BRAINBODY OCD Counseling

EXPOSURE AND RESPONSE PREVENTION (ERP)

WORKBOOK

PRACTICAL TOOLS FOR A CALMER MIND
AND A BRIGHTER TOMORROW

A Clear Path Forward for OCD & Anxiety

This workbook belongs to:

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MODULE 1: INTRODUCTION

Goals in this module:

1. Understand what Obsessive Compulsive Disorder (OCD) is and how it develops
2. Learn about the treatment for OCD and why this treatment is effective
3. Understand how inhibitory learning occurs during Exposure and Response Prevention (ERP)
4. Determine if Exposure and Response Prevention (ERP) is right for you

OCD OVERVIEW

Obsessive Compulsive Disorder includes three primary characteristics: obsessions, compulsions, and significant distress or interference in daily life. Although OCD can look very different from person to person, these three components help us understand how the disorder develops and why it can become so persistent.

1. Obsessions

Obsessions are recurrent thoughts, images, impulses, sensations, or doubts that are unwanted or distressing. Common types of obsessions include fears of contamination, illness, or serious disease; excessive doubt; intrusive thoughts about harming others; unwanted sexual thoughts; religious or moral concerns; fears of making a serious mistake; feelings that things are “not just right”; and perfectionism.

The content of an obsession is often less important than the meaning OCD assigns to it. A thought that another person might briefly notice and dismiss can feel extremely important, dangerous, or urgent to someone with OCD.

2. Compulsions

Compulsions are physical or mental acts that an individual feels driven to perform, often according to rigid rules. These can include more obvious behaviors such as excessive washing, checking, or re-checking, but they can also include less obvious behaviors such as seeking reassurance, mentally reviewing an event, replacing “bad” thoughts with “good” thoughts, confessing, researching, praying, or trying to figure something out until it feels certain.

Avoidance can also function like a compulsion. A person may avoid certain people, places, objects, thoughts, situations, or activities because avoiding them temporarily reduces distress or decreases the chance of having an obsession.

Most compulsions are attempts to reduce distress, prevent a feared outcome, or obtain certainty. Unfortunately, although compulsions may provide temporary relief, they can also teach the brain that the obsession was important and that the compulsion was necessary.

For example, imagine that someone has the thought, “What if I left the stove on?” They check the stove and briefly feel better, but the brain may learn, “When I feel uncertain, I need to check.” The next time uncertainty appears, the urge to check can become even stronger.

This is one of the reasons OCD can become such a powerful cycle. ERP helps interrupt this cycle by teaching the brain that fear, uncertainty, and intrusive thoughts can be experienced without automatically performing a compulsion.

3. Distress

The obsessions and compulsions cause distress, take up significant amounts of time, or interfere with daily functioning. OCD can affect relationships, school, work, parenting, sleep, hobbies, decision-making, and many other parts of life.

It can sometimes feel like you are the only person struggling with OCD, but you are not alone. OCD is treatable, and with effective treatment, people can significantly reduce the amount of time and energy controlled by OCD and return their attention to the things that matter most to them.

OCD commonly begins during the teenage years or young adulthood, although symptoms can appear at many different ages. Symptoms may also change over time or become more noticeable during periods of stress or major life transitions.

TREATMENT OVERVIEW

The gold-standard psychological treatment approach for OCD is called **Exposure and Response Prevention (ERP),** which is the focus of this workbook. ERP is a form of cognitive behavioral therapy that helps you approach the thoughts, situations, sensations, images, memories, or uncertainties that trigger OCD while learning to respond differently.

ERP includes both **exposure** and **response prevention**. Exposure means intentionally approaching something that activates the OCD fear, while response prevention means choosing not to perform the compulsions, avoidance behaviors, reassurance seeking, mental rituals, or other safety behaviors that OCD normally uses to reduce distress.

ERP treatment generally includes the following steps:

Step 1: Introductory Phase

This program begins with understanding what OCD is and how the OCD cycle develops. Your therapist will explain the details of ERP, identify how OCD is operating in your life, and help you understand why compulsions often strengthen the problem over time.

During your initial visits, your therapist will ask about your specific obsessions and compulsions. They will also explore situations that trigger OCD, what you fear might happen, what you do to prevent that feared outcome, and the ways you try to obtain certainty or reduce distress.

During this first phase, you may also be asked to monitor your obsessions and compulsions on a regular basis. This helps you and your therapist identify patterns that can later become targets for exposure and response prevention.

Step 2: Treatment Phase

Once you understand what OCD is, what triggers it, and the nature of your obsessions and compulsions, you will work with your therapist to collaboratively create an exposure hierarchy or exposure map. This will include situations, thoughts, images, sensations, and uncertainties related to your OCD fears.

Your exposure plan may include both real-life and imaginal exposures. The purpose of these exercises is to help you confront feared situations and uncertainties while resisting the compulsive responses that OCD tells you are necessary.

In addition to practicing exposures, you will learn HOW and WHY to begin reducing compulsions and avoidance. Exposure and response prevention together create opportunities for the brain to develop new learning about fear, uncertainty, distress, and your ability to choose how you respond.

HOW ERP WORKS: HABITUATION AND INHIBITORY LEARNING

In the past, exposure therapy was often explained primarily through a process called **habituation**. Habituation means that when a person stays in contact with something that creates anxiety for long enough, the anxiety may naturally decrease over time.

For example, a person might begin an exposure with a distress rating of 80/100 and notice that the distress eventually falls to 40/100. Older models of exposure placed a great deal of emphasis on this decrease in anxiety and sometimes treated the reduction itself as evidence that the exposure had worked.

Anxiety reduction can certainly happen during ERP, and it can be a welcome result of treatment. However, research and clinical practice have increasingly emphasized that anxiety does not have to decrease during an exposure for meaningful learning to occur.

Sometimes anxiety goes down during an exposure, while other times it remains elevated or moves up and down. A person may even finish an exposure still feeling very anxious, and that does not mean the exposure failed.

Modern ERP places greater emphasis on a model called **inhibitory learning theory**. Rather than focusing primarily on making fear disappear, inhibitory learning focuses on helping the brain build new learning that can compete with the old fear-based learning.

For example, your brain may have learned, “If I feel contaminated, I need to wash my hands.” During ERP, you practice a different response and begin learning, “I can feel contaminated and choose not to wash compulsively.”

Your brain may have learned, “If I am not certain, I need to check.” During ERP, you practice learning, “I can feel uncertain and still leave without checking again.” The goal is not necessarily to erase the original fear association. Instead, ERP helps create new learning that becomes increasingly available when OCD is triggered.

The old pathway may say, “This feeling is dangerous, so I need to do something immediately.” The newer pathway may say, “I can experience this thought, feeling, or uncertainty without responding with a compulsion.”

Over time, the goal is for this new learning to become stronger, more flexible, and easier to access. This is why repeated practice is so important in ERP. The emotional processing centers associated with OCD learn best through repeated experience, not logic or words.

THE GOAL IS NOT TO MAKE ANXIETY GO AWAY

One of the most important differences between a purely habituation-based approach and an inhibitory learning approach is the goal of the exposure. In modern ERP, we are not requiring anxiety to decrease during every exercise.

If you approach an exposure believing, “I have to stay here until my anxiety goes away,” your brain may accidentally learn another rule. It may begin to believe, “I can only handle this situation if I eventually feel calm.”

Instead, we want your brain to learn that you can continue even when anxiety is present. You can feel uncertain, uncomfortable, afraid, or distressed and still choose not to perform a compulsion.

For example, you may begin an exposure at 70/100 distress level and end at 70/100 distress level. That exposure can still be very successful if you practiced resisting a compulsion, tolerated uncertainty, or discovered that you could continue functioning while distress was present.

Anxiety often decreases over time with repeated ERP practice, and many people ultimately experience significant relief. However, anxiety reduction is better viewed as a possible outcome of treatment rather than the requirement for a successful exposure.

WHAT ARE WE TRYING TO LEARN DURING EXPOSURE?

Before an exposure, it is often helpful to identify what OCD is predicting. OCD may predict that something terrible will happen, that you will not be able to tolerate the distress, that an intrusive thought means something important about you, or that you must obtain certainty before you can move forward (this helps us to identify the core fear associated with the obsession).

During exposure, you intentionally allow the fear or uncertainty to be present while resisting your usual compulsive response. This gives your brain an opportunity to discover information that would be difficult to learn while you are avoiding, checking, washing, seeking reassurance, or mentally neutralizing.

After an exposure, you and your therapist may discuss what you learned. You may discover that the feared event did not occur as OCD predicted, or you may discover that you were able to tolerate more distress than expected.

You may also learn that you do not need complete certainty before continuing with your day. In other situations, the learning may simply be that an unwanted thought or feeling can be present without requiring you to do anything about it.

These are examples of **inhibitory learning**. The goal is to develop a broader set of responses so that OCD is no longer the only pathway your brain knows how to follow.

EXPECTANCY VIOLATION

An important concept in inhibitory learning is called **expectancy violation**. This means paying attention to what you predicted would happen before an exposure and then comparing that prediction with what you actually experienced.

For example, a person might predict, “If I do not check the door again, I will not be able to leave the house.” During the exposure, the person locks the door once, experiences significant uncertainty, and leaves without checking again.

The person may still feel anxious after leaving, but something important has been learned. The prediction that they would be unable to leave without checking was not accurate, and the brain has now experienced another possible response.

Another person may predict, “If I touch this object and do not wash, the anxiety will become unbearable.” The anxiety may become very uncomfortable, but if the person is able to continue without washing, the brain can learn that distress can be tolerated without performing the ritual.

In OCD treatment, we are not always trying to prove that a feared event could never happen. Trying to obtain that type of guarantee can itself become another form of reassurance and another attempt to achieve certainty.

Instead, we are helping you learn that uncertainty can exist without requiring a compulsive response. We are also helping you discover that OCD’s predictions about danger, distress, and your ability to cope are often incomplete or exaggerated.

WHY WE VARY EXPOSURES

Another important part of inhibitory learning is **variability**. We want the new learning you develop during treatment to work in many different situations, not only under one very specific set of circumstances.

For example, if you repeatedly touch the same doorknob in your therapist’s office, your brain might learn, “This particular doorknob is okay.” Although that is helpful, it is more limited than the broader learning we want to develop.

Instead, your therapist may have you practice with different doorknobs, different public places, different surfaces, and different levels of uncertainty. The goal is for your brain to learn, “I can experience contamination uncertainty in many different situations without automatically responding with a compulsion.”

Exposures may therefore be practiced in different locations, at different times, with different people, and under different emotional conditions. Sometimes the same exposure may be repeated, while other times small details will intentionally be changed.

This process helps the learning **generalize**. Generalization means that the new response becomes useful across many different situations rather than remaining tied to one specific exposure.

YOUR EXPOSURE HIERARCHY IS A LEARNING MAP

Traditionally, exposure hierarchies were often described as ladders. A person might begin with a lower-SUDS exposure, repeat it until the anxiety decreased, and then gradually move toward more difficult items.

There can still be good reasons to begin with more approachable exposures, especially early in treatment. Starting with manageable challenges can help you understand how ERP works and give you experience practicing response prevention.

However, an inhibitory learning approach does not require the hierarchy to be followed in a perfectly rigid order. You do not have to wait until one exposure feels easy or produces very little anxiety before practicing another.

Instead, it can be more helpful to think of your hierarchy as an **exposure map or learning map**. You and your therapist may move between exposures depending on what will create the most useful learning.

You may repeat an exposure, modify it, combine two exposures, or practice the same core fear in several different settings. Sometimes you may complete a more manageable exposure and at other times intentionally choose something more challenging.

The goal is not simply to make your way from the bottom of a ladder to the top. The goal is to create many different learning experiences that teach your brain that fear, uncertainty, and intrusive thoughts can be approached without relying on compulsions.

HOW SUDS FIT INTO INHIBITORY LEARNING

SUDS stands for **Subjective Units of Distress or Discomfort** and is usually rated from 0 to 100. A rating of 0 means little or no distress, while a rating of 100 represents the highest level of distress you can imagine experiencing.

SUDS are useful for describing your experience and helping you and your therapist plan exposures. They can help identify which situations feel more approachable and which situations are likely to be more challenging.

However, SUDS are not the outcome we are trying to change during the exposure. You do not need to wait for your SUDS to drop before an exposure is considered successful, and you do not need to repeat an exposure until it produces little or no distress.

Instead, your therapist will also be interested in what OCD predicted, what compulsion you resisted, what uncertainty you allowed, and what you learned from the experience. These questions keep the focus on new learning rather than simply trying to make anxiety disappear.

WHY RESPONSE PREVENTION MATTERS

Exposure by itself is not the entire treatment. The second part of ERP is **Response Prevention**, which means reducing the compulsions, avoidance behaviors, reassurance seeking, mental rituals, and safety behaviors that OCD typically uses to reduce distress or uncertainty.

Response prevention is essential because performing a compulsion during or immediately after an exposure can interfere with the new learning we are trying to create. If you touch a feared surface and immediately wash your hands, your brain may conclude, “I was okay because I washed.”

If instead you touch the feared surface and resist the excessive washing ritual, your brain has an opportunity to develop a different association. You may begin learning, “I can experience this uncertainty and continue without performing the compulsion.”

This is why both parts of ERP matter. Exposure activates the fear or uncertainty, while response prevention creates an opportunity for your brain to learn a different way of responding.

BENEFITS AND RISKS OF TREATMENT / MEDICATIONS

Benefits

Over the past several decades, numerous high-quality studies have supported ERP as an effective treatment for OCD. One of the goals of treatment is to help you eventually become increasingly capable of using these strategies independently in your everyday life.

The primary goal of ERP is to reduce the amount of time, energy, and resources spent responding to OCD. As compulsions and avoidance decrease, people often have more time and freedom to focus on relationships, work, school, hobbies, family, and other personally meaningful goals.

As treatment progresses, many people also notice that their anxiety becomes less intense or less frequent. This is a valuable benefit, but the treatment does not work by forcing anxiety to disappear.

Instead, repeated practice helps your brain develop new learning about uncertainty, intrusive thoughts, distress, and your ability to choose your behavior. Over time, OCD often becomes

less powerful because the brain has learned that these experiences do not automatically require a compulsive response.

Risks

The primary risk with ERP is the temporary discomfort or emotional distress that can occur when confronting anxiety-provoking situations, thoughts, images, sensations, and objects. This discomfort is expected because exposure intentionally activates the very experiences that OCD has taught you to avoid.

During ERP, anxiety may increase, decrease, remain elevated, or move up and down. The goal is not to make anxiety decrease during every exercise, but rather to help you learn that distress and uncertainty can be experienced without automatically engaging in compulsions.

This can be uncomfortable at first, but repeated practice can help you develop a greater sense of mastery over your response to distress. You begin learning that anxiety does not have to determine what you do next.

Medications

Medication can also be helpful for some people with OCD, particularly when symptoms are severe or make it difficult to participate fully in ERP. Decisions regarding medication should be made with a qualified medical provider who can consider your individual symptoms, medical history, and treatment needs.

One important consideration in ERP is how any coping strategy is being used. If a medication or another strategy is repeatedly used as an immediate way to escape distress or guarantee that an exposure will feel manageable, it can sometimes function similarly to a safety behavior.

This does not mean appropriate medication should be discontinued or avoided. Rather, your therapist and medical provider can help determine how medication can best support treatment without unintentionally interfering with opportunities for new learning.

WHAT TO EXPECT IN TREATMENT

Overview

ERP is an active form of treatment. This means that treatment involves more than talking about your fears or understanding where they came from, because meaningful change also requires practicing new behaviors.

The frequency and length of treatment may vary depending on your individual needs, symptom severity, availability, and treatment setting. Your therapist will work with you to determine an appropriate schedule and treatment plan.

Structure of Sessions

STEP 1

During your first few sessions, you will complete your intake appointment and assessments. Your therapist may ask about developmental history, mental health history, medical history, symptom history, and other factors that may be important for understanding your current concerns.

Your therapist will also complete an in-depth assessment of your obsessions and compulsions. This includes identifying avoidance, reassurance seeking, mental rituals, and other less obvious behaviors that may be keeping the OCD cycle going.

You will then receive an explanation of OCD and why ERP can be helpful. You may also begin monitoring your obsessions and compulsions between sessions so that you and your therapist can better understand your patterns.

STEP 2

In this step, you will review your self-monitoring with your therapist and begin creating an exposure hierarchy or learning map. SUDS ratings can be used to estimate how distressing different exposures may feel and help guide treatment planning.

Remember that the purpose of the hierarchy is not simply to make your anxiety decrease. The hierarchy is designed to create opportunities for new learning and to help you practice responding differently to fear and uncertainty.

Your therapist may therefore ask what OCD predicts will happen, what you usually do to prevent that outcome, and what new response you want to practice. You will also discuss what uncertainty you are learning to tolerate and what compulsion you will work on resisting.

STEP 3

You will begin sessions by reviewing self-monitoring and exposure practice completed since your previous appointment. Your therapist will then teach you more about exposure and response prevention and begin practicing exposures with you in session.

During exposures, you may record SUDS, but you will also pay attention to your predictions and what you learn. The goal is not simply to watch a number decrease, because valuable learning can occur even when anxiety remains present.

You will then develop a plan to practice the same exposure or a useful variation of it outside of session. Practicing in different settings is important because we want the learning to carry over into your everyday life.

STEP 4

As treatment continues, sessions will begin with a review of your between-session practice. Your therapist may also introduce imaginal exposure when it is appropriate for your particular OCD symptoms.

Imaginal exposure is especially helpful when the feared outcome cannot, should not, or realistically cannot be recreated in real life. The purpose is to intentionally contact the feared thought, image, or possibility while resisting the urge to check, reassure, neutralize, avoid, or mentally solve it.

The goal of an imaginal exposure is not to convince yourself that the feared outcome will definitely never happen. Instead, the goal is to practice allowing uncertainty and difficult thoughts to exist without performing compulsions to make them feel resolved.

ONGOING EXPOSURE PRACTICE

As treatment progresses, sessions will continue to follow a similar structure. You will review home practice, complete therapist-guided exposures, discuss what you learned, and develop new exposure exercises to practice between sessions.

Your exposures may become more challenging over time, but they may also become more varied. Your therapist may repeat exposures, change important details, combine triggers, or practice the same fear in different situations to strengthen and generalize the new learning.

This variability is an important part of inhibitory learning. We do not want your brain to learn only that one particular exposure was manageable; we want it to develop broader learning that can be applied when OCD appears in new situations. For example, the goal is not simply to learn, “That doorknob was okay.” The broader goal may be to learn, “When OCD gives me contamination uncertainty, I do not have to solve it by washing.”

Toward the end of treatment, you and your therapist will review your progress and develop strategies for maintaining the gains you have made. You will also discuss how to respond when old OCD fears or urges return. It is important to understand that the return of anxiety or intrusive thoughts does not mean treatment has failed. Old fear learning may sometimes return, but you now have a stronger and more flexible response available.

WILL THIS TREATMENT HELP ME?

Is this treatment right for you?

If you are experiencing obsessions that cause distress and you engage in compulsions or avoidance that take up significant time or energy, ERP may be an appropriate treatment. Your therapist will work with you to determine whether ERP fits your symptoms and current treatment needs.

Many people with OCD also experience depression, generalized anxiety, panic, trauma-related symptoms, or other concerns. Your therapist will consider the full picture and help determine which symptoms should be addressed first and how treatment should be structured.

If you are experiencing a mental health crisis, significant safety concerns, or difficulty participating in treatment because of another condition, additional support may be needed before or alongside ERP. Treatment should always be individualized based on your current needs and level of functioning.

What makes treatment most effective?

One of the most important factors in treatment is willingness to practice. ERP can be difficult because it asks you to approach experiences that OCD has taught you to avoid and to resist behaviors that may have provided relief for a long time.

You do not need to feel fearless or completely confident before beginning. Your therapist can help you begin with exposures that feel challenging but approachable and gradually expand your practice as your skills develop.

Regular practice is also important because the brain learns through repeated experience. The more opportunities you have to practice responding differently to fear and uncertainty, the more opportunities you create for new learning.

Variety also matters. Practicing the same core lesson across different situations helps the brain retrieve the new learning when OCD appears outside the therapy office.

Ways to Increase Motivation

Treatment is collaborative and led by you. Your therapist will guide you, provide ideas, and help design exposures, but ERP is most effective when you understand why you are practicing an exercise and are actively involved in choosing your treatment goals.

It can also be helpful to explore what compulsions are costing you. Consider how much time and energy OCD takes from your day and what you might be doing if you were spending less time checking, washing, reviewing, reassuring, avoiding, or trying to obtain certainty (this is part of why treatment starts with a self monitoring log).

ERP requires practice rather than only talking about exposures. Understanding OCD is important, but the brain develops new learning when you actually practice approaching fears and responding differently. Try not to become overly focused on the exposures at the top of your hierarchy. You can begin with more approachable exercises and build experience as you go, and your hierarchy can change throughout treatment.

It is also important not to minimize compulsions simply because they appear small or harmless. Each time a compulsion is used to resolve OCD uncertainty, the brain may receive the message that the ritual was necessary. Finally, support from other people with OCD can sometimes increase motivation and reduce isolation. Support groups can be helpful when they

reinforce ERP principles and recovery rather than reassurance, symptom comparison, or avoidance.

MODULE 2: ASSESSMENT

Goals in this module:

1. Complete the intake and OCD assessment with your therapist
2. Learn how to apply the information in Module 1 to your individual OCD symptoms
3. Identify your obsessions, compulsions, triggers, and patterns
4. Introduce and start self-monitoring

INTAKE INTERVIEW

During your first couple sessions, your therapist will be asking you about your history. This information helps your therapist understand not only your OCD symptoms, but also the larger context of your life and any other factors that may be important for treatment. They will ask questions about:

- Medical history and current medications
- Family of origin history and relationship with various family members
- Developmental history (did you hit all of your milestones on time?)
- Current living arrangement
- Educational history and current school/work history
- Dating and marital history
- Mental health history and history of mental health diagnoses in your family
- Any significant legal history or involvement
- Lifestyle information (exercise habits, eating habits, sleeping habits)
- Mental health symptoms including onset, severity, and how you experience these symptoms on a day-to-day basis

After the initial evaluation and if time permits, your therapist will then complete an OCD assessment called the **Yale-Brown Obsessive-Compulsive Scale (Y-BOCS)**. This is a detailed assessment about the nature and severity of your obsessions and compulsions that helps the therapist create a baseline of functioning. If you are also experiencing other symptoms, such as anxiety and depression, your therapist may also administer additional assessments to get a good idea of where you are currently.

These assessments are not tests that you pass or fail. They provide you and your therapist with a starting point so that symptoms and progress can be measured throughout treatment. After completing ERP, you may complete these assessments again to help measure progress in therapy.

APPLYING WHAT YOU LEARNED IN MODULE 1

In Module 1, you learned that OCD involves obsessions and compulsions and that compulsions can provide temporary relief while unintentionally strengthening the OCD cycle. You also learned that ERP works by helping the brain develop new learning through approaching feared thoughts, situations, feelings, and uncertainty while resisting compulsive responses.

In this module, we will begin applying those concepts specifically to **your OCD**. The goal of assessment is not simply to identify which thoughts bother you. We also want to understand what triggers those thoughts, what you fear might happen, what you do in response, and how those responses may be keeping the OCD cycle going.

This information will eventually help you and your therapist determine what needs to be targeted during exposure and response prevention. The better we understand your individual OCD cycle, the more specifically we can design treatment around the patterns that are maintaining it.

IDENTIFYING YOUR OCD CYCLE

Although the specific content of OCD can vary significantly from person to person, the general cycle is often similar. Something triggers an obsession, the obsession creates distress or uncertainty, and the person feels an urge to do something to reduce the distress or prevent a feared outcome.

For example, someone may have the thought, “What if I accidentally hurt someone?” The thought creates anxiety, guilt, or uncertainty, which leads the person to mentally review what happened, seek reassurance, avoid certain situations, or try to prove that they would never hurt anyone.

The compulsion may provide temporary relief, but the relief does not last. When the thought or uncertainty returns, the person feels another urge to perform the compulsion. Over time, this repeated pattern can teach the brain that the obsession requires attention and that the compulsion is necessary.

During assessment, you and your therapist will begin identifying this cycle in your own symptoms. We want to understand not only **what you fear**, but also **what you do because of that fear**.

HOW OCD DEVELOPS

Understanding how OCD develops and is maintained helps us understand why ERP targets both fear and compulsive responding. There are biological factors that may contribute to vulnerability to OCD, while learning processes can help explain how individual fears and compulsions become stronger over time.

Neurobiology of OCD

Research suggests that OCD involves differences in brain circuits responsible for detecting potential threats, recognizing when something may be wrong, and deciding when a response is complete. One commonly studied network involves connections between the frontal areas of the brain and deeper structures such as the striatum, sometimes referred to as cortico-striato-thalamo-cortical (CSTC) circuitry.

In OCD, these systems may have difficulty signaling that a potential problem has been sufficiently addressed, which can contribute to the persistent feeling that something still needs attention. This may help explain why a person can logically know that the door is probably locked while still experiencing a powerful feeling that they need to check one more time.

Importantly, these brain patterns are not fixed, and effective treatment can change how the brain responds to OCD over time. There is also evidence that genetic factors contribute to OCD, which is why OCD and related conditions can sometimes occur within families.

Emotional Learning Theory

One cognitive and behavioral framework for understanding how OCD develops and is maintained focuses on emotional learning. According to this framework, certain fear associations are learned. In the case of OCD, a thought that is initially harmless, such as “I might hurt my dog,” can begin to create a fear response and increase anxiety. Over time, the brain starts responding to the obsessive thought as though it represents danger, even though the thought itself is not an action.

To demonstrate what we mean, think about camping in the woods and hearing a bear outside the tent. This would be a very appropriate event to fear, causing a fight-or-flight response for survival. Now imagine a person safe in their bed THINKING about camping with a bear outside the tent. The person can experience a similar fear response even though there is no bear currently outside their bedroom.

In OCD, after feeling distress from a thought, such as “What if I contract HIV?”, a person may find temporary relief after doing a compulsion, such as excessively washing their hands. Initially, this makes them feel better in the moment, but what is actually happening is that the compulsion can reinforce the fear. The temporary relief that is felt after the compulsion can teach the brain that the obsession represented danger and that the compulsion was necessary.

As you learned in Module 1, we want to train the brain to respond differently to these thoughts, fears, and the uncertainty connected to them. The brain learns through experience, so approaching the fear while resisting compulsions creates opportunities for new learning that can compete with the old fear learning.

This is why assessment is so important. Before we can create effective exposures, we need to understand **what your brain has learned to fear and what behaviors you have learned to use in response to that fear**.

IDENTIFYING YOUR OBSESSIONS

For the first few sessions, you will work with your therapist to collect a list of symptoms and identify situations that trigger them. This includes identifying the thoughts, images, impulses, sensations, memories, or doubts that tend to get your attention and create distress.

It is important to be as open as possible about the content of your obsessions, even when they feel embarrassing, disturbing, irrational, or difficult to discuss. OCD frequently attaches itself to

topics that are deeply important to the person, which is one reason the thoughts can create so much distress.

Your therapist is interested not only in the specific thought but also in the **fear underneath the thought**. Two people can experience the same intrusive thought while fearing very different consequences, so understanding the meaning that OCD assigns to the thought is an important part of treatment planning.

For example, two people may both repeatedly check the stove. One person may fear accidentally starting a fire and harming their family, while another may fear being legally or morally responsible if something goes wrong. The behavior looks similar, but the core fear may be different.

IDENTIFYING YOUR COMPULSIONS

You and your therapist will also develop a detailed list of your compulsions. Some compulsions are easy to recognize, such as excessive washing, checking, repeating, arranging, or asking another person for reassurance.

Other compulsions happen entirely inside the mind and can be more difficult to recognize. These can include rumination, mentally reviewing events, analyzing thoughts, replacing “bad” thoughts with “good” thoughts, mentally checking how you feel, praying in a ritualized way, or repeatedly trying to determine whether something is true.

Avoidance is also important to identify. You may avoid certain people, places, objects, activities, words, thoughts, memories, or situations because they trigger OCD. Although avoidance can reduce distress in the short term, it can also prevent the brain from having opportunities to develop new learning.

It is also important to identify reassurance seeking and research behaviors. Repeatedly asking someone whether you are okay, searching online for answers, comparing your experience with other people's experiences, or repeatedly looking for evidence that a feared outcome will not happen can all function as compulsions when they are being used to resolve OCD uncertainty.

IDENTIFYING TRIGGERS AND PATTERNS

Once you begin identifying your obsessions and compulsions, you and your therapist will also look for patterns. Certain situations may repeatedly trigger OCD, while certain compulsions may occur across several different fears.

For example, someone may seek reassurance about contamination, relationships, mistakes at work, and whether they offended another person. Although the content changes, the underlying pattern may be the same: OCD creates uncertainty and the person seeks reassurance to make the uncertainty go away.

Recognizing these patterns helps us move beyond treating every obsession as a completely separate problem. Instead, you and your therapist can begin identifying the larger patterns of fear, uncertainty, avoidance, and compulsive responding that ERP will target.

PREPARING FOR EXPOSURE WORK

Once you and your therapist have a good understanding of your symptoms, you will begin developing your exposure hierarchy. You will identify situations, thoughts, images, sensations, or uncertainties that activate your OCD and estimate the distress associated with them using SUDS.

As discussed in Module 1, the hierarchy does not have to function as a rigid ladder that you complete from lowest to highest. SUDS help you and your therapist plan exposures, but the purpose of treatment is to create new learning rather than simply repeat an exposure until your anxiety decreases.

Your therapist will use the information gathered during assessment to create exposures that target your individual fears and compulsive responses. Exposures can then be varied across situations so that the new learning becomes more flexible and can be applied outside of the therapy office.

Exposure work will generally begin after you and your therapist have developed a clear understanding of your symptoms and treatment targets. You will first practice confronting feared situations and thoughts with your therapist so that you can learn how to practice ERP effectively outside of sessions.

SELF-MONITORING

One of the most important parts of the assessment phase is **self-monitoring**. OCD happens throughout your everyday life, so self-monitoring helps you and your therapist see patterns that may not be obvious during a therapy session.

Self-monitoring is not meant to become another activity that you have to perform perfectly. The goal is to collect useful information about when OCD occurs, what triggers it, and how you respond.

When an obsession or trigger occurs, try to identify what happened, what thought or fear showed up, and what you felt an urge to do in response. Pay particular attention to compulsions that may happen automatically or mentally, because these can sometimes be harder to recognize.

You will also begin noticing how much time you spend engaging in compulsions and avoidance. This helps establish a baseline and allows you and your therapist to see how these behaviors change throughout treatment.

When self-monitoring, make sure you are recording the following:

- Triggers and situations that activate OCD

- Obsessive thoughts, images, impulses, sensations, or doubts
- Mental and behavioral rituals
- Avoidance and reassurance seeking
- The amount of time you spend engaging in rituals
- SUDS or distress when useful
- Patterns you notice across different situations

Try to record the information as close as possible to when the OCD symptoms occur, while keeping your entries short and simple. We want self-monitoring to help you recognize OCD patterns without becoming another activity that requires excessive analyzing or certainty.

Later, when you begin completing exposures, your monitoring will expand beyond simply recording symptoms. You will also begin paying attention to what OCD predicted, what compulsions you resisted, what uncertainty you allowed, and what you learned from the experience.

The information you collect during this module will become the foundation for the next phase of treatment. Rather than creating exposures based only on what makes you anxious, you and your therapist will use these patterns to develop exposures that specifically target **the fear learning and compulsive responses that are keeping your individual OCD cycle going**.

MODULE 3: EXPOSURE PRACTICE & MOVING FORWARD

Goals in this module:

1. **Create and begin working through your hierarchy of exposures**
2. **Practice exposures in and outside of sessions and monitor progress**
3. **Learn how to use imaginal exposure and response prevention when appropriate**
4. **Prepare for the end of treatment and relapse prevention**

CREATING YOUR HIERARCHY OF EXPOSURES

A central part of ERP involves intentionally approaching situations, thoughts, sensations, images, or uncertainties that trigger your OCD while practicing **response prevention**, choosing not to perform the compulsions or avoidance behaviors OCD typically uses to create relief or certainty.

In Module 2, you and your therapist identified your obsessions, compulsions, triggers, patterns, and core fears. You will now use this information to create a collection of exposures that target these fears in different ways and across different situations.

Rather than creating only one simple ladder from “easiest” to “hardest,” you will develop a broad collection of exposures connected to your core fears and feared outcomes. Exposures may vary by setting, person, object, level of uncertainty, physical sensation, wording, or other details. Practicing across many examples helps your brain develop learning that is more flexible and more likely to carry over into everyday life.

You will estimate the distress or discomfort associated with each exposure using the **SUDS scale (Subjective Units of Distress)** from 0–100. A rating of 0 represents little or no distress, while 100 represents the highest level of distress you can imagine experiencing. A rating around 50 might represent noticeable discomfort that still feels manageable.

As you learned in Module 1, SUDS ratings help you and your therapist **plan, organize, and vary exposures**, but getting your SUDS to decrease is **not the goal of exposure**. You do not need to wait for anxiety to disappear before an exposure “counts” or before moving on to something more challenging.

Instead, exposures are opportunities to build **new learning**. Depending on your treatment goals, you might learn that you can handle uncertainty, experience anxiety without doing a compulsion, move forward without knowing for sure, or tolerate more discomfort than OCD predicted.

For this reason, your hierarchy does not have to be followed rigidly from lowest to highest. Your therapist may intentionally vary the difficulty, combine triggers, repeat an exposure in different settings, or practice the same fear using several different examples.

Think of your hierarchy as a learning map, not simply an anxiety ladder. The goal is not to prove that you are safe or to make anxiety go away. The goal is to expand what you are willing and able to do while making less room for OCD and its compulsions.

Example 1: Contamination / Illness Fears

Anna experiences intrusive fears about becoming contaminated and contracting HIV. Her compulsions include repeatedly washing her hands, avoiding doorknobs and other frequently touched surfaces, avoiding hospitals and medical offices, wearing gloves in public, and seeking reassurance about whether something could transmit HIV.

Anna's **core fear** is: *"What if I become contaminated, contract HIV, and cannot be certain that I am safe?"* Anna and her therapist develop a variety of exposures that activate this fear in different situations rather than focusing on only one trigger.

Example exposure hierarchy:

1. Touch commonly used doorknobs (include lots of variety) and do not wash hands - **50 SUDS**
2. Watch videos or look at pictures involving blood draws or blood donation - **55 SUDS**
3. Sit in a medical-office or hospital waiting room without using extra safety behaviors - **60 SUDS**
4. Go into a public place without wearing gloves - **65 SUDS**
5. Shake hands with another person and continue with her day without washing immediately afterward - **70 SUDS**
6. Touch several public surfaces and eat a snack without first completing her usual excessive washing ritual - **80 SUDS**
7. Spend time in a medical setting while allowing uncertainty about contamination to remain unanswered - **90 SUDS**

Across exposures, Anna practices responding differently to thoughts such as *"What if this is contaminated?"* Rather than trying to prove that she cannot contract HIV, the goal is to learn that she can tolerate uncertainty, experience anxiety without compulsively washing or avoiding, and continue doing what matters to her.

Her therapist may vary the exposures by changing the setting, surface, duration, or amount of uncertainty. This helps the new learning generalize rather than becoming tied to one specific doorknob, room, or situation.

Example 2: Checking / Responsibility for Harm

Brian experiences intrusive fears that he might accidentally cause something terrible to happen to his children. He repeatedly checks whether the oven is off, candles are extinguished, the garage door is closed, and the doors are locked. He may reopen and relock doors several times or return home to verify that everything is secure.

Brian's **core fear** is: *"What if I make a mistake, something terrible happens to my children, and it is my fault?"* ERP does **not** require Brian to behave recklessly. He continues to complete

reasonable safety behaviors once, such as turning off the oven or locking the front door, but practices resisting repeated checking that is driven by OCD's demand for certainty.

Example exposure hierarchy:

1. Turn off the oven once and leave the kitchen without returning to check - **50 SUDS**
2. Lock the front door once and walk away without testing the handle repeatedly - **65 SUDS**
3. Extinguish a candle once and leave the room without returning for reassurance - **70 SUDS**
4. Close the garage door once and continue driving without turning around to check - **75 SUDS**
5. Leave the house after completing a normal safety routine without mentally reviewing each step - **80 SUDS**
6. Complete an imaginal exposure involving uncertainty about accidentally starting a house fire - **85 SUDS**
7. Complete an imaginal exposure involving a feared break-in and uncertainty about whether he could have prevented it - **95 SUDS**

Imaginal exposures are useful when the feared outcome cannot or should not be recreated in real life. Brian is not practicing actually leaving an oven on or a door open. Instead, he is practicing allowing the **thought, image, and uncertainty** surrounding the feared outcome to be present without neutralizing them through checking, reassurance, mental review, or avoidance.

An important part of the learning is recognizing that **having a thought about harm does not cause harm**. OCD may argue that imagining something terrible is dangerous, irresponsible, "inviting it," or somehow increasing the chances that it will occur. Treating those thoughts as dangerous, however, can become another way of avoiding uncertainty.

Brian practices learning: *"I can take reasonable precautions without trying to achieve absolute certainty. I can have frightening thoughts without responding to them as if they are emergencies."*

Example 3: Negative Thoughts / Fear of Rejection

Sasha becomes distressed when she notices negative, critical, or unpleasant thoughts. She fears that having these thoughts means she is becoming a negative person and that, eventually, her friends and family will no longer want to be around her.

Her compulsions include replacing negative thoughts with positive ones, mentally reviewing whether she is a "good" or "positive" person, seeking reassurance, and avoiding situations that she believes might trigger unpleasant thoughts. For example, she may avoid gloomy weather, crowded stores, or stressful situations.

Sasha's **core fear** is: *"What if these thoughts mean I am a negative person and the people I love eventually reject or abandon me?"*

Example exposure hierarchy:

1. Notice a negative thought and allow it to remain without replacing it with a positive thought - **50 SUDS**
2. Write several deliberately negative or pessimistic statements and read them without correcting them - **55 SUDS**
3. Look outside during unpleasant weather and allow whatever thoughts or feelings arise — **60 SUDS**
4. Spend time in a crowded or frustrating environment without forcing herself to think positively - **70 SUDS**
5. Allow herself to think, *"Maybe I am more negative than I want to be,"* without mentally proving otherwise - **75 SUDS**
6. Complete an imaginal exposure about friends becoming tired of her negativity — **85 SUDS**
7. Complete an imaginal exposure involving the possibility of being rejected or ending up alone - **95 SUDS**

Sasha's goal is not to become more positive or prove that nobody will ever leave her. Instead, she practices allowing unwanted thoughts and emotions to exist without trying to immediately change, cancel, analyze, or neutralize them.

Her therapist may intentionally vary the exercises by practicing at home, in public, during good weather, during bad weather, or when she is already in a bad mood. This teaches Sasha that she does not have to control her internal experiences in order to participate in her life.

THERAPIST-GUIDED EXPOSURE PRACTICE

Once you and your therapist have developed an initial exposure plan, you will begin practicing exposures during sessions. Your exposure plan will continue to change as treatment progresses. New triggers may be added, exposures may be combined, and the same fear may be practiced in different settings so that learning becomes more flexible and generalizes to everyday life.

During a typical session, you may:

1. Review your self-monitoring and between-session exposure practice.
2. Identify the fear, prediction, or uncertainty you are working with.
3. Complete one or more **in vivo, imaginal, or interoceptive exposures**, depending on your symptoms.
4. Practice response prevention by reducing compulsions, avoidance, reassurance seeking, or mental rituals.
5. Discuss **what you learned**, rather than focusing only on whether your anxiety decreased.
6. Plan varied self-directed exposures to practice before the next session.

After an exposure, you and your therapist will look at the experience as a learning opportunity. You may discuss what OCD predicted would happen, what actually happened, which

compulsions you resisted, how you responded when uncertainty remained, and what you want your brain to learn from the experience.

REVIEWING HOMEWORK AND SELF-MONITORING

Each session, you will discuss with your therapist the self-monitoring and exposure practice you completed at home. Your therapist will walk through your triggers and help you identify any compulsions you may not have recognized and address reasons for resistance.

You will also discuss what you noticed during your exposures, including how much anxiety or distress you experienced, what you predicted would happen, what compulsions you resisted, and what you learned. This helps you and your therapist determine whether an exposure is targeting the intended OCD pattern and how future exposures can be adjusted.

Self-monitoring outside of sessions is important to the success of treatment because much of the new learning in ERP occurs through repeated practice in your everyday life. Just like learning any new skill, regular practice gives your brain more opportunities to use the new response instead of automatically returning to the old OCD pattern.

IN-SESSION EXPOSURE WORK

You will spend a substantial amount of the session completing an exposure that you and your therapist choose together. During the exposure, your therapist may ask you about your SUDS level, emotions you feel, what OCD predicts will happen, and whether you have inadvertently started using a compulsion or safety behavior.

Some compulsions can be subtle during an exposure. For example, you may physically remain in the feared situation while mentally reassuring yourself, distracting yourself, ruminating, praying, reviewing evidence, or telling yourself that everything will definitely be okay.

Your therapist will help you recognize these patterns so that the exposure provides an opportunity to practice a genuinely different response. You may also discuss your core fear during the exposure so that you are approaching the uncertainty OCD wants you to avoid rather than simply completing the physical activity.

UNDERSTANDING RESPONSE PREVENTION

People engage in rituals as a way to reduce distress, prevent feared outcomes, or obtain certainty. Response prevention aims to interrupt this pattern so that you have an opportunity to respond differently.

Rituals can include behaviors and mental patterns such as rumination, checking, excessive handwashing, replacing negative thoughts with positive thoughts, counting, reassurance seeking, reviewing, researching, confessing, or repeating actions until they feel “right.” Avoidance and subtle safety behaviors may also serve the same function.

You may still experience a strong urge to engage in rituals during ERP. Response prevention does not require the urge to disappear before you move forward. Instead, you practice experiencing the urge without automatically responding to it.

Over time, you will learn to live with more of the doubt and uncertainty connected to your core fears without having to spend precious time, energy, and resources on rituals. The rituals can provide an illusion of control while actually keeping you trapped in the OCD cycle.

By not engaging in rituals, you create opportunities for your brain to learn that distress and uncertainty can be present without a compulsive response. This new learning gives you greater freedom to decide how you want to respond instead of allowing OCD to make that decision for you.

IMAGINAL EXPOSURES

Some feared situations cannot or should not be practiced in real life. Examples might include fears of going to hell, unwanted sexual intrusions, accidentally running someone over with a car, losing someone you love, or being responsible for a future catastrophe (see Imaginal Exposure Handout).

Imaginal exposure allows you to approach fears that cannot appropriately be recreated through an in-vivo exposure. By intentionally contacting the feared thought, image, or possibility, you can practice responding differently to the fear and uncertainty without relying on compulsions.

You and your therapist may create a script that describes the sequence of your fears, including the feared outcome or worst-case scenario. You or your therapist may create an audio recording, or you may practice reading or visualizing the scenario while allowing the associated thoughts and feelings to be present.

Be sure to watch for OCD thought patterns that suggest the script itself is dangerous. These may include fears involving thought-action fusion, magical thinking, or beliefs that repeatedly thinking about an event somehow makes the event more likely to occur.

Imaginal exposure gives you an opportunity to practice having a feared thought without treating the thought as an action or emergency. The goal is not to prove that the feared outcome will never happen, but to allow the thought and uncertainty to exist without trying to neutralize, solve, or obtain certainty about it.

PRACTICING EXPOSURES AT HOME

You will practice exposures outside of therapy that are similar to the exposures practiced in session and, when useful, variations that help the new learning transfer to different situations. You will be asked to fill out the Exposure Homework Recording Form after each exposure.

Sometimes the exposures will involve situations that you are not able to practice in the office, such as going to a hospital waiting room, driving a particular route, entering a crowded store, or

interacting with an object that cannot be brought into the session. These real-life opportunities are important because your goal is to use ERP where OCD actually occurs.

Your therapist will discuss how often and how long to practice based on the learning goal of the exposure. You do **NOT** need to continue an exposure until your SUDS drops by a certain amount. Instead, the goal is to approach the fear, resist compulsions and safety behaviors, allow uncertainty and distress to be present, and notice what you learn from responding differently.

As you become more comfortable with the process of ERP, you and your therapist may intentionally vary your home exposures. This might mean changing the location, trigger, difficulty, timing, or amount of uncertainty so that your new learning is not dependent on one specific situation.

MEASURING PROGRESS

Progress in ERP is about more than whether you feel anxious. Anxiety and intrusive thoughts may still occur, particularly when OCD finds something new or important to focus on.

Instead, you and your therapist will also look at how you **respond** when OCD appears. You may notice that you spend less time performing compulsions, avoid fewer situations, seek reassurance less frequently, tolerate uncertainty more readily, or return to meaningful activities more quickly after being triggered. You may also notice that you are increasingly willing to approach situations that you previously avoided. These behavioral changes are important indicators that OCD is beginning to have less influence over your life.

Your SUDS may decrease over the course of treatment, and many people experience meaningful reductions in anxiety and distress. However, progress is not dependent on reaching a particular SUDS number. The larger goal is for fear and uncertainty to have less control over your choices.

THE LAST SESSION & RELAPSE PREVENTION

The last session will focus on the progress you made during treatment and will review changes in symptoms, compulsions, avoidance, functioning, and your ability to respond differently to OCD. Your therapist may repeat the Y-BOCS to help measure progress and compare your symptoms with where you began treatment.

You will revisit your exposure hierarchy and may re-rate each item. The goal is not for the distress level to be 0 or below a particular number. Instead, you will look at whether you are more willing to approach previously avoided situations, whether you rely less on compulsions, and whether you are better able to continue living your life when distress and uncertainty are present.

You and your therapist will also identify the strategies that have been most helpful and create a plan for continuing to use them independently. Ending regular treatment does not mean that

you will never experience another intrusive thought, uncomfortable feeling, or urge to perform a compulsion.

RELAPSE PREVENTION

OCD symptoms can fluctuate over time. Stress, major life changes, illness, loss, transitions, or simply encountering a new trigger can cause old fears or compulsive urges to become more noticeable again.

The return of an intrusive thought or an increase in anxiety does not automatically mean that you have relapsed. An important part of recovery is learning not to measure your progress by whether OCD shows up, but by how you respond when it does.

Continue approaching situations that matter to you rather than allowing avoidance to gradually return. Continue practicing response prevention when OCD asks you to check, reassure, review, wash, research, neutralize, or obtain certainty.

You will never have 100% certainty, and that is okay. Treatment helps you develop the ability to move forward without requiring certainty first.

If you notice old patterns returning, try not to get stuck in thoughts such as, “This won't work,” or “I'll never get better.” Instead, get curious about what has changed, identify which compulsions or avoidance behaviors may have returned, and begin using your ERP skills again.

A return of symptoms does not erase the learning you developed during treatment. It can instead become another opportunity to practice retrieving and strengthening that learning. You can also reach out to your therapist for additional support if you find that OCD is becoming difficult to manage independently.

MOVING FORWARD

The purpose of ERP is not to create a life in which you never experience another intrusive thought, uncomfortable emotion, or moment of uncertainty. Trying to achieve that goal would place you back in the same struggle with uncertainty that OCD has been asking you to solve.

Instead, treatment is about changing what happens **after OCD shows up**. You have practiced noticing fear without automatically avoiding it, allowing uncertainty without immediately trying to resolve it, and experiencing intrusive thoughts without treating them as problems that must be solved. You have also learned to recognize compulsions that once felt automatic and to make a different choice when the urge to ritualize appears.

As you move forward, the goal is to become increasingly able to serve as **your own ERP therapist**. When OCD presents a new fear, you can ask yourself what OCD is predicting, what it wants you to do for relief or certainty, and what response would give your brain an opportunity to learn something different. You can then approach rather than avoid, reduce the compulsive response, and allow the outcome to unfold without requiring certainty first.

There may be times when OCD becomes louder again. The goal is not to prevent those moments, but to recognize them sooner and return to the skills you have practiced. Each time you choose your life over a compulsion, you strengthen the learning that fear and uncertainty can be present without determining what you do.

ERP is ultimately not about becoming certain, fearless, or completely free from unwanted thoughts. It is about becoming freer to live the life you want even when uncertainty, anxiety, and unwanted thoughts come along for the ride!