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Development of a Patient Adherence Scale for Exposure and Response Prevention Therapy

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Abstract

Exposure and response prevention (EX/RP) is an evidence-based treatment for obsessive-compulsive disorder (OCD). For EX/RP to be maximally effective, it is believed that patients must adhere outside of sessions to the procedures they learn in therapy. To date, there is no standard measure of patient EX/RP adherence, despite the importance of accurately assessing EX/RP adherence in both clinical research and practice. This paper describes the development of the Patient EX/RP Adherence Scale (PEAS), which assesses the patient's between-session adherence to the therapist's EX/RP instructions, and presents initial data on the scale's reliability and validity. The scale was designed to focus on the key procedures of EX/RP and to be brief enough to be used at each treatment session. The scale demonstrates excellent interrater reliability and good face and content validity. The usefulness of the scale is considered in the context of being an important tool to researchers trying to understand and improve outcomes of EX/RP for OCD as well as to EX/RP therapists in clinical practice. Future research will need to test the scale's reliability and validity in a larger sample of patients over the course of treatment.

Cognitive-behavioral therapy consisting of exposure and response prevention (EX/RP) is an evidence-based treatment for obsessive-compulsive disorder (OCD; Foa et al., 2005). Clinical research and experience suggest that EX/RP is only effective if patients can engage in the necessary procedures of confronting their fears (i.e., exposures) and of voluntarily stopping their rituals (Foa, Steketee, & Milby, 1980; Huppert & Franklin, 2005). Patients are directed to adhere to these procedures not only in sessions, in which the therapist can

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directly monitor adherence, but also between sessions, when they are instructed by the therapist to carry out these procedures as practice (Kozak & Foa, 1997). Between-session adherence to EX/RP has been associated with successful treatment outcome (Abramowitz, Franklin, Zoellner, & DiBernardo, 2002; De Araujo, Ito, & Marks, 1996). To date, there is no standard way of assessing patient EX/RP adherence between sessions. In this paper, we describe the development of a brief measure to assess between-session EX/RP adherence that could be used both in clinical practice and research.

Standard EX/RP manuals (Kozak & Foa, 1997; Steketee, 1999) instruct therapists at the end of each exposure session to assign patients homework consisting of exposure practice, abstinence from rituals, and self-monitoring. For example, a patient with contamination fears might be assigned to touch door knobs in public places after having practiced this in session, while refraining from hand washing during and afterwards. At the beginning of the next session, the therapist begins by discussing the client's progress with the assigned homework and addressing any problems. However, the extent to which these homework assignments are followed by patients in clinical practice is unclear, and there is no standard patient EX/RP adherence measure for therapist use. Ideally, such a measure would be simple enough to be used at each session. This way, patient adherence to EX/RP procedures between sessions could be monitored over the course of treatment in a standard way.

The few research studies to date that have formally assessed patient adherence to EX/RP have used different methods. For example, De Araujo et al. (1996) measured patient adherence to EX/RP procedures by calculating the percentage of completed versus agreed upon exposure tasks. Woods, Chambless, and Steketee (2002) measured the quantity of adherence by assessing the number of assignments completed and the number of hours spent on homework; they also assessed the quality of adherence by using the average change in the Standard Units of Discomfort (SUDS) score during exposure. Finally, Abramowitz and colleagues (2002) measured patient adherence using Likert scales ranging from *poor* (0) to *outstanding* (6) for four EX/RP components: understanding the treatment rationale; compliance with in-session exposures; compliance with exposures assigned as homework; and self-monitoring of rituals (but not the prevention of rituals per se). Although each measure has its strengths, not one combines all of the following criteria: (a) simple enough to be used at every session; (b) ability to assess quantity as well as quality of exposure practice; and (c) ability to assess adherence to both exposures and response prevention. The latter is important because the combination of both procedures is important to EX/RP's efficacy (Foa et al., 1980). In addition, no measure to date has been psychometrically validated.

In this paper, we describe the development of a patient EX/RP adherence scale that meets all three of the above criteria. We present the scale and instructions for its use and provide initial data on its content validity, interrater reliability, and item correlations. Our goal in developing this scale is to provide clinicians with a patient EX/RP adherence measure that is simple enough to be useful in clinical practice and to provide researchers with a simple but reliable tool that can be further validated and used in future research.

Phase 1: Scale Construction and Content Validity

Method

We reviewed the anxiety disorders treatment literature for examples of measures of adherence to exposure-based assignments. We found no measure whose interrater reliability had been examined. However, certain key strengths thought to be important to reliability and validity were identified that influenced our final scale. These included use of detailed anchors (Primakoff, Epstein, & Covi, 1986), quantitative measurement expressed in

percentage of total homework completed (De Araujo et al., 1996), and qualitative measurement with specific exposure related criteria, such as “use of safety aids” (Schmidt & Woolaway-Bickel, 2000). None of the EX/RP measures reviewed contained all features. Thus, using our collective research and clinical experience in treating OCD patients, we designed a scale that did.

To assess content validity, the final scale, consisting of 3 items, was formally evaluated by 10 researchers and clinicians with expertise in OCD and EX/RP. These included the 5 authors who either drafted the scale (HBS and JP) or who consulted on the initial selection and wording of possible items (MM, EF, MF), and 5 other psychologists. The latter were chosen because of their expertise in EX/RP treatment, because they work at different clinics than the primary author, and because they were not involved in any way in scale development. All were sent the Patient EX/RP Adherence Scale (PEAS) by the primary author and asked to answer the following questions about the final scale and were given the opportunity to provide open-ended feedback. First, using Lawshe's (1975) approach to establishing content validity, each expert was asked to agree or disagree with whether each item was “central to the assessment of EX/RP homework for patients with OCD.” A second question asked each expert to agree or disagree with whether each item and instructions allowed the clinician to sufficiently rate the construct. This approach calculates a content validity ratio (CVR) expressed as $CVR = n_e - (N/2) / N/2$, in which n_e is the number of panelists who agree with each question (above) and N is the total number of panelists. A minimum critical value of 0.62 is necessary, based on ten panelists to ensure that the likelihood of a chance agreement among panelists is below 0.05.

Results

The PEAS (see Appendix A) is a 3-item scale that assesses the percentage of exposure assignments attempted, the quality of exposure assignments attempted, and the percentage of rituals resisted between session. Each item on the PEAS is rated using a 7-point Likert scale to capture a range of adherence behaviors observed in patients doing EX/RP assignments. A “99” is used in cases when no exposure or response prevention is assigned. Instructions for the scale with accompanying probes were also designed (see Appendix B) to ensure consistency of administration and use. The scale has the flexibility to rate multiple exposure assignments quickly and accurately, and it is designed for clinicians to utilize self-report, patient forms (i.e., exposure and ritual logs; see Appendix C and D), and their clinical understanding of the patient's OCD to arrive at a rating. The scale takes about 5 minutes to score if the therapist provides no feedback to the patient during administration; if the therapist uses the scale to structure a conversation about the between-session assignments and to provide feedback and additional instruction on how future assignments should be performed, administration can take longer depending on how much feedback is provided.

Independent ratings by the 10 OCD experts demonstrated good content validity. Specifically, the content validity ratio (CVR) demonstrated unanimous agreement by the panel that each item was “central to the assessment of EX/RP homework for patient's with OCD” with a CVR of 1.00 for each item. The second question asked whether each item and instructions allowed the clinician to sufficiently rate the construct. Nine experts agreed that Item A was sufficient (CVR = 0.80), 9 agreed that Item B was sufficient (CVR = 0.80), and 10 agreed that Item C was sufficient (CVR = 1.00).

Phase II: Interrater Reliability

Method

Participants—Seven female patients and 8 male patients, ages 24 to 65, participated. All patients met *DSM-IV* (American Psychiatric Association, 1994) criteria for OCD for at least a year based on a comprehensive psychiatric evaluation that included the Structured Clinical Interview for *DSM-IV* (First, Spitzer, Gibbon, & Williams, 1996) and the Yale-Brown Obsessive Compulsive Scale (YBOCS), a 10-item clinician administered measure of OCD symptom severity (Goodman, Price, Rasmussen, Mazure, Delgado, et al., 1989; Goodman, Price, Rasmussen, Mazure, Fleischmann, et al., 1989). Pretreatment YBOCS scores ranged from 23 to 33. The primary obsessions and compulsions of the 15 patients as a group included all of the OCD symptom dimensions (e.g., contamination, harm, hoarding, symmetry/exactness, sexual/religious; Rosario-Campos et al., 2006). Nine patients met *DSM-IV* criteria for other current Axis I disorders, which were usually major depressive disorder, generalized anxiety disorder, or a specific phobia; the remaining 6 had no other Axis I disorder.

Procedure and analysis—Patients were participating in a clinical trial of EX/RP funded by the National Institutes of Mental Health. After obtaining informed consent, patients began treatment. All treatment sessions were recorded on digital audio. As is standard in EX/RP treatment (Kozak & Foa, 1997), the EX/RP therapist reviewed at the start of each exposure session the between-session assignments from the prior session before beginning within-session exposure practice. The PEAS was used by the therapist to assess quantitatively the quality and quantity of adherence with these assignments.

To establish interrater reliability of the PEAS, we assessed 30 exposure sessions from 15 patients, sampling exposure sessions from each patient at different points in treatment (i.e., first versus second half of treatment) because adherence can vary not only between individuals but also across treatment; the goal was to ensure that a range of adherence behavior was assessed. Two independent raters who were trained EX/RP therapists listened to digital recordings of the beginning of these 30 sessions (i.e., in which homework was reviewed and until that session's in-session exposure practice began), and each rater independently completed the PEAS. Both raters were uninformed regarding the adherence ratings of the patient's EX/RP therapist but had copies of the patient's exposure homework form (Appendix C) and the self-monitoring of rituals log (Appendix D) so that they knew what exposures had been assigned and how well patients refrained from ritualizing. Together, this process generated three PEAS ratings (from the therapist and the two independent raters) for 30 different sessions from 15 different patients.

Intraclass correlation (ICC) analyses were performed on these ratings to examine interrater reliability for each item. A two-way, random effects model using absolute agreement on expert ratings was utilized for the ICC analysis. Correlational analyses explored the association of items (i.e., A to B, A to C, and B to C).

Results

A full range of patient adherence behaviors were rated, from complete noncompliance on certain assignments to full compliance on others (Table 1). The ICC results demonstrated excellent interrater reliability for Item A (ICC = 0.99; 95% CI 0.99–1.00; $p < 0.001$), Item B (ICC = 0.97; 95% CI 0.96–0.98; $p < 0.001$), and Item C (ICC = 0.99; 95% CI 0.99–1.00; $p < 0.001$). Item correlations were as follows: A to B, $r = 0.64$ (95% CI 0.37–0.81); A to C, $r = 0.33$ (95% CI 0.00–0.62); B to C, $r = 0.58$ (95% CI 0.28–0.78).

General Discussion

In this paper, we present the PEAS. The scale has face validity in that it asks about the two key procedures of EX/RP treatment (exposures and response prevention), and it allows the therapist to choose from a range of adherence behaviors for each item. In addition, clinicians using the scale reported that its administration was well received by patients in the context of EX/RP homework review. Content validity appears strong given that 10 OCD experts all agreed that each of the three scale items is central to patient EX/RP adherence. Finally, the scale has excellent interrater reliability (ICCs = 0.97), indicating that clinicians consistently agreed on how adherent patients had been to between-session assignments. Correlation analyses suggested that the relationship between the quantity of exposure (A) attempted and the quantity of response prevention (C) attempted was not strong; the relationship appeared stronger between the quantity (A) and the quality (B) of exposure, as might be expected, and between the quality of exposure (B) and the quantity of response prevention (C). It will be important for future research to examine the predictive power of these items individually as well as to consider whether their values should be combined to predict treatment outcome for EX/RP. For example, combining the exposure items might produce a stronger predictor than either one alone.

In terms of content validity, our panel of experts all agreed that the three scale items are central to patient EX/RP adherence. In addition, 10 out of 10 found Item C adequate to measure adherence to response prevention, and 9 out of 10 found that Item A and Item B were adequate to each respectively measure the quantity and quality of exposure assignments. The dissenting rater conveyed a preference on Item A for minutes spent on homework instead of assignments attempted. Although minutes spent on exposure could be a useful measure, our clinical experience is that many patients are inaccurate in their reports of time spent on exposures. In addition, minutes spent on exposure may be misleading as an adherence indicator because some patients habituate quickly to assignments and need to spend less time than others on exposures. For Item B, the dissenting rater was concerned that the assessment of exposure quality could confound EX/RP. This concern is not supported by the moderate relationship between Items B and C ($r = .58$), and it is in fact essential to consider the presence of compulsions during an exposure in order to rate the quality of the exposure assignment. However, to reduce any potential confound, we clarified the instructions to make clear that Item B is only assessing compulsions that occur in direct response to the exposure being rated.

Strengths of the PEAS include its brevity (3-item), ease of use, and focus on the two key procedures essential for EX/RP's efficacy: exposure and response prevention. Administration can take as little as 5 minutes; alternatively, the therapist can use the PEAS to structure a conversation about between-session assignments and to provide feedback and advice on how to conduct future assignments. Typically, the first 15 minutes of an exposure session involves reviewing homework (Kozak & Foa, 1997). Thus, the PEAS fits easily within this frame. Another advantage of the PEAS is that it has the ability to separately assess the quantity and quality of attempted exposures. This is important because the quality of patient's work in CBT for panic disorder has been shown to be a better predictor of outcome than the quantity of work (Schmidt & Woolaway-Bickel, 2000). The PEAS will allow future studies to examine whether the same is true in EX/RP for OCD.

This scale also has limitations. First, because it is purposefully brief, it focuses only on adherence to exposures and response prevention. It does not assess treatment adherence more broadly (e.g., whether patients read assigned psychoeducational materials). Second, it relies upon the therapist providing clear instructions to the patient at the end of each session about which exposures to perform and what rituals to stop; use of the scale may improve

treatment delivery because of this need for clear instructions. Finally, the scale depends upon patients' accurate self-report of their exposure practices and efforts at response prevention as well as therapists scoring these self-reports in a consistent manner; instructions provided with the scale were intended to help improve patients' self-report and to facilitate scoring consistency.

For clinicians in practice, the PEAS is brief enough that it can be used at the beginning of each treatment session to assess patient adherence with between-session exposures and the prevention of rituals. This is important, as attention to homework by clinicians has been found to be a strong predictor of homework compliance (Bryant, Simons, & Thase, 1999). This scale may also help the therapist structure the session and ensure that pertinent questions about between-session assignments are asked each time. In addition, regular use of this scale can provide the therapist with important information over the course of treatment about the degree of patient adherence to EX/RP. When adherence is lagging, this can prompt a conversation about the problem areas and allow therapists to tailor the treatment sessions to those areas so that the best outcome is achieved.

For researchers, the PEAS represents a first step in developing a valid and reliable measure to assess patient EX/RP adherence. The next step will be to validate this scale further in larger samples of patients and therapists. In particular, the relationship between patient self-reports and actual patient homework behavior and the test-retest reliability of the scale needs to be examined. Although there is a literature on treatment adherence in other anxiety disorders, patient adherence to EX/RP has rarely been assessed or studied. Armed with a reliable and valid scale to measure this important construct, researchers can not only examine the impact of EX/RP adherence on treatment outcome but also study what moderates and mediates adherence. The ultimate goal would be to develop evidence-based interventions that enhance EX/RP adherence and thus maximize treatment outcome. The PEAS is a first step in this direction.

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Appendix A. Patient EX/RP Adherence Scale (PEAS)

A) *Exposures*: What % of exposures assigned did the patient attempt since the last visit?

99 not assigned

1 none (0%)

2 minimal (<10%) (# attempted)—/—(# assigned) = —% attempted

3 very few (~25%)

4 about half (~50%)

5 many (~75%)

6 most (>90%)

7 all that were assigned (100%)

B) Exposures: How well did the patient do the assigned exposures that were attempted?

99 exposures not assigned

1 refused— did none of the assigned exposures

2 attempted exposures with no intent or attempt to refrain from compulsions (e.g., few or minimal exposures conducted with full intent to ritualize after)

3 attempted exposures with intention of refraining from compulsions but with obvious reluctance (e.g., repeatedly delayed starting, spent little time on exposures, did compulsions during the exposures without making real effort to refrain)

4 made a good effort to conduct the exposures as assigned by the therapist but gave into compulsions during or after the exposure

5 good—completed the exposures as assigned by the therapist (e.g., appropriate exposure, correct amount of time) with minimal compulsions or safety aids during or afterwards

6 very good—exposures performed as assigned by the therapist (e.g., appropriate level exposure, correct amount of time, no compulsions during or afterwards, no safety aids)

7 excellent—all of the exposures attempted were performed as assigned by the therapist (e.g., appropriate level exposure, correct amount of time, no compulsions during or afterwards, no safety aids), the patient facilitated the process (e.g., made modifications to the assignment that increased the exposure), and the patient looked for opportunities to extend the exposure homework into their lifestyle

C) Response prevention: What % of urges to ritualize did patient successfully resist since the last visit? (If full RP is not yet in effect, rate based on compliance with therapist's instructions for RP)

99 not assigned or no urges because symptoms are so minimal

2. minimal (<10%)

3 sporadically (~25%)

4 about half (~50%)

5 many (~75%)

6 most (>90%)

7 Most (> 90%) and re-exposed themselves if they slipped and did rituals or no urges because symptoms are so minimal or 100% response prevention.

Appendix B. Instructions for Patient EX/RP Adherence Scale (PEAS)

Item A. Exposures: What % of exposures assigned did the patient attempt since the last visit?

Explicit between-session instructions are necessary to ensure an accurate response. The therapist will document the number of exposures assigned. Each exposure episode counts as one (e.g., assigning the same exposure three times equals three exposures). Score will depend not only on number attempted but number assigned. For example, if the patient attempts one of two assigned exposures, this would score a 4 (~ 50%). If one of four is completed, this would score a 3 (~25%). An attempt is any effort to try the exposure at all. If an exposure is not done, regardless of the reason, it is scored as not done. If an exposure other than the one assigned was done because the assigned exposure was not possible, rate it if the exposure done was comparable in difficulty and spirit (e.g., touching the faucet handle instead of the door handle of public bathroom); rate as not done if the attempted exposure was easier, not in the spirit of the original or if it was substituted as deliberate avoidance (e.g., patient touches their own door handle instead of that of a public bathroom). If a patient attempts a specific exposure more times than it was assigned, only score the number assigned (e.g., if a patient assigned to use a public bathroom twice attempts 3 times, the rater should score 2 attempts, not 3).

Item B. Exposures: How well did the patient do the assigned exposures that were attempted?

Establish an average for attempted exposures. If there is significant discrepancy between quality of attempted exposures, establish by estimating the quality of each exposure and then averaging across them. Compulsions and safety behaviors being considered in this item are only those done in direct response to the exposure being rated. Do not rate exposures that were not attempted (i.e., if 4 exposures were assigned and 1 was done, only rate the 1 done without rating down for the 3 that were not done). If no exposures were attempted, rate Item B as 1. If a patient attempts a specific exposure more times than it was assigned, rate the patient's quality of adherence to the best attempts (e.g., 2 assigned exposures to public bathrooms and 4 are done, rate the best 2 attempts. If best attempts are at the 6 level, give the patient a "7" on both for facilitating practice).

Ask the patient:

- How did the — exposure go?
- Did you have any trouble getting started on the exposure?
- Were you able to complete the exposure without doing any compulsions during or afterwards?
- Did you do anything else to make yourself feel better during the exposure, like reassuring yourself? (if yes): *How much effort did you make to resist?*
- Did you seek out any additional opportunities for exposures?

Item C. Response prevention (RP): What % of urges to ritualize did patient resist since the last visit?

Scoring this item is inherently dependent on patient report. If the therapist has given instructions for partial RP (vs 100%), then this rating should be based on the % of time the

patient complied with the therapist instructions for RP (as per below). Self-monitoring and any other information the clinician has about patient rituals should also be considered in scoring this item. In case the patient under- or overestimates their ability to resist compulsions, refer to their self-monitoring to see if they change their answer or explain the apparent discrepancy. Use clinical judgment in making the rating. If the patient did not do self-monitoring, DO NOT rate the patient down on Item C.

Ask the patient:

- (For 100% RP) When you had an urge to do a ritual, what % of the time were you able to successfully resist since the last visit?
- (For partial RP) We discussed that you would resist — compulsions and rituals. What % of the time were you able to successfully resist these since the last visit?

If the patient is unable to provide percentage, use the guidelines below. Note patient's ability to spoil rituals and use to help with uncertain scores (i.e., round up if able to spoil, round down if no attempt to spoil). Also round down if many urges are blocked by avoidance (e.g., if patient says resisted half of 10 urges, but life is structured to avoid urges, then give 3, not 4). If the patient is doing very well near the end of treatment, and few or no urges are reported along with very few compulsions, rate using a 6 or 7. If no urges and no compulsions are reported, rate as 7.

Appendix C: Exposure Homework Form for a Patient With Contamination Concerns

Exposure Homework Form

1. Exposure exercise to practice (# times) Touch garbage can each day until the next appointment for 45 minutes or until initial SUDS decreases by 50%

Appendix C

Exposure Homework Form for a Patient With Contamination Concerns

Exposure Homework Form				
1) Exposure exercise to practice (# times) Touch garbage can each day until the next appointment for 45 minutes or until initial SUDS decreases by 50%				
Date	SUDS			Time Spent
	Pre	Post	Peak	
Tues	60	30	70	45 min
Wed	60	20	60	45 min
Thurs	50	10	50	45 min

2. Exposure exercise to practice (# times) Touch base of toilet each day until the next appointment for 45 minutes or until initial SUDS decreases by 50%

2) Exposure exercise to practice (# times) Touch base of toilet each day until the next appointment for 45 minutes or until initial SUDS decreases by 50%				
Date	SUDS			Time Spent
	Pre	Post	Peak	
Tues	----	----	----	0
Wed	80	60	80	30 min
Thurs	---	----	----	0

Response Prevention Instructions: Full Response Prevention is the goal. If any compulsions occur, please record all of them on your Self-Monitoring of Rituals form.

Response Prevention Instructions

Full Response Prevention is the goal. If any compulsions occur, please record all of them on your Self-Monitoring of Rituals form.

Appendix D: Self-Monitoring of Rituals Form for a Patient With Contamination and Harm Concerns

Appendix D

Self-Monitoring of Rituals Form for a Patient With Contamination and Harm Concerns

Self-Monitoring of Rituals				
In this treatment, you need to try your hardest not to ritualize. The goal of this form is to record any time you do ritualize and what triggers it. Please use one form for each day until the next session. To facilitate your record keeping, your primary rituals are:				
Ritual A: _____ washing _____				
Ritual B: _____ checking _____				
Ritual C: _____				
Date: _____				
Time of day	Situation/Activity/Thought that evokes the ritual	SUDS (0-100)	Ritual (A, B, C)	Minutes spent on ritual
6-7 am				
7-8 am	Taking out garbage	60	A	15 min
8-9 am	Leaving the house	50	B	1 min
10-11 am				
11-12				
12-1 pm	Co-worker with cold	60	A	20 min
1-2 pm				
2-3 pm				
3-4 pm				
4-5 pm	Passed homeless person	80	A	45 min
5-6 pm				
6-7 pm	Using the bathroom	70	A	45 min
7-8 pm				
8-9 pm				

Self-Monitoring of Rituals				
In this treatment, you need to try your hardest not to ritualize. The goal of this form is to record any time you do ritualize and what triggers it. Please use one form for each day until the next session. To facilitate your record keeping, your primary rituals are:				
Ritual A: _____ washing _____				
Ritual B: _____ checking _____				
Ritual C: _____				
Date: _____				
Time of day	Situation/Activity/Thought that evokes the ritual	SUDS (0-100)	Ritual (A, B, C)	Minutes spent on ritual
9-10 pm	Turning off lights	55	B	2 min
10-11 pm				
11-12				
12-1 am				
1-2 am				
2-3 am				
3-4 am				
4-5 am				
5-6 am				

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Table 1

Item Values for the Patient EX/RP Adherence Scale (PEAS) by Rater

PEAS Item	A	B	C
	mean (<i>SD</i>), range	mean (<i>SD</i>), range	mean (<i>SD</i>), range
Rater 1	5.13 (1.74), 1.00-7.00	5.13 (1.46), 1.00-6.00	5.03 (1.57), 2.00-7.00
Rater 2	5.17 (1.70), 1.00-7.00	4.93 (1.44), 1.00-7.00	4.97 (1.52), 2.00-7.00
Rater 3	5.10 (1.77), 1.00-7.00	5.03 (1.59), 1.00-7.00	5.00 (1.55), 2.00-7.00
Overall average	5.13 (1.73), 1.00-7.00	5.03 (1.47), 1.00-6.67	5.00 (1.55), 2.00-7.00

Item A. Exposures: What % of exposures assigned did the patient attempt since the last visit?

Item B. Exposures: How well did the patient do the assigned exposures?

Item C. Response prevention: What % of urges to ritualize did patient successfully resist since the last visit?