A Case Study of a Woman with Obsessions Related to COVID-19

An Empirically Supported Treatment Case Study
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By

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Abstract

The following is a de-identified case study that presents the assessment, diagnosis, and treatment of Obsessive Compulsive Disorder (OCD) during the COVID-19 pandemic utilizing Exposure and Response Prevention (ERP) provided via telehealth. To protect the client’s anonymity, names and other identifying details have been changed. When she presented for treatment, this 32 year-old Asian female, was struggling to manage OCD contamination and harm fears related to COVID-19. She was assessed with a general history interview, the Mini-International Neuropsychiatric Interview (MINI 7.0), the Yale Brown Obsessive Compulsive Scale (Y-BOCS), and a battery of self-report assessments. Jodie’s primary diagnosis was OCD with a secondary diagnosis of Persistent Depressive Disorder. Over the course of seven months, this client attended 24 ERP treatment sessions. Psychoeducation, self-monitoring, in-vivo and imaginal exposures, response prevention, and behavioral activation strategies were utilized throughout the course of treatment. Following treatment, this client was successfully managing symptoms and her scores on the Y-BOCS had decreased significantly.
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Obsessive Compulsive Disorder (OCD) is characterized by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) as the experience of clinically significant obsessions and/or compulsions. Obsessions are recurrent, distressing, intrusive thoughts, urges, or images the individual attempts to suppress or ignore. Compulsions are repetitive behaviors or mental acts an individual feels driven to perform in order to reduce anxiety or prevent a feared outcome. Compulsions are typically performed in response to an obsession in an effort to reduce the distress triggered by the obsession. To meet DSM-5 criteria, individuals must also spend significant time engaging in obsessions and/or compulsions, and experience considerable distress and/or related impairment in social, occupational, or other important areas of functioning.

While the presence of both obsessions and compulsions is not required for a diagnosis, most individuals with OCD experience both. In one study, adults with OCD were evaluated using the Yale Brown Obsessive Compulsive Scale checklist (Y-BOCS; Goodman et al., 1989). Of the 431 participants assessed, 96% had both obsessions and compulsions and just 2% were identified as having predominantly obsessions (Foa et al., 1995). Recent literature suggests that due to past research incorrectly omitting mental rituals and reassurance seeking as compulsive behaviors, “pure obsessional types” do not actually exist (Williams et al., 2011). That is, when mental rituals and reassurance seeking were included as compulsions, there were no OCD individuals (Y-BOCS ≥ 16) without an identifiable compulsion found in this sample.

The World Health Organization (2001) ranked OCD as one of the most debilitating mental health disorders, placing OCD among the top 20 causes of illness-related disability for people ages 15 to 44 years. OCD is a severe and chronic disorder often associated with
significant functional impairment and commonly leads to distress and interference in academic, occupational, social, leisure, or family functioning (Jacoby et al., 2014). OCD is also associated with broad impairments in executive functioning including disruptions encoding information, difficulties switching between tasks, and challenges with behavioral inhibition (Snyder et al., 2015). In the National Comorbidity Survey, a sample of 2,073 individuals with lifetime OCD estimated spending an average of 5.9 hours per day occupied by obsessions and an average of 4.6 hours per day engaging in compulsions (Ruscio et al., 2010). In addition, 90% of OCD sufferers also had a comorbid diagnosis, most commonly some other form of anxiety disorder, followed by mood, impulse control, and substance use disorders.

In the United States, the estimated 12-month prevalence of OCD is approximately 1.2%, with estimates of lifetime prevalence ranging from 1.9 to 3.3% (Coles et al., 2018; Ruscio et al., 2010). Research suggests age at onset (AAO) is an important factor for predicting the clinical course of the disorder. Earlier age of onset is associated with higher rates of comorbid tic disorders, family-history of OCD, and higher Y-BOCS severity ratings (Sharma et al., 2015; Taylor, 2011). However, there is a lack of consensus on a clear definition of AAO in regard to what constitutes the beginning of OCD symptoms as well as what should be considered a threshold for ‘adult-onset’ phenotypes (Dell’Osso et al., 2016). In a recent epidemiological study consisting of 431 OCD individuals, 57% reported onset prior to age 18. Additionally, AAO for OCD has been observed as a bimodal distribution, with peaks occurring around age 14 and then again in early adulthood (Dell’Osso et al., 2016; Rasmussen & Tsuang, 1986).

OCD occurs equally in males and females, but gender differences related to AAO have been noted in the literature. Males are more commonly affected in childhood (with 25% of cases occurring prior to age 10). Females tend to experience a later onset and are affected at a higher
rate during adulthood (APA, 2013; Ruscio et al., 2010). One multinational epidemiological study discovered significant gender differences between pre-adult (<18) and adult onset groups (≥ 18). While females accounted for 49% and males 51% of pre-adult onset cases, the gender ratio for adulthood onset was 66.8% females to 33.2% males ($\chi^2 = 10.9, p < 0.001$). Additional analyses revealed further gender disparity when age of onset was ≥ 40. Of the 18 patients (4% of the total sample) who experienced later adulthood onset, 15 (83%) were female (Dell’Osso et al., 2016).

Theoretical Foundations of Obsessive Compulsive Disorder

The clinical presentation of OCD can be complex (Mataix-Cols et al., 2005). Due to the variable presentation of symptoms and a broad range of comorbidities, the disorder is frequently characterized as a heterogeneous condition (Markarian et al., 2010; Ruscio et al., 2010). Since OCD’s initial appearance in the DSM-III (APA, 1980), the etiology, maintenance, and mechanisms of treatment for OCD have been conceptualized within several models.

Behavioral Component of Obsessive Compulsive Disorder

Early models conceptualized OCD from a behavioral perspective. Mowrer’s two-factor theory (1960) suggested OCD is acquired through classical conditioning, and the primary mechanism responsible for maintaining symptoms is negative reinforcement. The classical conditioning model of OCD suggests a stimulus which naturally provokes anxiety and/or disgust (e.g., an unconditioned stimulus such as bodily fluids) has been paired and is therefore now associated with an experience or thought that is otherwise inherently harmless (e.g., a conditioned stimulus such as a light switch). Once this association has been established, the individual will continue to experience the unconditioned response (e.g., anxiety/disgust) when interacting with the previously neutral stimulus (e.g., a light switch). Thereby, the anxiety related
symptoms now also serve as the conditioned response (e.g. anxiety when touching the light switch due to an association with bodily fluids).

Operant conditioning served an important role in early understanding of the maintenance of conditioned fears (Mowrer, 1960). In an effort to escape the feelings of discomfort associated with the obsession, individuals engage in a ritual or compulsive behavior (e.g., handwashing). Enacting the compulsive behavior typically leads to a reduction of anxiety, which serves to negatively reinforce the compulsion. However, the relief is only short-term. The compulsive behavior is likely to be repeated the next time the individual experiences anxiety/discomfort elicited by the obsession because the individual has learned that doing so leads to relief from discomfort. The negative reinforcement mechanism strengthens the association between the obsession and the compulsion, with the Law of Effect (Thorndike, 1905) predicting that the obsession-to-compulsion sequence will occur more often, and possibly with a longer duration and greater intensity in the future. Extinction of the anxiety/fear response does not occur because the reinforcing stimulus-response-consequence sequence is rarely if ever disrupted. Therefore, the individual is precluded from the opportunity to realize the obsessive thought is not inherently dangerous, the compulsive behavior is not required to reduce the anxiety/fear response, nor does it prevent the feared outcome from occurring.

From the perspective of early conditioning models, exposure treatment was understood in the context of systematic desensitization and emphasized Pavlovian extinction learning (e.g., repeated exposure to the feared conditioned stimulus in the absence of the aversive unconditioned stimulus; Craske, et al., 2012). Individuals were encouraged to systematically face fears of increasing difficulty while using relaxation (reciprocal inhibition) in an effort to weaken the relationship between the stimulus and the anxiety response. However, early trials of exposure
found treatment to be equally effective regardless of the inclusion of relaxation training. Additionally, many individuals with OCD do not appear to have a history of conditioning experiences that would explain obsessional fears (Taylor et al., 2007). Although conditioning models contributed to the development of effective treatment approaches for OCD such as ERP, the mechanism of treatment and etiology of the disorder is no longer understood purely from a conditioning perspective and does not include relaxation training (Foa & Mclean, 2016).

Behavioral models of OCD were further explored by Foa and Kozak (1986) within emotional processing theory. Emotional processing theory suggests the presence of two fear structures: a normal/adaptive structure and a pathological/maladaptive structure. Among adaptive structures, learned associations are based in reality and feared stimuli are inherently dangerous. For example, an individual knows falling from a great height is dangerous, so being near a cliff activates the fear structure, which in turn leads to the adaptive response of moving away from the edge. In contrast, maladaptive structures are not based in reality and contain associations that lead to avoidance of safe stimuli. These maladaptive structures are characteristic of anxiety disorders (Foa & Kozack, 1986; Foa et al., 2006). For an individual with OCD, contact with a door handle in a public restroom may mean exposure to a deadly illness; therefore, touching the handle activates the fear structure, leading to significant anxiety, and perhaps a maladaptive response such as avoiding public restrooms or compulsive handwashing.

From the perspective of emotional processing theory, effective treatment would consist of activation of the maladaptive fear structures through exposure, so inaccurate meanings regarding danger can be corrected. Emotional processing theory also places emphasis on within and between-session habituation (fear reduction) (Arch & Abramowitz, 2015; Foa et al., 2006). Foa and colleagues (1986) suggest that habituation leads to the modification of memory structures
and results in extinction of conditioned fear as well as elimination of previously learned anxiety responses and compulsive behaviors to obsessional stimuli. Essentially, the anxiety no longer occurs or is more manageable, so the individual is able to resist engaging in the avoidance or compulsion that once served to reduce and maintain anxiety. However, recent research has revealed these basic assumptions; specifically the emphasis on habituation, are not well supported (Craske et al., 2008, 2012). In fact, successful habituation often fails to predict long-term outcomes, and successful outcomes can occur in the absence of habituation (Arch & Abramowitz, 2015; Craske et al., 2008).

Pavlonian conditioning models and the emotional processing theory contributed to the development of effective treatment approaches for OCD, such as ERP. However, these theories do not fully explain the etiology, maintenance, or mechanisms of treatment for the disorder. The discovery of the limitations of these models prompted researchers to continue to pursue alternative conceptualizations of etiology and maintenance within the inhibitory learning model.

**Treatment of OCD: Mechanisms of Exposure and Response Prevention**

ERP remains the most empirically supported treatment for OCD (Berman et al. 2017; Mckay et al., 2015; Rector et al., 2019). ERP was originally developed from learning theory and emotional processing theory (Foa & Kozak, 1986; Foa et al., 2006). However, more recent literature suggests the mechanism of exposure and response prevention is best conceptualized within the inhibitory learning model.

The inhibitory learning model has enhanced understanding about the formation and extinction of associations. These advances are incredibly relevant for enhancing the effectiveness of exposure therapy for individuals with anxiety disorders, who are thought to have deficits in inhibitory learning (Craske et al., 2012). The inhibitory learning model differs from early
behavioral models, as it does not claim that feared associations (CS – US) are erased or extinguished. Rather, secondary inhibitory learning about the CS-US relationship develops. More specifically, after exposure, the CS possesses two meanings: a new inhibitory meaning (CS-no US) and the original excitatory association (CS-US). Acquisition of this new inhibitory meaning does not extinguish the original excitatory association; rather, they coexist. For example, an individual with OCD may enter treatment with the learned association that touching a railing is dangerous (e.g., will cause illness). Engaging in exposures designed to violate threat expectancies does not eliminate this association but allows for the development of a new non-threatening association (e.g., touching railings is unlikely to cause illness). The original association is not unlearned, but inhibited. Through exposure and response prevention, new learning occurs and a non-distressing expectation is developed (Law & Boisseau, 2019).

Not only does the inhibitory learning model inform understanding of how new learning occurs throughout exposures, but also has practical clinical implications for designing effective exposures. Exposures can be carefully designed to maximize effectiveness and generalizability. Craske and colleagues (2012) described several techniques for maximizing exposures such as: 1) designing exposure trials so they disconfirm expectancies; 2) varying stimuli, duration, and intensity of the exposure; and 3) maintaining high levels of fear throughout exposure by eliminating safety behaviors. Within this model, habituation during in-session exposures is not emphasized.

Abramowitz and colleagues (2011) described three types of exposures: in vivo (real-life) exposure, imaginal exposure, and interoceptive exposure. Research suggests improved treatment outcomes can be achieved by employing several types of exposure simultaneously throughout treatment (Foa & Mclean, 2016). In-vivo exposures involve confronting or coming into contact
with actual anxiety provoking situations or stimuli (e.g., touching a doorknob in a public place).

Imaginal exposures allow individuals to confront feared thoughts or situations that are unable to be re-created in real life (e.g., giving a deadly illness to a loved one after touching something contaminated). Oftentimes the clinician and anxious individual work together to develop a script, a written account/story of feared thoughts, and then the individual repeatedly reads through the script while actively picturing the situation and actively focusing on fears as they arise.

Interoceptive exposures allow individuals to confront fears about physiological sensations/symptoms. For example, during an interoceptive exposure, an individual might be encouraged to engage in an exercise to mimic bodily sensations in natural panic/anxiety (e.g., breathing through a straw to initiate shortness of breath or a racing heart). The individual is then encouraged to focus on the discomfort they are experiencing and actively confront fears they have about the meanings behind the feared sensations (e.g., My heart is racing; I might have a heart attack and die).

**Cognitive Components of Obsessive-Compulsive Disorder**

Beck’s cognitive theory (1967) asserts an individual’s distorted thinking patterns and biased interpretations of the environment influence emotions and behavior. Rachman (1997) proposed that obsessions are caused by catastrophic misinterpretations about the importance of one’s intrusive thoughts, images, and impulses. Obsessions are maintained until this misinterpretation is weakened or eliminated. Numerous studies have demonstrated the normalcy of intrusive thoughts (Rachman, 1997; Rachman & De Silva, 1978; Rassin et al., 2007). Given that nearly everyone experiences unwanted intrusive thoughts, the cognitive model suggests it is the interpretation of the intrusion as significant, dangerous, or reprehensible that differentiates individuals with OCD from those who manage thoughts in more adaptive ways. The cognitive
model suggests that, upon experiencing a harmless thought (e.g., thinking about hurting their child), an individual with OCD engages in a cognitive misappraisal (e.g., I must want to hurt my child; I am a bad person). The distressing nature of the thoughts may compel an attempt to suppress them. However, thought suppression has been shown to be remarkably ineffective and tends to promote an increase in the frequency and salience of the unwanted intrusions (Purdon & Clark, 1993). Cognitive models also acknowledge the tendency for maladaptive avoidant (e.g., not going near their child) or compulsive behaviors (e.g., checking to ensure no harm has occurred) to arise in an effort to reduce anxiety and decrease the likelihood of a feared outcome.

Recent factor analytic studies have furthered understanding of the cognitive factors underlying maladaptive appraisals. The Obsessive Compulsive Cognitions Working Group (2005) identified three categories of dysfunctional belief systems: 1) inflated responsibility and overestimation of threat; 2) perfectionism and need for certainty; and 3) importance and control of thoughts that contribute to misinterpretation of obsessive thoughts. Inflated responsibility and overestimation of threat refers to individuals who believe they are responsible for preventing feared outcomes. Individuals who fall into perfectionism tend to have a low tolerance of uncertainty and may believe small errors will lead to catastrophic outcomes. Importance and control of thoughts is associated with thought action fusion, the belief that having a thought is equivalent to carrying out the thought or makes the thought more likely to occur. Cognitive therapy for OCD attempts to address maladaptive belief symptoms by providing psychoeducation on the normalcy of intrusive thoughts, discussing problems with thought suppression (e.g., it increases intrusions) and identifying common thinking errors (Purdon & Clark, 1993; Rachman, 1997; Wilhelm & Steketee, 2006).
Empirical Support for Treatment

Cognitive Behavioral Therapy (CBT) is widely supported and has become the most commonly employed treatment for OCD since approximately 1966 (Arch & Abramowitz, 2015; McKay et al., 2015; Rector, 2019). Cognitive Behavioral Therapy for OCD focuses on Exposure and Response Prevention (ERP) and integrates elements of Cognitive Therapy (CT). Although multiple meta-analyses have found both of these treatments demonstrated equal effectiveness individually (Eddy et al., 2004; Rosa-Alcázar, et al., 2008; Ost et al., 2015), controlled clinical trials have consistently found that CBT significantly reduces symptoms of OCD beyond employment of either CT or ERP alone (Anderson & Rees, 2007; Franklin & Foa, 2002; Rufer et al., 2006). Therefore, the psychological treatment of choice for OCD has become ERP as a part of an integrated, comprehensive cognitive behavioral approach (National Institute for Health and Care Excellence, 2006). Recent studies representative of this literature are reviewed below.

Cognitive Behavioral Therapy (Integrated Treatment: ERP + Cognitive Therapy)

A randomized control trial (N=127) conducted by Rector and colleagues (2019) compared ERP to an integrated treatment, cognitive therapy with exposure and response prevention (ERP + CT). Both conditions led to significant symptom improvement in OCD symptoms. However, the ERP+ CT condition showed greater improvement on OCD measures in comparison to the ERP condition alone (effect sizes of 1.89 and 1.05, respectively). Clinically significant improvement, defined as reaching mild illness status (Y-BOCS ≤ 15), was achieved for 65.4% of participants in the ERP + CT group and 45.5% of the ERP group.

Ost et al. (2015) conducted an extensive meta-analysis looking at the efficacy of treatment for OCD. The analysis focused on RCT’s that examined CBT, but also included a number of other conditions: ERP, CT (no ERP), pharmacological treatment, and combined
treatment (psychological and pharmacological). The meta-analysis included 37 studies and a total of 2,041 participants. All treatment modalities were efficacious in reducing OCD symptoms. CBT yielded large effect sizes compared to both waitlist ($ES = 1.31$) and placebo ($ES = 1.33$). CBT was significantly better than antidepressants ($g=0.55$) and the addition of antidepressants to CBT did not potentiate the effect of CBT ($g=0.25$).

Olatunji et al., (2013) conducted a meta-analysis with RCTs providing CBT for OCD. Studies included a control group (psychological placebo, waitlist, pill placebo). The 16 studies included in the meta-analysis had a total sample size of 756 participants. CBT demonstrated a large effect size ($g=1.39$), out-performing control conditions on primary OCD symptom outcome measures at post-treatment and at follow-up. Additionally, secondary outcomes (i.e., depression) also showed improvement in the CBT condition.

In summary, recent RCT’s and meta-analytic findings support CBT as an efficacious psychological treatment for OCD. CBT for OCD focuses on ERP but also includes psychoeducation to address maladaptive cognitions, the nature of intrusive thoughts, and common thinking errors. Based on recent literature, exposures should vary in difficulty, duration, content, and be designed to violate threat expectancy. Therapists should identify and address safety behaviors and avoidance through exposure as well as response prevention.

Efficacy of CBT/ERP Delivered via Telehealth

Research widely supports CBT for the treatment of anxiety and related disorders (Arch & Abramowitz, 2015; McKay et al., 2015; Rector, 2019). Unfortunately, due to lack of access, high quality empirically supported treatments are not always readily available for individuals (McHugh & Barlow, 2010). Telehealth allows clinicians to reach more clients and deliver efficacious treatments. Telehealth is a broad term that includes a number of treatment modalities
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(i.e., web-based groups, videoconferencing, internet self-help treatment; Krupinski et al., 2002).

In addition to wider access to treatment, telehealth offers reduced logistical barriers (e.g., travel time), lower cost, and reduced stigma (Acierno et al., 2016; Brand and McKay, 2012).

The literature supports the use of CBT administered via telehealth as an effective alternative to face-to-face treatment. Cuijpers and colleagues (2009) conducted a meta-analysis of 23 RCTs (N=1,468) that compared computer-aided psychotherapy (self-directed online protocol) to face-to-face psychotherapy for the treatment of anxiety disorders. Overall effect sizes of computer-aided compared to face-to-face psychotherapy were large (Cohen’s $d = 1.08$) and did not differ significantly from one another ($d = −0.06$). Brand and McKay (2012) had similar findings when comparing the efficacy of CBT/ERP for obsessive-compulsive related disorders when delivered via telehealth compared to traditional in person treatment. Based on the studies included in the review, telehealth treatment for OCD appears to be an efficacious alternative to face-to-face treatment (effect sizes of 1.41 and 0.91–2.32, respectively). However, it should be noted that none of the studies included compared the same treatment protocol, so variability in the quality of the CBT/ERP could also account for some of the considerable variance in treatment outcome and effect size.

Some research suggests telehealth may actually be an optimal format for treating OCD with ERP. For OCD in particular, telehealth may improve the client’s access to treatment within the environment where symptoms are often most problematic (e.g., at home). That is, efficacy of treatment is significantly enhanced when administered in the specific setting where symptoms occur (McKay et al., 2010). Lovell et al. (2006) compared face-to-face ERP to ERP conducted over the telephone for 72 patients diagnosed with OCD and found both treatments were similarly effective for treating OCD. Researchers conducted four follow-ups (immediately after treatment,
one, three, and six months) and clinical outcomes (as indicated by Y-BOCS) were equivalent for both groups at each timepoint. Similarly, RCT’s for prolonged exposure over telehealth found (synchronous videoconferencing) did not reduce effectiveness when compared to traditional in-person treatment (Acierno, Gros, Ruggiero et al., 2016; Acierno, Knapp, Tuerk, et al., 2016). Based on current available literature, provision of exposure treatment over telehealth appears to be an effective alternative to face-to-face treatment.

**Considerations for Treating OCD during COVID-19**

The COVID-19 pandemic prompted discussions about how to provide efficacious treatment safely for clients and therapists. Considerations for safely providing ERP/CBT for OCD with contamination concerns in the midst of a global pandemic is an area of particular interest. However, there is some precedent for adjusting ERP during periods where the risk of infectious disease is higher, and level of risk is somewhat unknown. In the early days of the HIV+/AIDS epidemic, there was very little information about how the virus spread. In addition to limited knowledge about the virus, there were false beliefs about risk associated with surface contact (Bishop et al., 1991). At that time, clinicians treating OCD were required to analyze existing information, balance ethical requirements, and continue to provide an evidence based approach to treatment for clients with obsessions relating to contamination (Logsdail et al., 1991).

Clinicians who treat OCD are required to use the current scientific evidence available to them and adjust treatment accordingly. Chenneville and Schwartz-Mette (2020) noted pandemic or not, ERP remains the most efficacious intervention for OCD. Clinicians are ethically obligated to identify the best way to provide ERP while adhering to recommended safety protocols. In the context of ERP, exposures are gradual and systematic and are designed to eliminate rituals and
avoidance. Notably, exposure tasks are not designed in a way that would place the client at more than average risk for encountering the feared outcome (Sheu et al., 2020). A client engages in tasks that pose ‘usual risk,’ and then refrains from engaging in rituals. Doing so allows learning to occur (e.g., feared outcome did not occur, I was able to cope, or I was able to tolerate that level of distress and uncertainty). This approach was adopted for the current case.

**Presenting Problem and Relevant History**

**Identifying information**

For the purpose of protecting the client’s anonymity, names and other identifying details have also been changed. Jodie is a 32 year-old Asian female who lives with her husband, Drew, in a midsize city in the Midwestern United States. Jodie and her husband have been together for 8 years. Jodie does not identify as religious and the family income places her in the SES category of upper-middle class.

**Presenting Problem**

Jodie presented for treatment during the summer of 2020, following the emergence of COVID-19. She reported significant difficulties completing tasks, especially at work, due to intrusive thoughts about items being contaminated by COVID. Jodie reported following her previous treatment, she was easily able to identify which fears and behaviors were irrational, and which were not. However, the COVID-19 pandemic made it much harder to determine which fears and behaviors were related to OCD. Jodie noted she began obsessively washing her hands, sanitizing items throughout the day, spending significant time and effort avoiding possible contamination, and constantly second guessing if items had been touched, and therefore needed to be washed or sanitized again. Jodie also noticed intrusive thoughts and rituals unrelated to COVID-19 had returned, but she was more readily able to identify these as OCD content.
Psychiatric/Medical History

Jodie presented to a midsize anxiety, obsessive-compulsive, and related disorder specialty center with a recurrence of OCD symptoms due to COVID-19. She had previously received CBT/ERP treatment for OCD in the same center while in high school. Jodie reported the treatment skills she had learned, especially facing anxiety in the moment and remembering feelings of anxiety will eventually pass, were extremely helpful. Moreover, her OCD symptoms had been very well-managed for a number of years. Jodie reported her father likely had OCD, primarily related to hoarding, but he never received treatment. She denied a significant medical history and reported the results of her most recent physical were normal.

Education and Work

Jodie holds a bachelor’s degree from a midsize public university. For the past 4 years, she has worked as an Information Technologies Specialist for a large organization. Prior to COVID-19, she enjoyed her work and spending time with co-workers. At the time she presented for treatment, she noted that due to COVID-19, her routine at work had been disrupted. As a result, she was having difficulty prioritizing tasks, especially those that led to her confronting potential contamination.

Assessment

In addition to a general clinical interview, Jodie was administered the Mini International Neuropsychiatric Interview version 7.0.2 (MINI-5; Sheehan, 2015) and the Yale Brown Obsessive Compulsive Scale (Y-BOCS; Goodman et al., 1989). Following the diagnostic interview, Jodie received the clinic’s standard set of measures via email, which she completed and returned prior to beginning treatment.
Diagnostic Interviews

Mini International Neuropsychiatric Interview

The Mini International Neuropsychiatric Interview (MINI; Sheehan, 1998) is a brief diagnostic interview developed based on the criteria of the major psychiatric disorders. The MINI version 7.0.2 (MINI-5; Sheehan, 2015) has been revised to reflect DSM-5 diagnostic criteria, and was utilized as a diagnostic tool for the present case study. The MINI is comprised of 17 modules to assess for disorders including: anxiety, bipolar, depressive, obsessive-compulsive, trauma and stressor-related, feeding and eating, and substance-related/addictive disorders. The assessment is administered by a clinician in an interview format and requires a Yes/No response to indicate the presence of symptoms. Each disorder-specific module begins with screener questions. If the client’s responses to the screener questions indicates the presence of symptoms in a specific section, the clinician continues administering the section until it is completed or until the client responds with a “no” that would indicate they do not meet diagnostic criteria. After administering each disorder-specific module, the clinician indicates whether the client is likely to meet criteria for each specific DSM-5 disorder. The OCD module on the MINI has concordance of (k=0.63) with Structured Clinical Interview for DSM-III-R Patients (SCID-P) diagnoses of obsessive compulsive disorder (Sheehan et al., 1998). In addition, the specificity of the OCD module of the MINI has been shown to be very high (98% of the 349 individuals with non-OCD diagnoses were correctly identified as not having OCD) with comparably lower sensitivity (62% of the 21 OCD individuals in the sample were correctly identified). For OCD, the MINI has excellent inter-rater reliability (k =1.00) and test/retest reliability over a period of 1-2 days (k = 0.85). Refer to Appendix A for information about accessing the MINI.
On the MINI, Jodie endorsed symptoms warranting a primary diagnosis of OCD. She reported recurrent, intrusive thoughts/impulses, attempting to suppress or neutralize obsessions, obsessions recurring when attempting to ignore/suppress, feeling driven to do something repeatedly in response to an obsession or rigid rule, and utilizing excessive rituals to reduce distress/prevent something bad from happening. Her symptoms caused significant distress and interference and consumed more than one hour per day.

Jodie also endorsed depressed mood, loss of interest, difficulty sleeping, fatigue, feelings of worthlessness and guilt, difficulty concentrating, and passive thoughts about suicide. She denied having any intent or plan to kill herself. This cluster of symptoms also caused significant distress and interference with daily functioning. The client reported that, between past episodes of depression, her symptoms did not fully remit. She noted depressive symptoms persisting for several years, but that it was currently worse than it had been in the past. Jodie also noted an increase in depressive symptoms usually coincided with worsening of OCD. Based on these symptoms, a diagnosis of persistent depressive disorder, with intermittent major depressive episodes, with current episode, moderate, was assigned.

**Yale-Brown Obsessive-Compulsive Scale (Y-BOCS)**

The Yale Brown Obsessive Compulsive Scale (Y-BOCS; Goodman et al., 1989) has long been considered the gold-standard for measuring symptom severity in people with OCD (Deacon & Abramowitz, 2005; Farris et al., 2013). The Y-BOCS is a clinician-administered semi-structured interview and is used to assess the presence and severity of OCD symptoms. The measure consists of two main parts: the symptom checklist and the severity scale. The symptom checklist contains 67 items and is organized into three main sections: obsessions, compulsions, and avoidance. The symptom checklist is not scored but allows the clinician to identify the
primary obsessions and compulsions. The severity scale includes 10 items (e.g., “How much do the thoughts get in the way of work, family, or social activities?”) which are clinician-rated on a 5-point scale based on the client’s response. Specific questions have varying response options tailored to fit the question, with the most common format being a 5-point Likert scale where 0 = none and 4 = extreme. The first five questions assess obsessive thoughts, and the remaining five assess compulsions. For both obsessions and compulsions, questions identify time spent, interference, distress, resistance, and degree of control. The Y-BOCS is scored by summing the 10 items on the severity scale, which produces total scores ranging from 0 to 40, with higher scores indicating a more severe presentation. Although the Y-BOCS is not a diagnostic measure, the following clinical cutoffs are well-established and can be used to assign a severity level as well as to monitor progress throughout treatment: 0-7 (subclinical), 8-15 (mild), 16-23 (moderate), 24-31 (Severe), 32-40 (Extreme) (Goodman et al., 1989).

The psychometric properties reported in studies of the Y-BOCS are consistently strong. A number of studies have noted strong internal consistency (α = 0.87), excellent interrater reliability (ICC = 0.93 – 0.99), and strong test-retest reliability ranging from 2-14 weeks (r = 81–0.97) (Frost et al., 1995; Kim et al., 1990; Woody et al., 1995). In addition to strong psychometrics and ease of administration, the Y-BOCS is consistently used in outcome research for OCD, making the Y-BOCS an ideal measure to monitor progress (Farris et al., 2013). Refer to Appendix B to view a copy of the Y-BOCS.

On the Y-BOCS Symptom Checklist, Jodie endorsed obsessive thoughts and compulsive behaviors from a number of symptom areas. Her primary obsessions were contamination fears about contracting and spreading COVID-19, leading to unintentional harm of others. Jodie’s primary compulsions involved excessive decontamination of herself and objects and avoidance
of places and objects that felt contaminated. For the Y-BOCS severity rating, Jodie’s baseline score of 26 placed her in the severe range. The Y-BOCS severity scale was administered monthly to track treatment progress. Jodie’s scores as obtained across the seven months of treatment can be seen in Table 1.

Table 1

*Y-BOCS Scores Throughout Treatment*

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<thead>
<tr>
<th>Time</th>
<th>Score</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>26</td>
<td>Severe</td>
</tr>
<tr>
<td>Month 2</td>
<td>19.5</td>
<td>Moderate</td>
</tr>
<tr>
<td>Month 3</td>
<td>20.5</td>
<td>Moderate</td>
</tr>
<tr>
<td>Month 4</td>
<td>17.5</td>
<td>Moderate</td>
</tr>
<tr>
<td>Month 5</td>
<td>16</td>
<td>Moderate</td>
</tr>
<tr>
<td>Month 6</td>
<td>15</td>
<td>Mild</td>
</tr>
<tr>
<td>Final</td>
<td>13</td>
<td>Mild</td>
</tr>
</tbody>
</table>

**Self-Report Measures**

Jodie filled out the clinic’s standard battery of self-report measures following the diagnostic interview to aid in treatment planning. She completed measures again at the mid-point of treatment and following the termination session to assess treatment progress. Scores on all self-report measures can be found in Table 2.

**Depression, Anxiety, and Stress Scale (DASS)**

The 42-item Depression, Anxiety, and Stress Scale and the 21-item short form (DASS, DASS-21; S. H. Lovibond & P. F. Lovibond, 1995) are self-report measures used to assess the
frequency and severity of depression, anxiety, and stress within the past week. The DASS-21 was utilized for the current case. Items are evenly divided among the following three subscales: Depression (e.g., “I couldn’t seem to experience any positive feeling at all”), Anxiety (e.g., “I found myself in situations that made me so anxious I was most relieved when they ended”), and Stress (e.g., “I found it difficult to relax”). Items are rated on a 4-point Likert scale ranging from 0 = did not apply to me at all to 3 = applied to me very much, or most of the time. Scores are calculated by summing items within each subscale, then doubling that score, producing a range of 0-42, with higher scores representing more severe distress.

The DASS-21 is based on a dimensional rather than a categorical conception of psychological disorders, and differences between the depression, anxiety and the stress experienced by normal subjects and clinical populations are essentially differences in the degree of symptoms experienced. Lovibond & Lovibond (1995) identified the following cut-offs for the depression subscale: 0-9 (normal), 10-13 (mild), 14-20 (Moderate), 21-27 (severe), and 28+ (extremely severe). The anxiety subscale has cutoffs of 0-7 (normal), 8-9 (mild), 10-14 (moderate), 15-19 (severe), and 20+ (extremely severe). Cutoffs for the stress subscale are: 0-14 (normal), 15-18 (mild), 19-25 (moderate), 26-33 (severe), and 34+ (extremely severe). Each subscale on the DASS-21 demonstrated excellent internal consistency (coefficient alpha; depression = 0.97; anxiety = 0.92; stress = 0.95). The anxiety and depression subscales on the DASS also display strong convergent validity. The DASS anxiety scale was strongly correlated with the Beck Anxiety Inventory \((r = .85)\), and the correlation between the DASS depression scale and the Beck Depression Inventory was also strong \((r = .79)\) (Antony et al., 1998). Refer to Appendix C to view the DASS-21. At intake, Jodie’s depression score of 28 indicated extremely
severe depression symptoms. Her anxiety score of 24 indicated an extremely severe anxious emotional state. Her stress score of 28 indicated severe stress.

Sheehan Disability Scale (SDS)

The Sheehan Disability Scale (SDS; Sheehan, 1983) measures how current symptoms contribute to functional impairment across three domains: work, social life, and family life. Respondents indicate to what degree symptoms have disrupted their activities during the previous week. The three items, one for each domain, are rated from 0 (not at all disrupted) to 10 (extremely disrupted). The three items are then summed to produce a global functional impairment score which ranges from 0 (unimpaired) to 30 (highly impaired). Although there are no formal norms or cutoff scores, the authors recommend clinicians pay special attention to patients who score five or greater on any of the three scales, because such high scores are associated with significant functional impairment (Leon et al., 1997). SDS demonstrated excellent internal consistency ($\alpha = .89$) in a sample of primary care outpatients assessed for mental health disorders. Additionally, 80 percent of patients with a diagnosis also had an elevated SDS score. For individuals with OCD (N=26), the mean score was 14.56 ($SD = 10.37$) compared to a mean of 3.68 ($SD = 5.04$) for individuals without any diagnosis. Refer to Appendix D to view the SDS self-rated questionnaire. At intake, Jodie scored a 10 in each domain and indicated an extreme disruption in functioning at work, home, and in social settings. Her total score of 30 indicated significant and broad impairment.

Obsessive Compulsive Inventory-Revised (OCI-R)

The Obsessive–Compulsive Inventory-Revised (OCI–R; Foa et al., 2002) is a self-report measure designed to assess distress and presence of OCD symptoms across the following dimensions: washing (e.g., “I wash my hands more often and for longer than is necessary”), checking (e.g., “I repeatedly check doors, windows, drawers, etc.”), ordering (e.g., “I need things
to be arranged in a particular order”), obsessing (e.g., “frequently get nasty thoughts and have difficulty in getting rid of them”), hoarding (e.g., “I collect things I don’t need”) and mental neutralizing (e.g., “I feel I have to repeat certain numbers”). The OCI-R includes 18-items which participants rate using a 5-point Likert-type scale, where 0 = not at all distressed and 4 = extremely distressed. All items are summed, with scores ranging from 0 to 72, and higher scores indicating greater distress.

Foa and colleagues (2002) demonstrated the OCI-R was effective at discriminating between OCD and other anxiety disorders. The OCI-R’s specificity was 63.4 with sensitivity of 65.6, which suggests the OCI-R is effective in accurately screening out persons who do not meet OCD criteria, as well as in capturing persons who do. The mean score for persons with OCD is 28.0 (SD = 13.53), and the recommended clinical cutoff score for consideration of assigning a diagnosis of OCD is 21 (Foa et al., 2002). Recent literature demonstrates strong psychometric properties for the OCI-R. Abramowitz and Deacon (2006) reported strong internal consistency for individuals with OCD (α = .83). Foa and colleagues (2002) reported strong two-week test–retest reliability (rs = .74–.91). Abramovitch and colleagues (2020) established severity ranges for the OCI-R: 0-15 (mild), 16-27 (Moderate), 28-72 (severe). Refer to Appendix E to view the OCI-R. At pretreatment, Jodie’s score of 41 was in the severe range and consistent with the presence of OCD.

Social Phobia Inventory.

The Social Phobia Inventory (SPIN; Conner et al., 2000) is a self-report scale designed to evaluate social fear (“Parties and social events scare me”), avoidance (“I avoid having to give speeches”), and physiological discomfort (“Heart palpitations bother me when I am around other people”). The SPIN includes 17 items rated using a 5-point Likert-type scale from 0 = not at all
to $4 = \textit{extremely}$. Scores are calculated by summing all items and range from 0-68, with higher scores indicative of more distress. Conner and colleagues (2001) identified a clinical cutoff of 19, with scores at or above indicative of the likely presence of social anxiety disorder (specificity = 72%). The SPIN has also demonstrated strong psychometric properties with internal consistency ranging from .82 to .94, and test-retest reliability ($r = .89$) across 1-3 weeks (Connor et al., 2000). Refer to Appendix F to view the SPIN self-report questionnaire. Jodie’s score of 63 at pretreatment was clinically significant.
Table 2

**Self-Report Measures**

<table>
<thead>
<tr>
<th>Measures</th>
<th>Pre-Treatment</th>
<th>Mid-Treatment</th>
<th>Post-Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DASS-21</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>28, Extremely Severe</td>
<td>22, Severe</td>
<td>30, Extremely Severe</td>
</tr>
<tr>
<td>Anxiety</td>
<td>24, Extremely Severe</td>
<td>18, Severe</td>
<td>16, Severe</td>
</tr>
<tr>
<td>Stress</td>
<td>28, Severe</td>
<td>28, Severe</td>
<td>28, Severe</td>
</tr>
<tr>
<td><strong>SDS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work</td>
<td>10, Extremely</td>
<td>9, Markedly</td>
<td>5, Moderately</td>
</tr>
<tr>
<td>Social</td>
<td>10, Extremely</td>
<td>7, Markedly</td>
<td>5, Moderately</td>
</tr>
<tr>
<td>Home</td>
<td>10, Extremely</td>
<td>5, Moderately</td>
<td>2, Mildly</td>
</tr>
<tr>
<td>Total</td>
<td>30, Highly Impaired</td>
<td>21</td>
<td>12</td>
</tr>
<tr>
<td><strong>OCI-R</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washing</td>
<td>12, Elevated</td>
<td>10, Elevated</td>
<td>9, Elevated</td>
</tr>
<tr>
<td>Checking</td>
<td>7, Elevated</td>
<td>1, Normative</td>
<td>4, Normative</td>
</tr>
<tr>
<td>Obsessions</td>
<td>9, Elevated</td>
<td>7, Elevated</td>
<td>12, Elevated</td>
</tr>
<tr>
<td>Mental Neutralizing</td>
<td>7, Elevated</td>
<td>3, Elevated</td>
<td>8, Elevated</td>
</tr>
<tr>
<td>Ordering</td>
<td>6, Elevated</td>
<td>6, Elevated</td>
<td>7, Elevated</td>
</tr>
<tr>
<td>Hoarding</td>
<td>0, Normative</td>
<td>1, Normative</td>
<td>4, Elevated</td>
</tr>
<tr>
<td>Total</td>
<td>41, Severe</td>
<td>28, Severe</td>
<td>44, Severe</td>
</tr>
<tr>
<td><strong>SPIN</strong></td>
<td>63, Clinical</td>
<td>61, Clinical</td>
<td>60.5, Clinical</td>
</tr>
</tbody>
</table>

*Note: DASS-21 = Depression, Anxiety, and Stress Scale. SDS = Sheehan Disability Scale. OCI-R = Obsessive Compulsive Inventory-Revised. SPIN = Social Phobia Inventory.*
Subjective Units of Distress and Exposure Hierarchy (SUDS)

Current common practice for treating OCD includes use of an exposure hierarchy (Gillihan et al., 2012). An exposure hierarchy is a list of situations in which the client experiences distress related to obsessions and/or compulsions. Creating a hierarchy is a collaborative process completed early in treatment. The client and clinician begin by discussing how OCD symptoms impair daily functioning to generate a list of anxiety provoking situations. When identifying hierarchy items, it is important to be specific (e.g., touch public door handle with bare hand). Items are then rated and ranked, based on the level of anxiety.

To assign anxiety ratings, the client and clinician used a tool known as the Subjective Units of Distress Scale (SUDS; Wolpe & Lazarus, 1967). To assist clients in assigning ratings, the following anchor points were used; 0 = no distress, 5 = anxiety is definitely bothersome, but individual is able to cope, and 10 = worst anxiety the individual has experienced or can imagine experiencing. To create the hierarchy, the situations are ordered based on SUDS ratings. SUDS ratings are also employed throughout treatment. The clinician asks the client to rate SUDS throughout exposure exercises to gauge how anxious the client is before, during, and after the exposure. The exposure hierarchy and SUDS ratings are useful tools for treatment planning, monitoring progress throughout treatment, and to measure individual treatment outcomes.

In developing an exposure hierarchy for Jodie, a list of anxiety provoking situations and respective SUDS was generated during the initial assessment. The list was sufficient to begin initial exposures and because Jodie was familiar with ERP, spending a session developing a formal hierarchy was not necessary. As treatment progressed, additional exposure targets were identified. Table 3 represents an exposure hierarchy that was created based on exposures that were completed throughout treatment.
Table 3

*Exposure Hierarchy*

<table>
<thead>
<tr>
<th>Situation</th>
<th>SUDS Pre-treatment</th>
<th>SUDS Post-treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting food from restaurant without use of barriers (gloves) and eating directly from takeout containers</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Doing a load of laundry that mixes clothes worn to work with other clothing</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Fill car with gas, no wipe down of credit card</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Opening mail/packages immediately, no handwash after, or wiping of surfaces</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Spreading contamination from work items around the home (e.g., touch work bag/computer and then touch household objects)</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Imaginal script about surface contact leading to the COVID-19 related death of a loved one.</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>“Good enough” wipe down of items at work before leaving</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Socially distanced trip to the store.</td>
<td>9.5</td>
<td>3</td>
</tr>
</tbody>
</table>
Diagnosis

300.3 (F42) Obsessive Compulsive Disorder, with good or fair insight
300.4 (F34.1) Persistent Depressive Disorder (Dysthymia), with intermittent major depressive episodes, with current episode, moderate.

Differential Diagnosis

300.23 (F40.11) Social Anxiety Disorder (Social Phobia) During the clinical interview, Jodie endorsed persistent fear and significant anxiety in social situations including large groups, meeting new people, and public speaking. She reported these situations almost always trigger fear and anxiety and that fear of these situations has led to avoidance of as well as suffering through social situations. She also exceeded the clinical cutoff for Social Anxiety Disorder on the SPIN. Jodie, however, denied that her anxiety was excessive or unreasonable in these situations. She also denied that social worries caused significant distress or interference in functioning, ruling out the diagnosis. Additionally, the client noted her primary social fears were about how others may judge her for her obsessive thoughts or if someone saw her rituals. These social fears were better conceptualized within OCD.

Case Conceptualization

Etiology

People who are biologically predisposed to a mental disorder will tend to exhibit or experience an exacerbation in symptoms particularly when affected by stress. A diatheses-stress model of OCD involves interactions between genetically determined vulnerability factors and critical environmental influences that ultimately lead to the manifestation of the disorder (Adams et al., 2018; Bey et al., 2017). Research has demonstrated that for OCD periods of psychosocial stress affect symptomology in three primary ways. Stress can precipitate the initial expression of OCD, lead to a re-emergence of symptoms following a period of latency, or cause an
exacerbation of existing symptoms (Adams et al., 2018). A diatheses-stress model of OCD would suggest an individual with a genetic vulnerability would present with the disorder when environmental stressors exceed a threshold.

Jodie presented with multiple contributing factors to the development and exacerbation of her OCD symptoms. Although Jodie’s father had never received an OCD diagnosis, she reported that he had experienced OCD symptoms throughout his life. Heritability studies have demonstrated that OCD has a significant genetic component, but have also made clear that environmental factors play an important role in etiology (Pauls et al., 2014; Taylor, 2011). Based on her report about her father’s symptoms, Jodie may have inherited a biological predisposition to OCD and this disorder was ultimately expressed. Jodie reported she first began to experience symptoms of OCD as a preteen. At that time, her obsessions were primarily contamination related. Following a course of CBT/ERP, she experienced a decrease in symptoms, and using the skills she developed in treatment, Jodie successfully managed her symptoms for nearly 15 years.

The largest precipitating factor for Jodie’s exacerbation in symptoms, following a long period where symptoms were relatively latent, is the environmental context in which symptoms re-emerged. She presented for treatment in July of 2020 with obsessions and compulsions related to COVID-19 contamination. While there is limited research on how the stress of a global pandemic affects individuals with OCD, a pandemic is certainly objectively stressful. Many of the fears individuals without OCD were dealing with during the pandemic, such as worries about getting sick, worries about contamination on surfaces, and concerns about spreading contamination to others are common fears individuals with OCD experience outside of a global pandemic. Additionally, Jodie’s work environment presented a number of objective risks. Her job required her to interact closely with others (some whom she observed ignored COVID-19
CASE STUDY OF OBSESSIONS RELATED TO COVID-19

precautions) and frequently touch surfaces many others have touched. Her work environment, overall psychosocial stress, and limited information about how COVID-19 spreads led to significant uncertainty about which of her worries and related behavior were reasonable and which were related to OCD. In addition to experiencing concerns about contamination, her OCD led to an amplification of worries about unintentionally bringing harm to others such as her mom and husband. For Jodie, her genetic predisposition and an environmental stressor such as the COVID-19 pandemic interacted and ultimately led to a manifestation of OCD.

**Maintenance**

When Jodie presented for treatment, there were a number of factors maintaining her symptoms. A natural response to discomfort or anxiety is to get rid of that feeling as quickly as possible. For individuals with OCD this occurs with avoidance, reassurance seeking, and compulsive behaviors. Engaging in avoidant or compulsive behaviors is only a short-term solution for anxiety and does not allow individuals to learn anxiety will eventually pass, feared outcomes are likely worse than the real outcome, and they can continue to function even while experiencing anxiety. Jodie engaged a variety of behaviors to reduce distress, but ultimately these behaviors served to maintain her symptoms. Jodie frequently washed her hands, cleaned items repeatedly, used barriers (e.g. gloves, paper towels), and would seek reassurance from her husband. She also avoided a number of situations that would lead to anxiety, such as going to the store, touching items touched by others, and engaging in tasks that required contact with others.

Consistent with the cognitive model, distorted cognitions, misinterpretations, and attention biases play an important role in maintaining symptoms. When a person with OCD experiences an intrusive thought, he or she tends to pay significant attention to the thought, and may erroneously interpret the thought as dangerous. Jodie’s intrusive thoughts were focused on
fears of possibly having come into contact with a contaminant (novel coronavirus), obsessions about spreading contamination to others, and uncertainty about whether items or her hands had been sanitized well enough. Like many others with OCD, Jodie gave significant attention to her intrusive thoughts and exhibited thinking errors. For example, underestimating her ability to cope with uncertainty, (e.g. “I will not be able to continue with my day if I am not certain that I am not contaminated”) overestimating the likelihood of bad outcomes, (e.g. “I am very sure I will contract/spread COVID-19 if I do not wipe down surfaces multiple times”) and an inflated sense of responsibility, (e.g. If my husband dies from COVID-19 it will be my fault because I was not careful enough).

Jodie’s report of her experience was consistent with the inhibitory learning and cognitive models. Prior to seeking treatment, her symptoms were maintained by frequently engaging in compulsive or avoidant behaviors in response to her thoughts, avoidance of situations that led to anxiety, and cognitive misappraisals. Cognitions (e.g., “There could be Coronavirus on my hands;” “I could be responsible for by husband dying from COVID”) influenced how she felt emotionally and physiologically (e.g., anxious; increased heart rate) and influenced her behavior (e.g., washing hands multiple times). When Jodie noticed her heart rate increase or shortness of breath, she was even more likely to pay attention to her intrusive thoughts or engage in compulsive behaviors. By engaging in compulsive behaviors and avoidance, Jodie did not have the opportunity to experience new learning (my thoughts are not dangerous, my anxiety will decrease without compulsions, and engaging compulsions does not prevent feared outcomes) and as a result continued to experience symptoms.
**Treatment Goals and Plan**

**Assessment**
- Diagnostic evaluation
- Continue to monitor symptoms on a monthly basis using Y-BOCS severity rating

**Feedback and Psychoeducation**
- Psychoeducation on OCD, anxiety, & ERP

**Exposure with Response Prevention**
- Facing fears and avoided activities using a gradual, systematic approach
- Reduce distress/life interfering behaviors

**Relapse Prevention**
- Develop plan to further generalize and maintain gains independently following treatment.

**Booster sessions and support groups**
- Monitor ongoing application of strategies, lend extra therapeutic direction as needed
- Attend support groups for additional support and to maintain progress

**Course of Treatment**

Jodie was seen over the course of seven months and attended a total of 24 CBT/ERP sessions. Due to the COVID-19 pandemic, these sessions were all conducted via synchronous televideo. Treatment consisted of a diagnostic interview and subjective assessments, self-monitoring, psychoeducation about OCD and ERP, activity scheduling, identifying goals for response prevention, exposures including in-vivo and imaginal exposures, and identifying opportunities/setting goals for self-directed exposures.
Assessment & Psychoeducation

The first and second sessions were focused primarily on assessment, psychoeducation, and introducing self-monitoring. Following the assessment, Jodie received education about CBT/ERP and how this treatment could be applied to her symptoms. At the time she presented for treatment, Jodie was quite familiar with OCD as well as CBT/ERP, as she had previously received extensive psychoeducation about OCD and the mechanisms of CBT/ERP treatment. Additional psychoeducation was provided throughout treatment as needed. Following the first assessment session, Jodie was introduced to self-monitoring. She was asked to track situations, SUDs, intrusive/obsessive thoughts, and the compulsion/behavior she engaged in. Reviewing this self-monitoring allowed clinician and client to establish initial targets for reducing compulsions through response prevention. Self-monitoring was also used throughout treatment to record exposure practice and adherence to response prevention goals.

Cognitive Behavioral Therapy with Exposure and Response Prevention

Jodie worked with clinician to design exposures that would systematically challenge OCD fears. Consistent with the inhibitory learning model, exposures were designed to vary in content, duration, and intensity, included the removal of safety behaviors and compulsions, and combined in-vivo and imaginal scripts. Following assessment and psychoeducation, the initial six sessions were focused on designing and completing in-session exposures and subsequently independently repeating these exposures as homework. After several weeks of in-session exposures, session focus shifted to identifying and designing exposures for Jodie to independently engage in outside of session. Many of Jodie’s independent exposures occurred at work, as she spent a great deal of time there, and work was an area where OCD caused significant distress. Additional in-session exposures were completed on an as needed basis.
Throughout treatment, Jodie displayed excellent adherence and consistently completed nearly all assigned exposures. Self-monitoring of exposure practice and response prevention goals included over 250 recorded exposures. Activity scheduling was utilized to address depressive symptoms and improve mood.

**In-Vivo Exposures**

In-vivo exposures were frequently used throughout treatment to allow Jodie to directly confront contaminated items and situations, eliminate compulsions, and reduce avoidance. Jodie completed in-vivo exposures in session, as well as independently as a part of her treatment homework. In-session exposures focused on increasing tolerance of interacting with outside contaminants and reducing rituals associated with interacting with perceived contamination. For example, bringing mail and packages into her home without decontaminating or quarantining them, touching items she had taken to work and spreading the associated contamination throughout her home, and cleaning items in a way that felt wrong/differed from her typical rituals. During in-session exposures, Jodie presented as engaged and was often willing to take on additional challenges during the exposure. Outside of session, Jodie engaged in independent exposure practice. In addition to repeating the exposures practiced within session, exposures also were utilized to address contamination worries at work and in public. Exposures to facing contamination fears at work included: reducing avoidance of high touch surfaces, reducing decontamination rituals, and identifying reasonable risks for interacting with contamination. For Jodie, exposures that required her to confront contamination fears at work were consistently challenging. Additional in-vivo exposures included going to the store, filling her car with gas, and getting take-out. Jodie successfully completed exposures outside of session. If fact, she often
would identify additional opportunities for, and subsequently engage in, exposures that had not been assigned as homework.

*Imaginal Exposures*

Imaginal scripts were utilized throughout treatment to allow Jodie to confront fears about causing harm to others by unintentionally spreading COVID-19 and directly face uncertainty about the potential for contamination. The session six transcript (See Appendix F) depicts how a primary imaginal script was developed and incorporated as a part of treatment. Additionally, secondary imaginal scripts were frequently used in tandem with in-vivo exposures to promote engagement with thoughts and face uncertainty associated with resisting a ritual. For example, during one in-session exposure Jodie retrieved the mail. After doing so, she repeated the following script: “I just got the mail/packages and brought them right inside. I know that someone else has recently touched it, and they might be sick. OCD wants me to wait to open the packages and wash my hands. I am still going to open it right away without washing my hands. I might be contaminated, and I am going to have to sit with not knowing for sure.” Additionally, Jodie reported she frequently utilized scripts when she was at work and reported she found scripts to be one of the most helpful aspects of treatment.

*Response Prevention Goals*

Goals for response prevention were identified throughout treatment. In addition to identifying response prevention goals prior to individual exposures, day to day ways to challenge anxiety were also identified. Daily response prevention goals included limiting handwashes based on recommendations by the CDC, mixing objects that feel contaminated with objects that are not contaminated, limiting how often and how frequently objects are cleaned, and delaying showering following work. Examples of response prevention goals following exposures included
resisting handwashes, reducing or eliminating decontamination process and reducing or eliminating avoidance of thoughts through scripts.

**Behavioral Activation and Activity Scheduling**

In addition to using ERP to reduce distress related to OCD, Jodie was encouraged to engage in regular activity scheduling as a way to improve mood. Jodie was provided with psychoeducation about behavioral activation. She was introduced to activity scheduling, intentionally planning and then engaging in activities from four categories: pleasurable, productive, social, and physical. Following the psychoeducation, Jodie began by tracking her current level of activity to increase awareness of daily accomplishments, and to see what areas she could be more intentional about engaging in. In regard to initial tracking, Jodie reported she often completes something productive but other areas can be harder to complete. She noted a desire to “try and hit all four each day” as she noted she had noticed a difference in her mood on days where she had done more activities. Jodie reported she found planning small goals in advance was helpful. For example, talking with a friend on the phone, riding her exercise bike for 15 minutes, watching an enjoyable show, and completing a project at work. Jodie noted success with activity scheduling, that she enjoyed keeping track of her activities, and reported a desire to continue to approach activity scheduling as a “non-negotiable” part of her day.

Following initial psychoeducation on behavioral activation and activity scheduling, Jodie independently engaged in activity scheduling throughout treatment. Jodie found it much easier to complete productive and pleasurable activities, but engaging in physical and social activities were more difficult.
Termination and Relapse Prevention Planning

By the 5th month of treatment (Session 20), Jodie had consistently demonstrated good insight into her symptoms, was able to design exposures for herself, and frequently and independently took on additional exposure challenges throughout the week. Therefore it was appropriate to titrate the frequency of sessions and allow more time for Jodie to independently apply skills between sessions. Prior to the termination session, clinician and client collaboratively developed a relapse prevention plan which included discussing remaining goals, behavioral indicators of OCD, and skills Jodie can use to address OCD symptoms when she notices them. During the termination session, clinician and client reflected on progress throughout treatment and identified how Jodie can continue to maintain progress and apply the treatment skills developed thus far to address new symptoms should they arise. Jodie also noted she would likely need to meet for a couple additional sessions once COVID-19 is “over” to identify new “post- COVID-19” guidelines.

Evaluation of Treatment Outcomes and Disposition

As she progressed through treatment, Jodie maintained consistent progress and managed her symptoms. Her progress is especially notable given a number of outside environmental factors. During the course of treatment, the COVID-19 pandemic worsened and progress with OCD remained consistent. Additionally, Jodie’s work environment was objectively difficult. While many people were able to work from home and limit contact with others, Jodie was not. Her work presented increased opportunities for exposure to the virus, necessitated contact with other people who did not appear to follow social distancing or mask guidelines, and required her to frequently interact with objects others had touched. Despite her challenging environment, Jodie demonstrated consistent progress and displayed an excellent treatment response.
The Y-BOCS continues to be the gold standard for assessing severity, progress, and treatment success. Farris and colleagues (2013) pooled data from four treatment outcome trials \((N=288)\) to identify criteria for establishing response, remission, and wellness in individuals with OCD. They determined a pre to post treatment reduction of 35% or more on the Y-BOCS was consistent with treatment response. A post-treatment Y-BOCS of less than or equal to 14 was the best predictor of symptom remission. A score of less than or equal to 12 was the best predictor of wellness. From baseline to post-treatment, Jodie’s Y-BOCS decreased by 50% (26, severe to 13, mild). This 50% decrease and post-treatment Y-BOCS of 13 is not only indicative of treatment response, but is also consistent with standards for symptom remission.

A final Y-BOCS was administered during the termination session, and Jodie subsequently completed the remaining self-report measures at home. Jodie’s self-report on the OCI-R (44, severe) was inconsistent with the Y-BOCS (13, mild) completed in session. When Jodie was contacted after completing the self-report measures, she reported she had completed them while experiencing symptoms consistent with COVID-19 and undergoing testing for COVID-19. As contracting COVID-19 and being responsible for spreading it to others was a core fear, this situation likely contributed to her higher scores. In fact, Jodie’s ability to continue to manage symptoms when faced with her core fears provides additional evidence for treatment success. Jodie provided a new OCI-R at one month post-treatment. At this follow-up, her score was 13.5, which is in the mild range and is a full standard deviation below the mean for individuals with OCD (Foa et al., 2002).

Jodie’s self-report on the SDS is consistent with treatment progress, in that she experienced improvement across all three categories, with the most significant decrease occurring within the home domain. Post-treatment scores of the DASS appear to reflect
continued distress, however this can in part be attributed to continued psychosocial stress associated with the pandemic and a history of high reporting on measures.

As she progressed throughout treatment, Jodie reported her OCD was becoming easier to ignore and she was beginning to feel more confident in her ability to recognize what worries and behaviors were reasonable to COVID-19 and which behavior/worries were related to OCD. Jodie was able to disengage from her obsessions, resist engaging in compulsions, and tolerate the associated distress. She also reported that she was less distressed by her thoughts and resisting compulsions. Additionally, Jodie presented with excellent awareness about how transitioning from managing OCD within a pandemic to continuing to manage OCD outside of a pandemic could be somewhat difficult. Jodie’s awareness and willingness to seek additional sessions is another testament to her strong ability to manage her symptoms, act as a self-advocate, and anticipate when she may benefit from additional therapeutic support.

Transcript: Self Evaluation

This case study includes a transcription of the sixth session. The transcript includes additional comments highlighting areas of clinical strength, relating aspects of the session to the theory, and reflecting on areas for improvement (See Appendix G). This session was conducted via televideo and involved designing an in-vivo exposure for the client to complete outside of session as well as an in-session imaginal exposure.

What I Did Well

The treatment outcomes in this case and the procedures implemented during the sample session reflect my strong understanding of the theoretical models which underlie ERP. When reviewing the transcribed session, I was able to reflect on specific areas where I demonstrated effective therapeutic skills. For example, when engaged in planning the grocery store exposure, I
was thorough and collaborative, providing Jodie an opportunity to practice the process of planning an exposure. Designing effective exposures is an integral part of an ERP protocol, and doing so helped Jodie to develop these skills and ultimately increased her ability to independently address new symptoms should they arise following treatment. Additionally, I thoroughly assessed avoidance and safety behaviors and encouraged the development of clear and concrete goals. From an inhibitory learning perspective, identifying safety behaviors and avoidance not only creates an opportunity for increased learning, but also serves to maximize the effectiveness of exposure practice. During the in-session exposure, Jodie became quite anxious. While it can be difficult to observe someone who is experiencing a great deal of discomfort, I know a client experiencing anxiety during exposures is incredibly important for long term success. My understanding of the mechanisms of exposure allowed me to encourage Jodie to continue with the exposure. Allowing her to discontinue could have not only reinforced that her feared outcome is something she cannot handle, but also could have left her core fear unaddressed. Addressing core fears is a vital part of an ERP protocol. For Jodie, completing this in session exposure, in addition to continuing to practice the script outside of session, addressed her core fear of being responsible for spreading COVID-19 to a loved one.

**Needs Improvement**

Reviewing the transcribed session also allowed me the opportunity to reflect on areas where I can continue to grow as a clinician. I noticed Jodie may have benefited from a more thorough review of the rationale for engaging in imaginal scripts, as it is important to dispel any misconceptions. While she appeared to have a baseline understanding of the rationale, additional explanation may have been useful. For example, discussing why incorporating a feared outcome is important. Additionally, I realized the script may have been more effective had I encouraged...
her to add more details to the script once we had identified her feared outcome. Perhaps encouraging Jodie to describe what it would feel like to learn she had given her husband COVID-19 or having her describe what it would be like to live with the feelings of guilt and responsibility. Following the exposure, she also may have benefited from a more thorough opportunity to reflect on her experience with the script. Asking Jodie what she learned from the exposure practice, or if practicing the script had differed from her expectations may have been helpful as directly asking these questions is an effective way to reinforce learning.

Throughout the case I could have been more intentional in my consideration of cultural factors. More specifically, given the increase in violence and racist acts directed towards Asian-Americans that occurred during the pandemic it may have been beneficial to ask Jodie about her experience and any associated worries. While this client presents as highly acculturated, there were possibly elements of being an Asian female that were present such as being limited in emotional expressiveness (pp. 365, Wing Sue & Sue, 2008). For example, when engaged in the exposure script about being responsible for her husband’s death, the client reported being at a 9 (with 10 being maximum fear), but she did not outwardly express distress. Awareness of how cultural differences may impact therapy in addition to encouraging an open dialogue about these differences within the context of treatment is an important part increasing multicultural competence (Asnaani, & Hofmann, 2012; Carter et al., 2012).
References


https://doi.org/10.1037/10802-000


https://doi.org/10.1016/j.janxdis.2020.102314

https://doi.org/10.1177/2167702614534210

https://doi.org/10.1016/j.cpr.2011.09.008

https://doi.org/10.1037/11543-001


https://doi.org/10.1002/da.20820


Appendix A

The Mini International Neuropsychiatric Interview (MINI-5; Sheehan, 2015) is a copyrighted measure that cannot be reproduced. A detailed description of the measure, including information for obtaining copies of the specific modules, can be accessed using the information provided below.

# Appendix B

Yale Brown Obsessive Compulsive Scale (Y-BOCS)

## Y-BOCS Severity Ratings

Yale-Brown Obsessive Compulsive Scale

**Administering the Y-BOCS Symptom Checklist and Y-BOCS Severity Ratings**

1. Establish the diagnosis of obsessive compulsive disorder.
2. Using the Y-BOCS Symptom Checklist (other form), ascertain current and past symptoms.
3. Next, administer the 10-item severity ratings (below) to assess the severity of the OCD during the last week.
4. Readminister the Y-BOCS Severity Rating Scale to monitor progress.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Date 1st Report</th>
<th>Date This Report</th>
</tr>
</thead>
</table>

**Obsession Rating Scale (circle appropriate score)**

Note: Scores should reflect the composite effect of all the patient’s obsessive compulsive symptoms. Rate the average occurrence of each item during the prior week up to and including the time of interview.

**QUESTIONS ON OBSESSIONS (ITEMS 1–5)**

"I am now going to ask you questions about the thoughts you cannot stop thinking about." (Review for the informant(s) the Target Symptoms and refer to them while asking questions 1–5)

<table>
<thead>
<tr>
<th>1. Time Occupied by Obsessive Thoughts</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Be sure to exclude ruminations and preoccupations which, unlike obsessions, are ego-syntonic and rational (but exaggerated)]</td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td>Score</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Interference Due to Obsessive Thoughts</th>
</tr>
</thead>
<tbody>
<tr>
<td>• How much do these thoughts get in the way of work, family, or social activities?</td>
</tr>
<tr>
<td>• Is there anything that you don’t do because of them? (If currently not working, determine how much performance would be affected if patient were employed)</td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td>Score</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Distress Associated with Obsessive Thoughts</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
<tr>
<td>Score</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Resistance Against Obsessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• How hard do you try to stop the thoughts or ignore them? (Only rate effort made to resist, not success or failure in actually controlling the obsessions. If the obsessions are minimal, the patient may not feel the need to resist them. In such cases, a rating of “0” should be given.)</td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td>Score</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Degree of Control Over Obsessive Thoughts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Control</td>
</tr>
<tr>
<td>Score</td>
</tr>
</tbody>
</table>
**Questions on Compulsions (Items 6–10)**

"I am now going to ask you questions about the habits you can't stop."

(Review for the informant(s) the Target Symptoms and refer to them while asking questions 6–10)

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Extreme</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>Time Spend Performing Compulsive Behaviors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Score</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7.</td>
<td>Interference Due to Compulsive Behaviors</td>
<td>How much do these habits get in the way of work, family, or social activities?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Score</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8.</td>
<td>Distress Associated with Compulsive Behavior</td>
<td>How would you feel if prevented from carrying out your habits? How upset would you become?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Score</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9.</td>
<td>Resistance Against Compulsions</td>
<td>How much do you try to fight the habit(s)? (Only rate effort made to resist, not success or failure in actually controlling the compulsions.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Score</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10.</td>
<td>Degree of Control over Compulsive Thoughts</td>
<td>How strong is the feeling that you have to carry out the habit(s)? When you try to fight them, what happens?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Score</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Compulsion subtotal (add items 6–10)

Y-BOCS total (add items 1–10)

Total Y-BOCS score: range of severity for patients who have both obsessions and compulsions

<table>
<thead>
<tr>
<th>Score</th>
<th>Subclinical</th>
<th>Mild</th>
<th>Moderate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–7</td>
<td>24–31</td>
<td>32–40</td>
<td>16–23</td>
</tr>
</tbody>
</table>
**Appendix C**

Depression, Anxiety, and Stress Scale (DASS-21)

<table>
<thead>
<tr>
<th>DASS21 Name:</th>
<th>Date:</th>
</tr>
</thead>
</table>

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0  Did not apply to me at all
1  Applied to me to some degree, or some of the time
2  Applied to me to a considerable degree or a good part of time
3  Applied to me very much or most of the time

<table>
<thead>
<tr>
<th>1 (a)</th>
<th>I found it hard to wind down</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 (a)</td>
<td>I was aware of dryness of my mouth</td>
</tr>
<tr>
<td>3 (d)</td>
<td>I couldn’t seem to experience any positive feeling at all</td>
</tr>
<tr>
<td>4 (a)</td>
<td>I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)</td>
</tr>
<tr>
<td>5 (d)</td>
<td>I found it difficult to work up the initiative to do things</td>
</tr>
<tr>
<td>6 (a)</td>
<td>I tended to over-react to situations</td>
</tr>
<tr>
<td>7 (a)</td>
<td>I experienced trembling (e.g. in the hands)</td>
</tr>
<tr>
<td>8 (a)</td>
<td>I felt that I was using a lot of nervous energy</td>
</tr>
<tr>
<td>9 (a)</td>
<td>I was worried about situations in which I might panic and make a fool of myself</td>
</tr>
<tr>
<td>10 (d)</td>
<td>I felt that I had nothing to look forward to</td>
</tr>
<tr>
<td>11 (a)</td>
<td>I found myself getting agitated</td>
</tr>
<tr>
<td>12 (a)</td>
<td>I found it difficult to relax</td>
</tr>
<tr>
<td>13 (d)</td>
<td>I felt down-hearted and blue</td>
</tr>
<tr>
<td>14 (a)</td>
<td>I was intolerant of anything that kept me from getting on with what I was doing</td>
</tr>
<tr>
<td>15 (a)</td>
<td>I felt I was close to panic</td>
</tr>
<tr>
<td>16 (d)</td>
<td>I was unable to become enthusiastic about anything</td>
</tr>
<tr>
<td>17 (d)</td>
<td>I felt I wasn’t worth much as a person</td>
</tr>
<tr>
<td>18 (a)</td>
<td>I felt that I was rather touchy</td>
</tr>
<tr>
<td>19 (a)</td>
<td>I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)</td>
</tr>
<tr>
<td>20 (a)</td>
<td>I felt scared without any good reason</td>
</tr>
<tr>
<td>21 (d)</td>
<td>I felt that life was meaningless</td>
</tr>
</tbody>
</table>
Appendix D

Sheehan Disability Scale

Please mark ONE circle for each scale.

**WORK* / SCHOOL**

The symptoms have disrupted your work / school work:

<table>
<thead>
<tr>
<th>Scale</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Mildly</td>
<td>Moderately</td>
<td>Markedly</td>
<td>Extremely</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I have not worked / studied at all during the past week for reasons unrelated to the disorder.

* Work includes paid, unpaid volunteer work or training

**SOCIAL LIFE**

The symptoms have disrupted your social life / leisure activities:

<table>
<thead>
<tr>
<th>Scale</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Mildly</td>
<td>Moderately</td>
<td>Markedly</td>
<td>Extremely</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FAMILY LIFE / HOME RESPONSIBILITIES**

The symptoms have disrupted your family life / home responsibilities:

<table>
<thead>
<tr>
<th>Scale</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Mildly</td>
<td>Moderately</td>
<td>Markedly</td>
<td>Extremely</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Days Lost**

On how many days in the last week did your symptoms cause you to miss school or work or leave you unable to carry out your normal daily responsibilities?

**Days Unproductive**

On how many days in the last week did you feel so impaired by your symptoms, that even though you went to school or work, your productivity was reduced?
Appendix E

Obsessive-Compulsive Inventory-Revised

The following statements refer to experiences that many people have in their everyday lives. Circle the number that best describes HOW MUCH that experience has DISTRESSED or BOTHERED you during the PAST MONTH. The numbers refer to the following verbal labels:

<table>
<thead>
<tr>
<th></th>
<th>0 Not at all</th>
<th>1 A little</th>
<th>2 Moderately</th>
<th>3 A lot</th>
<th>4 Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I have saved up so many things that they get in the way.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2.</td>
<td>I check things more often than necessary.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3.</td>
<td>I get upset if objects are not arranged properly.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4.</td>
<td>I feel compelled to count while I am doing things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5.</td>
<td>I find it difficult to touch an object when I know it has been touched by strangers or certain people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6.</td>
<td>I find it difficult to control my own thoughts.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7.</td>
<td>I collect things I don’t need.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8.</td>
<td>I repeatedly check doors, windows, drawers, etc.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9.</td>
<td>I get upset if others change the way I have arranged things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10.</td>
<td>I feel I have to repeat certain numbers.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11.</td>
<td>I sometimes have to wash or clean myself simply because I feel contaminated.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12.</td>
<td>I am upset by unpleasant thoughts that come into my mind against my will.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13.</td>
<td>I avoid throwing things away because I am afraid I might need them later.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14.</td>
<td>I repeatedly check gas and water taps and light switches after turning them off.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15.</td>
<td>I need things to be arranged in a particular order.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16.</td>
<td>I feel that there are good and bad numbers.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17.</td>
<td>I wash my hands more often and longer than necessary.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18.</td>
<td>I frequently get nasty thoughts and have difficulty in getting rid of them.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
## Appendix F

### Social Phobia Inventory

The Social Phobia Inventory (abbreviated as SPI[N]) is a 17-item questionnaire developed by the Psychiatry and Behavioral Sciences Department at Duke University. It is effective in screening for, and measuring the severity of social anxiety disorder.

Please read each statement and click in the column that indicates how much the statement applied to you over the past week.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not At All</th>
<th>A Little Bit</th>
<th>Somewhat</th>
<th>Very Much</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am afraid of people in authority.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I am bothered by blushing in front of people.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Parties and social events scare me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4. I avoid talking to people I don’t know.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>5. Being criticized scares me a lot.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I avoid doing things or speaking to people for fear of embarrassment.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Sweating in front of people causes me distress.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. I avoid going to parties.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. I avoid activities in which I am the center of attention.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Talking to strangers scares me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. I avoid having to give speeches.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. I would do anything to avoid being criticized.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Heart palpitations bother me when I am around people.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. I am afraid of doing things when people might be watching.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Being embarrassed or looking stupid are among my worst fears.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. I avoid speaking to anyone in authority.</td>
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<td>17. Trembling or shaking in front of others is distressing to me.</td>
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Appendix G  
Session Six Transcript:

C: Hey
T: It’s good to see you this week. How have things been?
C: Umm, this week was rough.
T: I’m sorry to hear that, what’s been going on?
C: So school started this week. Officially all the kids came back on Tuesday and so it has been pretty much been the usual, lots of things have gone down. Like lots of our device management systems have been crashing, so as a result lots of kids and teachers have been coming in to ask questions. Basically a lot of the normal beginning of the year stuff, but since COVID is a part of it… I am always a little anxious when it comes to being around other people in general, but also having to touch all of their stuff because that's what they're used to. We are trying to implement more policies that kind of require a bit more distancing, and a bit more independence on their part, but at the same time I think instinct kind of takes over and they want me to take their stuff and fix it for them.
T: Yeah, and so this time of the school year sounds like it's normally stressful as is, and then add in COVID and it’s just a whole new level of stress.
C: Yeah.
T: I know the past couple times we talked about how you felt like exposures kind of prepped you for the challenges that you were anticipating would come up this week and the next as school starts. So how do you feel, was that prediction true? I know that it's still been really hard, but what are your thoughts about that?
C: I think they are true. Mostly because in the past, like when we first went virtual, before I even reached out to start therapy I was probably going through like a box of a hundred gloves, maybe… if I were using them at the rate I was when I was on site, I was probably going through a box like every week or two weeks, and that was when we were working one day on site a week. And so, overall it was like every two or three days I would have gone through a whole box, but at this point like my hand washing in general has gone down by like a lot. I think when I first started I was probably washing my hands maybe 20-30 times a day, like for the whole day combined and at this point it's almost like half that.
T: Yeah!
**Reinforcing the client for engaging in exposure (handling equipment that has been handled by others) and response prevention (eliminating excessive glove use and reducing handwashing).**
C: It’s more infrequent and there's a lot more activity being done in between washes rather than like I touched this one thing so I have to go wash, I touched another thing I have to go wash again. It's more like consolidating all the things I have to touch and then doing like that final wash before I leave, or before I eat or something like that.
**Reducing handwashes was a homework goal, so checking in on this could have been more structured. Also asking for more details about which handwashes are still difficult to resist may have provided an opportunity for some problem solving and future exposures.**
T: Mmmhmm, and you know what, we you know that you've been working really, really hard at doing exposures and challenging OCD. So how does it feel to see those changes, to really see that huge drop in hand-washing, to see that drop in your use of gloves. How does that feel?
**Enhancing self-efficacy and treatment motivation by highlighting improvements derived from treatment compliance.**
C: It feels really good especially like the process of washing my hands, because I feel like I've gotten to the point where I can start washing my hands, check how many seconds I need to count to get to 20, and then by the time I've reached like 20 or 25 that’s my stopping point. Rather than thinking well maybe I should do it just like 10 more seconds, maybe 20 more seconds and then it just spirals. So I think it feels really good that I managed to lockdown that stopping point, whenever I do my hands, so it feels good.

C: That’s good! I mean both Katie and I, we can tell you've been working so hard. I know that things are still hard at work, and they're probably going to continue to be hard for a little bit. But you know what, we just got started, and truly it's amazing that in just this little time we really got handwashing almost where we want it to be. We’re not stuck in a really long handwash, and we’re not disrupting our workday so much to wash hands or change gloves. What other things have you noticed as far as your ability to function throughout the workday? Do you feel better about being at work? Better about being able to do your job?

**Reinforcing treatment-consistent behaviors and enhancing client self-efficacy and motivation.**

C: I do feel better in that like if somebody does need me to take their device from them… I still don't want to take it, but it's one of those things where I don't feel like I'm going to have a heart attack if I do touch it. Which is huge because before it was one of those things where if somebody handed me a device I would ask them to set it on the table and I wouldn't touch it until I had gloves, or I had prepared a space for it to sit-in, where it was like in my head safe.

T: Mmhmm

C: Where as now I think it was kind of a combination of me having the exposure practices and just the fact that it's so busy this time of the year, I don't get a chance to worry about it because it has to be done whether or not my OCD is telling me not to touch it.

T: Right, and it must feel just so nice to know that even though it is hard, you can still do it. We are able to touch those things. You know what, anybody right now is anxious about contact, so we really are in a hard spot. We’ve talked about how your OCD just has that little bit of an extra challenging part, to an already challenging time in everyone's life, in an already challenging job. But yet you’re still doing it everyday, we're still doing our job, we're still helping kids fix their devices and that's awesome.

**Reflection of feeling. Positive reinforcement. Motivational enhancement through pointing out the larger goal of exposures that is related to meaning and values.**

C: Yeah, I think what's nice is all this preparation up until now. I feel like if I hadn't done any of that - like if I never sought treatment or anything like that. I honestly feel like at this point in the year I wouldn't get any work done. I feel like work would fall on the backburner because I'd be so worried about touching things that I just wouldn't respond, or answer emails, or answer questions. So overall I feel like this has allowed me to work, and still do my job.

T: As you know, OCD can really, really mess with people's lives. But it is something if you’re willing to challenge it and willing to do the things that you've been doing for the past couple weeks we can push back against OCD. It's not only about just being able to function, it's about being able to do the things that you want. And from what we have talked about, being able to do those things at work is something that you want to do.

**Here I am encouraging the client to look for additional reasons to engage in exposure. This can be important to build motivation for engaging in more difficult/higher level ones. I am wanting her to recognize exposures can help us feel less anxious, function better, and allow us to do things we care about/want.**

C: Mmhmm, yeah.
T: So we are doing exactly what we need to be doing to be able to continue doing the things that we want to do at work, and then continuing to do other things that we would like to do, that right now OCD makes really hard.

C: Mmhmm

T: So what are some of those other things that we haven't quite gotten to yet that you would like to be able to do?

**Over the course of exposure therapy, the client understands that the model requires her to face what she is avoiding and become more involved in planning her own exposures. Asking the client what fears she is ready to challenge is one way to build self-efficacy and gets the client thinking about how to identify exposure targets.**

C: Well I think I mentioned this during the first re-evaluation, but I have not been in a physical store like Target, or Best Buy, or Walmart like I haven't gone to the grocery store or any of those places since March.

**The client has not been to the store in 6 months. This long period of avoidance was not only causing significant interference, but also contributing to anticipatory anxiety. Identifying avoidance is an important part of designing effective exposures within ERP.**

T: It's very interesting that you bring that up, because that was definitely something that Katie and I talked about trying to talk through today. During that initial evaluation it sounded like that was something that was hard. You were feeling like, man I really wish that I could do that sometimes. Well, when there's a lot of internal motivation to want to do something that OCD makes really hard, that's a good thing to tackle. We've gotten enough exposures under our belt that we know that we can do hard things, and it sounds like it's pretty important to you to be able to go to the store.

**Encouragement & pointing out there is additional motivation for the exposure. Collaborative goal setting is taking place.**

C: Yeah, there’s a lot of guilt involved especially since Drew has been the sole grocery shopper since March. I just don't think that's right, I don't think that's something he should have to do because I'm too scared to go, so I think it's time for me to kind of face that one.

T: Okay! So today I thought that we could spend some time talking through what a grocery store exposure might look like, and maybe set some goals for that. Then if you would like, this could be something that we could do as an additional session this week. A short one, so if you felt like that was something that you wanted someone on the phone with you, or someone over text for, that is certainly something that we can do.

**The next portion consists of detailed planning/goal setting for this exposure. Identifying specific ways to challenge OCD during an exposure and eliminating specific safety behaviors is consistent with providing efficacious ERP as well as with the inhibitory learning model. Doing so with the client allows her the opportunity to learn the skill of designing effective exposures.**

C: Okay

T: So let’s go ahead and start planning what that exposure would look like. What kind of store would you like to be able to go to, or where do we want to start with the store?

C: I would say let’s start with Target. That’s typically the one, like after work it's on my way home, so if I were to have gone, it would have been like after work, on the way home.

T: So Target is the store that you would typically go to, and who doesn't want to be able to go to Target! Target is a great place to be able to go walk around, they have everything you could possibly want.
**More motivational enhancement and also helping the client to access other emotions (e.g., interest, humor, excitement) related to the exposure target besides just anxiety.**

C: Right, you always leave with like five extra things.

T: Oh yes, that is I thi... 

**Confirming her goal about using a cart to get groceries. The client is concerned about coming into contact with potentially contaminated objects (like a shopping cart). As this client’s OCD would likely prefer that she avoids touching surfaces, like a shopping cart, that many other people touch, this is an excellent goal.**

C: Yeah, and usually… I don't know if you have this, but I have the Circle App where you can get coupons and stuff specifically for Target. And so it would be an activity where I would have to have my phone in my hand while doing all of this. So if I’m touching things I think are contaminated, like the cart or fridge doors where you get milk and stuff like that. Whenever I touch that, I would need to be touching my phone at the same time to check my list, to check the app for discounts and things like that, so yeah I would say having my phone.

**The client is aware that having her phone out at the store presents an opportunity for her to challenge contamination fears. If she is interacting with objects in the store and her phone, it will feel contaminated. This is another good goal for this exposure.**

T: So using that app like you normally would. If I am understanding that app correctly, you can also scan and see if things have coupons. Is that kind of what it is?

C: Yeah

T: So just continuing to use that app like you would when you were just taking a regular trip

C: I also use it for my list of stuff I have to get too.

T: Alright, we're going to use that app like normal. What else do we need to do to make sure that we're really treating a trip to Target like an exposure?

C: I would say more than anything to treat the entire trip like a normal trip. Because in the past I always used their self-checkout, which requires you to touch a lot of the things yourself, and use like the little scanner to scan your phone and scan things that can't reach the tabletop scanner thing.

**Here the client recognizes another way to challenge OCD during the exposure.**

T: Okay

C: Especially because I feel like that's an environment where I will have to recognize and kind of do the exposure script of like: Other people have gone through this line, more people have
probably touched this than the line where it's just one person checking everything out. So I think that would be part of it is well

**The client is aware that the addition of a secondary imaginal script will be useful. Not only is she going to face fears by using the self-checkout, she also plans to intentionally face intrusive thoughts and address uncertainty with a script. Combining two types of exposure (in-vivo and imaginal) is consistent with providing good ERP.**

T: Okay would OCD want you to wear gloves to the store?

**Here I am checking to see if there is any avoidance/safety behaviors the client has missed. In the past, the client would wear gloves in public to reduce her anxiety about becoming contaminated. Engaging in safety behaviors during an exposure can reduce anxiety and ultimately interferes with new learning (reducing efficacy of exposure). In order to provide successful ERP it is important to be aware of common safety behaviors that occur for individuals as well as behaviors that your own client is likely to engage in.**

C: I think it would.

T: Do you think we are ready to challenge not wearing gloves to the store?

C: Yes

T: Okay, I'm going to go ahead and say that our goal for this exposure is to go and not wear gloves. Of course wear your mask and do your best to stay 6 feet apart. What we know about the grocery store is that one we can't control other people, and two there is sometimes where you're just not able to be six feet apart, but that's kind of going back to treating it like as normal of a trip as possible. You know if there's someone that's in the aisle that you want to go down of course we're not going to wait for them to leave, but you don't have to be right next to people. Does that make sense? I know that might be a bit tricky to navigate because it is different, but what are your thoughts about that?

**Working to identify and eliminate safety behaviors that could interfere with learning. Exposure goals that help the client to engage in behaviors that are consistent with what people without OCD do in a similar situation are ideal.**

C: I think it's doable. I think it's one of those things like when I go, I have to remind myself of set guidelines where it's like 6ft, wear a mask. Typically anything more than that, that's my OCD talking. If I am beyond 6ft, and there's something I need, then I'm going to need to go and get whatever is there.

**Client is learning to recognize the difference between following standard COVID guidelines and behaving consistent with her obsessions. This shows good insight into her symptoms.**

T: Yup, I think that's a perfect way to put it. We're going to try and maintain six feet as much as possible, but if someone's there and we need that item we're just going to go ahead and get it, and then go back to being 6 feet apart. I know that when I'm in the grocery store sometimes it's kind of busy and there's people hanging around, and if I had to stay six feet apart the whole time, I would be in the grocery store for longer than I want to spend. Speaking of how long we want to spend in Target, how long would you say we want to make our Target?

C: I would say between 15 and 30 minutes.

**This was a shorter than I would have liked but after a such long period of avoidance I felt it was a good place to start. Here I could have encouraged her to do a longer time or asked more about the length of her “normal grocery trip” to identify if the 15 minutes was typical or due to anxiety.**

T: Okay and I think that that is a really good place to start. We haven't been to the store for a while. I would say if we're hitting 20 minutes and our SUDS are really high, I would challenge
you to continue to stay in Target just a little bit longer. And if we are hitting 30 minutes and we're still feeling anxious, that's okay. This is something that we haven't done in a while so we might not see those SUDS, our anxiety, come down right away. But what we know about anxiety is that when we are doing an exposure if SUDS don't come down right away that's not the important thing. We're doing the exposure, we're learning that we can handle it, and with continued practice that's when we can usually see that anxiety level drop, and when we know that what we're doing is really working.

**The inhibitory learning model places less importance on within-session habituation (decrease in SUDS during an exposure) as new learning can still occur without this decrease. This client has experienced a decrease in SUDS during previous exposures, but the store is a more challenging exposure, so preparing her for the fact her SUDS may not drop while she is in the store (as continued practice, or multiple trips may be needed) emphasizes the importance of facing fears over decreasing anxiety and may reduce frustration.**

C: Mmhmm

T: All right so what other things do we need to make sure to put in place during this Target exposure?

C: I think one thing that I'll need to consider is, what I do whenever I leave the store. Once I am out of that environment to be a little more mindful of what I'm avoiding or just like behavioral, mindful things to consider whenever I leave. Like to actually grip the steering wheel like a normal person when I'm driving home, instead of trying to not use too many surface contact points. Treating everything like normal on the drive home, for obvious safety reasons, but also for the sake of facing it head-on … I would consider not wiping down everything that I buy when I get home.

**Client is showing excellent awareness for the need to identify response prevention goals and avoid safety behaviors if one is to maximize the effectiveness of exposures, consistent with the inhibitory learning model.**

T: I think that that would be a good challenge. Kind of consistent with some of the other things we've done with wiping, and we can definitely use a script as we do that.

**Encouraging the client to engage in a secondary imaginal script during an in-vivo exposure increases the feelings of uncertainty and increases engagement with cognitions. Combining multiple types of exposures also increases effectiveness within ERP**

C: Yeah

T: Is there specific foods or items that you, that OCD, really wants you to wipe down?

C: I've noticed that it's higher if it's like a plastic container; because several months ago I had read somewhere that it survives longer on different surfaces. I think I had read something that said plastic was one of the ones where it was like days. Those were ones in the past whenever Drew came home with groceries, even though I wasn't at the store I wouldn't touch them… for days. I think that’s one that whenever I buy something that’s got a plastic jar, or can, or something like that, then those will probably be the most difficult to resist wiping down.

**By asking which items are hardest, it is easier to establish doable goals.**

T: Okay and so I think that for this one, because it's something we've been doing, I would challenge you to not do wiping. Do your best to resist on wiping, but if there's things that we need to wipe, let's try and stick to the one and done and then let's put it away. Similar to what we've been doing with packages and mail we’re opening it up, we’re touching it, we’re interacting with it, and we’re not doing wipe downs. I can certainly understand those feelings of anxiety about wiping down, but also what we know about surfaces is there's more information
about services that tells us that generally it's a pretty okay risk to not wipe it down. When doing exposures we are never going to ask you to do anything that is going to pose more than average risk, and I feel pretty comfortable saying that not wiping down every single grocery item is going to fall into that category. 

**This recommendation is consistent with the CDC guidelines. In conducting exposure therapy during a pandemic, the recommendation is to use available data and adjust accordingly, which is what I did here.**

C: Mmkkay

T: But it's our first grocery store exposure after a really long time, and so if that is going to be too challenging, the exposure is still going to be successful. We are not going to ruin the exposure by doing a wipe down.

**I did not want the client to disqualify the positive and turn the exposure into a failure if she does not follow every exposure guideline perfectly. It is pre-emptively dealing with distorted cognitions that may arise if the client does wipe some things down. Cognitions that the client has “failed” an exposure may decrease the likelihood of engaging in exposures in the future, according the cognitive model.**

C: Right

T: So try your very hardest to resist, see if we can resist most of the things, and if there's items that we can't resist, stick to the one-and-done wipe.

C: Okay

T: Does that sound doable?

C: Mmmhmm

T: Something else that Katie and I were talking about when we were considering some ideas for the store exposure, was when in the store, sometimes we take an item off the shelf look at it, then and put it back. What would that be like for you?

**One of the client’s core fears is that she would unintentionally spread COVID to others (primarily loved ones).** Asking the client if she would be anxious about putting an item back after touching it may have created an opportunity for the client to engage in an exposure to this fear.

C: I don't think it would be very difficult.

T: Okay

**I could have directly asked the client, “Do you think that picking something up and putting it back would bring up any worries about spreading COVID?” This may have provided an opportunity to develop an in-vivo challenge to a core-fear.**

C: I think shopping just in general like touching the cart, touching the handles to open fridge doors things like that, those would considerably be like higher SUDS or me than picking up something I don't plan on buying and putting it back. Just because in my head more people have touched like those former surfaces.

T: Okay, the picking stuff up and putting it back doesn't sound like we need to make that a specific goal, but it probably falls under that we're going to try and make this as normal of a trip to Target as possible.

C: Yeah

T: Because I know that when I'm shopping for groceries there are certainly times where I pick something up to look at it, and I decide that it's not what I want, and I put it back. If that happens to occur, then that's just part of sticking to our normal Target trip.

C: mmmhmm
T: Okay so is there anything else that we need to maybe set goals for? For going to Target? Before? Afterwards? For this exposure?
C: Umm I do think… I could see myself struggling to do like the one wipe and done whenever I’m wiping down my steering wheel or parts of my car whenever I get home. And so that is one where I would still like to wipe it down, but I don't want it to be like I'm using 4 or 5 wipes because I feel like the Clorox wipes aren't wet enough and I'm not covering every surface. I'd rather be like you get one wipe, it's for every surface in the car that you want to wipe down, and then after that, that’s it.

**Again, Client demonstrates excellent awareness for the need to identify response prevention goals. We will eventually eliminate wiping down her car completely but identifying doable goals can increase adherence with exposures as the client builds efficacy and learns that she can tolerate the distress associated with an “incorrect wipe down” before eliminating it completely.**

T: Okay and so we can just set that as our goal and see if that's something that we’re able to do at this point. You know, this is a doozy of an exposure. There's a lot of goals here, there's a lot of challenges here, and we know that you can do hard exposures.
C: Mmhmmm
T: We can just set that as another goal. When we're going to wipe stuff, we're going to stick to one wipe. Maybe we can even do one wipe for any groceries that we're going to wipe, and one wipe for … the same wipe for the car. Do one wipe for the grocery store trip.
C: Mmhmmm
T: How does that feel?

**Reviewing goals for the exposure and inviting feedback as part of making goal planning collaborative.**
C: That feels good depending on how many groceries I end up getting, but I think it's doable.
T: Okay, alright. I think that that sounds like a really good plan, so what are your thoughts about wanting to do this exposure by yourself versus wanting maybe like a text check in, or a phone call while you're walking through that? What are your thoughts about that?
C: I think I should be able to do it myself the first time around. I will probably bring Drew with me.
T: Okay
C: He's very open to learning about how this whole process is going for me and he's always looking for ways to make sure he's not a enabling me, so…
T: Perfect
C: I think that’s really helpful, and so I think if I just tell him like these are my rules, if I look like I'm about to ask you to do something for me you're not going to do it because that’s enabling me.
T: Awesome, okay so it sounds like Drew might be a nice exposure coach for this one.
C: Mmmhmmm
T: Sounds like a pretty good plan. Just like always, if there's ever any questions that come up, or things that you are like hey, I really want to ask about that, you can always shoot us an email during the week.
C: Okay
T: Okay. The other thing that I just wanted to talk briefly about was exposure scripts. Looks like you really did a great job leaning into them this week, and it was kind of the first time that we had really used them on your own. How do you feel like those went?
CASE STUDY OF OBSESSIONS RELATED TO COVID-19

C: I think it went okay… Especially during the workday it was kind of difficult for me to get into the mindset of like, I need to say a script for this action. Mainly just because of the week, just because, it was so busy, and there was so much stuff happening. I feel like I didn't give myself as many chances to look for opportunities for exposure scripts. It was more of, I have to pick up this device, and I have to touch it, and I have to do all this stuff to it, while trying to fix it. And so my thought process would be focused on the problem-solving part of it, rather than the exposure script of it. And so I think a lot of the exposure scripts that I did say, were primarily whenever I was in the cleaning stage of things. When I was washing my hands or wiping stuff down. At that point I would be telling myself like I may not get everything, I'm only going to wash my hands for 20 seconds and it might not be enough, but I'm just going to stop at that point. So it was a little spotty how frequently I was able to do it throughout the day.

T: You know what, when we use exposure scripts, they are really helpful when a certain exposure is hard, or maybe you are really struggling with some of those thoughts during an exposure. When you were interacting with the devices, it sounds like maybe OCD wasn’t being so loud.

* Using a script can be an effective response to an intrusive thought as well as a way to increase uncertainty during an exposure (like with a handwash/wipe down). The client noted that she had not use scripts as much as she would have liked, but from what she described, she utilized scripts effectively. A script requires a lot attention, so expecting herself to be able to fix a device and engage with a script is not very doable.

C: Mmhmm

T: In that moment, we’re still able to interact with the device, we’re doing what we need to be doing as far as solving the problem, and we're pretty engaged with that. Maybe OCD isn't really yelling at us right then. In times like that, you might not need to use a script for that to be an effective exposure, because you're just doing it, and doing okay with it.

** Here I could have been more explicit in telling the client that she had utilized scripts correctly, this may have provided an opportunity for clarifying rationale for and when to use scripts.

C: Hmm

T: So it sounds like when you were able to use scripts; like you said with the wipe down or when we’re struggling more with stopping the wipe down. Those are the times when a script is beneficial, or most beneficial. Scripts can be beneficial all the time, but those are the exposures where we really want to use scripts — where those scripts are really important, versus maybe there is another time where we are just coming into contact with something and are able to do that without really needing to use a script. So it seems like you were really, really, successful in coming up with those scripts and using those scripts. How do you feel like using the script impacts your experience with exposure?

C: I think it's helpful primarily because it forces me to acknowledge what I'm afraid of and kind of differentiate the difference between what's a rational versus an irrational fear. Basically like determining what's OCD and what's like a genuine thing to be worried about. So I think it was helpful in that sense.

T: Okay were there any concerns or questions you had as far as using scripts during exposure?

C: Let me look back at some of the ones I had.… C is looking over tracking form, I don't think so, I don't think I have any questions about them.
T: I did notice that in a few of your notes this week there were some thoughts that have been coming up about some OCD fears about getting Drew sick. I know we’ve talked about some fears about getting Mom sick, so what are your thoughts about those OCD thoughts?
C: Those have been difficult to deal with. Just because of like the emotional weight of thinking through consequences like that. It was one thing if I was not touching things because I was afraid I was going to get myself sick, but then once I start bringing people that I love and care about into it I think it just like magnifies it by a lot.
T: Mmhm
C: So those have just been hard.
T: Yeah and that makes sense. Nobody likes to think about being responsible for a loved one getting sick or dying, but OCD really likes to grab on to those fears and they can get kind of stuck, and they can be hard to deal with.
**Reflection of feeling and content to demonstrate understanding and enhance the therapeutic alliance.**
C: Yeah
T: One way that we know can help with those thoughts is using an imaginal script. How this script would work is we would go pretty darn far with those fears. We might walk through.. So today at school I touched this and this happened and I got contaminated —one of those scripts you are familiar with. Then we take it to the next step by saying and then I came home, and I hugged Drew, or I touched Drew, and I had COVID on my hands, and now I gave it to him. Then we would kind of walk though Drew or your mom getting sick. We would talk about what you're noticing. All those fears that are coming up. All those thoughts that are coming up. We would say them aloud, and then really lean into the anxiety that we would feel about being responsible for that. The anxiety is about being responsible for someone else getting hurt?
C: Mmmhmm
T: And so we would walk through that script, and we really focus on that feeling of responsibility that anxiety, OCD is grabbing onto. While really talking through that worst case scenario
C: Mmmhmm
T: When we're doing this we're probably going to feel sad too, because nobody… it's hard to talk about our mom dying or our partner dying and so it's really natural to feel both sad and feel anxious while we're saying script of this nature. The purpose of the script is not to be comfortable with the sadness, but to get more exposure to those feelings of anxiety about being responsible for something like that. By talking through your belief, and doing that over and over again, and just seeing what happens as we continue to walk down that OCD kind of spiral — those feared thoughts we can get stuck in.
C: Mmhmmm
T: What are your thoughts about taking on something like that today for an in-session exposure?
**We are about to write/engage in a primary imaginal script. Imaginal scripts are an integral part of ERP. As they allow client's to confront fears that cannot be re-created in real life (e.g., giving a deadly illness to a loved one after touching something contaminated).**
C: I think it's doable. I like the concept of framing it as an exposure script rather than thoughts I have in a panic. Just for the sake of like when it's a script it feels more like I have control
T: Say more about what you mean about thoughts you have when you're in a panic?
C: So a lot of these thoughts they will come up when I’ve come home from work and I’ve opened a door, and I worry like what if Drew opens that door, and what if he get sick. Whenever
I have those thoughts, it's less of an exposure script and more of just me thinking in my head over and over again, Drew might die and it would be my fault.

T: Yeah, that makes perfect sense. In those moments, OCD is really loud and we're really getting stuck on those thoughts and can't get it out of our head. In that moment it's not an exposure, we're just really sitting in our own fear and discomfort. And you are right, by taking it into our own control and doing it outside of one of those really high, distressing, moments — especially when we're just getting started, can be helpful in the long run.

**What I said was unclear, “It sounds like facing thoughts about Drew has been really hard. You tried a to use a script and OCD thoughts just got stuck. It did not feel like other scripts you have done, and that makes sense. We have not had the chance to practice an exposure to those thoughts yet, and the thoughts that Drew might die because you contaminated something are really scary. I am thinking that practicing this script together could be really helpful” would have been a useful statement here.**

C: Mmhhmm.

T: Okay so if you're willing to do that today, I would like to work through coming up with that script.

C: Yeah

T: I think that that script will be most helpful if we try and tie it to an experience you've had recently, with coming into contact with something at school, or outside. Something that you really touched, so that we can really picture it. And then thinking about an interaction you've had with Drew. Have there been any recent interactions with your mom?

C: There have not.

T: Okay, so let's start with Drew, and then when we get to the part about your mom, let's frame it from I went and I hugged my mom and then this happened. That one will be more imaginal in nature since, there's not an experience lately that you could draw from.

C: Mmhmm

T: What questions do you have about developing this script?

C: I don't think I really have any. I think it's my understanding that... so basically like I think the best place to start would be my work bag because that one still gives me like quite a bit of anxiety. Just to backtrack a little bit, whenever I wipe down items at school, I will use one wipe, like one physical Clorox wipe, or whatever brand it is per item.

T: mmm okay

C: To kind of go back to the tracking...script that has like all my notes and stuff... A lot of the ones where I wipe down my phones twice, it was because I had used one wipe for both of them, and then thought that's not enough I need to go back and use one wipe per phone. So that's something I need to work on.

T: Okay

C: But yeah, I think my work bag would be a good place to start.

T: Today I don't, we don't need to touch our work bag to do this exposure. I'm not going to ask you to go touch your work bag and then go touch Drew. I just want you to say: Today when I got home from work, I carried my work bag in, and I put it inside. My work bag... at work today it was on the floor, or kind of walk through why COVID is on the work bag. Or, what is some interaction at school today that might have caused you to become contaminated? How you came home and interacted with things in your home, or interacted with Drew, and how he touched those things and then will get sick. As much as you can tie the script to things that have
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happened recently, today or in the past week, and then building on what has actually happened with what our OCD fears are telling us is going to happen.

C: Mmmkay

T: I know that this is probably a little bit challenging, but I think that you can do it, and we can work together to add to the script and make it really effective.

C: Okay

T: All right so what are your SUDS thinking about coming up with this script?

C: Just thinking about it I would probably put myself at like 5 or 6.

T: Okay so let's go ahead and just you start talking through. Start coming up with it aloud.

C: So at work today, well basically work this whole week, I have been touching like a lot of devices. Then throughout the day I more than likely had to touch my backpack before I was able to wash my hands or wipe it down. So from all of my interactions with people throughout the day and having to walk through all the halls, with all the schools back, there is a very high chance that I've been in contact with someone who has been exposed, or has COVID. That is something that might have stayed with me on my way home or may have been on something that I had touched. Whenever I got home, all the door knobs, all the light switches, the fridge door… all the things that I touched could have COVID on them. If I were to hug Drew whenever I got home there's always a chance that I could pass it on to him and he might get sick, and there's always a chance that someone could die from COVID and that might be him.

T: Great, did you hug Drew today when you came home from work? I know you guys are kind of on opposite schedules. Is that right?

C: Yeah, I didn’t. So I basically don’t see him till like 1 in the morning when he gets home.

T: Okay, so then let’s make our script about things that you touched when you came home, and then how he is going to touch those things. What I want to do for the purposes of this script is really walk through, Drew came home, and he touched the light switch that I touched when I had COVID on my hands, and then he got COVID. Whatever the fears are about him getting COVID and him dying, I want that to be … we're going to walk through that fear. I know we've been using a lot of mights or mays. For this exposure we're going to talk it through like it’s happening.

C: Okay. So whenever I get home I always use the door that goes from the garage into the basement and the door that goes from the basement to upstairs. Since it's that route, I don't get to wash my hands before anything else, and so I could…. so I have COVID on my hands. Those are the same doors and light switches that Drew l has to touch whenever he gets home… so umm…

T: Drew came home and he touched those door knobs…

C: Drew came home and he touched those door knobs and he got COVID, and he got bad, and he died from COVID because he touched the same surfaces I did.

T: Where are your SUDS at?

C: Um I would say like at a 9, 9 and a half.

T: I am writing out this script as we are talking through it, so that we can have a more concrete one that we can say. I want you to go through that again, and just continue adding as much detail as possible, and any new things that come up, feel free to add them. Okay?

C: mmhhmm

T: Let’s do that one again

C: This week all the kids came back and a lot of stuff is breaking, so I had a lot of visitors in my office today. There were a lot of incidents where someone would come into my office, or walk into the space they weren't supposed to, or touch things they weren't supposed to. There were a lot of instances where I touched my work bag without getting a chance to wash my hands or
sanitize it before. Through all of that I came home and I would always take the route of going from the basement … going from the garage to the basement to upstairs. I would touch a lot of doorknobs and light switches before I got a chance to wash my hands. Whenever that happens I have COVID on my hands that are now on the light switches or door knobs. Then Drew came home and he used all the same door knobs and light switches that I did. He opened the fridge door that I touched before I washed my hands as well. So as a result Drew got COVID because he touched all of the things that I did, and he died as a result.

T: Good. Alright, I have one that I'll keep adding to. I will send it to you in the chat. I really liked how you added a lot of details beginning of that script, to what was happening at work today. Where are your SUDS at?
C: Um I’d say still at a 9… I think there is more of the emotional component than the….
T: Yeah
C: So like there’s that weight there which isn’t great.
T: Yes, that is completely to be expected, in an exposure like this we are going to feel sad.
C: Mmhhmm

Client appears to be reading through script.
T: Can you see that chat?
C: Yeah I just got it.
T: Okay, and feel free to change it however. The beginning that you just gave was really good, and I didn't have the chance to change that yet.
C: Mmmhmm
T: Okay so let’s do it again
C: So do I just add stuff if it’s not in there?
T: Yup. Add it in.
C: Today at work and this week I've been touching a lot of devices and I had a lot of face to face interactions with students and teachers. I had to take devices from students and teachers and work on them before giving them back, and there were a lot of incidents where I just couldn't wash my hands. I had to touch both of my phones, and my backpack a couple of times when I didn't get to wash my hands or sanitize things. I may have come into contact with someone who has COVID, and I most likely came into contact with somebody with COVID multiple times this week. Whenever I came home I touched the door and the light switches that lead from the garage to upstairs before I had a chance to wash my hands. I had COVID on my hands and it got on the doorknob and light switches. Then when Drew came home he touched all those same places in order to get back into the house and he got COVID and it's my fault because I had touched them before I could wash and then he got really sick and then he died.
T: How is that script feeling? As far as, is it feeling real? Are we able to lean into the feelings of guilt about being responsible for Drew getting sick? What do we need to add?
*Checking in about what part of scripts are most bothersome, ensuring we are hitting the core fear.
C: I think it works. To a certain extent, I would say the consequence of thinking he got sick and died and it's my fault. I think that just that phrase holds a lot for me.
T: Is the it's my fault pretty important to OCD fears?
C: mmmhmm
T: Okay so let’s go through again and really focus on that part. So let's go through the story again, and when we get to the end let's say the part about: I had COVID on my hands and then
Drew came home and touched the doorknob and the light switches. He got COVID and it’s my fault because of something I did, and he got sick and died. Just say that end part several times.

**I could have increased the effectiveness of the script had I asked her to add details about what it was like to be responsible for Drew’s death. Does the guilt last forever and ruin her life?**

C: Okay, starting from the beginning and kind of repeating the end part?

T: Mmmhmm

C: Today at work, and this week I’ve been touching a lot of devices from students and teachers. Then throughout the day I would touch my backpack or my phones without washing my hands. Most likely I was in contact with several people that were either exposed to COVID, or were carrying it, or have it. Whenever I came home there are a lot of surfaces that I touched like the door and the light switches. I had COVID on my hands whenever I touched all those places. Whenever Drew came home, he touched all those same places that I did. So when he got COVID it was my fault because I had touched them, and I didn't wash my hands, and then he touched the same surfaces and maybe like touched his face before he had a chance to wash his hands. So when he got COVID it was because of my responsibility because I touched those surfaces. So whenever he got really sick it was my fault as well, because I didn't wash my hands before. Then he died and that was also my fault because he touched the door knobs and the light switches I had to touch whenever I came home, when I had COVID on my hands.

T: Really great job making that script your own. Where are your SUDS at?

C: I’d say still at a 9.

T: Okay, let's do that last part again.

**Recognizing that the last part of her script contains the feared outcome for her, exposure to that feared outcome becomes the focus of the exposure.**

C: Whenever I came home and I touched all the door knobs and light switches I had COVID on my hands, and I didn't wipe them down, or wash my hands before touching them and so then there was COVID on the doorknobs because of me and then when Drew came home he touched all those same door knobs and light switches, and he may have maybe eaten a snack or touched his face before he had a chance to wash his hands. When he got COVID it was because of me, and whenever he got really sick and died it was because I had not wiped down those surfaces or washed my hands before touching the surfaces.

T: Okay, go through it again

C: When I came home I touched the door and light switches when I had COVID on my hands and then whenever Drew came home he also touched all those doors and light switches and surfaces that I touched when I had COVID. So I basically gave COVID to him, and so when he got sick, when he got really sick, it was my fault because I gave him COVID and then when he died it was my responsibility because he touched the surfaces that I touched. Surfaces that I didn't wipe down after touching them when I had COVID in on my hands.

T: Okay. What are you noticing as we keep reading this script?

**Checking in with the client, and attempting to bring awareness to any changes she has noticed as we continue with the exposure. Awareness of new thoughts and anxiety levels can be important when debriefing after the exposure.**

C: Umm, I think towards the end I started saying he got it because of me; rather than saying he got it because he touched something that I touched. I think the more I went, the more I made it about it being about it's because of me, it’s because of something I did.
T: That is really what we want to do when we're developing these scripts; so you're doing a really good job of making this script really effective. Even though those things are really hard to say and really hard to think about. So let's do it a couple more times.

**Reinforcing the client for confronting a feared outcome. Providing encouragement.**

C: Okay so when I came home I touched the door and light switches when I had COVID on my hands because I was exposed to it at work. And then when Drew came home he touched all of the same surfaces, and so whenever he got sick it was because of me not wiping down the surfaces and when he got really sick it was because I didn't follow up, and didn't wipe down stuff and so I gave him COVID and he died.

T: Where are your SUDS at?
C: I want to say an 8, but I think it's still drifting like from a 9
T: Okay. It's okay if it's still at 9, this is a really, really hard exposure.

**The inhibitory learning model does not emphasize habituation as necessary part of exposure. Although her SUDS are still high it was appropriate to end the exposure. It was also the first time she has practiced an exposure to the core fear of causing harm to a loved one, so the high SUDS and lack of decrease make sense.**

C: Mmhmm
T: Did it ever get any higher than a nine?
C: I don't think so. Like for me whenever I think of a 10, I think of like completely incapacitating like I can't function or form words or anything like that so..
T: That makes sense, and that's why we call it the subjective...SUDS, subjective is the key word there
C: Mmhmm
T: Really great job of going through this script. I want you after session today to continue practicing with this, going through it just a few more times. Then every day this week when you get home from work I want you to go through something similar. Come up with a script based on what you touched that day. If you can tie it to a little part of your day and realize ...Yep that was where the COVID was, bring that in, and then talk about what you touched when you came home, and how Drew is going to touch those things, and he's going to get COVID. Really focusing on those OCD fears that it is going to be your fault.

**It may have been useful to give the client a chance to reflect on what she learned.**

C: Mmhmm
T: Okay
C: Mmhmm
T: What questions do you have about doing that this week?
C: I don't think I have any.
T: Okay. I can send you this one that we made today, but it seems like you really were doing awesome coming with those words on your own, and you were able to do that. If you would like it, I’ll send it to you. I also feel pretty confident in your ability to come up with scripts that are reflecting the fears in your head.
C: I did already copy it so I do have it.
T: Okay perfect, you are on top of it. What other thoughts or reactions do you have to today?
C: Umm I think the exposure script of thinking through the consequence of Drew getting COVID because of me I think that's going to be a really, really big challenge.
T: Mmhmm, and so what do you think our goal is, when we're spending time focusing on those fears? Why might I ask you to do a script like this?
*The rationale behind imaginal scripts can be difficult for clients to understand. Asking her to explain why is a good way to check for understanding and provides an opportunity to provide corrective information about the rationale.*

C: I think the goal is to not necessarily be comfortable with the idea of giving him COVID. But more so not letting those thoughts spiral into I need to clean this, this, and this because I don't want him to die. Kind of… not necessarily like detaching the idea of him dying to my actions, but rather um just kind of forcing myself to walk through it and acknowledge it as like this is OCD. Rather than like… not tying an action to the thought

T: Yes, by allowing ourselves to focus on those fears or really telling ourselves: This is OCD, I can handle thinking about these fears, I can handle saying these things aloud, and you know with the goal of eventually getting to the place where… yes that is OCD and I know how to handle it. I know how to say: thank you OCD for that lovely thought that I'm going to be responsible for Drew's death, and I'm going to ask you to get on out of here.

**Rather than saying “I am going to ask you to get on out of here” I could have said “I don’t need to pay attention to you, you do not control my life. This is more consistent with learning to how to recognize and ultimately disengage from ignore obsessions/intrusive thoughts. The way it was originally said implies that she can get rid of obsessions.**

C: Mhmhm

T: This is a hard task to do, but I think that you can do it

C: Right, like differentiating between what’s OCD, and what's a reasonable fear.

T: Right and the more that we sit with things that we’re afraid of, we can become more comfortable with them. Even though the thought of giving Drew COVID is really really distressing right now, you might be surprised that if the more that you sit with this and more that we say these things aloud, we're not sure what's going to happen, but you might surprise yourself. It might become the that feeling of responsibility becomes less distressing

C: Mhmhm.

T: We can’t…we don't know what's going to happen, but we can certainly try it out

C: Yeah that makes sense

T: Okay so any other things that we missed today that we need to talk about? Questions that you have about our goals for the week?

C: Um… I don’t think so

T: Okay, so we're going to go to Target. Let's continue taking on exposures as they come, you've been doing a really great job doing that, and then we're going to add in this this script everyday.

**Encouraging the client to practice the exposure every day is consistent with the inhibitory learning model/maximizing the effectiveness of exposure. Spaced practice as well as varying the content (based on what she experienced that day) are important.**

C: Okay

T: Okay. Really awesome work today. Next week it'll be both Katie and I. Is 4:00 or still working? Is it still good on Thursdays?

C: Yes it is.

T: Okay so we will plan to see you at 4 next week. Just stick with that script for maybe 10 more minutes. Really, Really great work today.

C: Alright thank you

T: We’ll see you later

C: Alright, bye

T: Bye