Exposure and Response Prevention for “What If” Thinking in Disorders Other Than OCD

by David A. Raush, PhD

"What if" thinking is not unique to Obsessive-Compulsive Disorder (OCD). It is a feature to a greater or lesser extent in several other conditions. Using what we know about Exposure and Response Prevention (E/RP) for OCD might improve treatment for these other conditions.[1]

A few basic concepts underlie E/RP. Life is inherently uncertain[2], and "what if" thoughts are a reflection of that uncertainty. Trying to attain certainty mires us in obsessive thinking. Avoidance and efforts to "neutralize" the "what ifs," using thoughts or actions, fuels the production of more "what ifs" in an endless loop. Approaching fears increases anxiety at that moment, but ultimately increases self-efficacy, helps us overcome fears, and moves us toward a more realistic sense of risk. Neutralizing reduces benefit from approaching fears. Avoidance and efforts to neutralize fears provide immediate fleeting relief, but ultimately decrease self-efficacy, increase fear, and exaggerate our sense of the likelihood that what we fear will happen and of how catastrophic that might be. E/RP requires approaching fears, resisting the urge to neutralize, and acceptance of uncertainty regarding the feared "what ifs."

People who have Generalized Anxiety Disorder (GAD) have "what if" worries about several realistic life concerns: e.g., What if I lose my job? What if my loved one has a car accident? Efforts to neutralize frequently include reassuring oneself that what is feared won't happen or that if it does happen it won't be that bad; planning for every contingency; efforts to control situations; and checking. People who have GAD frequently get stuck in worry and avoid taking action. E/RP involves making decisions and taking action; abstaining from efforts to neutralize; and acceptance of a possibility of job loss, accident, or other feared events.[3]

People who have Body Dysmorphic Disorder (BDD) have "what if" worries about a perceived physical flaw: e.g., What if people notice my flaw (e.g., scar, nose, pores)? What if they judge me unfavorably because of the flaw? They neutralize by compulsively checking the perceived flaw in the mirror and by monitoring others' gazes and reactions. People who have BDD avoid going out among people, especially in certain light conditions or without wearing makeup or a hat to mask the flaw. E/RP includes living with the flaw and going out among people without efforts to conceal the flaw, while risking judgment and rejection by others.

People who have Illness Anxiety Disorder have "what if" worries about having a serious illness. "What ifs" about having undiagnosed heart disease, cancer, HIV, schizophrenia, and dementia are common. People who have this condition neutralize by compulsively checking and monitoring how they are feeling; researching symptoms on the internet; reassuring themselves and seeking reassurance from others; repeatedly consulting physicians; and self-referring for medical tests. Some people with Illness Anxiety Disorder avoid medical care, rather than seeking reassurance from it.

Exposure includes living with the possibility of an undiagnosed or misdiagnosed illness. Response prevention consists of resisting the urge to research symptoms, seek reassurance, or pursue medical care and tests driven by anxiety. I recommend that the patient choose a physician to trust with their care. Only if the trusted physician recommends the patient see a specialist or have certain tests, are they to do so. This allows the medical care to be guided by the physician's knowledge

instead of the patient's anxiety. For patient's who are seeking reassurance from their physician whenever they are anxious about a symptom, I recommend collaborating with the physician to determine the frequency with which the patient should be seen, considering both the patient's medical condition and anxiety. If they experience a symptom for which they would ordinarily seek immediate reassurance from the physician, they are to wait the short time until their next scheduled appointment. This requires them to practice E/RP to discomfort and uncertainty until the scheduled appointment, and they are not receiving immediate reassurance at the peak of their anxiety. The interval between appointments is gradually increased until it is determined only by medical needs, not by anxiety.

Some people who have Illness Anxiety Disorder have difficulty sustaining a course of treatment for a diagnosed medical condition. They are sensitive to side effects of medications and worry about receiving the wrong treatment. In collaboration with their physician, I encourage the patient to commit to a treatment regimen for an agreed upon trial period and only to change it with the recommendation of the prescriber. For example, they might commit to taking the dose of medication until the next scheduled medical appointment. As the interval between appointments increases, so does the duration of their commitment to the treatment.

Some people who have Illness Anxiety Disorder have received recommendations from their medical providers to limit certain activities, like intensity of exertion or consumption of certain foods. "What if" worries about making the condition worse impose limits well beyond the recommended restrictions. I question patients regarding actual recommended restrictions versus additional self-imposed restrictions. They are to follow their physician's recommendations completely and to clarify those recommendations if needed, but not to add to those restrictions based on anxiety. Anxiety driven neutralizing behaviors are eliminated by following the recommendations of the medical professional.

People who have Social Anxiety Disorder have "what if" worries about doing or saying something embarrassing or offensive; sounding unintelligent; not measuring up compared to others; and experiencing rejection. Some people who have social anxiety disorder also worry about others noticing the physical manifestations of their anxiety, like sweating, blushing, or shaking. They neutralize by preparing in advance what to say; trying to sound smart; monitoring others' reactions; comparing themselves to other people; and trying to control their tremors or sweating. In addition to avoiding interacting with people, they avoid being themselves. E/RP consists of being themselves, by doing, asserting, disagreeing, sweating, tremoring, and talking or choosing not to talk without trying to control the impression made and while accepting the risk of incurring rejection or offending others.

People who have panic disorder worry about having panic attacks and about the implications of having panic attacks: e.g., What if I can't get help when I have a panic attack? What if I'm having a heart attack? What if having panic attacks means I am going crazy? They neutralize by trying to control the panic attacks using breathing and distraction techniques and by reassuring themselves or seeking reassurance from others that panic attacks won't harm them. They avoid situations in which they are likely to have panic attacks, and some avoid traveling a distance from home or a

hospital. It is almost reflexive to neutralize by trying to control the intense discomfort of panic attacks. The way to disarm this automatic tendency to try to control the panic attack is to deliberately make the panic attack worse. E/RP is accomplished by deliberately bringing on, prolonging, and worsening panic attacks, including exposure to situations in which they are likely to occur, while accepting uncertainty regarding going crazy or other related harm from the panic attacks.

People who have Specific Phobias also have "what if" thoughts: e.g., What if I get trapped in the elevator? What if I lose control and jump or fall from a height? What if I lose control and drive off the side of the bridge or cross into oncoming traffic? They neutralize by trying to control the situation, for example, by checking whether the elevator is working and by clutching the handrail. These efforts to control can be intertwined with avoidance, for example, of driving in the scariest lane. They might try to breathe in certain ways or use self-talk in efforts to control their anxiety in phobic situations. E/RP consists of standing close to the handrail, even deliberately looking down; jumping up and down in the elevator risking it getting stuck; driving in the scariest lane; and deliberately making oneself anxious, while accepting uncertainty regarding getting stuck, falling, losing control, or other "what if" worries.

People who have PTSD have anxious worries about recurrence of the trauma: e.g., What if that debris in the road is an IED? In addition to processing the traumatic experience, E/RP involves resisting the urge to analyze, reassure, or otherwise neutralize, while accepting uncertainty regarding the feared possibility. People with PTSD also blame themselves for the trauma. In doing so, they obsessively analyze: e.g., What if it was my fault? What if I could have prevented it? They neutralize by replaying and analyzing the circumstances of the trauma. Family members and clinicians repeatedly trying to reassure them that it was not their fault is also neutralizing. E/RP involves engaging in life while accepting that they cannot fully resolve the question of responsibility for the trauma.

People who have low self-esteem and certain depressive disorders do not directly express the thought "What if I'm not good enough?" but it is implied. They neutralize by mentally reviewing their accomplishments; defining their expertise; and investing self-esteem in wealth, social status, and appearance. Sometimes people engage in neutralizing through driven efforts at self-improvement or overvaluing praise or recognition. E/RP requires accepting oneself as possibly not good enough and fully engaging in life without trying to prove one's worth.

In sum, "what if" thinking plays a role in several disorders in addition to OCD. Avoidance and neutralizing increase distress by sustaining a loop of "what if" thinking. Challenging avoidance and neutralizing using E/RP plus acceptance of uncertainty disrupts that reinforcement loop, potentially reducing distress and improving outcomes.[4]

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1. This article is based on a presentation I gave at APA in 2014.
2. Jonathan Grayson, PhD, introduced me to the importance of uncertainty in understanding and treating OCD in 1996.

3. Lee Fitzgibbons, PhD, and I presented together about similarities between Generalized Anxiety Disorder and OCD at several OCF and ADAA annual conferences 2000-2003.
4. Jason Goodson, PhD, provided invaluable suggestions to improve this article.

About the Author

Dr. David Raush earned his Ph.D. in Clinical Psychology from the University of Iowa and completed his Clinical Psychology internship in the Department of Psychiatry at Temple University Medical School. He has presented on the treatment of Generalized Anxiety Disorder, Obsessive-Compulsive Disorder, and obsessive thinking in disorders other than OCD at national conferences of the Anxiety and Depression Association of America, the International OCD Foundation, and the American Psychological Association. Dr. Raush is a Clinical Associate in the Department of Psychiatry at the Perelman School of Medicine of the University of Pennsylvania. A licensed psychologist in Pennsylvania and New Jersey, he has been in private practice in Stratford, New Jersey, since 2000. davidraushphd.com

Anxiety
Anxiety Disorders
Body Dysmorphic Disorder (BDD)
Generalized Anxiety Disorder (GAD)
Obsessive-Compulsive Disorder (OCD)
Panic Attacks
Panic Disorder
Posttraumatic Stress Disorder (PTSD)
Social Anxiety Disorder

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