

Strengths .....	25
V. CASE FORMULATION AND TREATMENT PLAN.....	27
Formulation .....	27
Treatment Plan and List of Treatment Goals .....	29
VI. COURSE OF TREATMENT.....	35
Phase I: Sessions 1-7.....	35
Sessions 1-4: Introduction to therapy and building therapeutic rapport .....	35
Sessions 5-7: Speaking about more serious topics, psychometric measures, and psychoeducation regarding OCD.....	38
Phase II: The Beginning of CBT with ERP .....	40
Sessions 8-13: Damnation hierarchy and the homework issue.....	40
Phase III: Sleep Avoidance Behavior Emerges.....	45
Sessions 14-15 .....	45
Sessions 16-21: Problem solving sleep avoidance behavior.....	48
Redefining homework assignments.....	50
Phase IV: Start of ERP For Contamination Fear leads to -> Reemergence of Sleep Avoidance Behavior .....	50
Session 21 .....	50
Finding his groove again .....	53
Sessions 25-28 .....	54
Phase V: Hand up, Identify Thoughts, Stand/Jump.....	55
Sessions 31-37: Another groove .....	56
Phase VI: The Return of Drowsing.....	58
Sessions 39-44 .....	59

Phase VII: The Final Efficacious Intervention and Turning Point! .....	65
Phase VIII: Relapse Prevention (sessions 58-62) .....	72
VII. THERAPY MONITORING AND USE OF FEEDBACK INFORMATION.....	75
VIII. CONCLUDING EVALUATION OF THE THERAPY’S PROCESS AND OUTCOME .....	77
The Outcome of Jack’s Therapy .....	77
Quantitative results .....	77
Qualitative results.....	78
Discussion of the Broader Issues Raised by Jack’s Case .....	81
Lessons Learned about CBT with ERP with Clients Demonstrating Confounding Sleep Safety Behavior .....	84
REFERENCES .....	87



LIST OF TABLES

Table 1	Jack's Scores: Children's Yale-Brown Obsessive Compulsive Scale .....	90
Table 2	Jack's Scores: Yale Global Tic Severity Scale .....	91
Table 3	Diagnosis at Beginning and End of Treatment.....	92
Table 4	Fear Ladder: Global.....	93
Table 5	Fear Ladder: Damnation .....	94
Table 6	Fear Ladder: Contamination .....	95

## CHAPTER I

### Case Context and Method

#### The Rationale for Selecting This Particular Client for Study

The goal of this dissertation was to analyze the difficulties, which arose within the clinical application of a manualized treatment protocol involving Cognitive Behavioral Therapy (CBT) with Exposure and Response Prevention (ERP) with a patient with Obsessive Compulsive Disorder (OCD). Specifically, my goal was to systematically study a client who presented with safety behaviors that were significant confounds to the treatment process and thus required an individualized case formulation and associated treatment plan. Additionally, my goal was to chronicle the interventions, which were designed to overcome the deleterious impact of these behaviors on the treatment process and outcomes.

The case which was selected for analysis in this study, hereafter referred to by the pseudonym “Jack,” was chosen due to both the severity of his symptoms, as well as, the manifestation of a relatively rare safety seeking behavior during in-session ERP tasks: falling asleep. At the time of his treatment, Jack was a 15-year-old male, who presented with OCD symptoms, which were assessed to be in the “extreme” range of symptom severity based upon his scores on the *Children’s Yale-Brown Obsessive Compulsive Scale* (CY-BOCS) (Scahill, Riddle, McSwiggin-Hardin, Ort, King, Goodman, Cicchetti, & Leckman, 1996). Due to his rare, yet impactful, form of safety behavior Jack's treatment process lent itself well to analysis and discussion in order to provide

the reader with insight into the function of the behavior, as well as, methods for successfully treating his OCD symptoms despite this confound.

Due to problems that arose from his response to the treatment manual, as the therapist I needed to create and employ an additional individualized case formulation and related individualized treatment plan. This dissertation will describe the process by which these additional elements were developed and introduced along with the therapeutic process that emerged following creation of the individualized treatment plan, including outcome results at regular points throughout the therapy process.

As mentioned, Jack's case was specifically selected for write-up due to the uniqueness of his use of sleep as a safety behavior, which arose during Exposure and Response Prevention (ERP) tasks. This sleep behavior presented as a major confound to the therapeutic process and thus required the implementation of specifically targeted interventions in order to overcome its potential negative impact on treatment. This dissertation adds to the extensive literature (cited below) on problems that develop in conducting empirically supported, manualized treatment with OCD patients, and on how these problems can be addressed by creating individualized case formulations and treatment plans with creative modifications to such programs.

Therefore, through a systematic single-case study design, this dissertation intends to explore the following questions with regards to clients with OCD:

1. What function does a client's falling asleep serve during ERP tasks?
2. Does falling asleep during in-session ERP tasks have a deleterious impact on treatment for OCD symptoms?

3. How does a clinician effectively respond to such behavior?
  - a. Creation of an individualized case formulation that includes modifications to address safety behavior
  - b. Implementation of an individualized treatment plan to incorporate the safety behavior
  - c. Monitoring of effective and ineffective interventions to address and overcome the deleterious effect of the safety seeking behavior of sleeping in session

### **The Clinical Setting in Which the Case Took Place**

The setting for this case was a Tourette's Syndrome (TS) specialty clinic associated with a graduate school at a state university. The fee was set according to the client's financial income. At the time of therapy, as the therapist, I was an advanced doctoral clinical psychology student and a member of the treatment team of the TS Program. During the first year of this case, I was supervised after each therapy session by a doctoral fellow. At the year mark, it was decided that the Clinic Director (a clinical psychologist) would provide me with ongoing supervision for this and other cases due to my increasing experience. Both of these supervisors were knowledgeable and experienced working with both TS and OCD clients and provided supervision within a CBT framework. The research design and methodology of this project was approved by the Institutional Review Committee of Rutgers University. The treatment lasted 63 sessions, which occurred consecutively.

Jack's case was assigned to me upon his initial phone intake through the Tourette Syndrome clinic. Due to both the mild nature of his TS symptoms and the severity of his OCD symptoms, it was collaboratively decided among Jack, his mother, and me that his OCD symptoms would be the focus of our treatment. Jack and his mother both stated that they were against treating his symptoms with medication due to fear of medication side effects and thus preferred psychotherapy. After a discussion of the relative effectiveness of CBT with ERP in treating OCD symptoms, treatment began.

### **The Methodological Strategies Employed for Enhancing the Rigor of the Study**

Detailed clinical notes were kept for each therapy sessions, which were then reviewed with my supervisor. DVD recordings were made for several sessions, which I reviewed in an analysis of the client's safety behavior during in-session exposure exercises. These were also discussed with my supervisors. The case was further reviewed in case conferences with the treatment team at the TS clinic, which provided for rich discussion of the case and brainstorming of ideas related to the development of potentially effective interventions targeting the client's safety behavior. All of the above were instrumental in the development of effective interventions utilized with Jack toward positive treatment outcomes. Additionally, two quantitative measures were utilized repeatedly throughout the treatment process in order to provide continuous monitoring of the client's symptom level. These measures and the results are discussed below in Chapter IV on assessment and in Chapter VIII on outcome.

**Sources of Data Available Concerning the Client**

Prior to the beginning of therapy, no information regarding the client was available to me as the therapist. The clinical staff who had conducted the initial phone intake provided a brief overview of the client's demographic information and symptoms.

**Confidentiality**

The client's confidentiality was strictly maintained throughout the treatment process and within this document. No information by which the client may be recognized is included in this text. In other words, all information has been de-identified and/or disguised in order to protect the client's identity. However, I believe the description of the case maintains an accurate telling of the clinical process of this client's treatment.

## CHAPTER II

### THE CLIENT

Jack is a 15-year old Caucasian male with a primary diagnoses of Tourette Syndrome (TS) and Obsessive Compulsive Disorder (OCD) (APA, 2000). Despite receiving the TS diagnosis at age 5, his tic symptoms have been assessed to currently be in the mild range of severity. At the start of therapy Jack presented with one tic, an eye blink. His TS was reported not to interfere with his day-to-day functioning, and thus was not the focus of treatment. Jack was assessed to be in the extreme range of OCD symptoms on the *Children's Yale-Brown Obsessive Compulsive Scale* (CY-BOCS) (Scahill, et al., 1996). He had many different content areas of obsessions, which are presented in Table 4, and included an excessive concern with right and wrong and morality (scrupulosity), a fear of germs, a fear of being videotaped, and a fear of harm coming to self and others. These obsessions were often followed by his completion of a compulsion (either knocking with his hand and/or tapping his feet), and these occurred at such a high frequency that they significantly interfered with his academic and social life.

Jack came from an intact family, which included his father, mother, and younger brother. Jack was personable and insightful, but demonstrated significant anxiety early in treatment. When expressing this anxiety, Jack would become quiet, distanced, and/or outwardly show his fear by squirming in his seat, staring at the feared stimuli (e.g., video camera in the therapy room), conducting ritualized behavior (i.e., knocking on the arm of his chair and/or tapping his feet on the ground), and grimacing his face.

As Jack began to become more open in therapy, he expressed having a strained relationship with his parents and relied on a few close friends for emotional support. He thus spent much of his free time with his friends playing videogames and socializing. Prior to our treatment, Jack had no previous experience with therapy and thus required some socialization into the therapy process. Our treatment took place over 63 sessions over a two-year span.



## CHAPTER III

**Guiding Conception, with Research and Clinical Experience Support****Treatment of OCD**

**CBT with ERP.** Although several treatment approaches are available, Cognitive Behavioral Therapy (CBT) is considered the most effective in reducing symptoms associated with Obsessive Compulsive Disorder (OCD). Franklin, Freeman, and March (2010) state that CBT “has emerged as the initial treatment of choice for pediatric OCD” (p. 80). Kircanski, Peris and Piacentini (2011) echo this sentiment in affirming that “CBT is now widely recognized as the gold standard intervention for childhood OCD and relies on exposure and response prevention (ERP)” (p. 239). The authors continue in describing CBT with ERP noting that the treatment process “includes psychoeducation, creating a symptom hierarchy, imaginal exposures, cognitive interventions, and a contingency management system” (Kircanski, Peris, & Piacentini, 2011, p. 239). This last technique is most appropriate with younger patients and/or individuals who lack the internal motivation to become an active participant in treatment and thus may not be an active component with all patients.

In their often-cited article, *Identifying and Developing Empirically Supported Child and Adolescent Treatments*, Kazdin and Weisz (1998) lend a further description of CBT for anxiety in youth:

as part of the educational component, children learn about the biological arousal associated with anxious feelings, and they may identify their own distinctive pattern. Another common educational focus involves identifying,

testing, and modifying negative cognitions. Finally a key element of all CBT for child anxiety approaches is exposure. Therapist work with children to set up encounters with anxiety-arousing events and situations, typically low grade at first but often progressing to high anxiety arousing” (p. 23).

The components cited by both Kircanski, Peris, and Piacentini (2011) and Kazdin and Weisz (1998) make up the critical mechanisms that the CBT clinician actively implements in treating the youth with OCD and many other anxiety disorders. Cognitively, the child will learn to challenge their own maladaptive thoughts about the situations in which they find themselves and which directly relate to their experience of physiological arousal and anxious feelings. Behaviorally, in gradually exposing the child to the feared stimulus, he or she should begin to accumulate competing cognitions toward the maladaptive ones, which should in turn lead to a decrease in anxiety symptoms. The Cognitive Triad is highly implicated in this process in that the patient’s thoughts, physiological arousal/emotions, and behaviors are interrelated.

Cognitive Behavioral Treatment with ERP was originally designed for the treatment of adult anxiety disorders but over the course of the past two decades empirical research has demonstrated that this treatment is in fact efficacious with children and adolescents. For instance, Franklin, Kozak, Cashman, Coles, Rheingold, and Foa (1997) conducted an open clinical trial aimed at studying the impact of CBT on pediatric OCD symptoms. The authors found that their “CBT program was effective in ameliorating OCD symptoms in children and adolescents and that gains were maintained over time. The mean reduction in Y-BOCS was 67% at posttreatment and 62% at follow-up” (p.

417). The authors concluded that CBT with ERP showed great promise in treating OCD in youth and suggested further research be conducted in this area. In the years that followed, many successful, randomized, controlled trials have been conducted regarding what was then seen as a promising treatment.

Bolton, Williams, Perrin, Atkinson, Gallop, Waite, and Salkovskis (2011) conducted a randomized controlled trial comparing three groups: a full regiment of CBT (12 sessions), brief CBT (5 sessions), and a wait-list control group. The authors found “statistically significant symptomatic improvement in both treatment groups compared with the wait-list group. Improvements were maintained at follow-up an average of 14 weeks later” (p. 1269). These findings are consistent with earlier work by Bolton and Perrin (2006) who explored the impact of intensive CBT with ERP during a 5-week period. The authors demonstrated “statistically and clinically significant symptomatic improvement in the E/RP group compared with controls, with improvement maintained at follow-up an average of 14 weeks later.” The authors concluded that “ERP is an effective treatment for childhood OCD” (p. 11).

**CBT versus pharmacotherapy.** In addition to psychotherapy, pharmacological treatments have also proven effective in treating OCD symptoms. Selective Serotonin reuptake inhibitors (SSRI’s) have become the most widely accepted efficacious medication for OCD symptoms and appear to be utilized at a higher rate than is psychotherapy (Abramowitz, Whiteside, & Deacon, 2005, p.55). Despite their increased use, a meta-analysis by Abramowitz, Whiteside, and Deacon (2005) found CBT with ERP to be as, or more, effective than medication at symptom reduction in individuals with

OCD. Specifically, Abramowitz et al. analyzed the effectiveness of CBT with ERP compared with pharmacotherapy for pediatric OCD. The authors included 18 total studies found through a search of relevant research articles between 1970 to 2004 on the PsycINFO and MedLine databases. Their findings showed that

SRI medication and ERP are effective in reducing pediatric OCD symptoms.

Some findings suggest that ERP is superior to SRI medication. ERP was associated with larger effect sizes on OCD measures and few residual symptoms compared to medication (p. 60).

Supporting the superior efficacy of CBT with ERP over pharmacotherapy is a similar meta-analysis of randomized control treatment trials for pediatric OCD conducted by Watson and Rees (2008). In their analysis the authors included 13 studies containing 10 pharmacotherapy to control comparisons (N=1016) and five CBT to control comparisons (N=161). A wide array of pharmacological agents were included across studies and included buspirone, citalopram, clomipramine, fluoxetine, fluvoxamine, paroxetine, sertraline, and sumatriptan. Findings showed that

both treatments were significantly superior to control, with CBT yielding a larger treatment effect ... [and thus] CBT should comprise the first-line treatment for pediatric OCD, followed by pharmacotherapy (Watson & Rees, 2008, p. 494).

All told, from empirical research and clinical experience, it appears clear that CBT with ERP is the gold standard treatment of choice for pediatric OCD. Pharmacotherapy has also demonstrated effectiveness in OCD symptom reduction, but to a lesser degree

than CBT. As is common among psychotherapy patients, upon entering treatment Jack and his mother expressed concern over the short and long-term side effects that could be associated with various psychopharmacological agents. Therefore, it was important that I was trained and experienced in CBT with ERP, in order to effectively treat his OCD symptoms, with what has been shown to be the most effective form of treatment available.

### **Safety Behaviors within CBT with ERP**

Despite the success clinicians and empirical researchers have demonstrated in utilizing CBT with ERP for OCD symptoms, challenges do present themselves in the psychotherapy process. Of note, and of importance to the present study, is the impact of safety behaviors among patients with OCD within exposure tasks. Safety behaviors are overt or covert actions designed to avert or cope with a perceived threat (Salkovskis, Clark, & Gelder, 1996). “The most common class of safety behaviors involves avoidance” (Powers, Smits, & Telch, 2004, p.448). Salkovskis (1991) proposed that “safety behavior functions to maintain fear by enabling the avoidance of feared outcomes in anxiety-provoking situations” (p. 6). If this statement were to prove accurate in clinical settings, it would seem that safety behaviors should be of critical consideration to the clinician whose goal it is to successfully reduce OCD symptoms in his or her patients.

Much research has demonstrated the deleterious effects of safety behaviors on the treatment process and its effectiveness. Deacon and Maack (2008) examined the effects of safety behaviors on the fear of contamination in an undergraduate

population. In their study the examiners manipulated safety behavior implementation and found that “subsequent to the safety behavior manipulation, participants evidenced statistically significant increases in threat overestimation, contamination fear symptoms and emotional and avoidant responses” (p. 537). It is possible that the use of such safety behaviors allows for the development of inaccurate beliefs about the perceived danger of the stimuli and also prevents the individual from acquiring disconfirming data thus the fear of contamination is solidified.

Sloan and Telch (2000) studied the effects of safety-seeking behavior and guided threat focus and reappraisal on claustrophobic fear reduction during exposure tasks and found that

those subjects encouraged to utilize safety-behaviors during exposure showed significantly more fear at post-treatment and follow-up relative to those encouraged to focus and reevaluate their core threat during exposure. Moreover, growth curve analysis of treatment process data revealed that safety-behavior utilization exerted a detrimental effect on between-trial habituation; whereas guided threat reappraisal enhanced between-trial habituation (p. 235).

From these results it appears that utilization of safety behaviors during in-session ERP has a far reaching negative impact on anxiety symptoms within the therapy setting, as well as, for clients’ lives between sessions.

Adding further light on this issue, Power, Smits, and Telch (2004) studied the effect of safety behavior availability and safety behavior utilization within exposure

tasks for subjects with claustrophobic fear and found that “it is the perception of the availability of safety aids as opposed to their actual use that exerts a disruptive effect on fear reduction” (p. 448). Thus, it may be that clients who allow their attention to be consumed by the availability of a safety behavior instead of focusing on reappraising their fear belief and allowing their anxiety to naturally habituate, may show a marked increase in anxiety symptoms and thus resist the benefits of the ERP treatment itself.

Strengthening the stance against the use of safety behaviors in ERP treatment, Hedtke, Kendall, and Tiwari (2009) conducted the only study focusing primarily on safety behavior in child anxiety disorders and found “the usage of safety behavior was associated with poorer outcomes” (p. 1). These results are of particular interest to the case study of Jack, since it applies directly to youth.

Despite the rather convincing data provided above describing the negative impact of safety behaviors on ERP treatment, some controversy does exist. For example, Rachman, Shafran, Radomsky, and Zysk (2011) examined the effect of safety behavior (hygienic wipe) on contamination fears in an exposure task with undergraduate students. The authors found that “the ERP and exposure plus safety behavior conditions both produced large, significant and stable reductions in contamination. Significant reductions in fear, danger and disgust were also reported in both conditions” (p. 397). Despite the significant findings reported by the authors, due to a homogenous undergraduate, non-clinical sample, generalizations of these findings to clinical populations must be strongly qualified.

Milosevic and Radomsky (2008) studied the impact of safety behavior in the treatment of specific phobia. Sixty-two participants with a fear of snakes were randomized to a single 45-minute session, which included in vivo exposure to a snake with or without safety behaviors (i.e. safety gear including gloves, a protective apron, a beekeeper hat, and goggles). The results showed that “during the treatment, participants in the safety behavior group were able to achieve a significantly closer initial distance of approach to the snake compared with controls. When tested post-treatment, both groups demonstrated comparable treatment gains involving significant reductions in fearful cognitions and subjective anxiety” (p. 1116). However, this study was also conducted with undergraduate, non-clinical subjects, and thus the effectiveness of its findings being extrapolated to a clinical population seems very limited.

In a similar study which replaced the feared object of the snake with that of a spider in the exposure task, Hood, Antony, Koerner, and Monson (2010) demonstrated that “both safety behavior and no-safety behavior participants reported significant and comparable reductions in self-reported anxiety and negative beliefs about spiders at posttest and 1-week follow-up, however participants in the safety behavior group showed a significant decrease in approach distance at follow-up” (p. 1161). It is appropriate to question whether the “safety behavior” subjects' demonstration of a decrease in approach distance was suggestive of a potential future trend resulting in full return of fear symptoms. Again, the generalizability of the study's findings to clinical situations is unclear, as the participants included were undergraduate students.



The evidence regarding the use of safety behaviors in ERP treatment is inconclusive and has placed clinicians in somewhat of a clinical quandary. Providing some clarity to this issue, Parrish, Radomsky, and Dugas (2008) conducted an article review pertaining to the potential benefits of safety behaviors in ERP treatment and concluded that

clients' anxiety-control strategies may be less likely to become counter-productive when: they promote increase in self-efficacy, they do not demand excessive attentional resources, they enable greater approach behavior and integration of corrective information, and they do not promote misattributions of safety (p. 1400).

As this pertains to the present study, it is clear that Jack's utilization of sleep as his safety behavior of choice during ERP tasks functioned to circumvent all of the productive aspects of safety behaviors highlighted by Parrish, Radomsky, and Dugas (2008). In fact, sleep seems to directly counteract any of the potential benefits that safety behaviors may provide during ERP, as the client, by definition, slumbers in order to avoid exposure to the feared stimulus.

Recognizing the importance of the controversy over the use of safety behaviors in CBT with ERP, Helbig-Lang and Petermann (2010) conducted a meta-analysis of all studies examining the impact of safety behaviors on anxiety symptom reduction following exposure. Upon their review the authors concluded, "there is rather clear evidence that safety behavior use contributes to the maintenance and exacerbation of anxiety" (p. 229). The authors acknowledge that findings regarding the effects of safety

behavior use in exposure therapy are inconclusive but submit that “overall, existing evidence suggests that most kinds of safety behaviors increase discomfort and avoidance, and interfere with therapy effects in exposure-based treatments” (p. 229). It may then be judicious for clinicians treating clients with anxiety symptoms to error on the side of caution and work to prevent all safety behaviors during exposure tasks. In fact, Wolitzky and Telch (2009) have demonstrated that “exposure with actions oppositional to safety behavior might even be superior to exposure alone” (p. 57). As described below, an example in the present case was taking a walk with the patient during exposure tasks so as to circumvent his ability to fall asleep during engagement with the feared stimulus. This allowed for the attainment of disconfirming data and anxiety habituation.

In total, the majority of evidence has demonstrated a deleterious effect of safety behaviors on the treatment of OCD symptoms with CBT with ERP. In the case to be presented in this study, Jack, it was increasingly reasonable to believe that the client’s utilization of sleep as a safety behavior during ERP tasks was unilaterally effective in avoiding his coming into contact with the feared stimuli. In order for ERP treatment to be effective in this case, it was critically necessary for me to develop methods of intervening with the client in order to prevent sleep and allow for the empirically proven therapeutic effects of exposures therapy to take hold and reduce his anxiety symptoms.

## CHAPTER IV

**Assessment of the Client's Presenting Problems, Goals, Strengths, and History****Presenting Problems**

Jack presented for treatment with severe anxiety symptoms, which included both obsessive thinking and compulsive behavior. He was soon assessed to be in the extreme range of symptoms on the *Children's Yale-Brown Obsessive Compulsive Scale* (CY-BOCS) (Scahill, et al., 1996). During our initial meeting together he responded to my query about what had brought him into therapy by stating "I worry about everything all day long." Jack could not recall the precipitant to this but he believed that his compulsive behavior had begun 8 months prior to his beginning therapy. He was entering treatment due to his obsessions and compulsions having intensified to the point where he did not feel like he could do anything other than attend to his OCD symptoms.

At the beginning of therapy Jack reported that he was knocking (his compulsion of choice at that time) every 10 seconds throughout the day, all day. These knocks were typically conducted in a gentle manner with the knuckles of his hands. Jack would knock on any hard surface at his disposal including tables, chairs, doors, windows, walls, car interiors, his desk and locker at school, the handle bar on his bike, and video game controllers. He estimated that in total he was knocking at a pace of approximately 750 times per day. These knocks were in response to an obsessional fear of many stimuli that he encountered in his environments. Included were potentially contaminated surfaces, video cameras which may have been recording his image, a fear of magical

numbers (6), a fear of saying the wrong thing, intrusive violent images, and fears that harm might come to his friends, family, or himself. Additionally, Jack discussed the powerful hold that his fear of “damnation” or offending God had over him. He elaborated that this anxiety guided his every behavior, as his fear of “going to Hell” was extremely intense.

Jack was also diagnosed with Tourette’s Syndrome (TS) at the age of 5. His tic symptoms were assessed to be in the mild range via the *Yale Global Tic Severity Scale* (YGTSS) (Leckman, Riddle, Hardin, Ort, Swartz, Stevenson, & Cohen, 1989). His scores can be found in Table 2. Anecdotally, Jack reported that his tic symptoms had followed a waxing and waning course during his life and had never been intense. He stated that they did not impact his functioning and that his sole current tic was a mild eye blink. Due to the relative lack of interference in Jack’s life, his TS symptoms were not the focus of treatment.

Jack’s mother often brought up the issue of his academic performance as cause for concern. According to his mother, Jack had apparently “slipped” in his focus, attention, and motivation to tend to his schoolwork. At the time of assessment, the family was unclear if this was due to the distracting nature of Jack’s OCD symptoms or some other source. They would later be referred for a learning evaluation and Jack would subsequently receive targeted accommodations to allow for him to perform at his best in school.

Jack and his mother presented with a strained relationship throughout the course of treatment. He often would shut-down when she entered the therapy room,

thus making family discussions difficult. The issue of family therapy was raised several times throughout our therapy together, but the family repeatedly denied interest.

Ultimately, Jack appeared motivated to be engaged in the treatment process. Despite this, he was resistant to facing his fears through exposure and response prevention tasks. In many ways, his resistance and avoidance became the focal point of his treatment, and subsequently the topic of this case study.

### **Quantitative Assessment**

The client's symptoms of obsessions and compulsions were assessed with the *Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS)*, which is a "10-item, clinician-rated, semi-structured instrument designed to assess the symptom severity of OCD over the previous week" (Scahill, et al., 1996, p. 845). The authors have shown the CY-BOCS to "yield reliable and valid subscale and total scores for obsessive-compulsive symptom severity in children and adolescents with OCD" (p. 844). This assessment was completed at the beginning of treatment, during the 36<sup>th</sup> session (near the midpoint of treatment), and during the 56<sup>th</sup> session (end of treatment) in order to obtain a measure of the client's symptoms in relation to treatment delivery. The CY-BOCS was also completed during the three-month post-treatment follow-up session, and thus a strong record of the client's progress in treatment and his maintenance of those treatment gains were obtained. Jack's scores are presented in Table 1. As a reference, scores on the CY-BOCS are grouped into the following clinical levels: 0-7 = Subclinical, 8-15 = Mild, 16-23 = Moderate, 24-31 = Severe, and 32-40 = Extreme.

Jack's CY-BOCS scores (Table 1) show that at the onset of his treatment with me he scored within the "extreme" range of OCD symptoms with a score of 37. This score is consistent with his report that his OCD symptoms impacted his every movement in life, as he stated that he was "not able to do anything" without the interference of his anxiety.

### **Relevant Personal History**

Jack comes from an intact family consisting of his biological mother and father, and younger brother, age 8. At intake his mother reported a family history of OCD on the paternal side, and tic disorder and depression on the maternal side. Jack was born full-term with no complications. He also reported that he had "chronic strep throat" as a child. This is of interest as researchers have shown a potential connection between streptococcal infections and the triggering of OCD symptoms (Swedo, et al., 1998). This connection has come to be known as PANDAS or Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections. However, researchers have been careful not to mistakenly conclude that all children having had streptococcal infections will develop OCD symptoms. Therefore, it is unclear if his having had repeated experiences of strep throat is related to his later development of OCD symptoms.

Jack and his mother reported that his anxiety symptoms began eight months prior to their seeking treatment with me. Upon their origination, his symptoms gradually increased and included fears related to being videotaped, fear of offending religious objects, excessive concern with right/wrong and morality, fear of

contamination, fear of the numbers six (related to Satanism), and a fear of harm befalling himself or others. These fears were greatly exacerbated upon his entering the 9<sup>th</sup> grade, for his first year in high school. This was a stressful time for Jack, as he had some difficulty adjusting to his new school. Jack believes that this transition provided the trigger for his OCD symptoms to intensify to a point where he was “knocking all day long,” which made it difficult to concentrate on his academics. This of course made his transition to the new school even more difficult, resulting in a vicious cycle.

Jack stated that shortly before his admission into treatment his anxiety symptoms occurred across contexts, as he would have obsessive thoughts throughout the day and thus complete compulsive rituals wherever he might be. These compulsions (i.e. knocking or tapping) ranged from being covert in school, to out in the open at home. His parents often asked him, “What is wrong with you?” after witnessing his ritualizing, which created increased stress for Jack, thus resulting in his need to increasingly complete his obsessive compulsive routine. Ultimately, his symptoms became so disruptive and distressing to Jack and his family that they chose to seek treatment with me. In fact, the family appeared quite distressed upon our initial meeting together.

Of note, as the treatment process unfolded I came to learn that Jack had a strained relationship with his parents. He often spoke about the tremendous amount of pressure they levied upon him for doing well in school and behaving in an appropriate manner. Jack experienced them as uncaring and harsh at times. If he received a poor grade in school or behaved inappropriately his parents were reported to yell and curse

at him, to which he responded by yelling back and retreating to his room. He felt that they didn't understand him very well and thus he avoided being home during his free time, as much as possible. There is no telling how these relationships impacted the manifestation and maintenance of his anxiety symptoms but this does provide a context within which to understand his OCD symptoms.

### **Presentation at the Beginning of Therapy**

During our first few sessions together Jack presented as amicable, although somewhat reserved. Having never had any experiences with therapy in the past, he was intrigued by the ins and outs of therapy, as well as whom I was. On the surface, Jack and I built a fondness for one another through humor and casual chatter. However, his affect and the general tone of our sessions changed when the content of our conversations shifted from innocuous topics to those related to his anxiety. As this occurred, Jack would become increasingly withdrawn, less talkative, and at times non-verbally demonstrate his experience of severe anxiety by grimacing his face and tightening the muscles of his body. This often resulted in Jack pulling himself into a tight fetal position in his chair.

An example of this occurred minutes after his having entered the therapy room for the first time, as he spied the video camera mounted in the ceiling and immediately recoiled. He asked me several questions related to whether the camera was currently taping, who was viewing him through the monitor, who would be seeing the videotape, and was he safe to talk about private matters. While asking me these questions, he maintained the noted restricted fetal position and only came out of this when the



conversation shifted to a more casual one about his school experiences. Ultimately, this cycle of behavior was one that would be repeated many times during the course of our work together, as Jack expressed his severe anxiety, when it was triggered by discussion or exposure tasks.

Additionally, despite his friendly demeanor and our positive therapeutic rapport, Jack was ambivalent about his own treatment. He much preferred to discuss topics such as sports, school friends, and worldly news, instead of directly discussing his anxiety. My attempts to initiate a thorough analysis of his anxiety symptoms often resulted in his outward avoidance of this, as he would simply change the subject and ruminate on the new topic, as long as he was allowed to.

Early on in the treatment process, Jack's mother was present and participated in my getting a full family history and data regarding his OCD symptoms. During this time, it became increasingly clear that he and his mother had somewhat of a strained relationship, as he would angrily protest some of her answers to queries about his symptoms. At times, a clash between Jack and his mother would occur, which often resulted in his shutting down. This trend became even clearer after our initial assessment sessions, as his mother was only brought in at the end of sessions. On many of these occasions, Jack would be fully engaged and in a positive mood throughout my meeting with him, but once his mother entered the room he became disengaged and withdrawn. As a matter of fact, he simply avoided speaking with her all together during some of our sessions.

**Diagnosis (Table 3)**

As shown in Table 3, at the onset of treatment Jack met the DSM-IV-TR criteria for Obsessive Compulsive Disorder (APA, 2000). Although not required for the diagnosis, Jack presented with both obsessions and compulsive rituals. His obsessions spanned many content areas including fear of religious damnation, fear of contamination, fear of being videotaped, and fears that harm may come to him or others. These obsessional fears were pervasive, as Jack reported that they persistently consumed his cognitive energy and attention. Jack's compulsive rituals consisted of his knocking his hands on any surface which felt "just right" until his experience of acute anxiety dissipated. Additionally, Jack would at times tap his feet as his compulsion of choice, aimed at reducing his anxiety. These two ritualized behaviors were utilized interchangeably throughout his days and Jack gave no reason for his choice of one or the other in any given situation. Jack vacillated between demonstrating good and poor insight into his symptoms, as he would sometimes recognize that his fears were excessive or unreasonable, while at other times he struggled with this. His anxiety symptoms were so severe that they had a significant impact on his ability to function normally within the realms of his academics and socially with his peers and family.

**Strengths**

Jack presented with many strengths during our treatment together. He demonstrated excellent social skills while developing and nurturing positive therapeutic rapport with me, despite this having been his first experience with therapy. When not giving in to his desire to avoid, he displayed an ability to challenge himself beyond what

he perceived were his ultimate limits within exposure tasks. Jack did so in allowing himself to trust me and believe in the cognitive behavioral principles which underlie his treatment protocol. This was obviously balanced with his experience of intense anxiety and the confounding behavior of sleep avoidance during many of our treatment sessions. However, despite his propensity for neglecting to complete homework assignments and employing safety behaviors during in-session ERP tasks in an attempt to avoid anxiety inducing stimuli, Jack also often pushed himself to complete tasks he simply did not want to engage in due to intense fear. As a matter of fact, he often surprised me when asked which item on his fear hierarchy he would like to complete, in that, he may be feeling rather brave on a particular day and thus he would choose an item much higher than expected. This proved critical in his progress through treatment and the reduction of his global anxiety.

Additionally, Jack displayed a great sense of humor and allowed himself to laugh with me. Early on this worked to forge and fortify our therapeutic bond. Later in treatment our shared humor functioned to offset the intensity of the exposure tasks. Overall, Jack is a kind and good natured young man. Despite the sleep behavior which had such a deleterious impact on many of our sessions, he was very motivated to work through the challenges which his OCD symptoms and subsequent treatment presented him. Even when he stalled, Jack always returned for therapy during his next scheduled session to face it once more.

## CHAPTER V

### Case Formulation and Treatment Plan

#### Formulation

Jack entered treatment with symptoms of anxiety, which included a severe level of obsessions and compulsive ritualized behavior that took up an enormous amount of his energy, attention, and time throughout all of his days. His symptoms were so severe, in fact that he was no longer able to tend to his academic and social lives, as he had done quite well in the recent past. Within a cognitive behavioral framework it can be understood that his symptoms manifested and were maintained within the “Anxiety Triad” (Wagner, 2005). Specifically, once confronted with a feared stimulus Jack had thoughts like, “This surface is contaminated and if I touch it I will definitely become ill.” This would lead to physiological arousal and his experience of anticipatory anxiety. Still within the Anxiety Triad, after experiencing this anxiety, Jack would avoid coming into contact with the potentially contaminated surface and complete a ritualized compulsion, in order to reduce his experience of anxiety. As reported by Jack himself, his knocking or tapping would immediately eliminate his anxiety. Problematically however, Jack was restricted from touching many items that he was required to in order to function normally in his many environments.

In her text, Wagner (2006) defines the impact with which “the vicious cycle of avoidance” has on a patient’s anxiety symptoms in stating “avoidance and escape may be the most powerful of the factors that perpetuate OCD. They fuel OCD through (the) process of negative reinforcement” (p.111). Jack’s behavior of avoiding contact with

feared stimuli was rewarded by his avoiding the negative consequence of ruminating obsessions, which led him to experience the anxiety. Wagner (2006) also states that when an individual escapes through their compulsions

they never wait long enough to find out if the situation is really as frightening and insurmountable as he thinks it is. The person begins to believe that the compulsions are the only way to get rid of the obsessions, because he does not attempt any other ways to overcome obsessions. The belief is reinforced and strengthened with each successful escape (p. 111).

This explanation fits perfectly with Jack's experience of his OCD symptoms and also accounts for the gradual intensification of his anxiety over time. As Jack increasingly escaped through avoidant compulsive behavior, his anxiety symptoms garnered greater strength and intensity.

Additionally, Jack's avoidance of coming into contact with feared stimuli did not allow for him to obtain disconfirming information regarding that stimulus. This in turn, provided a context in which Jack would simply accept that all feared stimuli were in fact worthy of being feared, because of his belief that they were somehow dangerous. Meanwhile, had he allowed himself to obtain evidence that ran counter to this thought, Jack might be able to incorporate that information into his active assessment of the danger of objects or situations.

All told, Jack's OCD symptoms are seen to have developed due to maladaptive and erroneous fear appraisals. These are due to his avoidant reactions via compulsive behavior to obsessional fears about potentially dangerous objects or situations. This

avoidance, thus, did not allow Jack to obtain more accurate and adaptive information. Jack also lacked the support of his parents, as he depicted a strained relationship with both his mother and father. This led him to cope with his anxiety on his own, in only the way he knew how, which was through avoidant compulsions. Within this vacuum, Jack's symptoms strengthened over time and at the beginning of therapy, negatively impacted his functioning within all contexts.

### **Treatment Plan and List of Treatment Goals**

Prior to entering treatment with me for his anxiety symptoms, Jack had no prior experience with psychotherapy. Therefore, our initial meetings were aimed at acquainting him with the process of therapy and the expectations for all parties. As with all my clients, I took great care to build and maintain positive therapeutic rapport with Jack. This was especially important with Jack, considering how guarded he was due to his anxiety, as well as, the need for he and I to have a positive therapeutic rapport, as this would be implicated during intense exposure tasks while in active treatment.

When considering treatment options for Jack, I referenced the literature which generally states that "CBT is now widely recognized as the gold standard intervention for childhood OCD and relies on exposure and response prevention (ERP)" (Kircanski, Peris, and Piacentini, 2001, p. 239). This is a sentiment which has been echoed among many authors in the field and thus my supervisor and I felt that CBT with ERP was the most appropriate course of treatment for Jack. We did however want to utilize an age appropriate treatment manual due to Jack's age, 15. Wagner's (2004) manual, *Up and Down The Worry Hill: A Children's Book About Obsessive-Compulsive Disorder and Its*

*Treatment* was chosen due to its age appropriate protocol and child-friendly treatment forms. Although some of the forms in this manual are somewhat childish for Jack's age, he and I worked collaboratively to ensure an appropriate treatment fit. Likewise, the choosing of a manual directed toward children (as opposed to adults) allowed for better attunement between Jack, myself, and his treatment while providing for a fluid transition into the treatment process during the psychoeducation phase.

Creating a fluid, individualized treatment plan was critical in Jack's case, in order to allow for the development of interventions, aimed at overcoming his avoidant safety behaviors within in-session ERP tasks. Within the context of his treatment, I always sought out instances in which I believed Jack might be avoiding coming into contact with a feared stimuli and worked collaboratively with him, and my supervisor, to incorporate novel interventions which might help us overcome his avoidance and thus allow for true exposure. His becoming a full participant in his own CBT with ERP treatment, sans avoiding, was a critical part of our therapy together.

The following were Jack's treatment goals. They are not presented in order of importance, as they were all simultaneously targets of his therapy throughout the treatment.

**GOAL 1: To develop and maintain a positive therapeutic relationship.** During the assessment phase of our treatment it became clear, that although Jack was engaged and demonstrated age appropriate social skills, he was resistant to actually engaging in discourse related to topics that would incite his experience of anxiety. In order for Jack and I to have success through the intense exposure tasks, which was at the core of our

future cognitive behavior treatment, I was certain that he and I would first have to build a solid, stable, and positive therapeutic relationship in which he trusted me to have his best interests in mind at all times.

**GOAL 2: Build Jack's motivation for treatment.** Due to his severe anxiety, Jack was resistant to engaging in any topic of discussion that led to him experiencing anxiety. Thus, our mere discussions about anxious stimuli were small exposures for him. In order to overcome this resistance, I engaged Jack in motivational interviewing related to the many ways that OCD got in his way in life and how his symptoms impacted him doing the things he wanted to do on a daily basis and in the future. These were discussions that proved fruitful and were had at multiple points throughout his treatment, whenever I suspected his motivation to engage in the treatment was waning due to his desire to avoid.

**GOAL 3: Cognitive restructuring of Jack's maladaptive and erroneous beliefs.**

**GOAL 4: Gradually expose Jack to feared stimuli.** Exposing Jack to the feared stimuli on the fear hierarchies that he created made up the bulk of his treatment. His coming into contact with objects or situations that he rated as anxiety inducing allowed for his experience of anxiety to naturally habituate and for Jack to learn that he was actually able to appropriately cope with such high levels of anxiety. With each successful exposure task, Jack was also able to internalize new pieces of disconfirming evidence that were in stark contrast to his maladaptive thoughts. For example, each time he did not become ill via an exposure task within his contamination hierarchy, his



thoughts shifted from “I’m going to get sick” to “This thing is harmless. I never seem to get sick.”

Additionally, as Jack avoided less and became more and more fully exposed to feared stimuli, he learned that he was able to manage his own anxiety. This subsequently built his self-esteem that further fueled him to challenge himself in future exposure tasks and within the context of his real life.

**GOAL 5: Decrease or eliminate Jack’s avoidance behavior (including safety behaviors).** As will be outlined below in Chapter VI, this goal was absolutely critical in Jack’s treatment. Jack presented with the confounding safety behavior of falling asleep during in-session ERP tasks, which had a rather deleterious impact on his progress in therapy. It became clear that while Jack slumbered, no actual therapy or exposure was occurring at that time. With this being the case, Jack, my supervisor, and I, worked diligently to develop targeted interventions to negate his utilization of safety behaviors during our sessions in order to allow for the therapeutic benefits of CBT with ERP to take hold. Because Jack’s use of safety behaviors arose on many separate occasions this is something that would be repeatedly addressed throughout our treatment together.

**GOAL 6: Have Jack take responsibility of his treatment progress.** As a means of avoiding, Jack often occupied a stance that it was other’s responsibility to convince him to be engaged in his treatment, in this case his mother and me. During the early phases of treatment he would respond to queries about his homework completion in saying “You didn’t give me a new form,” “My mom misplaced my treatment folder,” or “Mom didn’t remind me to do my homework.” Due to the negative impact his externalizing of

the locus of control was having on his progress, he was placed in full responsibility of all things related to his treatment. Jack decided which days he would complete homework, where he would keep his folder, what days of the week worked best for him to attend sessions, etc. I also put him in charge of providing his mother with a short summary of what he had accomplished in each session. In this way, over time, Jack's ownership of his own treatment grew and as he made progress, he was able to take full credit for that progress, thus further building his self-esteem.

**GOAL 7: To encourage Jack to go beyond his perceived limits in facing his fears.**

Avoidance played a major role in Jack's life and within our in-session exposure tasks. I saw it as part of my role, as his therapist, to push Jack to push himself when I believed he was ready to do so. This played out during ERP tasks in that I often suggested that he do an item one or two levels higher on the hierarchy than he had planned to do. If he said he would touch a door knob on a given day during a contamination exposure, I might suggest that he also eat a pretzel with the hand that touched the door knob. This became a common trend that ran the length of our treatment. In the later parts of our therapy together, Jack increasingly challenged himself beyond his perceived limits, despite knowing it would make him even more anxious. He had internalized my propensity for challenging him to challenge himself and my belief that he could do more than he believed. This certainly led to Jack's own treatment progress and personal growth.

**Goal 8: To decrease Jack's experience of anxiety.** The entirety of the chosen CBT with ERP treatment protocol was aimed at affording Jack with techniques and skills

that would allow him to more effectively assess the danger of stimuli across his environments. In facing his fears, he would learn to more effectively manage anxiety when it arose, but ultimately significantly decrease the frequency, duration, and intensity of his anxiety.

**Goal 9: To increase Jack's flexibility in responding to his environments.** In reducing Jack's overall anxiety, the goal was to allow him to approach his many contexts with a freer range of behavioral options. He would no longer be restricted by his anxiety, which was certainly the case in the past, where his OCD disallowed him from doing things he most enjoyed. As Jack's anxiety dissipated this would allow him to do the things he wanted to do on his own terms.

## CHAPTER VI

**Course of Treatment****Phase I: Sessions 1-7**

**Sessions 1-4: Introduction to therapy and building therapeutic rapport.** During his first visit for therapy, Jack walked with this clinician and his mother from the waiting area to the therapy room, while completing rituals tied to his OCD, throughout the short walk down the clinic hallway. Likewise, he scanned the therapy room as he sat down and immediately asked if the camera positioned in the upper corner across from him was in fact recording him. He was told that it was not recording but when I asked why the inquiry, he responded abruptly in seeking reassurance from me that he was not being recorded or watched by a group of people in another room. By his questioning, reassurance seeking, and restricted non-verbal behavior (body tensing and facial grimacing) it became clear that Jack was very anxious for his first therapy session. This rather quickly set the stage for what would be a challenging process of rapport building with a client whose anxiety would soon be formally assessed on the *Children's Yale-Brown Obsessive Compulsive Scales (CY-BOCS)*, to be in the "extreme" range of OCD symptoms.

In addition to Jack's OCD symptoms, it also appeared that he and his mother had a strained relationship. This became evident during the first three sessions, as during the intake process he and his mother often disagreed on topics, which resulted in either outright anger-laden, verbal-battling between them or Jack shutting down completely. This made it difficult for me to receive a clear history of his symptoms and the family's

history. Furthermore, it became clear that Jack perceived his mother and me as being in an “adult alliance” against him. Because I was perceived to be in alliance with his mother, who was often a source of contention, Jack was resistant to developing an open and positive therapeutic alliance with me during the early stages of therapy.

An additional deterrent to Jack and me building a positive alliance was his avoidance of discussing any topic that would lead to his being anxious. This of course, included taking a history of his symptoms, discussing compulsions witnessed in session, completing the CY-BOCS, and introducing the rationale behind the chosen treatment of Cognitive Behavioral Therapy (CBT) with Exposure and Response Prevention (ERP). Jack balked at each of my initial attempts at engaging him in these tasks by either changing the subject, asking for the task to be delayed, or asking to get a drink of water or to visit the men’s room.

I realized that without a strong therapeutic alliance Jack’s treatment would have a poor prognosis due to his avoidance. Therefore, I decided to stray from the specific tasks in the therapy manual I was using for CBT with ERP for OCD and instead focused solely on getting to know Jack apart from his OCD symptoms. This turned out to be the first of several occasions that this case required that I move away from the manualized treatment, in order to provide Jack with an individualized treatment that met his therapeutic needs at any given time in the treatment process.

My first intervention was to remove his mother from the therapy room, aside from a 5-minute “update on treatment” section at the end of each therapy session. This was meant to shift, what Jack had perceived as an alliance between me and his mother,

to the stronger alliance being between Jack and myself. During these 5-minute sections, Jack was placed in charge of updating his mother, with my role to only be to provide supportive statements or supplemental information required in the treatment. As part of this process, I no longer met with Jack's mother alone, as had occurred during the first couple of sessions, in my attempt to acquire an accurate history of Jack's symptoms. This shift proved effective, as Jack began to place more trust in me and our relationship.

After failed attempts at completing the typical data collection measures that encompass most initial therapy sessions, it was decided by Jack and me that sessions 3-4 would be dedicated to more free form discussion. This allowed for me to really engage in his interests, his family and social life, his academic successes and failures, and any other topic he wanted to discuss. We spoke about his love of the 1950s' era, the sports we both liked, athletes we enjoyed watching, TV shows and movies we enjoyed, favorite holidays, and our favorite types of music. In fact, Jack actually brought in his harmonica during session #4 and played a bit for me. As we went along, I thanked him for sharing all of these bits of his life, as I became confident that our chatter was creating a bond between us. When times got tough during our ERP sessions, I would always be able to relate back to how difficult it must have been for him to learn to play the several instruments, which he had described. This process also instilled in Jack an understanding of flexibility, as I was willing to adapt the treatment process in order to fit his needs and meet his emotional state on a given day.

Through our more casual talks, which were often infused with humor, we became increasingly aligned with one another. This was a critical step in Jack's treatment because I believe without this strong therapeutic alliance, treatment may have been a slow, resistance-filled undertaking due to the severity of his OCD symptoms and his avoidance of anxiety inducing topics.

**Sessions 5-7: Speaking about more serious topics, psychometric measures, and psychoeducation regarding OCD.** As our alliance took hold Jack was increasingly willing to discuss more serious topics, such as the nature of the relationships within his family. He stated that his mother was often "on his case" about his schoolwork and tended to yell at him instead of speaking with him calmly, while helping him problem-solve situations that arose in his life. He explained that this created great stress for him at home, and he coped with this by either relegating his home life to his bedroom or by spending much of his leisure time at his friend's home.

Jack also related the strong hold that anxiety had come to have on his daily life. Anecdotally, he told me that he "wasn't able to do anything he used to enjoy," such as read books or go out socially, because he always found himself obsessing over a feared stimulus and was required to complete his compulsions, which embarrassed him. He told me a story, about going out for a bike ride with his friend, only to worry the entire time that when he was in his friend's garage that he had mistakenly leaned another bike against the heating system that could cause an explosion. This obsession resulted in him knocking on his bike handle the entire ride. Jack talked about having been on vacation to Disney World with his family, only to have to run out of the park after

becoming obsessed with the endless number of video cameras taping him and the “fact” that everything was contaminated by the other vacationing revelers. Jack often expected “others” to have harmful germs on their hands, and thus once someone came into contact with a surface he no longer allowed himself to touch that surface. This was generalized to surfaces that he actually saw someone touch, as well as, those he simply expected someone had come into contact with, such as a railing or bench.

As Jack continued to become more open about his anxiety, he told me about his debilitating fear of damnation, which impacted his every thought and behavior. He reported that he was living an entirely restricted life governed by his OCD symptoms and not by him. Jack stated that in most instances he was not able to act freely. Instead, when he aimed to do a certain task, this was often rejected by his obsessive thoughts and his time was subsequently consumed by his compulsion of knocking. As one example, if Jack had a thought which he found “impure” or “immoral” (e.g., religion is made up and God doesn’t exist) he would very quickly begin to obsess about these thoughts and thus fear he was going to be damned to Hell because of them. This thought would then result in a surge of anxiety. Jack would then knock on the wooden crucifix in his bedroom. Jack explained that this knocking quickly relieved his intense anxiety, until the next time he obsessed about some anxiety inducing topic. In terms of degree of preoccupation, at this time, Jack estimated that he was completing a “knocking” compulsion 750 times per day!

During these sessions, Jack was also able to complete the CY-BOCS and YGTSS instrument and receive psychoeducation regarding OCD and the planned treatment



process. Although still hesitant, Jack was much more willing to discuss these more serious matters knowing that I was “on his side” and would be a supportive figure in his treatment. Jack also became more comfortable with having his mother in the therapy room at the end of sessions, in order to update her on our progress, knowing that he and I had a strong therapeutic alliance. However, he continued to ask about the video-camera taping and often completed compulsions while in-session, such as subtly knocking on the arms of his chair and the table in the room and tapping his feet on the bottom of his chair and floor.

## **Phase II: The Beginning of CBT with ERP**

**Sessions 8-13: Damnation hierarchy and the homework Issue.** Jack’s treatment for OCD comprised gradual exposure tasks utilizing a hierarchy of feared stimuli in two areas: first, the fear of spiritual damnation (scrupulosity) (presented in Table 5), and second and later in the treatment process, the fear of germs/contamination (presented in Table 6). Both hierarchies followed a similar path that I will outline presently, as it related to the onset of CBT with ERP for his fear of damnation.

As Jack and I had built a strong therapeutic alliance and he had begun to be more comfortable discussing anxiety-fueled topics, the timing was right to begin exposure treatment with much support from me. Therefore, Jack was oriented to the manualized treatment protocol, Wagner’s (2004) *Up And Down The Worry hill: A Children’s Book About Obsessive-Compulsive Disorder And Its Treatment*. He was allowed to familiarize himself with the protocol’s workbook, which we would utilize in facilitating our treatment together. This was aimed at providing Jack with the perception of control

over his own treatment and to reduce his anxiety about the therapy itself and his avoidance of impending exposure tasks. This also worked to normalize his symptoms and to provide him with feedback from the literature, which notes the high rate of efficacy of CBT with ERP for OCD symptoms.

Jack's first in-session ERP task was scheduled to be completed in session 8. Jack was reminded of this as he entered the session but he adeptly attempted to stall or avoid the exposure task by discussing unrelated topics with me. As I attempted to redirect him to the exposure exercise, Jack agreed that we needed to complete it but simply changed the subject once again. As the stakes rose due to the dwindling of time remaining in our session, Jack increased the intensity of the topic he was discussing. At one point, he mentioned an interest in the Nazi party, which I believe was designed to provide a provocative topic that he anticipated I would be interested in discussing with him, thus further putting off the start of the exposure task.

These attempts at avoidance and procrastination became Jack's go-to tactic, as he would enter each session with several provocative topics he wanted to discuss. He would talk without pause, despite having been prompted that our exposure tasks would begin after initial casual greetings and the review of his homework assignment. One day he would talk about the Nazi party, another day he would raise the issue of an argument with his parents, while other days he would raise school-related incidents to which he had a strong reaction. Any large events that had occurred in the news on a given week were sure to be raised at the session's inception that week.

During this phase of treatment it became very difficult to derail Jack in his loquacious avoidance tactic. I feared that a stern approach to stopping his chatter this early in the treatment process could have a negative impact on our therapeutic alliance. However, it became abundantly clear that Jack was dead-set on avoiding the anxiety that would accompany any exposure task, no matter how low on the feared stimuli hierarchy this fear might be. Therefore, some intervention was required.

Prior to session 10, in meeting with my supervisor, we decided that “chatting” should be scheduled into the session’s agenda. This was done at the end of each session, as to ensure that exposure tasks would begin no later than 15 minutes into each session. The intervention proved effective, as each time Jack would attempt to raise an ancillary topic, he was cued that we could discuss it after completion of his exposure task.

In this fashion, Jack became fully exposed to feared stimuli related to his fear of damnation between sessions 10-13. For example, in session 11 Jack completed an exposure that involved him saying to me, “Go to Hell.” The level of Jack’s anxiety on a 10-point scale (with 1 being the lowest and 10 the highest) was tracked by me throughout the exposure exercise, in order to monitor the gradual habituation of his anxiety. More specifically, I asked Jack for his fear rating at the start of the ERP and at intervals of 1, 2, 5, 10, 20, and 30 minutes. In this exposure task, after Jack uttered the words “Go to Hell” he immediately rated his anxiety as a “10.” It remained a 10 for the first 5 minutes of the exercise and then slowly decreased to a “5” at the 20 minute mark and finally a “1” at the 30 minute mark which is where we stopped the exposure.

Throughout the habituation process Jack and I discussed how having said “Go to Hell” had affected him, the thoughts he was having, the evidence for and against these thoughts, and the likelihood he would be “damned to Hell” for having said those words. I also spoke about Jack's tendency towards fusing thoughts and actions, in order for Jack to begin to gain some distance from his own thoughts. I said, “Just because you think it, it doesn't mean that it IS.” As the session came to completion, we discussed how having experienced both the exposure and the natural habituation of his anxiety was for Jack. He stated that it was extremely difficult, but that he was surprised that the anxiety went away on its own, without his having to knock.

Session 12 consisted of a very similar exposure task and process as in session 11, except in this case during the exposure, Jack closed his eyes and provided me with the imagery he was having due to his anxiety. He gave vivid depictions of what Hell would look like and what it would be like for him if he was “damned to Hell for eternity.” He estimated that for having said “Go to Hell” and “There is no Heaven or Hell, they're fake” that he was 90% assured of going to Hell. During this exposure, and all of those to follow, when Jack did not employ sleep safety behavior, he allowed for a detailed discussion of anxiety provoking content related to the exposure topic. This was done in order to create a context in which Jack was exposed to all aspects of his anxious thoughts, while preventing him from completing escapist compulsions. Through this process he would learn that he could experience extreme anxiety, confront it directly through our discussion, no harm would come to him, and his anxiety would habituate without his having to avoid through safety behaviors and/or compulsions.

Generally, Jack often rated his fear at the beginning of exposure tasks at a “10,” with his anxiety very gradually and slowly habituating, typically over the course of 30-35 minutes. This proved to be an effective stretch of sessions, resulting in Jack sharing that his overall fear of damnation was decreasing. This was especially true for the items on the hierarchy that he had completed. The more we completed a certain item the easier it became for him.

Despite his progress with in-session exposure tasks, Jack would not complete his homework assignments during this time. He was assigned daily ERP practice exercises of whichever item on his feared stimuli hierarchy that we had completed in session that week. For example, for his homework after sessions 11 and 12 cited above, he was to say “Go to Hell” and “God is fake.” He was to document these practices on a standardized form from the treatment protocol. When asked about his homework he often delivered excuses, including his having misplaced his treatment forms folder, having simply forgotten, and/or his having had a heavy school work load. Despite his rationales, it became clear to me that he was simply avoiding completing the exposure tasks outside of the confines of the therapy room. Jack was confronted on his avoidance during session 11 and he agreed that he did not want to complete the exposure tasks without my support. He was reinforced for having been truthful with me, as we continued to fortify our alliance. I shared with him that I would rather know exactly what his experience was, so that we could effectively problem solve the situation, as homework could have a significant impact on both the pace of his treatment progress and ultimate treatment outcome. In our problem solving of this

situation, Jack decided that he would keep his treatment forms folder in plain sight in his room, as a cue, and his mother would remind him to complete his homework in case he forgot to do so. However, this was an issue we would soon revisit.

At the start of session 13, Jack admitted that despite our having problem-solved his ability to remember completing his exposure homework assignments, he was not doing so. He stated that he simply could not get himself to become exposed to the feared stimuli of damnation, in saying “Go to Hell” and “God is fake,” for fear that he would be “damned to Hell for eternity.” In an effort to fortify our rapport, I expressed empathy for how difficult this process must be for him. Likewise, in order to maintain my perceived role as an unwavering source of support, it was decided that we would forgo homework altogether, until such time that he felt he was capable of completing exposure tasks on his own. In-session exposures would continue as normal.

### **Phase III: Sleep Avoidance Behavior Emerges**

**Sessions 14-15.** As we entered our 14<sup>th</sup> session together, Jack had been fully oriented to the treatment process and to the schedule and timing of each session. He understood the theory and rationale behind exposure treatment. Intellectually, he knew the impact the therapy would have on his symptoms as he had begun to see a decrease in both obsessions and compulsions. As a matter of fact, Jack estimated that he was knocking 250 times per day (which is a rather significant decrease in compulsions considering that at treatment onset he had reported performing compulsions at a rate of 750 times per day).

However, as we moved up the hierarchy of feared stimuli presented in Table 5 (becoming increasingly more fearsome), it had become more difficult for Jack to complete exposures in session. It was at this stage in the treatment that Jack developed and employed a rather effective means of avoiding his exposure to anxiety during in-session ERP tasks: falling asleep. Mere minutes into session 14's ERP task, Jack began to slouch back in his chair, roll his eyes sleepily and ultimately appeared to have fallen asleep. As I continued attempts at engaging him in the exposure task, Jack simply became unresponsive. To any untrained eye it would appear that Jack was taking a mid-day nap. No attempts at speaking with Jack proved effective in rousing him. I could do nothing but continue to speak about the feared stimuli interspersed with request for him to awaken. During this session, Jack finally awoke after I changed the topic of conversation to some unrelated issue. We then processed why he had fallen asleep, which he explained was due to his having not slept well the night before. A discussion ensued regarding the importance of getting a full night's sleep and of his being awake and an active participant in our treatment sessions. He agreed that he would be sure to regulate his sleep in the days/weeks to come.

Session 15 proved very similar to the previous session however. Despite previously having agreed that Jack would not conduct compulsions during exposure tasks, he admitted to covert knocking during the early stages of the ERP. Jack explained that when anxious in-session he would put his hands behind his chair and knock on the back of his chair. He had also knocked gently on the wall and table in the room, on such an angle that I could not hear or see this. He stated that he was simply "too fearful of

being damned” and his knocking worked to rectify his wrong doing, which was instilled by the exposure stimuli. Jack stated that his knocking also wiped out his anxiety. Once he was re-exposed to the feared stimuli in this session and it was agreed that he would not knock, he again fell asleep. My behavior was similar to that in session 14, in that I attempted to rouse him while also staying the course of my typical verbiage during exposure tasks (aimed at creating an atmosphere of exposure to the feared stimuli in a safe and supportive manner). Again, my efforts were futile, as Jack appeared to slumber in his chair while maintaining an unresponsive stance. At the session’s end Jack once again stated that he had not slept well but that he was also taking allergy medication that may have made him drowsy.

*I was confused!* Was Jack actually drowsy due to this supposed medication and/or lack of sleep? Did the safe space of the therapy room incite him to fall asleep? But then why did he awaken once I began discussing a topic unrelated to the feared stimuli present in the exposure task? In completing a functional behavioral analysis with my supervisor at this time, it was suggested that Jack’s sleep behavior was in fact avoidance behavior. Our hypothesis became that Jack would employ the appearance of falling asleep, or perhaps actually falling asleep, in order to avoid the anxiety associated with items higher on the fear hierarchy related to his fear of damnation. In these terms, it became clear that this sleep avoidance behavior was something that would require specific interventions aimed at eradicating the behavior in order to allow him to be fully exposed to the feared stimuli. This exposure would thus provide Jack the opportunity for anxiety habituation and for him to obtain disconfirming information and learn new



behavioral responses to feared stimuli and his own anxiety. Therefore, in addition to the manualized treatment, an individualized case formulation and treatment plan was created, which allowed for the ongoing development and administration of interventions to reduce his sleep behavior (Persons, 2008).

**Session 16-21: Problem solving sleep avoidance behavior.** A first attempt at intervening with Jack's sleep avoidance behavior occurred during session 16. I began the session recanting the difficulties we had experienced during the previous two sessions. Jack apologized for sleeping and recognized that it was negatively impacting the treatment process. I then explained to Jack my hypothesis, that I thought Jack's falling asleep was due to his wanting to avoid the anxiety associated with the exposure task. After a convoluted attempt at further rationalization of his sleeping which I did not agree with, Jack finally admitted that he thought the true purpose of his falling asleep during sessions was so that he could avoid the feared stimuli and save himself from "eternal damnation."

Upon coming to this common understanding of his sleep behavior, Jack and I worked together to differentiate his natural sleep and that which was associated with him wanting to avoid exposure tasks. Jack thus named his sleep avoidant behavior as "drowsing," a term we from this point further utilized to demarcate times when Jack started to become sleepy in anticipation of in-session exposure tasks. This allowed us to create distance from his rationalizing his avoidant behavior as being the product of poor sleep habits and instilled honesty in our treatment together. From this point forward, when one of us would identify that Jack was indeed beginning to "drowse," we both

knew this meant that anticipatory anxiety was beginning to get the better of him, encouraging him to fall asleep in order to avoid an exposure to his most feared stimuli.

This also provided a common language within which Jack and I could collaboratively develop interventions that worked to counter his drowsing behavior. The first of such interventions occurred in session 16, where Jack and I agreed that once he began to drowse during an exposure task, he would promptly stand up in front of his chair and continue the ERP. This proved very effective in arousing Jack, while resisting his desire to fall asleep. Furthermore, it allowed the evidence-based benefits of ERP therapy to take hold.

During sessions 16-21, Jack found great success at eradicating his sleep avoidance behavior by standing up each time he became drowsy. Significantly, this allowed us to complete the top items on his fear hierarchy for damnation, including a final flooding exposure in which we completed all of the items on the entire hierarchy. He had gotten into a groove, realizing that he did not need to avoid his anxiety but instead could resist the urge to fall asleep and no harm would come to him in the process. As a matter of fact, during sessions 20 and 21 he refrained from sleeping without needing to employ the technique of standing up at all. Jack related that he completed items on the damnation hierarchy that at the beginning of therapy he never would have imagined he could do. These included “blaspheming the holy spirit,” “praising Satan,” and “ripping up a drawing of a cross.” Therefore, he was beginning to feel proud and thought positively of himself and his ability to engage in the treatment process, regardless of how difficult it was.

Jack stated that he felt freer after having completed the entire damnation hierarchy. He had previously stated that his fear of God and his being “damned” had governed every behavior in his life and now he felt at liberty to behave as he pleased, without concerning himself with this type of obsessive thinking.

**Redefining homework assignments.** Due to his newfound confidence in confronting his fear, during session 20 Jack agreed to reinstate his completing of a modified homework. I presented the idea that we could attempt to decrease his daily compulsions by his taking stretches of several minutes per day where he would not allow himself to ritualize (at this time comprised of knocking and foot tapping), no matter the intensity of his obsessions. Jack immediately liked the idea, as he wanted to challenge himself. This would turn out to be a major turning point in Jack’s completion of homework, as he enjoyed the challenge it presented him. He entered each session subsequent to this one eager to report the amount of time each day that he had not ritualized and each week increased his goal time. This continued for the remainder of our treatment together.

#### **Phase IV: Start of ERP For the Contamination Fear Leads to Reemergence of Sleep**

##### **Avoidance Behavior**

**Session 21.** As Jack had completed the fear hierarchy for his fear of damnation, it was decided that session 21 would be the first session where he was exposed to his fear of germs/contamination. We began the session by creating a hierarchy of feared stimuli related to this fear (Table 6) and chose a task he had rated as relatively low in its ability to induce anxiety, touching a door knob. As Jack and I began to discuss the

probability of him becoming ill after having touched the door knob to the therapy room, it became clear that he was becoming increasingly anxious, evidenced by his restrained non-verbal movements and facial grimacing.

When asked for a fear rating, Jack quickly stated that he was having a lot of anxiety and rated this exercise as a “10 out of 10.” He stated that he was certain he was going to become ill and provided a multitude of rationales as to why this was true such as: “a lot of people still have colds,” “so many people touch that door knob every day,” and “I have a poor immune system.” Within the first three minutes of this exposure task Jack reverted back to his utilization of sleep avoidance behavior and began to doze off. Because it had proved effective in the past, I asked him to stand up to avoid falling asleep but Jack simply appeared to fall into a deeper sleep while becoming unresponsive. He would only wake after I changed the topic of discussion to an unrelated matter, which I believed would draw him out of his “drowsy” state.

Upon Jack’s revival, his drowsing was processed. He admitted that on this first day of exposure to germs he simply did not think he could manage his anxiety as it was very intense. He was “100% certain (he) would become ill.” The reemergence of sleep avoidance behavior was once again identified as an issue that we must work to overcome. Collaboratively, Jack and I developed the intervention of me calling out his name upon first sight of drowsiness, in addition to him standing up during ERP tasks, as had proven effective in the past.

During our next session, #22, Jack began to drowse shortly after the ERP exercise began. As planned, I called his name out, which momentarily awoke him and focused

him on me saying, "I know this must be very difficult for you to face such a high level of anxiety but let's stick with it and not avoid by falling asleep." He agreed that he would stick with it, but as we continued to discuss germ-related content Jack once again began to doze off. I asked him to stand up as we had agreed and he did so, ever so slowly. He stood in the room for the remainder of the session, which allowed successful completion of the ERP task. The last five minutes of the session were devoted to casual chatter in which Jack presented as fully awake and engaged.

Session #23 provided further evidence that Jack's "drowsing" was in fact avoidant behavior. As he began to fall asleep during the early stages of the ERP task, I simply remained silent, in order to gauge what reaction this would instill in him. After two minutes of silence, as Jack was fully laid back in his chair asleep, Jack slowly opened one eye to look at what I might be doing. The use of therapeutic silence allowed me to confront Jack on the fact that he was *choosing* to drowse in order to avoid the anxiety associated with the exposure task. After some rationalization, when confronted with this, Jack admitted that he was continuing to employ sleep as an escape from his anxiety.

Due to the use of silence, Jack and I came to a new understanding and honesty about his sleep avoidance behavior, as it was labeled as such. The consequences for this behavior were discussed, as his avoidance by whichever means would not allow for the expected treatment effects to take hold. He agreed with this rationale but continued to be hesitant, for fear of both experiencing his anxiety at such great levels and due to his fear of becoming ill. At this, we agreed that each exposure task from here on forward

would begin with Jack standing up in the room, as to avoid any possibility of him beginning to drowse.

However, during session #24 Jack still found a way to circumvent his active participation in the exposure task, by simply falling asleep well before he knew the exposure exercise would begin. I slowly brought him back from his slumber by engaging him in topics unrelated to his anxiety and in this discourse he shared with me that despite his in-session avoidance of exposures, he believed that his overall OCD symptoms had greatly improved. He explained that he believed his treatment was generalizing to other anxiety areas that we had not worked on, as he no longer feared being videotaped. This was reinforced as due to his hard work in and out of sessions. This feedback was also utilized to encourage Jack to continue pushing himself within his treatment, as he was experiencing positive results.

**Finding his groove again.** At the start of session #25 Jack estimated that he had been tapping his feet (which had in large part replaced the knocking of his knuckles as a go-to compulsion) 100 times per day, which was a significant improvement from our last informal measurement. Jack's tapping and knocking were used interchangeably and no significant difference in intensity existed between them. They also served the same purpose; to extinguish his anxiety. I believe that Jack's reliance of one over the other was simply a matter of habit and situational opportunity. Nonetheless, this decrease in compulsive behavior showed improvement in his symptoms. Additionally, during the ERP in session 25 Jack stood up for it's entirely and did not drowse, and thus was fully exposed to his anxiety. I celebrated this with Jack as a major milestone, as it had been

the first time he had gone through an exposure task for germs and had not attempted to avoid it through sleep.

**Sessions 25-28.** Jack found himself in a positive groove of becoming fully engaged in his exposure treatment. During these sessions he ceased attempts at engaging me in unrelated chatter, completed his homework each week in its entirety, and stood up at the beginning of each ERP exercise without prompting from me. He experienced significant anxiety in each session, but became very interested in challenging himself and refused to avoid. In part, he seemed to get a kick out of pushing his boundaries and limits, having learned that he was able to expose himself to all types of potentially contaminated surfaces and objects through ERP tasks and that he would not become ill. Through this process Jack accumulated and internalized evidence that ran counter to his anxious thoughts. For instance, if he had previously thought that touching a stair railing would surely make him ill, then repeated ERP tasks in which he touched that very railing and consumed food, without becoming ill worked to change his thoughts about the danger of the railing. Jack came to make more accurate appraisals of the danger involved in touching objects in his world, which led to a global decrease in his anxiety.

Between sessions 28 and 29 a month long hiatus in therapy occurred due to both of our schedules. Due to this break, Jack may have been out of practice with exposure tasks, as much of the “groove” he had been in prior to the break appeared to have dissipated during session 29. At the beginning of the exposure task Jack stood up against the wall and immediately rested his head on the wall. He appeared to be

struggling to stay awake but was engaged in the discussion with me. Ten minutes into the ERP he stated that his legs were tired and asked to sit in his chair, which he did. Ninety seconds into his having sat down, Jack once again fell asleep. Calling out his name did nothing to stir him. I spent several minutes attempting to stay within the confines of anxiety laden content but eventually abandoned this tactic and changed topics which gradually awoke Jack. We again processed his sleep avoidance behavior, which he agreed was problematic. He was reminded about his great success during sessions 25-28 and was encouraged to challenge himself to stay fully engaged during the exposure tasks in order to improve his symptoms.

#### **Phase V: Hand up, Identify Thoughts, Stand/Jump**

After session 29 I met with my supervisor and further problem-solved the issue of his falling asleep in session while becoming unresponsive. My supervisor and I believed that it was critical that Jack remain awake and an active participant in exposure tasks because we could not be certain if he was in fact sleeping or feigning sleep. Thus several new interventions were developed.

1. At the first sign of drowsiness, Jack would raise his hand (physical activity which ran counter to his falling asleep).
2. Jack would identify the thought he was having that directly preceded his desire to fall asleep. These thoughts would be processed and counter evidence would be sought.
3. Jack would stand up in order to stay awake and jump up and down in place if necessary.



During session 30 Jack was taught these new techniques at combating his sleep avoidance and was immediately on board with this plan. As he began to fall asleep at the start of the ERP, Jack raised his hand and identified the following thoughts:

- “I don’t want to do this.”
- “This is too hard.”
- “You don’t have to do this. It’s not going to work.”
- “If I go to sleep I won’t get sick.”
- “Just close your eyes and you won’t be anxious anymore.”

As Jack presented each of these thoughts we explored what may be more adaptive thoughts that ran counter to these anxiety-inducing and/or anxiety-avoidant thoughts. He struggled to stay awake as we did this but worked hard to maintain his engagement in the discussion. Jack then stood up and successfully completed the ERP. This new series of interventions worked very well in providing Jack with evidence that his drowsing was in fact fueled by anxious thinking and thus we had novel tactics in refusing to give in to this avoidant behavior. The employment of these new techniques would result in a stretch of extremely productive sessions in Jack’s treatment.

**Sessions 31-37: Another groove.** In utilization of the above set of interventions, Jack got himself into another string of sessions where he ceased his sleep avoidance behavior and was fully engaged in each in-session exposure task. During this time Jack worked hard to stay awake in sessions, by raising his hand at the first sign of him becoming drowsy, identifying his anxious thought, standing up, and occasionally jumping up and down. The use of these interventions allowed for Jack to challenge

himself beyond his perceived limits during ERP exercises. This included his not only coming into contact with potentially contaminated surfaces but also his ingesting food items with his hands and rubbing his ears, eyes, nose and mouth. Jack viewed these tasks as critical means of him becoming ill. Thus his anxiety during these sessions was very high, BUT he completed each task nonetheless. This was a far cry indeed from past sessions where he had drowsed at the beginning of sessions in mere anticipation of an upcoming ERP.

Throughout these sessions Jack's confidence grew, his anxiety decreased, and he related that he felt freer in his interactions with the world. Jack described how he had stopped his dogmatic use of hand sanitizer upon coming into contact with any surface. He had begun eating his school lunch without having to wash his hands and/or obsessing over what he may have touched that morning that would make him ill. Jack talked about how he felt that "OCD had hijacked (his) thoughts" in the past, but he felt much more in control of his thoughts at that time. He was able to read long passages in books that had been problematic in the past due to incessant obsessional thinking, which interfered with his ability to concentrate on what he read.

Within this time, there were sessions where Jack simply did not show any signs of drowsing and so the interventions of him raising his hand, standing, and jumping were not required. These sessions were seamlessly conducted with him sitting in his chair. While during other sessions he raised his hand at the first sign of sleepiness, identified his anxious thought, provided a more adaptive counter thought on his own, stood up, jumped in place, and completed his exposure standing in the therapy room.

Overall, he appeared to make great progress, as the interventions that my supervisor and I had designed worked extremely well to negate avoidant behavior and instill a confidence in Jack related to his ability to confront his anxiety directly.

### **Phase VI: The Return of Drowsing (Sessions 38-44)**

Up to this point, a general pattern had emerged in Jack's treatment: avoidance, avoidance, avoidance. However, once his in-session sleep behavior was identified as avoidant and relabeled "drowsing," Jack, my supervisor, and I were able to develop interventions that proved effective in reducing this avoidant behavior, in order to allow the benefits of ERP treatment to take place. However, the pattern referenced was that Jack would present with avoidant behavior when he anticipated a rise in his anxiety. A given intervention would then prove effective in reducing this avoidance but would gradually lose its usefulness over time. Each time, this resulted in a return of sleep avoidance behavior. This is depicted in visual form below:



As sleep avoidance behavior returned it provided a new frustration to the therapy process. Just when I thought a given set of interventions would be the final say in the breaking down of Jack's avoidant behavior, these interventions infallibly withered away, allowing Jack to begin sleeping in session once more. This resulted in my searching for new answers to "solve" the ever-evolving treatment barrier of Jack's avoidance.

Jack opened session #38 with a loquacious story about how difficult things were at home between him and his mother. He stated that she continued to be “on his case” most of the time due to what she perceived as poor academic performance. After extensive processing of this and as our typical time for the beginning of the ERP task arrived, I checked in with Jack stating, “It sounds like this has been very difficult on you. I am however wondering if any bit of you telling this story today has been aimed at avoiding doing an exposure exercise.” Jack immediately smiled, laughed even, and said “You got me!” He went on to relate that he did not want to do an exposure during this session and would appreciate if he could just talk freely about the things that had been stressing him lately (mostly his family life). To date, Jack had not been allowed to speak at length about these types of matters since our earliest sessions together, therefore, despite highlighting it as avoidant, he was allowed to talk freely for this session. This further helped to continue our positive therapeutic rapport, which I hoped would carry us through the difficult work that was ahead of us in his treatment.

**Sessions 39-44.** These sessions saw a full return of Jack’s sleep avoidance behavior. This also coincided with his attempt to tackle items he had rated as much more anxiety inducing than those he had completed previously within the germ hierarchy (Table 6). This included his touching a toilet seat in the clinic’s bathroom, which he had given a fear rating of 10 out of 10. During session #39, upon returning to the therapy room from the bathroom, Jack immediately sat down and within 60 seconds began to fall asleep. As had proven effective in recent sessions, I asked him to raise his hand due to his apparent drowsing, identify the thought he was having, and provide

counter evidence for that thought. Unlike in previous sessions where these interventions proved effective however, Jack was unresponsive. He simply continued to sleep. Nothing I did roused him.

Eventually I asked him to stand up in order to wake him up. At this request, Jack very slowly came out from under his sleepiness and stood up against the therapy room wall. At this point we discussed his drowsing behavior and he acknowledged that touching the toilet seat was simply too anxiety inducing for him to cope with. He was reminded about how in the past he had completed exposures that he simply didn't believe he could cope with the associated anxiety. My aim in citing these previous successes was to build hope and motivation. We agreed that during our next session we would be proactive in utilizing our interventions to combat his sleeping and that Jack would work hard to "face his fear."

At the beginning of session #40 Jack stated that he forgot to complete his homework, which I interpreted as avoidant considering how his anxiety had been so significant in our last session. We again completed the toilet seat ERP exercise during this session. Jack immediately stated, "This is the hardest one yet... I rate it a 13 out of 10!" He once again began to drowse soon after reentering the therapy room from the bathroom, but this time was able to raise his hand and identify the anxious thought he was having. He was also able to provide evidence that ran counter to that thought. However, Jack still began falling asleep as he had in the previous session. He stood up upon request but soon after asked to sit back down saying "I can do it... I won't fall asleep again," but upon sitting in his chair he did in fact fall back to sleep. He was

unable to be aroused, until the topic of discussion shifted to his being able to free form chat about dating, school, and video games.

Session #41 began with me checking in with Jack about his present compulsive behavior. He stated that he had seen an increase in his knocking behavior. When asked why he believed this was true, he inferred that it may be due to the increase in overall anxiety he has had recently. Connecting the dots in an attempt to build motivation in therapy, I suggested that his inability to complete in-session or homework exposure assignments due to his avoidant behavior might be related to this increase in compulsions. At this provocation, Jack and I reviewed the recent waxing and waning course of his anxiety. He stated that he believed that when he was doing his homework and not drowsing in session that he was far less anxious than when he avoided. Despite knowing this intellectually, Jack retorted that his anxiety had been so high in recent sessions that he simply wanted to forget about the treatment. I again provided psychoeducation about the nature of OCD and how avoidance actually fuels the strength of his anxious thinking. The need for him to “face his fears” through not avoiding was reinforced, and he agreed with this stance, stating that he would try harder to stay awake and reduce his avoiding.

After this discussion my sense was that Jack truly wanted to challenge himself in his treatment but simply could not overcome his fear in completing these highly ranked items on his hierarchy for contamination. After coming into contact with these feared stimuli, Jack estimated that there was a 90% chance he would become extremely ill, fearing for the worst each time. My goal was to continue to provide Jack with these

experiences of exposure, in order to allow for his anxiety to habituate and to provide disconfirming information about his fear of becoming ill. I reasoned that the more he touched the toilet seat and did not become ill, the more he would be able to internalize the new adaptive thought, "Touching a toilet seat won't make me sick." Therefore, I continued to operate under the guise that we would continue completing in-session exposures and hope that on the heels of this recent discussion with Jack, as had occurred in the past, our interventions would prove effective in decreasing Jack's sleep avoidance behavior.

Prior to session #42 my supervisor and I discussed incorporating two new interventions aimed at reducing Jack's ability to avoid ERP tasks.

1. Begin ERP tasks within the first few minutes of the therapy session, in order to cut down on Jack's loquaciousness about unrelated topics.
2. I would stand with Jack the entire therapy session, thus making it clear that sitting back down during the ERP task was unacceptable. This was clearly aimed at keeping Jack awake throughout the exposure.

At the onset of session #42 this was discussed and agreed upon with Jack who seemed motivated with these new interventions in place. We immediately began our exposure task while Jack explained that his anxiety had been higher in the last few weeks (which had become a theme of discussion since he began to increasingly avoid both homework and in-session ERP between sessions 38-44). He was encouraged to stick with the exposure during this session and we would build from there. Despite the immediate start of the exposure, with both Jack and I standing in the therapy room, Jack

still managed to drowse against the therapy room wall. Within minutes of our return from the bathroom to the therapy room, Jack leaned up against the wall, placed his head up against it, and closed his eyes. As I attempted to redirect him to the exposure task by empathizing that I knew this must be difficult for him, while asking him to walk about the room, Jack stated that his legs felt very tired and he wanted to sit. I disallowed this, by again asking him to walk around the room. After some time with his face planted against the therapy room wall, eyes closed, Jack finally walked around the room which was effective in slightly rousing him. However, after just a minute or so of discussion related to the exposure task Jack simply sat down, again complaining of leg fatigue, and quickly fell asleep. He would only awaken when I stated that the session was coming to a close, to which he awoke and spoke to me about musical instruments he had become interested in learning to play.

Session #43 was in many ways a mirror of session #42. Jack and I both stood at the onset of the ERP task, which began at the very beginning of the session but as his anxiety increased he leaned up against the wall with his eyes closed and eventually sat down in his chair and drowsed. Having grown frustrated with his avoidant behavior during the past several sessions, I confronted Jack about this, stating that I wasn't sure what he expected to get out of his treatment if he slept through sessions with me and also did not complete his homework. The connection between his avoidance and the increase in his current anxiety symptoms was highlighted. Jack appeared to agree while falling silent in the session. He stated that he truly wanted to "beat (his) OCD," but didn't know if he could do it. I reminded him about the difficult stretches of sleep



avoidance behavior we had overcome in the past, encouraging him that there was hope in overcoming it, once again, if he worked hard to do so. Jack and I made a pact to work harder during our next session.

Our next session was attended by me, and me alone. Jack was a no show. When I called his mother to ask what had happened, Jack stated that he did not know we had scheduled a session for this week. He and his mother had always been reliable in their attendance of sessions, having never even been late for a session, and thus this was interpreted as avoidant behavior. I was at a loss. It was clear that Jack had made progress in his treatment, but more work was to be done due to his elevated anxiety levels. Jack seemed, however, determined to avoid the exposure work that had proven so effective in reducing his anxiety symptoms in the past. He simply didn't believe he could tolerate such high levels of anxiety whereas I was convinced he could. Some new intervention was needed, as nothing we had devised in the past was presently effective.

During session #44 Jack and I had a rather frank discussion about his treatment progress to date and the impact that his sleep avoidance behavior was having on treatment. He was complimented for developing such an effective avoidant behavior, as this demonstrated creativity and personal strength. Jack was encouraged to use this personal strength to work through facing his largest fears. I acknowledged a need for me to do a better job developing interventions that ran counter to his sleep avoidance behavior, as it was temporarily stalling his therapy. This discussion brought Jack and I to a common understanding about his sleep avoidance and the impact it was having on his symptoms. We once again bonded as a team. He appeared renewed in his motivation

to endure the high levels of anxiety that were required, in order to ultimately decrease his global anxiety and allow for him to effectively manage the anxiety he encounters in his daily life. We then completed an ERP task for germs, while both standing up. Jack stuck with it the entire session. He resisted drowsing when it appeared he might resort to his faithful defense. He made sure to stay clear of his seat and walked around the room as we talked. He jumped up and down when he became increasingly drowsy. In this manner, Jack was able to be a full participant in an exposure task for the first time in over two months. He related being very proud of himself for having not avoided his anxiety and I reinforced him for having done so. It was a joyous and hopeful end to a session for the first time in many weeks.

#### **Phase VII: The Final Efficacious Intervention and Turning Point!**

Between session 44 and 45, I met with my supervisor and discussed this last remarkable session with Jack. It felt as though a turning point for his sleep avoidance might have been upon us, but I wanted to capitalize on what appeared like new found optimism and treatment motivation for Jack. I asked, "What else can we do to stop him from sleeping? Had we tried everything? Could he get any more out of treatment at this point?" In our discussion, my supervisor and I came to the agreement that Jack moving around is what prevented him from drowsing and thus avoiding the ERP task. Jumping up and down in place had proved both effective and ineffective in the past, based on Jack's level of determination to avoid, so we chose not to employ this intervention again. Walking around the therapy room had worked well in our last

session, but I suspected this would run its course sooner or later, with the draw of his chair beckoning Jack to sit throughout our sessions.

Thus the discussion between my supervisor and I moved to a somewhat non-conventional intervention in any therapy; shifting the therapy outside of the therapy room. With the Spring season upon us and with its warmer temperatures, we reasoned that if Jack and I were able to complete the entirety of our exposure tasks outside, while walking the college campus in which our clinic was located, Jack would not be able to utilize his sleep avoidance behavior. Instead he would be asked to touch potentially contaminated surfaces all over campus while eating items, touching his facial orifices, all the while moving about campus with me alongside him as a support.

Despite its unconventionality, I immediately became excited about the potential of this new intervention. It seemed to be the piece we had been missing in all of our interventions targeting Jack's sleep avoidance behavior. How could he fall asleep while walking around campus? Or could he? As the thought entered my mind I wondered how Jack would ultimately sabotage our newly designed intervention, because to date I had been conditioned to believe this would be the case. It turned out, however, that I was simply being too pessimistic.

Session #45 was the first session that I introduced the idea of walking the campus during our exposure tasks, in order to prevent him from sleeping. Jack excitedly agreed that this was a "great idea." We thus planned to incorporate what we called "campus walks" into our sessions, whenever the weather was accommodating.

Beginning with session #45, all of our campus walk ERP sessions began with a brief review of Jack's homework and then we would leave the therapy room, become exposed to a feared stimuli, and walk around the campus discussing content related to the exposure. Our first trial run in this session went seamlessly. At the midway point of our exposure, Jack stated that it was "chilly out" which alerted me to this being a potential red flag for avoidance, but he never stated that he wanted to return to the therapy room due to being cold. Instead, he actively participated in touching potentially contaminated surfaces, in addition to items that were on his designed fear hierarchy. While walking, I introduced my stance that these campus walks could provide the added benefit of generalizing his exposure to feared stimuli and subsequent management of his anxiety. The full habituation of his anxiety provided a natural stopping point in which we agreed we would return to the therapy room. This process would become the recipe for all future campus walk sessions. Once back in the therapy room, Jack stated "that was great," while I agreed and reinforced him, "See, you can tolerate those high levels of anxiety and don't need to avoid by sleeping." He expressed excitement at this new method for dealing with both his anxiety and avoidance of that anxiety.

Our next session together, session #46, was a mirror of session #45. Our campus walk exposure ran extremely smoothly, with Jack at one point stating, "This may sound crazy but I'm actually enjoying being out here despite the exposure." Throughout our walks, I continually asked him to touch any surface I might think he would perceive as contaminated: door knobs, bike racks, soda machine buttons, a random pen, and/or a table coated with remnants of someone's lunch. After touching these objects, Jack

would either rub his mouth or eat a pretzel from the bag of pretzels I had provided him. I too would engage in the exposure, modeling that I was willing to take the risk as well.

On our walk, I engaged him about how he was beginning to generalize his anxiety management skills to the “real world.” For example, I said “If you can touch all of this stuff out here, what can’t you touch!?” Jack fully bought-in-to this process. Walking around campus appeared to change his view of our therapy, as treatment that was solely done in the clinic, to skills he could engage with in his real world setting. It felt to me that a major turning point was occurring, and thus I became very motivated myself to continue these campus walk exposures.

Session #47 came after Jack had gone on a family vacation to Disney World. In the past, Jack had shared with me that a trip to Disney had been impossible for him due to all of his fears about germs and him being filmed by the many security cameras. I believed that whatever reaction he had to the amusement park on this occasion would be a noteworthy qualitative measure for the progress of his anxiety symptoms. In fact, Jack stated, “I had no issues at all.” When I asked specifically about his reaction to the cameras and contaminated surfaces at Disney he responded, “It wasn’t a big deal.” I then engaged Jack in a comparative discussion regarding his experience at Disney World this time around versus his last trip there two years ago (at the beginning of our treatment together). He was shocked at how much of a difference there was in his anxiety symptoms and credited his treatment for this shift. Jack appeared extremely proud of himself, as I stated that he had worked very hard to get to this point. He expressed further motivation to continue working on his anxiety, especially now that we

had “solved the sleep thing.” From this, Jack and I completed another campus walk exposure with no issues.

Remarkably, between sessions 45 and 57 Jack completed campus walk exposures that consisted of a rapid climbing through his fear hierarchy for contamination. Because he was not able to avoid these exposures, by virtue of our being outside walking which negated the possibility of his use of sleep avoidance behavior, Jack was able to experience full habituation of his anxiety, while also acquiring disconfirming information related to his anxious maladaptive thoughts. The higher he went up his fear hierarchy and the more surfaces he touched without becoming ill, the less anxious Jack became. Likewise, the easier these exposure tasks became for him. During this time, Jack walked around the campus and without my cueing him he would identify surfaces that he believed would make him anxious and say, “Hey, let’s go touch that... I’m hungry for a pretzel.” In part, Jack appeared to be mocking the very anxiety that had restricted him for so long.

By the time session #50 occurred, Jack was in a mode where he always looked to challenge himself. For example, I suggested that we do the second to highest item on his fear hierarchy for germs and he responded in agreement, but also suggested that we incorporate the top fear on the hierarchy into the exposure exercise. These two exposures consisted of “touching a toilet seat” and “touching a fly.” When Jack originally placed these on his fear hierarchy he stated, “I’ll put those on there but I’m never going to do them.” Now he was excited to push himself to successfully complete these ERPs and did so gradually in this session, by touching the toilet seat and carrying

around a dead fly in a plastic bag, while examining it. This was also true as it related to his homework completion, in that he now often suggested that he do more than I was asking him to do. I was feeling that Jack's treatment motivation was "through the roof."

In a landmark moment for his treatment, during session #52 Jack performed the top item on his fear hierarchy, directly touching a dead fly. (Yes, we had a dead fly present in the room for this exposure). As we began the ERP, Jack stated that he wanted to conduct the session in the therapy room, as he didn't believe he needed to walk around the campus any longer in order to keep from sleeping. His request was granted and framed as a further challenge to himself. Jack passed this test for himself with flying colors. Not only did he touch the fly, but he did not become drowsy despite the provocative discussion regarding contamination which followed. After touching the fly he stated, "Wow that wasn't nearly as gross as I thought it would be."

After returning for session #53, without having become ill, Jack's fear of flies seemed to dissipate rather quickly. During our exposure with the fly in this session, Jack appeared much less bothered by the fly and touched it with much more ease, despite noting "I still won't go around touching these things, but if I had to swat it off of me I think I could do that now without going ballistic." During this session, his anxiety reached a level of 10 but habituated much more quickly than had been the case in the past. This trend would continue for the remainder of our exposures for contamination.

The exposure with the fly in session #54 demonstrated a sharp decrease in Jack's anxiety, as it related to the flies in that he rated his fear of them at a 2. This was incredibly significant, as he had initially rated this as a "14" out of 10 when we created

the fear hierarchy for contamination, saying, "They are the vilest creatures... so filthy!" As we spoke during the exposure task for this session Jack related, "Now I have a 'functional fear' of things. I have learned that it is ok to fear things but that doesn't mean I have to run from it. I can go directly at whatever that fear is and my anxiety will go away. I don't have to avoid or knock/tap to get rid of it."

It had been a long road to this point but Jack's statements were suggestive of a major shift in his thinking and perspective as it related to his anxiety symptoms. He seemed to have made major strides toward a more "functional fear" of the stimuli he confronted in his environments, instead of a debilitating fear which restricted him from functioning in the ways he desired. The remainder of our treatment proper sessions that incorporated ERP (the last of which was session #58), Jack continued to complete the entirety of his fear hierarchy for contamination, while walking around campus because he enjoyed it so much. During each session, as we walked, we discussed how his treatment generalized to real world settings. Through these campus walk exposures Jack learned the crucial lesson that no matter how intense his anxiety became he did not need to avoid it. He could face it directly and allow his anxiety to habituate. Because he ceased avoiding through sleep behavior, Jack was also able to internalize critical disconfirming information, which changed his perception about how dangerous the world around him was. Ultimately, Jack's fear became much more normative and in his words "functional."

In addition to the direct impact on his management of his anxiety symptoms, Jack also spoke about ancillary benefits he had experienced. These included an increase



in his self-esteem and a more optimistic perspective on life. In the past he had said that due to his obsessions about spirituality and damnation he had “hated” many different groups of people, whom he saw as living wrong morally, but now he believed each person should live their life as they saw fit, based on their own values and morals. Quite simply, Jack said “I’m free!” When I asked what he meant by that, he stated, “OCD doesn’t boss me around anymore. I can live my life the way I want to and do the things I want to do, when I want to do them. That wasn’t possible before.” As he talked, we were both transported back to our earliest sessions together, as he stated, “Whoa, do you remember what it was like for me back then? I couldn’t do anything. I came in here freaking out about the video camera, the germs on the door, chairs, and table in here. I remember not even wanting to touch your pen that you handed me to sign the consent form. Everything bothered me back then.”

#### **Phase VIII: Relapse Prevention (sessions 58-62)**

Jack had made tremendous progress during his CBT with ERP treatment, over the course of a two-year span with me. His anxiety symptoms had been assessed to plateau during the most recent 6-month span, and he had become quite adept at completing exposure tasks on his own. When his anxiety did arise, Jack stated that it was manageable and that he no longer felt hindered by his symptoms. He was now able to function freely in his world. Due to this progress, it was collaboratively decided that treatment would be terminated over the course of four final sessions.

During these last four sessions, we conducted a thorough review of his treatment process and progress. In this, we discussed psychoeducation material about

OCD, my formulation of his disorder, and the theory supporting our treatment protocol. Jack and I spoke at length about how his avoidant safety behaviors negatively impacted his treatment progress at different stages of our therapy together. My goal here was to drive home the point that avoidance works to fortify anxious thinking and thus strengthens his experience of OCD symptoms. Jack was bought in and agreed that going forward he would try his hardest at facing his fears as they arose, in order to avoid a future reemergence of his OCD symptoms.

During our relapse prevention phase, Jack again went through Wagner's (2005) treatment protocol handbook and reviewed each step to the treatment, including the cognitive triad. Each skill that he had learned throughout the therapy was reinforced as methods in which he can effectively manage his anxiety when it arises in the future. Jack also asked me for print-outs of forms we had utilized in the treatment, which he said he would keep somewhere safe for future reference as needed.

Lastly, prior to our last session, Jack asked if I thought meditation could help him manage his anxiety, to which I responded in the positive. Our last session together was thus devoted to teaching Jack both diaphragmatic breathing and meditation techniques. He seemed to enjoy it as we practiced these in session and stated that he would begin using these immediately.

Importantly, in our relapse prevention phase, Jack and I discussed post-treatment expectations. He was educated about the potential waxing and waning course that OCD might take throughout the rest of his life. The good news, however, he was told, was that the treatment he had just completed would provide him with all of

the tools necessary to combat any future obsessions or compulsions that might reemerge. He appeared to take confidence in this message, despite expressing annoyance with having to continually cope and resist against his OCD and TS symptoms.

Throughout our treatment, Jack mostly presented with either no tics or just a mild eye-blinking tic, which continued at the time of termination. However, during these last few sessions together, Jack and his mother raised the issue of potential behavioral treatment for his tic. However, upon receiving psychoeducation from me about the Habit Reversal Training therapy that our clinic provided, both Jack and his mother decided that they would not pursue this treatment at that time, due to the mild nature of his tics. They were encouraged to return to our clinic if they changed their minds, or if the severity of Jack's tics increased.

After having worked together for nearly two years, saying goodbye was difficult for all of us. I expressed gratitude for Jack having stuck with his treatment and for challenging himself, despite how difficult it was for him. I also stated that I appreciated how much he taught me about himself and his disorder. Both Jack and his mother related how much our treatment meant to them, as it had such a positive impact on the entirety of Jack's life. It was a very warm and heart-felt farewell. As our final session came to completion, I requested that I meet with the family for a 3-month follow-up session, to which Jack and his mother responded with joy saying, "I'm so happy that we'll get to see you again and this isn't it." I responded in kind, stating that I'd be looking forward to seeing how Jack was doing in 3 months.

## CHAPTER VII

### **Therapy Monitoring and Use of Feedback Information**

My treatment with Jack was continuously monitored on a weekly basis, through one-on-one supervision with my direct supervisor. During supervision meetings I would provide a full recap of the prior session with Jack, which led to a rich discussion between my supervisor and me. This entailed an analysis of Jack's treatment needs and often the development of individualized interventions aimed at providing him with the best possible treatment. I also made DVD recordings of several sessions, which I utilized in a detailed analysis of Jack's sleep safety behavior during in-session exposure tasks. These were discussed with my supervisors and led to the creation of novel interventions. Overall, this type of supervision allowed for the development of a fluid and individualized treatment plan, which met Jack's unique needs at each step of our therapy.

I also had the opportunity to present Jack's case to the Tourette's Syndrome clinic's treatment team, which included both clinical supervisors, as well as, other practicum students. This experience was incredibly helpful, in that as the case was reviewed, I was provided with thought-provoking feedback from the team, which led to the further development of novel interventions when Jack's treatment progress had appeared to stall, due to his use of sleep safety behavior.

Additionally, two psychometric measures were utilized to track Jack's symptoms during his treatment, the *Children's Yale-Brown Obsessive Compulsive Scale* (CY-BOCS) and the *Yale Global Tic Severity Scale* (YGTSS). Most notably, the CY-BOCS was

administered at the beginning, the mid-point, at termination, and at 3-month follow-up of treatment. This provided me with a barometer of Jack's OCD symptoms at critical points in our therapy. From these scores, I was able to provide Jack with feedback that made clear the impact his participation in treatment was having on his symptoms. The YGTSS was administered at the beginning of treatment and near the end, in order to assess if his tic symptoms had changed in any discernible manner. Because Jack's YGTSS score did not change during our treatment it was confirmed that his TS symptoms would not be the focus of treatment.

## CHAPTER VIII

**Concluding Evaluation of the Therapy's Process and Outcome****The Outcome of Jack's Therapy**

Jack's treatment progress was slow but steady and eventually resulted in a positive outcome. This is supported by both quantitative and qualitative data, which is detailed below. Jack's increasing ability to cease avoiding exposure to anxiety provoking stimuli over the course of his treatment provided a good indicator of his progress. As he gradually refrained from utilizing safety behaviors during ERP sessions, Jack began to demonstrate an ability and willingness to challenge himself within exposure tasks, pushing himself past what he once perceived were his limits. This trend resulted in a significant decrease in Jack's anxiety and also an improved functionality in academic and social realms.

**Quantitative results.** Table 1 depicts Jack's scores on repeated measures of the *Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS)*. At onset of treatment, Jack's total CY-BOCS score was 37, which placed him in the upper "extreme" range. The extreme range (32-40) encapsulates the highest range of scores on the CY-BOCS. Of note, by our 36<sup>th</sup> session together Jack's total CY-BOCS score had significantly decreased to the lower "moderate" range of symptoms with a score of 16. In fact, this was the same score that Jack was assessed to score upon re-administration of the CY-BOCS at the end of treatment (session 56 = score of 16).

At his three-month post-treatment follow-up session, Jack's score had further decreased to a 10, placing him in the "mild" range of symptoms. This score

demonstrates that Jack's achieved treatment gains were maintained and built upon after our treatment together was completed.

**Qualitative results.** Considering both the quantitative and qualitative data which has been discussed above, I believe that through his treatment Jack was able to meet all of the treatment goals which were defined early on in the treatment process and presented in this text within the treatment plan in Chapter V. They were as follows:

*GOAL 1: To develop and maintain a positive therapeutic bond*

*GOAL 2: Build Jack's motivation for treatment*

*GOAL 3: Cognitive restructuring of Jack's maladaptive and erroneous beliefs*

*GOAL 4: Gradually expose Jack to feared stimuli*

*GOAL 5: Decrease or eliminate Jack's avoidance behavior (including safety behaviors)*

*GOAL 6: Have Jack take responsibility of his treatment progress*

*GOAL 7: To encourage Jack to go beyond his perceived limits in facing his fears*

*Goal 8: To decrease Jack's experience of anxiety*

*Goal 9: To increase Jack's flexibility in responding to his environments*

In association with Jack having met these treatment goals he experienced many improvements in his daily life. The following are some examples:

- Jack no longer concerned himself with damnation or his offending of religious objects. He became much more of an independent thinker as it related to his own morals and that of others. This was a significant shift from his presentation at the start of our treatment, in that he often voiced concern that he "was going to Hell" or his abhorrence of others who behaved in what he perceived to be an

amoral manner. He stated, "I don't think about religion at all now actually and believe people should do what makes them happy. That's not my business to worry about."

- Jack also entered treatment with an intense fear of becoming ill due to contamination. As a result of his treatment however, Jack no longer feared coming into contact with common environmental surfaces. He proudly reported, "Now when I eat lunch at school I don't have to think about what things I touched all day or if I should go wash my hands a bunch of times before eating." Jack functioned in much more of a normalized and autonomous fashion, instead of in the restricted manner that had been the case in the past.
- Another of Jack's fears that proved quite disruptive to his social and family life, was his fear of being videotaped in public spaces. Anecdotally, early on in his therapy Jack had shared a story about his having to run out of an amusement park that his family was visiting after he became obsessed with the video cameras everywhere. After several months of treatment, however, Jack and his family returned to the same amusement park and upon my inquiry about how he felt about the trip he said, "It was a great time." Because he seemed oblivious as to why I had asked, I then directly questioned him about his experience of the video cameras to which he responded, "Oh yea *that*. It didn't even occur to me when I was there. That doesn't bother me anymore."
- Due to his newfound ability to engage with his world in a freer fashion, Jack reported that he was making many more friends, whom he was very fond of. He



enjoyed spending time with his friends on a daily basis and no longer consumed himself with the morality of their actions. He simply allowed himself to be happy and enjoy his time with them.

- When bad things did happen around him in the past, Jack had a very difficult time coping with the event. This was no longer true, as he seemed capable of processing the negative event, but was now able to let it go more quickly. This is in stark contrast to his having obsessed over negative events for several days or weeks in the past.
- At the beginning of treatment, Jack reported that he was completing compulsive rituals (knocking or tapping) at the rate of 750 times per day. At the end of treatment, he stated that on many days he was not ritualizing at all and on days that were more difficult he had caught himself knocking “about 10 times per day.” He also stated that he rarely found himself obsessing about one topic, as he had become better at identifying these types of thoughts and redirecting his cognitive attention elsewhere.

Overall, Jack made tremendous progress while in treatment for his OCD symptoms. I believed him when during our last session, prior to the 3-month follow-up session, he stated, “I’m a completely different person now.” This sentiment was a testament to both the intense hold his OCD symptoms had on Jack prior to our treatment and how free Jack felt once his anxiety symptoms began to wane. Because OCD no longer governed his every behavior and decision, Jack was able to live a full and more rewarding life in which he was able to obtain an increasing amount of reinforcers.

This led to his experiencing an increase in self-esteem, more rewarding social relationships, and an overall happier life.

These positive outcomes appeared to have been maintained based on Jack's report during the 3-month follow-up session. During this session, Jack stated that he had continued to experience an overall more positive mood and was happy with his life. In fact, Jack was proud to share with me that due to his being less socially restricted by his OCD, he had met and fallen in-love with a young lady at his school. As it directly related to his OCD symptoms, Jack reported that he experienced much more control over his symptoms than ever before, as he was able to "resist obsessive thoughts all the time." Overall, Jack stated that his attention is very infrequently focused on his fears.

#### **Discussion of the Broader Issues Raised by Jack's Case**

As I treated Jack's case, several confounds to the treatment process arose. In seeking guidance from the literature, I realized that most of the available literature regarding the use of CBT with ERP has been provided by those conducting randomized control trials (RCT). In their quest to "nail down" quantifiable and objective truths about human behavior during the era of modernism, many psychologists and other social scientists have come to uncritically accept the results of quantitative, group, positivist research as the gold standard in coming to "know" about an individual's psychology. The randomized controlled trial (RCT) model has come into power and dominates how an individual's psychology is understood and treated by psychologist the world over. It is from these RCT's that manualized treatments, much like the one utilized in Jack's treatment, are informed and designed. However, much is left to be desired for the

therapist who is charged with treating a client that is impacted upon by various complex systems and contexts. In this case, I found a more postmodern approach to treatment is necessary. Such an approach incorporates an understanding that each client's psychological make-up is constructed and reconstructed through their ongoing experiences in the world. In this case, the application of a step-by-step "cookie-cutter" manual to treatment misses the complex nature of a client's psychopathology. In such "missing" it can easily be argued that the client receives a square peg of treatment where square, circle, and triangle pegs are required.

In his text, *The Case for Pragmatic Psychology*, Fishman states the following:

In contemporary American psychology, psychological practitioners are beleaguered, caught between two unattractive alternatives. If they attempt to follow the applied science model and base their actions on the scientific literature, they do not receive relevant and effective substantive guidance for dealing with the context-specific complexities of the individual case. On the other hand, if practitioners follow the disciplined inquiry, reflection-in-action model, they are accused of not being "science-based" by politically and academically dominant, positivist researchers (Fishman, 1999, p. 13).

As a solution to this quandary Fishman calls for a joining of constructs from the two models' designs. He states, the (postmodern) pragmatic paradigm in psychology seeks to develop an integrative approach in combining the epistemological insights and value awareness of skeptical, critical, and ontological postmodernism with the methodological and conceptual achievements of the positivist paradigm (Fishman,

1999). It is thus suggested that in adopting components from both modern and postmodern methods for studying human psychology that we will gain enhanced understandings of our client's psychopathology and incorporate this into our treatment. It is clear that the resulting body of treatment afforded one's client would more closely address each client's specific needs and thus more efficacious treatment is projected.

The tool which Fishman puts forth to achieve the above integrated method is the pragmatic case study approach. This approach dictates a systematic review and analysis of a client's treatment, which incorporates both positivist quantitative data, as well as, postmodern-related qualitative data from treatment sessions. It is this exact approach that I adopted in the present review and analysis of Jack's case. The pragmatic case study approach fit well in my analysis of Jack's treatment, being that our therapy required divergences from the treatment manual, due to Jack's presentation of sleep safety behaviors that functioned as his avoidance of exposures to anxiety. As depicted above, due to this safety behavior, I had to make several detours from the manualized treatment protocol in order to take a more postmodern approach to understanding and treating the symptoms that were specific to Jack alone.

Ultimately, I would have found it incredibly useful and efficient had I been able to consult a database of past case studies, which referenced the confound of in-session sleep behavior. A report which outlined a clinician's experience with such a client and the methods utilized to overcome sleep behavior would have been invaluable to me in Jack's treatment process. An exhaustive search of RCT-based literature made no mention of such a confound, thus I was left to my own devices (with the support of my

supervisor) to continually assess Jack's sleep, clearly define the function of the behavior, and repeatedly develop interventions which addressed it. Likewise, the field of psychology would greatly benefit from an increased number of published pragmatic case study papers, which may provide clinicians with scientific literature available for reference when treatments with clients experience stalls, resistance to progress, and/or confounds which may ultimately lead to premature treatment terminations.

### **Lessons Learned about CBT with ERP with Clients Demonstrating Confounding**

#### **Sleep Safety Behavior**

Having a client fall asleep in session would certainly prove to be a confound to any therapy. I found this especially true in Jack's case, due to the severity of his OCD symptoms along with my desire to guide him toward a positive outcome. One initial lesson that occurs to me now, in retrospect, is the need for an accurate identification of the client's confounding behavior. In Jack's case, I simply was not clear about the true nature of his in-session sleeping for several sessions. Part of me believed his excuses of being fatigued, not having slept enough the night before, not having drank his usual caffeinated beverage on the way to the session, etc. An accurate functional analysis, which was later completed, would have more quickly provided me and my supervisor with the understanding that Jack's sleep behavior was in fact aimed at avoiding exposure to anxiety. This of course would have allowed us to more swiftly develop effective interventions targeting his sleep behavior, thus not allowing Jack to develop a routine of sleeping during our sessions. Because this behavioral routine had become

established early in the treatment process, it became more difficult to shift Jack away from this later in the treatment process, while shaping new behavioral expectancies.

Despite this lag, the ability to approach Jack's case via an individualized case formulation and treatment plan was critical, in that it allowed for the ongoing development of necessary interventions to negate Jack's in-session sleeping, while allowing him to experience the benefits of ERP. Within this experience, I learned that an intervention's effectiveness can wane at any moment, regardless of it having been carefully developed to meet a specific client's needs and/or how much success may have been achieved with its use in the past. In these situations a clinician must be active in developing new techniques to address the reemerging treatment issue. As illustrated above, this was certainly the case in Jack's treatment.

A crucial element of Jack's treatment was our shifting the ERP experience from inside the therapy room to outside the clinic walls. Walking around the campus in which our clinic resides not only voided Jack's use of sleep as an avoidant defense but also worked to generalize his treatment gains and the corrective learning experience to the real world. This then provided a context in which Jack was able to conduct his own exposure exercises in his "real world" (i.e. eating lunch at school without washing his hands). Our campus walk exposures also removed some of the stigma of his being in therapy, as he rather enjoyed walking around a college campus, as this was something he aspired to. It is also possible that his weekly anticipation of our "outside" ERP tasks actually increased his motivation in treatment and led to further treatment gains. I

don't believe enough can be said about the powerful impact that these walks had on reducing Jack's anxiety.

Lastly, Jack's treatment taught me a great deal about the importance of building and maintaining a positive therapeutic relationship with clients in CBT with ERP treatment for OCD. If I would have neglected to focus on the development of a relationship built on trust, I don't imagine Jack would have allowed me to challenge him in his therapy, especially when it became more difficult for him with exposure tasks. We jointly relied on our therapeutic relationship to provide a stable base for Jack to propel himself from when taking such great-perceived risks in ERP tasks. Clearly, his ability to become a full participant in weekly exposure experiences led to his rather significant treatment gains. It can be argued that this was only made possible due to our collaborative work in first developing and then maintaining our therapeutic bond over the course of 63 sessions.

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Table 1

Jack's Scores: Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS)**Name:** Jack

	PRE	MID	POST	3-month Follow-up
Overall CY-BOCS score	37	16	16	10
Range of severity	Extreme	Moderate	Moderate	Mild

\*Total CY-BOCS score ranges of severity groupings for patients who have both obsessions and compulsions are as follows: 0-7 (subclinical), 8-15 (Mild), 16-23 (Moderate), 24-31 (Severe), 32-40 (Extreme)

Table 2

Jack's Scores: Yale Global Tic Severity Scale (YGTSS)**Name:** Jack

	PRE	Post	3-month Follow-up
Tic Impairment Score	10	10	10
Range of severity	Minimal	Minimal	Minimal

Table 3

Jack's Diagnosis at Beginning and End of Treatment

	DSM-IV Diagnosis at Beginning of Therapy		DSM-IV Diagnosis at End of Therapy	
Axis I	300.3	Obsessive-Compulsive Disorder	300.3	Obsessive-Compulsive Disorder
Axis II	V71.09	No diagnosis	V71.09	No diagnosis
Axis III		None		None
Axis IV		Strained relationship with parents, academic difficulties, difficulty making new friends		Strained relationship with parents
Axis V		GAF = 45		GAF = 80

Table 4

Fear Ladder: Global

Name: Jack

<b>Fear Topic: Various</b>	
<b>Things I'm afraid to do</b>	<b>Fear Rating (0-10)</b>
Damnation	10
Contamination/Becoming ill	10
Being videotaped	9
Fear of hurt coming to others	8
Fear of hurt coming to self	8

Table 5

Fear Ladder: Damnation

Name: Jack

<b>Fear Topic: Damnation, Spirituality, Hell</b>	
<b>Things I'm afraid to do</b>	<b>Fear Rating (0-10)</b>
Blaspheming the Holy Spirit	10
Praising Satan	10
General Blasphemy	10
Ripping up The Cross	10
Stepping on the Cross	10
Hanging the Cross upside down	10
Tell someone to go to Hell	8
Someone tell me to go to Hell	8

Table 6

Fear Ladder: Contamination

Name: Jack

<b>Fear Topic:</b> Contamination and becoming ill			
<b>Things I'm afraid to do</b>	<b>Session #20 Fear Rating (0-10)</b>	<b>Session #50 Fear Rating (0-10)</b>	<b>Session #55 Fear Rating (0-10)</b>
Touch a fly	14-15	8	7
Touch toilet seat	12-13	7	6
Touch toilet flusher handle	12	7	3
Eat something after touching a 9-10 item	11	4	4
Touching a trashcan	10	6	4
Using a public bathroom	9	7	6
Touching public salt & pepper shakers	9	4	2
Touch a shopping cart	9	7	5
Touch outside railing	9	4	4
Touch window handle	9	1	2
Touch dirty fork Jack randomly found	8	3	2
Touch light switch	7	1	1
Touch wall	4	1	1
Touch Door	4	2	1