Thanks for joining us on Not Boring CEs, where we don’t think you should be bored to death while getting your Continuing Ed. Keep listening here, then hop over to notboringces.com to get all your online CE credits. Alright, y’all, let’s get to learning.

Beth Brawley is a Licensed Professional Counselor in St. Louis, Missouri. In 2013, she began pursuing specialization in utilizing evidence-based treatments with individuals struggling with OCD, anxiety disorders, and body-focused repetitive behaviors. Beth has been running her private practice, Life Without Anxiety LLC, since 2015, as the goal of utilizing evidence-based practice is to live a life without anxiety making our decisions for us. She has presented yearly at the International OCD Foundation's annual conference since 2015 and completed the Behavior Therapy Training Institute through the IOCDF in 2016. Beth has also presented at the Trichotillomania Learning Center for Body-Focused Repetitive Behaviors' conferences in 2017 and 2019. She also presented at the Anxiety and Depression Association of America's conference in 2023. Beth is an adjunct professor at the Brown School at Washington University in St. Louis, where she teaches Exposure and Response Prevention skills labs and Cognitive Behavioral Therapy. Beth is co-founder and co-president of OCD Missouri, the Missouri IOCDF affiliate. Welcome, Beth!

Allison Puryear (she/her): Welcome back to Not Boring CEs! I'm your host, Allison Puryear. I'm here with Beth Brawley, and we are talking about evidence-based treatment for OCD, I'm super excited. Hi.

Allison Puryear (she/her): I don't know if this is accurate or not. So I'm gonna ask you, and it's okay. If you don't know

Allison Puryear (she/her): is there an increase in diagnosis for OCD like? Has there been an increase in it? Or do you know, if it's remained fairly steady over time?

Beth Brawley LPC (she/hers): I would say.

Beth Brawley LPC (she/hers): now I I'm not pulling from research here, but I would say that there's an increase in diagnosis only because the treatment's relatively new. I think it started to be developed in the 70s. And so the more we know, the more we can identify. Oh, this person, you know, actually is displaying OCD symptoms. But before we might have just labeled them, as you know, just a highly anxious person, and like the more

Beth Brawley LPC (she/hers): research the OCD community does, the more subtypes.

Beth Brawley LPC (she/hers): I don't even wanna say that we're discovering. But perhaps we're discovering our thing, and so that people are. Oh, my gosh, I identify with that. I just didn't know that was a part of OCD, so there's a non answer for your question. Yeah, I just feel like anecdotally. I know a lot more like, especially like

Allison Puryear (she/her): friends. Kids are being diagnosed at a rate that I don't remember before. And I don't know if that's because of different kinds of stressors these days, and different kinds of ways of dealing with stressors leading to OCD, if that's just like

Beth Brawley LPC (she/hers): the genetic, the way the genetics or shake it out right now. What? Or if it's just like more informed providers who are recognizing? That's yeah, I mean, who knows? I'm I'm curious to see the research that's hopefully coming out with an increase in contamination fears and contamination OCD given Covid, and the experience that that has been

Allison Puryear (she/her): so I'm curious about. You know, the genetic component was there, and that was the spark that lit the fire. And you know what we'll see moving forward. Yeah, absolutely. Well, let's let's just start with basic like understanding what OCD is, what it's not. Let's just lay a good foundation for folks.

Beth Brawley LPC (she/hers): Okay.

Beth Brawley LPC (she/hers): I love talking about this. I'm super excited about this. Okay? So yeah, so OCD is Obsessive Compulsive Disorder. So it's a mental health diagnosis. And we can kind of break it up into 2 kinds of symptoms if you will. So first, we have the obsessions. So these are unwanted, intrusive thoughts, images, or urges that pop into our awareness.

Beth Brawley LPC (she/hers): They are ego disc tonic. So we don't wanna have them. They create a lot of distress. They go against who we are at our moral ethical core. And now that I've experienced this very distressing, unwanted thought, I have the compulsion come in, or the urge to compulse, and a compulsion in terms of like lingo. Here.

Compulsion can also be called a safety behavior or a ritual

Beth Brawley LPC (she/hers): but a compulsion is something that I do now, in order to get rid of the distress and the anxiety OCD.

Lives in the negative reinforcement cycle starts with that intrusive thought, I have a worry. Oh, my gosh!

That is a really scary thought. I feel anxious.

Beth Brawley LPC (she/hers): No human likes to feel anxiety.

Maybe there's fun anxiety, like roller coasters or skydiving. But that's not. Yeah.

Obviously, what we're discussing. We don't want to feel that level of fear. So we do something, some safety behaviors, some ritual, in order to get rid of that anxiety.

Beth Brawley LPC (she/hers): What happens for the individual that has a CD. Is that it then leads to some temporary relief. If I'm worried that I'm going to snap and like a harm. OCD example. Let's say I'm chopping vegetables in the kitchen. I'm worried that have this really sharp knife in and boom. I'm worried. I'm gonna stab my partner. Let's say, well.

Beth Brawley LPC (she/hers): what do I wanna do? I'm gonna avoid maybe chopping vegetables. I will avoid using knives. I've had people where they would block up all their cabinets and give their partner the key so that they couldn't, you know, snap and grab something sharp. So what do I? What do I do then like that makes me feel better now I know it's behind lock and key, and I'm not going to stab my partner. But because it's a negative reinfor

Beth Brawley LPC (she/hers): reinforcement cycle. The very next time I'm in a similar situation my brain is already prime to worry about the same thing. So it just, you know, I think about it like a cartoon where there's a snowball rolling down amount. It gets bigger and bigger over time when a client's in your office presenting with OCD. It didn't start the way that it's presenting to you. It's gotten bigger and

scarier over time.

Beth Brawley LPC (she/hers): Also, it's important to note, too, all humans have intrusive thoughts. Another example. Another example I give is, let's say, you know, we have a human. They don't have OCD. They're driving down the road. They might have an intrusive thought of like, oh, there's a person over there. It'd be so easy for me just to kind of drive.

Beth Brawley LPC (she/hers): turn the wheel, and I could hit them. But I don't have OCD so that thought is not relevant. It's not meaningful. And so I'm just like, Oh, that's odd. I'm not gonna do that. And then I just go about my business. Someone with hit and run some type of Harm OCD would have a very different experience of that intrusive thought, same intrusive thought. But because I thought it oh, my gosh, it's relevant, it's meaningful. It's scary.

Beth Brawley LPC (she/hers): I maybe I'm a danger to society, so I need to do something. I perhaps avoid driving. So intrusive thoughts are a human thing. Our brains are ever creative, but an individual's experience when they have those OCD will be very, very different of that intrusive thought. I think about that. Like

Allison Puryear (she/her): people who have a non pathological fear of heights like it's not impacting their life in any sort of way. It's not a phobia and how so many of them have the fear. Not that they'll fall off, but that they'll jump off

Allison Puryear (she/her): but it's not OCD because it's not impacting your life, and it's just like it's the thought they have when they're, you know, on a rooftop bar, not yet drunk, maybe, or like

Allison Puryear (she/her): going up a clear elevator or something like that on the outside building. But we have the St. Louis arch here, and they have those windows at the top, and you know it's like people without a phobia are gonna feel uncomfortable looking out and feeling the swaying. Yeah, absolutely. Yeah. Okay, can we talk about? So we've got the obsessions. We have the compulsions. We have this like negative reinforcement cycle.

Allison Puryear (she/her): Can we talk about the subtypes cause? I feel like in my I didn't know about subtypes until a good bit after grad school. It was like a CE. Where I learned about subtype. So here we go, maybe see where other people learn about subtypes.

Allison Puryear (she/her): How they like.

Beth Brawley LPC (she/hers): how they are similar to one another, and how are they are different from one another within this like matrix of OCD. Yes, I love this question because

Beth Brawley LPC (she/hers): you know it. It's perhaps a blessing and a curse. Sometimes we try too hard. Where where do I fit? In? What subtype do I fit in? And other times it can be really helpful like, oh, my gosh, Beth, you just described my experience like I feel seen, I feel, you know, like this is treatable. My favorite example for the subtypes with OCD. Is that Baskin Robbins, Baskin Robbins has 31 different flavors of ice cream.

Beth Brawley LPC (she/hers): and yet it's all still ice cream at the end of the day, and that's with OCD. We have a ton of different OCD subtypes, and yet they are all treatable with the same treatment method. So it's all OCD, it's just different flavors. So some examples of some subtypes. Obviously, I think one we see the most talked about, or maybe portrayed. In the world is contamination OCD and so with contamination, you could have someone afraid of

themselves getting ill. You can have someone have contamination with the harm OCD subtype of. I'm worried. I'll be con contaminated and spread harm to other people negatively impact others. We could also have contamination. OCD, where I'm not worried about getting sick. I'm

not worried about getting others sick, but it's just that like feeling of grossness or disgust. You know it's like I can't see

Beth Brawley LPC (she/hers): creepy, crawly germs crawling around on my hands, but I can feel them. And now like the more that I'm thinking about and talking about it, Allison, I'm like feeling it on my head. Yeah, we have. You know, the harm OCD subtype, where there's such a big umbrella to the different things that fit into, that you might have a client who's worried about, you know, snapping and becoming a pedophile harming a child. You might have someone with

Beth Brawley LPC (she/hers): Harm OCD, where the example I gave earlier. I will stab someone else. I can't be around sharp objects.

Beth Brawley LPC (she/hers): I need to check to make sure that I didn't do something and forgot about it later. Hit & Run OCD is pretty common. I you know there's a lot of potholes. There's a lot of bumps out there. Someone might, you know, worry that I hit this pothole. How can I be sure that I didn't, you know, run someone over, and anxiety loves to live in doubt. I could give myself reassurance all day long. No, Beth, you

for sure didn't hit someone, and OCD. Always likes to say.

Beth Brawley LPC (she/hers): but what if you're wrong? I just missed something. So we don't use. I'm getting a little off topic. But we don't use logic to fight OCD, because that just doesn't. It doesn't work. It actually can feed OCD and make it worse, harder, right? Oh, totally like it's never going to be like oh, back you got me, you convinced me like, of course you didn't do anything. It it's so creative.

Beth Brawley LPC (she/hers): let's see what else? We can have more like sexuality. OCD. Or sexual orientation. OCD, how do I know for sure where I fall on the spectrum. We have more scrupulosity. OCD. And I like to think of it as a tree with

Beth Brawley LPC (she/hers): 2 branches. One is religious scrupulosity. I'm worried that I will, you know, think something or do something, and then, you know, lose God's favor. I'll be tormented in hell forever. We can also have scrupulosity that isn't related to religion at all, and that's more of moral or ethical, OCD. I have to make sure that I never tell a lie, or I never, you know, do something wrong.

Beth Brawley LPC (she/hers): And again, like with all of these, it's just so frustrating, because well, for a variety of reasons, obviously. But the negative reinforcement cycle helps us out in a lot of other areas of our lives. And it's functional in other areas of our lives. This is the area of our life where we're doing something that works out over here. But it's not working here, and in fact, I'm feeling worse. And the thing about subtypes to Allison is that

Beth Brawley LPC (she/hers): there's the I like to tell my clients that there's the whack-a-mole effect. So as we start to go after like you come in, you have a presentation contamination. OCD, and let's say, scrupulosity. OCD, and we start attacking those when OCD. Feels threatened

Beth Brawley LPC (she/hers): it doesn't wanna give up power. So it will you look for? Oh, well, let's throw this other thing that maybe they've never even been concerned about before, and now they're oh, my gosh! Why am I, you know, experiencing this other thing that's never been a concern for me. And it's, you know, actually like a positive sign. Your OCD. Is feeling attacked and threatened, and so we would just utilize our treatment method. To go after that and not let it grow

Beth Brawley LPC (she/hers): any more than it already has. Awesome.

Allison Puryear (she/her): I'm thinking about how if you like. When I went to grad school, which was, you know, 20 years ago. But

Allison Puryear (she/her): if you were kind of left with the impression of of OCD. Is

Allison Puryear (she/her): like, often you'll see it in overly, like hand washing, or like you have these like stereotypes of what OCD. Is. I imagine if somebody comes into your office for anxiety, not they're not self identifying as OCD. Or as having OCD. And you don't know about the subtypes, and they say something like.

Allison Puryear (she/her): I'm afraid I'm going to touch a child.

Allison Puryear (she/her): or I'm thinking about stabbing my husband. or like all these harm to self and other things that we are then required to report.

Allison Puryear (she/her): It can get

Allison Puryear (she/her): so messy, so quickly, so harmful to the client. So

Allison Puryear (she/her): dysregulating for the therapist who thought they were just gonna like, Have somebody with GAD in there, and they're like she's gonna kill her husband.

Allison Puryear (she/her): How difficult that can be if you're not aware of what's going on in your clients not coming in, or where either they just they recognize the anxiety, but they don't know that there's a name for it.

Beth Brawley LPC (she/hers): Yes, and you know I'm I'm biased just because this has been my specialty, my niche, my entire time of practicing. You know. But I think

Beth Brawley LPC (she/hers): that main question being like, is this ego syntonic or ego disc tonic? The person who is okay touching a child stabbing their partner. They're not scheduling a session to come in and sharing. Oh, my gosh, Allison, I'm so worried about this, and it's consuming me, and you know, like that person's not coming in cause, or they're not disclosing that to you like their their urges or their intrusive thoughts. Work for them.

Beth Brawley LPC (she/hers): And you know it's it's if this causes you to stress.

Beth Brawley LPC (she/hers): that's telling us something, and that's where it's so helpful to give psycho Ed to our clients

Beth Brawley LPC (she/hers): so that they know, you know they can like, sit in. They? Oh, yeah, this is a thing like I've had people say, like, Oh, so I'm not crazy. It's like we're not. No, you just have OCD, and we'll attack it together. But yeah, I think that's where and I can put a plug in. They're not paying. I can put a plugin for the International OCD Foundation's website, where they have a huge list of the different subtypes and

different ways that you can see that manifest because I think.

Beth Brawley LPC (she/hers): Allison, like you're saying, even if you're not an OCD specialist, it's so important to be aware that this is a thing, and these are the ways that you might see it manifest in case you do like need either need to refer out or to work in conjunction with an

OCD. Specialist. I've done that many a time, and other therapists like will work on with the eating disorder, and I will work with the OCD piece, and you know that can be a really beautiful thing. But it can't happen if we don't know.

Beth Brawley LPC (she/hers): You know what those really scary ego dystonic thoughts are.

Allison Puryear (she/her): I'm thinking, too like differential diagnosis stuff as somebody who's been working in eating disorders for so long? There's there are a lot of OCD. Traits among my clients who don't have OCD. How do you like? Do you have a quick trick, or being able to parse out without breaking out. The DSM like are there tells for you, in a session of like, okay, these are traits that are driving your behavior to some extent, but not enough that it's full blown. OC. OCD.

Beth Brawley LPC (she/hers): well, I like to look for I mean, we know there's a high comorbidity between eating disorders and OCD, I think you know, there's some kind of

Beth Brawley LPC (she/hers): similar tenants or structure, if you will. Perfectionism is hugely intertwined in both diagnoses guilt. I like to say my clients have an overactive guilt muscle? What does this thought mean? I did something bad. I thought something bad over responsibility. I mean, that can be a component with both eating disorders, and I see as well. And then, having extremely high standards, which I think, really back to the perfectionism high standards.

Beth Brawley LPC (she/hers): That could be a really functional thing. I like to kind of parse out. Are we striving for excellence, or are we striving for for perfection? We really can only attain one of those.

Beth Brawley LPC (she/hers): So yeah, I would look for like, oh, it makes sense that you feel like, overly responsible for having these thoughts. Let's explore that more. What does that mean about you? Or what do they mean to you?

Allison Puryear (she/her): Yeah, okay. I'm thinking, too, about like OCPD. And being able to parse that out in assessment.

Allison Puryear (she/her): How do you do? Yes.

Beth Brawley LPC (she/hers): Well, first off, I would just like to say, whoever named it

Beth Brawley LPC (she/hers): just set us up for confusion. Yeah, totally so obsessive, compulsive personality, disorder. I if you quote unquote, have one, it doesn't automatically mean you have the other. You can have someone who experiences both. But with OCPD. What I think about is that there that the behaviors they're doing are not distressing.

Beth Brawley LPC (she/hers): They they they are okay with it. It feels functional, it feels helpful. It feels sustainable. That doesn't mean they are and you know it can be very unhelpful, very disruptive. I think. You know I've only had a handful of people come in with OCPD. And each time it was they were like. I'm only here because my partner is threatening to leave because I do these things. But I don't understand why everyone doesn't do these things.

Beth Brawley LPC (she/hers): These things make life like make some sense out of life or whatever. But when we get into it's like, Oh, that's actually not incredibly helpful. And there's no morality here. You're not doing something right or wrong. An example.

Beth Brawley LPC (she/hers): I had someone who throughout the year they would save all their receipts, everything they bought, and then at the end of the year they would make an excel spreadsheet. And I asked, You know, what's what's the function of this? What's what's this? You know what? What's the intention of engaging in this? And it was.

Beth Brawley LPC (she/hers): you don't do this that, like this is a helpful thing, and it wasn't because of budgeting. It wasn't because of anything like meaningful in terms of finances, but it was something that they just felt was responsible and good to do and so, you know, I'll ask my clients like, Are you okay with that? Because if you're okay with that, like, I'm not here to tell you. Stop doing that. But that would fit more in line with the OCPD. They were okay with it. Yeah. So it's more that like egocentonic experience. Right?

Beth Brawley LPC (she/hers): So it's driving everyone else crazy. But not you. Yeah, yeah, like, you can say, you can say like, Oh, that looks like OCD, but there's no distress like you, said Egocentric. They're okay with it. Other people are not okay with it. But they are. So yeah.

Allison Puryear (she/her): okay, so thank you for taking us down to differential. I was like this.

Allison Puryear (she/her): yeah, so

Allison Puryear (she/her): can we get into treatment what that looks? What like effective evidence-based treatment for? OCD, looks like.

Beth Brawley LPC (she/hers): yes.

Beth Brawley LPC (she/hers): yeah, let's go there. Yeah. So currently, our gold standard treatment method for OCD is exposure and response prevention. One of the many family members of CBT, we know that cognitive behavioral therapy, hey? I love it. I teach it. It's great. It's not enough, though, for OCD, so we need that

Beth Brawley LPC (she/hers): extra specialized really niche treatment. So ERP, I like to say 2 steps exposure and then response to prevention being 2 separate kind of entities. They're already being exposed. They're out there living their lives. They're living with their brains. So they're already being exposed to their triggers and their thoughts. But the reason why exposure on its own is not enough is because of those compulsions or the safety behaviors. So the response prevention piece is like that huge.

Beth Brawley LPC (she/hers): like robust part of the treatment of learning that they can resist their rituals or safety behaviors, have tools to ride out that wave of anxiety and see that you know our brains can naturally habituate.

Beth Brawley LPC (she/hers): Typically, you know, perhaps not as quickly as if I were to go compulsively like, seek reassurance or wash my hands or do something like that. However, over time, I can kind of move on from those feelings of distress faster, because when we trigger ourselves, when we expose ourselves over and over and over we are

Beth Brawley LPC (she/hers): having the opportunity opportunity to learn something.

Beth Brawley LPC (she/hers): Perhaps that's very new. I'm learning. My anxiety is a liar. Maybe it overestimated the probability of danger. And so that thing I thought was super, you know, scary and dangerous. Now I can see that like oh, sure, that has been scary to me, but it's actually scary safe, not scary dangerous. I like to say.

Beth Brawley LPC (she/hers): And then oh, did I lose my train of thought? Here we go. Oh, yeah. But I learned that, you know. Perhaps anxiety overestimated the probability of danger. Or maybe the thing I'm worried about is more realistic. I've treated people, and their fear was that they'll get the common cold. And you know, is that something that's realistic to get? Sure, it's called common for a reason. The way their anxiety was lying to them, was saying, you can't tolerate that experience either of having a cold.

Beth Brawley LPC (she/hers): or you can't tolerate the uncertainty of if it'll happen or not. And so there are a few different ways that you know anxiety is a liar.

And so with ERP, we're learning that these things we felt incapable of doing, or we felt we couldn't tolerate, are actually actually tolerable experiences.

Beth Brawley LPC (she/hers): and something that you know, I can learn that that thought. Thoughts are not equivalent to actions. I can have a thought of like, oh, I'm gonna you know. What if I punch that person? And yet I'm still in control if I punch them or not. And so that's something that OCD. Would never offer me as an option. And so that's where the ERP would come in, and that's ERP

Allison Puryear (she/her): in a nutshell. I'm thinking about the difference between like treating phobia, which doesn't have that response prevention piece like it might just be like II did like, for some reason, a good bit of

Allison Puryear (she/her): phobia treatment like 18 years ago. Maybe as a generalist in an agency. Somehow they a bunch ended up in my case, loaded. It was great fun to help people like move up their fear levels of the things they were scared of and like we could take field trips. It was wonderful

Allison Puryear (she/her): and subjective units of distress and things like that, like what are the components of ERP clinically. I mean, I know you're not teaching us how to do ERP in here, but I mean, are there subjective units of distress you're checking in with.

Beth Brawley LPC (she/hers): how are you? How does it look in session? Totally? Yes, so I love a good set scale. And so, you know, I'll ask you how? Where? Where's your anxiety, or how worried do you think you would be if you did blank exposure without, you know, engaging in whatever it is that you have the urge to engage in. A cool thing about ERP is that I mean historically, it's been very hierarchy focused. You know, we have our sub scale.

Let's say you know, 0 to 10, 10 being the worst anxiety in the world. And I ask you, hey, Allison, how difficult would it be for you to you know. Go make that phone call and ask a silly question to target or whatever. And you're like, oh, Beth, that would be like a 7 out of 10. We put that on the hierarchy, and we come up with a bunch of different options.

Beth Brawley LPC (she/hers): That's great, that's effective. We also would fun. I say, fun. What's fun in the world of OCD therapy is that we're moving kind of away from that. It's called inhibitory learning theory, or an inhibitory learning method. Because what we're seeing I mean, what we're realizing is that life doesn't always happen on a rigid hierarchy, that we can then say, Okay, world, I'm ready for threes. And now I'm ready for fours. And I mean again, that's great to do in treatment and it, and it's workable and doable.

Beth Brawley LPC (she/hers): There also is something to be said about how much power someone gets from. I like to think of it like a claw machine or a grab back if we, you know, come up with all these different ideas for exposures, and then say, you know, are you up for

just randomly, having one, you know, assigned to you. It might be a 3. It might be a 7. Who knows

Beth Brawley LPC (she/hers): that mirrors more of what real life looks like and so there's power in, you know. Oh, my gosh! Out of the grab bag I pulled this 7 out of 10, you know, and that just feels super scary. But you know what I've seen that this is effective, and I can do this. So let's go do that thing. Perhaps I learned I could do more than I originally thought it was capable of doing.

Beth Brawley LPC (she/hers): Perhaps I learned that you know that thing that was like super big and looming, and I was dreading it actually turns out like it was tolerable and manageable. Not bad thing that I was sure was gonna happen actually didn't happen. Or again, if it did, I handled it and so with that, like, I'm you know. I'm always curious, like where your anxiety level is, and we can also say.

Beth Brawley LPC (she/hers): perhaps I don't have to rigidly structure my treatment according to okay, am I at an okay level of anxiety? It's like that one of the kind of the myths of exposure therapy is that like it's intolerable. Anxiety is not dangerous. I mean, it can feel dangerous. We don't like feeling that way. But you know, I'm thinking.

Beth Brawley LPC (she/hers): how could you know evolution equip humans with an alarm system for threats that actually is a threat in and of itself. And so, you know, we can learn that I can experience something. I can purposefully face my fear and actually be okay, actually come out stronger. Actually, you know, come out of it. With more

Allison Puryear (she/her): data, more information that I had moving into it. I'm not sure if I answered your question specifically. I got a little on a rabbit hole, but I do love a good rabbit hole so me, too. I love it. I'm wondering, too, like, how does it work with like? It's trickier with some obsessions and compulsion compulsions than others. Right? Like

Allison Puryear (she/her): cleanliness, for instance, or like that? One is maybe easier during not the peak of Covid. Then something like

Allison Puryear (she/her): pedophilia.

Beth Brawley LPC (she/hers): Yes, like, how do you figure out a hierarchy that is not gonna

Beth Brawley LPC (she/hers): get somebody on a watch list. Well, right? Right. That's why we don't do gratuitous exposures. I was telling my clients like I am willing to do everything I ask you to do, and I don't mess around with my life. And so I'm not going to go. Do something puts puts me on a watch list. I'm not gonna ask you to do that too. So I'm glad that you're bringing this up because

Beth Brawley LPC (she/hers): that can II think you know it would be safe to assume that if someone feels like that like well, I can't test this out. So what's the point in treating it like? Is this untreatable? Do I just have the one thing that can't be treated like you said some things we can test out. Bethan worried that if I sit on the floor in your office today. I'm gonna get the stomach flu. And it's like, Okay, well, I'll see in a week. And so I guess we'll see. You know, if you have a stomach flu. Just

Beth Brawley LPC (she/hers): me know we won't. We'll cancel session. but yeah, there are some things like, you know, some harm OCD subtypes more like existential. We can't

Beth Brawley LPC (she/hers): kill somebody, have them, experience the afterlife, and then come report back to us. So for those

Beth Brawley LPC (she/hers): those exposures that are fears that are really untestable. The the response prevention piece is to live in line with our values. So I can give an example of more. The Pedophile OCD piece and obviously for HIPAA reasons, we're making some changes to this. In the past. I had someone they had a new baby, and they love this baby. Obviously they were obsessed

Beth Brawley LPC (she/hers): part of the pun with this baby. But their OCD. Said, if you are around them like you might snap and do something harmful to them like you might molest them. And so for them, they had started to avoid changing the baby's diaper. They had started to avoid holding the baby, putting the baby down, really doing any of the things that the parent needs to do. And so it was causing a lot of pain. They

Beth Brawley LPC (she/hers): didn't get to spend time with their baby. Their partner was feeling overwhelmed and stressed with having to do all the things. So for them I'm not gonna ask them to harm their baby. I will ask them to pull back on the other things that they've been doing like avoiding.

Beth Brawley LPC (she/hers): like perhaps reassurance, seeking, asking, having their partner, you know, stand beside them while they change the baby's diaper so that they can make sure if I do something bad, my partner will stop me right? And so that was reassuring to them. So we had them pull back from meeting their partner around when they were bathing or changing the baby

and then checking is a big one, like internal checking, and what we know about what's called the groinal response. If I'm checking my body to see. Oh, do I feel aroused at all? The more I think about. I like to tell my clients, and this is an important psycho piece, too, because your client might have been doing this. And then, because of just basic wiring and plumbing, they can feel aroused. But there's no meaning to it. But if you have OCD, OCD. Says

Beth Brawley LPC (she/hers): there is meaning to it. So oh, my gosh! Now you are feeling aroused, and you're around your baby like you are a monster, and that's your evidence. But it was really, you know, kind of becoming a self fulfilling prophecy of feeling aroused because I was so, you know, compulsively in my head, checking to see if I feel that way. So those are the things you know. We have them create exposures that are in line with their values for this person.

Beth Brawley LPC (she/hers): and they identify what's the parent I want to be. The parent I want to be is involved and helpful and hugging and loving, and the partner I wanna be is helpful and loving and balanced. And so that's how we can create exposures. Take baby out by yourself. Rock baby to sleep. Give baby a hug. Things like that. We're not actively having people do things that are harmful.

Allison Puryear (she/her): wonderful. Okay.

Allison Puryear (she/her): I'm thinking about more differential diagnosis stuff based on that. Like, I'm thinking about like perinatal mood disorders and like perinatal anxiety, and how that might sometimes

Allison Puryear (she/her): look a lot like OCD. Or OCD may look like pairing, or let me, just, you know, be comorbid. Yeah. So how I'm thinking about our perinatal folks out there, how can they get more clear on if it's perinatal anxiety, or if it's OCD. Or if it's both

Beth Brawley LPC (she/hers): well, you know, the good thing is that if it like, if we're gonna use ERP across the anxiety spectrum. So GAD social anxiety, postpartum anxiety, postpartum or perinatal OCD and we do like to you know. Let our let people know that, and the non birthing

Beth Brawley LPC (she/hers): partner or spouse, or whoever they are, can also have perinatal OCD. And they didn't even give birth, and so that can impact like, I've seen this in a lot of partners where they're like, I don't understand why I'm worried about this like I didn't have the baby, so I shouldn't be having this experience. And you know, the good and bad news is that it doesn't pick and choose. It's just for everyone.

Beth Brawley LPC (she/hers): But regardless, you know, we're gonna use exposure response prevention, because there are things that they're doing and even if it's just avoidance. There's things that they're doing in order to kind of get through their day. Get through the distress that we can then

Allison Puryear (she/her): help them learn and see that they can have a different experience.

Allison Puryear (she/her): What's the typical? If if there is a typical length of treatment for someone?

Beth Brawley LPC (she/hers): Yeah. And I know there believe there's stats on this very specific research on this. Like the IOC website, I don't know the numbers off the top of my head. But

Beth Brawley LPC (she/hers): it's relatively, I like to say you can

Beth Brawley LPC (she/hers): get out of seeing me as fast as you want. I'll have people come in, Allison where they're like Beth. I have. You know this. I see. I researched it. This is what I have. This is what I wanna work on. I'm not really curious about anything else going on. I don't wanna process anything else. Just this. I'm like, great. I'm here for it. We'll do very, you know, structured ERP and get them out there living their best life just as soon as possible.

Beth Brawley LPC (she/hers): Other people are, hey, Beth, I have this OCD. But since you know, I don't live in a vacuum. OCD. Doesn't live in a vacuum. All these other places of my life are impacted by it. Or you know, there's other things going on outside of OCD. That I'd like to address, and I'm here for it. And so with that, it's we're gonna tackle the OCD. While we're also working on whatever whatever other piece

Beth Brawley LPC (she/hers): of work you want to do, and those people may stay around longer. I've had people. In fact, they started with very specific.

Beth Brawley LPC (she/hers): just ERP just to wanna work on OCD. And then after they got through that, they were like, Oh, yeah, well, there are other things that I would like to address. And so we're we're here for it.

Allison Puryear (she/her): I like to say I'm a therapist first and foremost, but then I also went on to get extensive training in OCD and anxiety. So we don't just have to, you know, address that and just really taking that holistic approach to whole human. Yeah, are there any diagnoses that are contraindicated for ERP?

Beth Brawley LPC (she/hers): I don't know.

Beth Brawley LPC (she/hers): Probably nothing common. Then it's not. I mean, you'd be like, yeah, depression. No, don't do it. But if that was so, yeah, no, II would. I wouldn't. Maybe I'm wrong. But yeah, like you just said, nothing is popping to mind. Okay, cool.

Allison Puryear (she/her): So for those of us who are not ERP trained, how do we know when to refer out versus

Beth Brawley LPC (she/hers): when we should bolster our competency run ERP for OCD

Beth Brawley LPC (she/hers): great question, and I first and foremost would say, like, if you're here, you are bolstering your competency about ERP and OCD. So I obviously don't think it ever hurts to like be invested in learning more about that, even if you're not like. I have colleagues where you know they've done the trainings. They are ERP trained. And then they're like, you know, what? It's not really my cup of tea. So they know what to do. They have the skills, and they can use them in other ways with their clients. But it just wasn't for them.

Beth Brawley LPC (she/hers): I would say, like when to refer out one, if you know your own limits, and it's like I can't talk about people harming their children like, I just uncomfortable with that. It's like.

Beth Brawley LPC (she/hers): you know, you might be well intentioned, but you could do more harm than good. Ben. Know your limits refer out, I would say, if it feels like, just kind of prioritizing. It's like, Wow, this OCD is really a bigger piece of their puzzle right now. It's really causing, like the most dysfunction for them, and I don't feel

Beth Brawley LPC (she/hers): I don't know. Comfortable is not the right word. Maybe it is confidence. I don't feel confident that that's a piece I can be effective in treating. And you know, I think that's the beauty of if someone has the resources, you know, being able to see. Perhaps you know this therapist for this thing? And then I also see it was referred to this adjunct therapist for my OCD.

Allison Puryear (she/her): How often or what percentage of your clients are on medication. At any given question

Beth Brawley LPC (she/hers): I would say a large or, I would say, a large

Beth Brawley LPC (she/hers): part, perhaps maybe like 75%. I would say and you know the thing is, it's like you don't have to be on medication to do ERP you can, but you know it. It's doable without a cool thing

Beth Brawley LPC (she/hers): within, you know, treating use using ERP if someone's on medication and they don't wanna be A cool thing can be to start, you know. Keep them. Stay on the medication. We'll do the ERP as you go through this journey. As you progress through this work with your doctor, obviously. But if you're wanting to come down on that or off of that.

Beth Brawley LPC (she/hers): that's a good thing to do while we're still doing this work, so that you know, if there is like a resurgence of like Oh, my gosh! I accept too overwhelming. You can go back on, or if someone does come off. I think that there's power in seeing that the change in my life happened, not because I took medication, because I did the hard thing I did the hard work. Medication is great. I'm all for it.

Beth Brawley LPC (she/hers): and medication can't teach us things. We teach us things and we teach our brain things. And so, you know, if somebody wants to stay on it forever.

Beth Brawley LPC (she/hers): I'm here for it. I'll support you if you want to get off. I'm here for it. I'll support you. As we, you know, do this work. Really, awesome learning can happen if that is kind of the route that they're wanting to take. Yeah, yeah, I just think about how like.

Allison Puryear (she/her): incredibly dysregulating OCD is, and how for some people like the medication enables them to do the work like it takes the edge off enough. They can do it. Yes, in a way that for some people without the medication, they it's just too too much, too overwhelming cause they they've got the story right that that it's too much for them. Right? Right? And so if yeah, if the medication can slow down our thoughts enough to get me in a place where I can clearly, you know, engage in this work.

Beth Brawley LPC (she/hers): Awesome. Let's do it

Beth Brawley LPC (she/hers): awesome. And the ERP is it used with kids as well. Yes, II like treating kids with ERP with kids. You're gonna be more behavioral focused with ERP, yes, I still do cognitive work with them. It sounds different again, based on age. And it's, you know, a fully formed adult. But yeah, we would still use ERP, and that's also really fun, cause we get to be like silly and goofy and creative. And I mean, we get to be that way with adults, too. But with kids there's just an extra component of like

Allison Puryear (she/her): I don't know, showing them that. You know they're in grade school, and they don't have to live the whole rest of their lives with this fear and anxiety. And it's just really empowering and frankly, just fun to see awesome.

Allison Puryear (she/her): So it sounds like we can bolster our confidence, our competence.

Allison Puryear (she/her): Much of the time like this isn't, gonna do it? You know, you need more ERP training within this one. See? To to work with somebody with OCD, but hopefully, this is like your gateway to getting that training. If that's something you're interested in

Allison Puryear (she/her): Would you recommend working with a clinical consultant or supervisor as well? Or do you feel like a a good training will kind of give you what you need.

Beth Brawley LPC (she/hers): I would say you need the good training, and then you need the support of supervision or clinical consultation. I mean, you know I have great respect for my OCD. Colleagues, who, you know we've been doing this for a while, and yet we still seek each other's, you know, consult because.

Beth Brawley LPC (she/hers): you know, there's something to be said about. I don't know everything. It's like the taking the humble realist position of you know. II I'm confident that I'm really good at this, or I know what I'm doing. And also I'm humble enough to know that I don't know everything, and I am not perfect so I would say, keep doing the trainings and then seek out other minds as well. Okay, great.

Allison Puryear (she/her): So I know, like the top down and the bottom up like there can be a split sometimes

Allison Puryear (she/her): in the therapist communities that isn't always kind and is, it doesn't always have respect for different things work better for different clients like there is validity and healing in both top, down and bottom up.

Allison Puryear (she/her): and I think exposure therapy is one of the things that gets a lot of heat, not just from the bottom up community, but from from some of the other top down folks, because it sounds

Allison Puryear (she/her): so bad on some level, and we like dispel some of the myths around. Yes, please.

Beth Brawley LPC (she/hers): it's like

Beth Brawley LPC (she/hers): you're right there. There's it can be a hatch button issue. I think, as therapists, don't we want our clients to feel better? So why are you actively making them feel worse, like, Okay, I can. I can get behind like the compassionate place that's coming from. Of course we want our clients to feel better, and yet

Beth Brawley LPC (she/hers): what we know is that anxiety is a safe and universal experience. We will all feel anxious at some point in our lives, so I like to think, like our clients are already feeling anxious. I, perhaps am not making them feel more anxious. Maybe I am. Maybe I'm making them feel anxious in a different way, but they're actually learning that anxiety is a safe, tolerable, universal experience through exposure therapy. And because we don't do

Beth Brawley LPC (she/hers): cruel, gratuitous exposures. Exposure is based in acceptable risk. There's always risk in life. We can never convince ourselves there's no risk. But there can be acceptable risk. And I think that's you know.

Beth Brawley LPC (she/hers): to where it comes in. I don't take unnecessary risk with my life. And since I practice what I preach, and I'm only gonna ask you to do things I'm willing to do myself. There's kind of like that safeguard as well when you're doing effective and ethical exposure therapy

Beth Brawley LPC (she/hers): and then another thing I think, could lead to, you know, ineffective treatment with this is.

Beth Brawley LPC (she/hers): is it? The therapist sees their client as being fragile. If I am, you know, sending you the message like, no, no, don't do that like I'm I don't think you're ready for that, or like that's too high on your hierarchy. What am I telling you? I'm telling you. I don't believe in you. I'm telling you that you can't do this, and they've probably already had other people in their life. Send them those messages, but we.

Beth Brawley LPC (she/hers): you know, surely know that their brain has already sent them those messages. They don't need us to get on team "You can't do this" because you're fragile. People with anxiety are some of the bravest, most courageous, strongest people I've ever met. And and especially Allison, I think about I've had

Beth Brawley LPC (she/hers): clients come in where they did work with someone before who said, You know, oh, I treat everything, including anxiety, and they're like, Well, I have anxiety. So maybe this will work. And

Beth Brawley LPC (she/hers): Allison, the horror stories I have for you of other therapists, just, you know, really making them feel worse. Believing that. Oh, my gosh! Your thoughts mean something! How could you have that? How brave and courageous it is of those clients who then willingly seek me out or seek someone else out and like try again, like

Beth Brawley LPC (she/hers): knowing that there could be the same experience like Beth might misunderstand me like this other person did, and yet they're willing to show up. That is amazing. That is not a fragile person, that is, person who is incredibly brave. And I'll always tell them bravery is not a feeling.

Beth Brawley LPC (she/hers): it is a choice. I don't feel brave. I feel scared. I am like shaking in my boots, but I am going to reach out to this new OCD therapist and give it another shot like you're choosing to be brave, and that's awesome. They just might not be aware that that is actual bravery and strength.

Allison Puryear (she/her): Yeah.

Allison Puryear (she/her): I'm I'm I know that, like in the eating disorder field, there are like landmines all over the place that people step in, and they don't even realize they stepped in it.

Allison Puryear (she/her): you know, like really seemingly innocuous things like.

Allison Puryear (she/her): If somebody's refitting and they come in and they say, like, you're just looking so healthy like healthy equals fat, you know, and if you're not trained in in eating disorders like that's a compliment to say you look healthy like you think you're helping bolster bolster them. I'm curious what some of those landmines in OCD. Work might be that we may. I may be saying, I don't know, like any of us may be saying like not even thinking twice about it.

Beth Brawley LPC (she/hers): I where my mind first goes, and I'm so glad you brought this up is reassurance giving I've had a client in the past describe. You know. I would go see my talk therapist, and I would get reassurance from them that you know there

Beth Brawley LPC (she/hers): what what we're they were dealing with. Like some of the like molestation fears. And so they would go in. Not necessarily say this is what I'm worried about, but get reassurance from their therapists that they're a good person, and they have a good heart, and they don't. You know they wouldn't hurt someone willingly, and then they would feel better. I got this reassurance from my therapist, and like therapists, know what they're doing right. And so then I leave, and I feel good. And then over the week kind of

comes back I feel worse. Oh, but I go to my next therapy session. I get that reassurance from them again, and then over the week. It kind of, you know, stops being effective. And so

Beth Brawley LPC (she/hers): I think you know, we can fall into reassurance.

Beth Brawley LPC (she/hers): Oh, no, that that thought isn't meaningful, or like you would never do that. No, you're a good person. Well intended

Beth Brawley LPC (she/hers): are those kind things to say to somebody you have a good heart that feels good to say and to receive. But for someone with OCD. You know, they might not even realize what's happening that, like therapies kind of become a compulsion. Without it I wouldn't be okay. So I have to keep going back, but I don't even feel better. So that can be a landmark for sure.

Allison Puryear (she/her): Yeah. Oh, how interesting of like therapy as a compulsion!

Beth Brawley LPC (she/hers): What a messy situation, right? Right? And in fact, you know

Beth Brawley LPC (she/hers): I something I will tell them at the beginning of treatment, too, is that they will eventually kind of take on the therapist role. We don't want, like Beth assigning exposures to be a compulsion as well. Okay, I can do this because Beth asked me to do this, and Beth wouldn't ask me to do something dangerous, and so I'll do this exposure in. It's like purest form, and I won't go outside the lines. And

Beth Brawley LPC (she/hers): you know, great, you didn't exposure. That's awesome. You didn't do something wrong here, but we ultimately want you to take on that ownership of. I'm gonna create my own exposures in life. I'm going to call out anxiety in my own life to show myself that I can be in the driver's seat, and I don't need someone's kind of

Beth Brawley LPC (she/hers): sanctioning of. You know, this is okay to do so that can be another way. Where, if we're the only one kind of coming up with exposure ideas that could also potentially become a compulsion as well.

Allison Puryear (she/her): I'm wondering about like. So we've got reassurance as one thing that we might be stepping in it.

Allison Puryear (she/her): I'm wondering about like trying to rationalize out of it, if that's another one, because I know you mentioned earlier like, you can't rationalize your way out of OCD if maybe

Beth Brawley LPC (she/hers): some of the traditional CBT like replacing the negative thought with a more positive thought, that's 100 true. Right? How does that usually play out for clients? Right? And that's really CBT again is great. But it can like, if we're getting really stuck in kind of the cognitive restructuring. It's great to do that in ERP as kind of a foundation. You need to know, like.

Beth Brawley LPC (she/hers): why this is why this will work. You need to know what you're signing up for, and so the kind of the psycho ed piece is, gonna look into what meaning are we putting on our thoughts? It's gonna set, feel sound more. CBT, and then at some point, we have to get to a place of sitting with uncertainty, which. So, if I can do the cognitive restructuring. Okay, here are the reasons, you know, why this thought might not be accurate, but then moving to a place of ERP. My favorite word here Allison, is. Maybe

Beth Brawley LPC (she/hers): so. If I have a what if that? What if blank bad thing happens? You know, Covid restructuring might look like, okay, well, here's the reasons why I wouldn't do that. And you know oh, there's like the overestimation of you know, danger, and that's one of the things we did at the beginning. We move away from that, and we go to. Maybe that bad thing will happen. Maybe it won't. I'll sit with the uncertainty, and I'll tolerate the distress that comes up with that, and show myself that I don't have to have a thought, and then immediately engage with it.

Beth Brawley LPC (she/hers): So CBT is great for that foundational. Why, we're doing this. But then ERP moves to, and this is where we can be a little like silly or goofy or playful with our thoughts of like.

Beth Brawley LPC (she/hers): oh, sure, I see. Yeah, of course it's gonna happen. Maybe it will. Maybe it won't. But I'm not dealing with you right now. I'm not playing with you right now. And then I'm gonna mindfully redirect to. Actually, I'm gonna go eat lunch now some hungry, or I'm gonna go outside for some fresh air now. And actually, you know, go live my life instead of sitting here playing tug of war with you.

Allison Puryear (she/her): I'm curious about like the different I'm I'm going back to subtypes. I'm just gonna Ping Pong is around but I'm thinking about subtypes, and if there are

Allison Puryear (she/her): certain subtypes that have

Beth Brawley LPC (she/hers): better prognosis versus worse prognosis if some of the compulsions, like some compulsions

Allison Puryear (she/her): like how they fit into our culture or society, if that makes it easier or harder with like the social norms and pressure of behaving a particular way. Does that help, or does that hurt

Allison Puryear (she/her): have a lot?

Beth Brawley LPC (she/hers): I have a and please remind me if I'm like missing one of your questions in my answer. I have had people say, you know, I was out in public, and I really felt compelled to engage in blah blah blah

Beth Brawley LPC (she/hers): compulsion.

Beth Brawley LPC (she/hers): But like I didn't wanna look weird. I didn't wanna be embarrassed. And so I was able to resist. And, like, you know, we could work on. The idea of like being embarrassed is a bad thing, or, like, you know, work towards like, who cares what people think of me? But if that in in that moment helps you, you know, not engage in said, behavior. That isn't helpful for you, like, okay, great. Let's let's take the win where we can take the win

Beth Brawley LPC (she/hers): awesome. What's the first thing that you asked? I had something come to mind. About subtypes. Yes, subtypes, and if their prognosis, different subtypes.

Beth Brawley LPC (she/hers): I would say no. Again I like to think of it's all ice cream. So it's all like rooted in their core fear which we can attack with ERP with one little caveat. Is that

Beth Brawley LPC (she/hers): the feeling of disgust

Beth Brawley LPC (she/hers): in like contamination OCD, for example, that one typically is harder for somebody to habituate to that one kind of like

Beth Brawley LPC (she/hers): we do have research for this like this has been my experience. It's just kind of harder to move away from that like icky growth, like feeling harder to habituate to that, or takes longer than perhaps the fear of, you know. I'll touch that doorknob handle on the way out. And then I'm gonna get sick over the next week like that is something that you could habituate to more quickly. But with disgust. I mean. It's not that we say, Oh.

Beth Brawley LPC (she/hers): this one's harder to habituate to. Sorry, Charlie, there's no hope for you.

Beth Brawley LPC (she/hers): if our treatment, if our goal is always led by values based living. Then what I can show myself is that I can tolerate feeling gross or disgust while I go live my life according to my values. We get very active.

Beth Brawley LPC (she/hers): so it's like that. That's the learning. So perhaps the learning is not that like oh, it'll go away that icky feeling. It'll go in 20 min. Perhaps not. But you learned something that before you were avoiding living your life. And now you are feeling that feeling and living life. And that's the whole point. So you're changing your experience, even though potentially still feeling the same way. Yeah.

Allison Puryear (she/her): how do clients like I'm imagining most clients when they're finally like they're coming in. They're seeing an OCD specialist.

Allison Puryear (she/her): They are like ready to tackle this thing, and then they're told you may still feel that same level of disgust. You're just gonna handle it better like

Allison Puryear (she/her): it's the more realistic answer of like, we're not gonna wipe this out.

Allison Puryear (she/her): You know you're you're not gonna always. You're not gonna start licking toilet seats, you know, like this is.

Allison Puryear (she/her): it's not changing your experience of disgust, but it will change your experience of life while disgusted.

Beth Brawley LPC (she/hers): Yes. Does that

Allison Puryear (she/her): take the wind out of their sales or their motivation to get into the work, or is it still compelling enough for them that they'll be living their life unhindered?

Beth Brawley LPC (she/hers): Yeah, well, and you know this is just my experience. But you know, if when we're able to frame it in a way of. maybe you'll still feel that maybe you won't. Maybe you will look at you. Wait. I just want to give you a heads up, you know, if if they're able to accept that

Beth Brawley LPC (she/hers): and see that. Okay, I could potentially still feel that way, and yet have an easier time moving through my day or moving through my life, or I get to engage with my life like I'll be in a place where I can engage with my life more, and perhaps this feeling won't hold the same power or weight.

Beth Brawley LPC (she/hers): You know. I think that that can still be a

Beth Brawley LPC (she/hers): a compelling argument. And and you know the whole, the whole goal. And this I named my practice Life Without Anxiety, because naming it, Life Without Anxiety In the Driver Seat of Your Life doesn't really fit on a yeah yeah. So the goal is not to live a life without anxiety. The goal is to live a life without anxiety.

Beth Brawley LPC (she/hers): calling the shots for us, making decisions for us, because we know, like anxiety in healthy doses is helpful. It's our natural alarm system. So we're not coming at this looking to get rid of this. Wipe this out like you said but we're looking at this from a place of okay. I'm a human and a human will experience anxiety. But I can be a human that experiences anxiety in a much different way.

Allison Puryear (she/her): Is there?

Beth Brawley LPC (she/hers): Go ahead. I was just gonna say it's the difference between like living with

Beth Brawley LPC (she/hers): fear versus living in fear. And so fear is not kind of our guide. Now, while we acknowledge that it can still be in our experience. Right?

Allison Puryear (she/her): Is there a fair amount of psycho Ed, you do for partners or parents in order to help them have like manage their own expectations. Basically.

Beth Brawley LPC (she/hers): Yes, that is always helpful when we can can pull the support system in to session into the pro process. And you know, largely because

Beth Brawley LPC (she/hers): if they'd have a loving partner, if they have a loving, you know, parent, or whoever that person is, probably gonna have to do their own ERP in allowing their loved one to feel distressed and save them from that often times, and this will be, you know, some of the things that we ask and talk about. You know what are the kind of accommodating behaviors that the support system the support person has been doing

Beth Brawley LPC (she/hers): and acknowledge and validate that comes from a place of love. When we love someone we don't want to see them suffer. And so, you know, having the partner

Beth Brawley LPC (she/hers): or parent, or whoever be able to ask questions of, you know oh, so actually like. They need to be uncomfortable, like they need to do the scary thing, and I need to step back, and I need to offer support without being accommodating, you know. Ha! Giving them that information can help the treatment process.

Beth Brawley LPC (she/hers): you know. Move along more quickly or smoother. If we don't have, you know, partner, parent kind of undoing the work through accommodation. I also always always tell them do not force anybody to do. Don't force a person to do an exposure, and don't surprise the person with an exposure unless they've given their consent. I've had a couple of people where we worked together, and it was awesome. And then.

Beth Brawley LPC (she/hers): towards the end of their treatment, I asked, you know, hey? Would you be up for a surprise exposure? You don't know what it'll be. You don't know what it'll be but you know, perhaps maybe next session or the following one. Would you be okay with that and

Beth Brawley LPC (she/hers): a a anytime. I felt like it was critically relevant that you've had the rapport established. They've, you know, seen that this works. They've been okay with that, and that also can mirror real life. Where exposures just pop up.

Beth Brawley LPC (she/hers): But we don't have their support. People force them or surprise them. That. Doesn't you know it doesn't bode well for trust or treatment process as a whole. So it's very important to like, give them that psycho ed piece as well like what your person signing up for might be hard for you as well.

Allison Puryear (she/her): That's such a good point, cause I can imagine, like a well meaning spouse like they've seen their partner make such great improvements. And there's this thing that they've been wanting to do with them. But they haven't been able to. And they're like, you're you've graduated to this, I've decided, and that

Beth Brawley LPC (she/hers): that being really rough for both of them. Right? You worked on your fear of flying. Hooray! You're off like you're you're you're in a better place. I bought us tickets for next week. Like, Don't do that.

Allison Puryear (she/her): Yeah. Coming from a place of love. I mean, it's it's the same thing with accommodation, right? It always totally comes from a place of love. It's so hard to watch your loved ones suffer. It feels so good to celebrate your loved ones, growth and accomplishments.

Allison Puryear (she/her): And I guess, like, I mean, this is like, you know, the rainbows and butterflies version. There are probably a lot of things being done out of ignorance, and like being sick of the person not

Allison Puryear (she/her): doing what they want them to do or whatever, whether it's a parent or a partner that probably doesn't want to

Beth Brawley LPC (she/hers): right or like parents. I've had this experience, you know, parents saying like, well, if you don't do your exposures that you don't get screen time, or like I, you know, take away. You can't hang out friends, I'm like, well, that's not gonna want them. That's not gonna help them want to do this anymore. That's not a natural consequence. And again, it's like that can really kind of erode.

Beth Brawley LPC (she/hers): not only like trust in the parents. But trust in the process like, why would I bother if I'm just gonna get, you know things taken away because exposure is hard, and I always tell my people like, Don't you? Don't try and be perfect with this. You can't like we're gonna come up with amazing exposures. And you know, you're gonna come back next weekend. I don't want you to do 100% of them absolutely correct all the time, like.

Allison Puryear (she/her): you know, like, that's not real life. Right? And it's also probably more rooted in people pleasing or trying to do totally like

Beth Brawley LPC (she/hers): the process itself. Yeah, right? I mean, it's a great exposure. Il will tell them, you know. Make a mistake. Do something wrong. Let someone down.

Allison Puryear (she/her): that's

Beth Brawley LPC (she/hers): yeah. But these, you know, the the compulsions that they've been doing have felt

Beth Brawley LPC (she/hers): and fit since. Feelings aren't facts have felt helpful. And so we're asking someone to give up something that felt like it saved them. And we're also asking people to give up things that have become perhaps habitual. They might not even realize all the times that they're doing it. And so, you know, there are going to be times where it's like, Oh, crap! Like, I know I'm not supposed to ruminate, and I've just been doing it for half an hour.

Beth Brawley LPC (she/hers): It's like that's where Allison I love to weave in a lot of self compassion work with this as well of him, human. And this is a hard therapy to do. I you know it's like I'm asking myself, that's asking me to willingly put me in on, put myself in uncomfortable situations and accept it. And you know this acceptance as a skill is not always Zen, and roses and rainbows and butterflies acceptance

can really suck. And so I think, learning to accept that

Beth Brawley LPC (she/hers): we're not perfect. We are human. We'll mess up on this journey, and that's okay. And in fact, the cool, powerful piece here is that we can help them learn to have a different experience with mistakes and failure. And I like to say, in my office we use the word failure, not from a place of morality or judgment. Failure is just data collection. Okay? That was a mistrial. What happened? What was going on? What was I thinking? What was I feeling that led me to blank

Beth Brawley LPC (she/hers): And so, you know, learning to neutralize. The idea of making a mistake or feeling like a failure is huge. And sometimes I'll say, like, what if we work on this piece? And they're like, no failure is always bad that that won't. That can't happen. But it can be just so freeing. Yeah.

Allison Puryear (she/her): yeah, it's interesting, because I think, probably

Allison Puryear (she/her): 99% of people listening when they hear the word failure. It's an immediate no, that's an awful thing, right? And how like being in the entrepreneur world.

There's this, there's this whole mantra of fail fast

Allison Puryear (she/her): like you get into action quickly. See if something works. If it fails, it fails. That's data move on and as somebody who like biggest fear in the world is failure, it's been really like healing in some ways for me to be like, okay, just feel fast. It's fine. It's all just it's fine. I know. I always.

Allison Puryear (she/her): I live my life hard enough that I think there's just always some exposure. Yeah. So I think there's this. It's an it's an interesting thing. Because when failure is just data, and it's not personal, it's not moral.

Beth Brawley LPC (she/hers): we're open to so much more

Beth Brawley LPC (she/hers): totally. If I can't fail. If I can't tolerate even the possibility.

Beth Brawley LPC (she/hers): what do I get to do in life? How do I get to evolve or learn like that can't happen unless I'm willing to take, and I come back to acceptable risk. Acceptable risk holds uncertainty, and it holds the potential for failure. So can I change the way I engage with failure and see myself in light of failure. It's a much easier way to live.

Beth Brawley LPC (she/hers): Not not easy. No, no easier. Yeah. Yeah. Cause there's just more great stuff to bolster the hard.

Beth Brawley LPC (she/hers): totally. Totally.

Allison Puryear (she/her): Oh, yeah, thank you so much. This is such a good conversation. I want everybody. I wanna go get trained in ERP. But it's the best.

Allison Puryear (she/her): Yeah, this is great. And I appreciate you educating us a lot on OCD. As well. Because I think that

Allison Puryear (she/her): there's just for those of us who don't treat OCD. Very much or at all. There's just so much to learn, and there's so much to know. So we do no harm if. Somebody does come into office, and we can write a referrals, or we can get the right training in order to support

Beth Brawley LPC (she/hers): right? Exactly. I appreciate this, Allison. Thank you.

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