OCD ESSENTIALS: DIAGNOSING AND TREATING OBSESSIVE-COMPULSIVE DISORDER

A 4-PART SERIES

HOPEWELL
a therapeutic farm community

Lindner Center of HOPE.
UC Health

CO-HOSTED BY:

Hopewell Therapeutic Community

Lindner Center of HOPE

WELCOME!

- Thank you everyone for joining
- Why do we do this?
- Housekeeping rules
  - Please keep all microphones on mute to avoid distraction
  - Please type any questions into the chat box
    - I will be keeping a running list of questions to be answered at the end
    - The clinicians can answer any quick questions they are written
      - If not, the questions will be presented at the end during the Q/A section
- The team will stay after the Q/A is over if you would like to learn more about our programs
- This first lecture is meant to serve as an overview, with subsequent seminars diving deeper in content
- 2 CEU's available for this seminar which will be loaded into CE Broker

SEMINAR SERIES SCHEDULE

Friday, January 20, 1:00-3:30 pm EST

Friday, February 17, 1:00-3:30 pm EST

Friday, March 17, 1:00-3:30 pm EST

Friday, April 21, 1:00-3:30 pm EST

ANY QUESTIONS BEFORE WE BEGIN?

KEYNOTE

Charles Brady PhD., ABPP

Dr. Brady is a nationally recognized board-certified clinical psychologist who has helped people conquer anxiety since 1992. In April of 2020, he left his positions as associate professor in the University of Cincinnati's Department of Psychiatry and Director of the OCD and Anxiety Services program at the Lindner Center of HOPE and moved to the Kitsap Peninsula in Washington. In addition to helping to launch and serving as vice-president of OCD Midwest, a regional affiliate of the International OCD Foundation, Dr. Brady has served as faculty for the IOCDF's Behavioral Therapy Training Institute and is a frequent presenter at the national conferences of the IOCDF and the Anxiety and Depression Association of America.

THE LINDNER CENTER OF HOPE

Jennifer G. Wells, LISW-S

Ms. Wells is one of the core members and current director of the Obsessive Compulsive Disorder/ Anxiety treatment team at Lindner Center of HOPE. She has over 25 years' experience providing outpatient therapy for children, teenagers and adults with Obsessive Compulsive Disorder (OCD) and other anxiety disorders utilizing the evidence based techniques of Cognitive Behavioral Therapy and Exposure and Response Prevention. Ms. Wells has recently been appointed as a faculty member for the IOCDF's Behavior Therapy Training Institute (BTTI).

Nicole Bosse, PsyD

Dr. Bosse is a staff psychologist and a member of the OCD and Anxiety team at the Lindner Center of HOPE. She also serves as the treasurer for OCD Midwest. Dr. Bosse provides psychological services for outpatients. Her area of expertise consists primarily of Exposure and Response Prevention, Cognitive Behavioral Therapy, as well as Acceptance and Commitment Therapy. Dr. Bosse received her doctorate in Psychology from Xavier University in 2014 and completed a post-doc at Lindner Center of HOPE focused on OCD.

Lindsey Collins Conover, PhD

Dr. Conover is a Psychologist and member of the OCD and Anxiety Treatment Team at the Lindner Center of HOPE. She serves as a therapist for patients with OCD and anxiety disorders and provides specialized OCD consultations on the two residential units, Sibcy House and Williams House. She also provides outpatient therapy services with 70% of patients having OCD. Dr. Conover earned a PhD in Clinical Psychology from Binghamton University. She has published several scientific papers on the treatment of OCD.

HOPEWELL THERAPEUTIC COMMUNITY

Daniel B. Horne, LPCC-S, LSW

Clinical Director, Clinician

As a licensed social worker and licensed professional clinical counselor, Daniel views treatment with a holistic approach. He was immediately drawn to the healing power of the Hopewell environment and program. Daniel's responsibilities as Clinical Director include overseeing Admissions & Intake, supervision of the Clinical Team, supervising counseling interns, overseeing all clinical aspects of the Hopewell program and serving on the marketing and program committees of the board of directors. Daniel also maintains a caseload of residents and provides individual and group counseling services to residents. From working in a pre-release prison program in Montana to long-term residential treatment programs in Maine to providing individual, family, and group counseling in Youngstown, Ohio, Daniel's experience brings a well-rounded perspective to his work at Hopewell. In his free time, Daniel is an artist-welder creating sculptures from salvaged steel.

Laura Scarnecchia, LPCC

Director of Admissions, Clinician

Healing happens at Hopewell, and Laura is grateful to be part of each resident’s journey toward recovery. The serenity of the farm and the power of the community impressed Laura when, while completing her Master’s Degree in Clinical Mental Health Counseling from Kent State University, she first arrived at Hopewell as an intern. After finishing her graduate studies and obtaining state licensure, Laura was pleased to join the staff as a clinician. As a licensed professional counselor, Laura provides individual counseling and facilitates therapeutic groups. She believes in working with both residents and their families to cooperatively and creatively nurture personal change in a holistic manner that respects the dignity and value of each person.

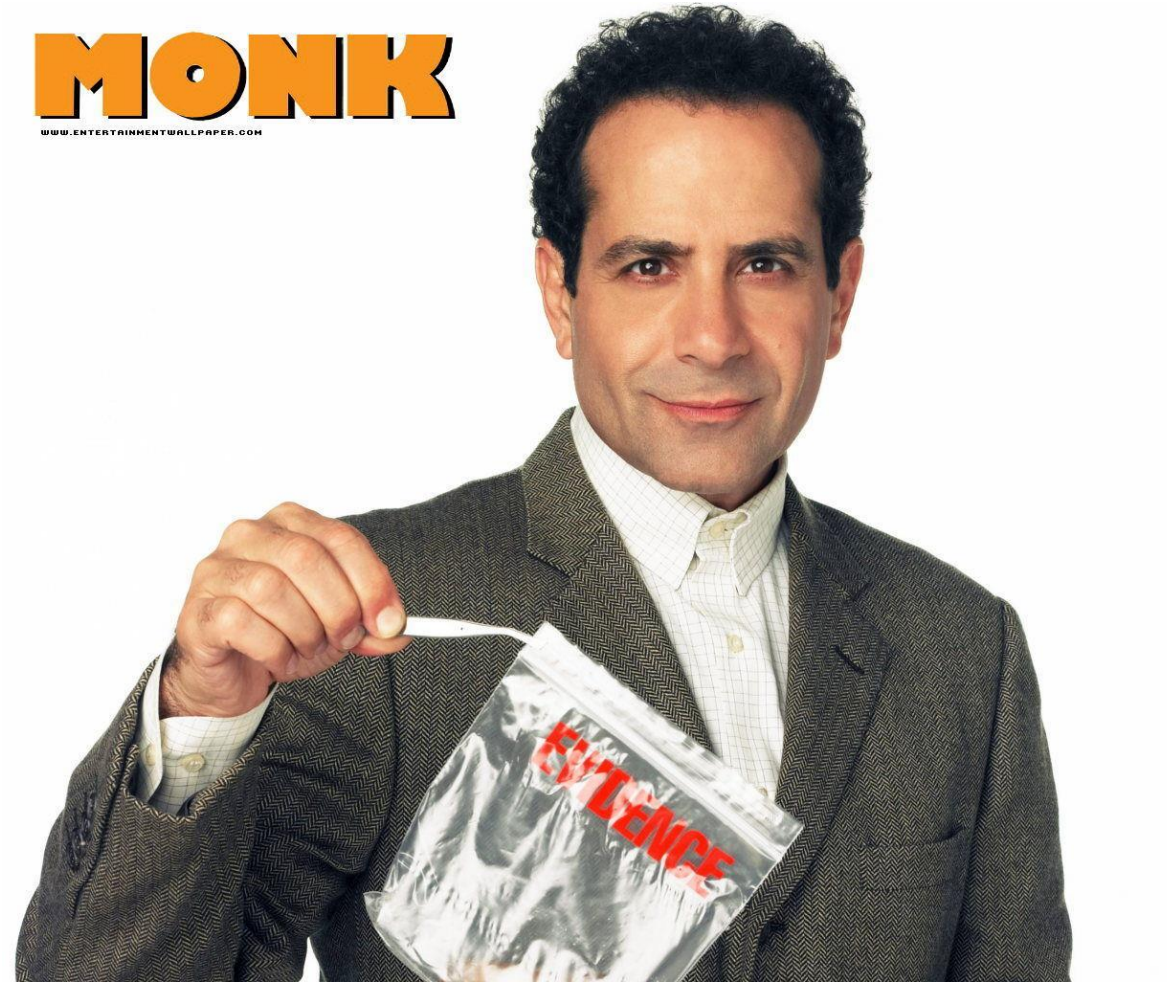
4 PART SERIES

- Part 1
  - Overview – Dr. Brady
  - Diagnosis : Subtypes – Laura Scarnecchia
  - Diagnosis– Co-morbidity – Daniel Horne
  - Assessment – Lindsey Conover
  - Treatment Approaches – Dr Bosse
  - Family Systems – Jennifer Wells
  - Q & A discussion led by Dr Brady

Each section 20 minutes in length

AN AERIAL VIEW OF OBSESSIVE COMPULSIVE DISORDER

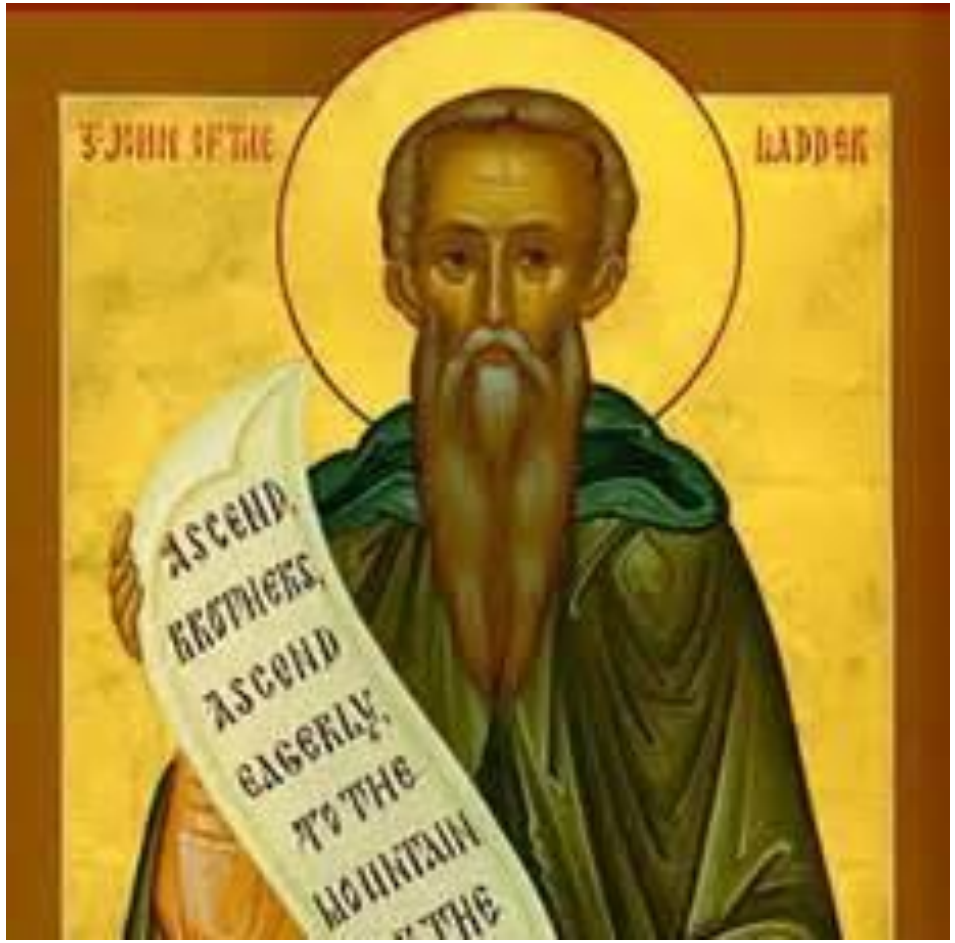
CHARLES BRADY, PHD ABPP


MONK
WWW.ENTERTAINMENTWALLPAPER.COM
EVIDENCE

OCD: NOT A NEW AGE DISORDER

"If you have blasphemous thoughts, do not think that you are to blame"

-John Climacus,6th century monk



OBSESSIVE-COMPULSIVE DISORDER:

Fast Facts

1 in 40 people will suffer OCD during their lifetime

8th leading cause of medical disability for people, ages 15 to 44

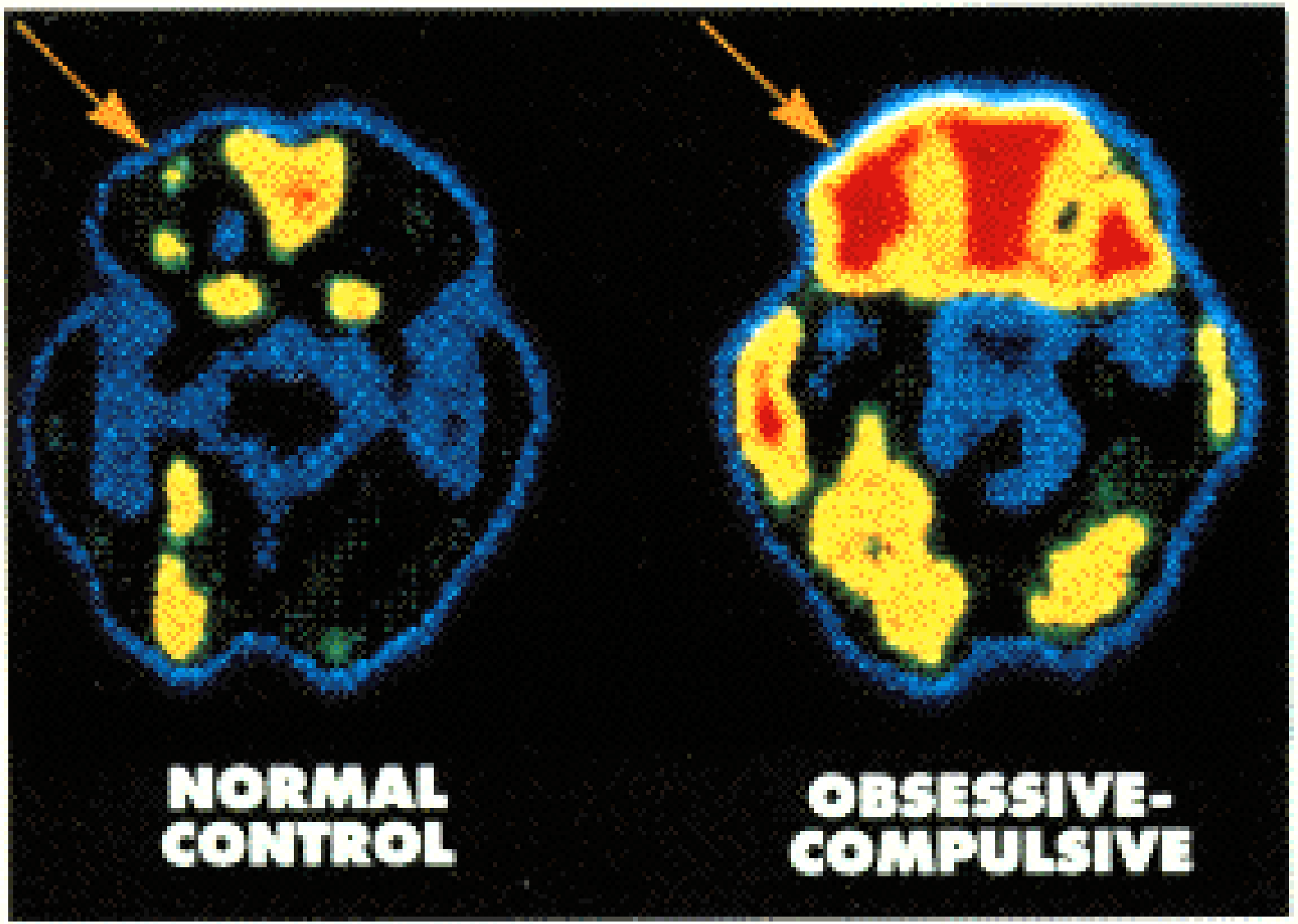
Equally common among men and women.

Median age of onset is 19, (25% by age 14.)

DIAGNOSIS OF OBSESSIVE-COMPULSIVE DISORDER:

Obsessions are unwanted and uninvited **thoughts, images, feelings,** and **urges** that trigger strong fears or substantial distress.

Compulsions are repetitive behavioral or cognitive counter-measures that the individual employs to **ignore, suppress,** or **prevent** the distress-triggering thoughts, images and urges and/or potential consequences.

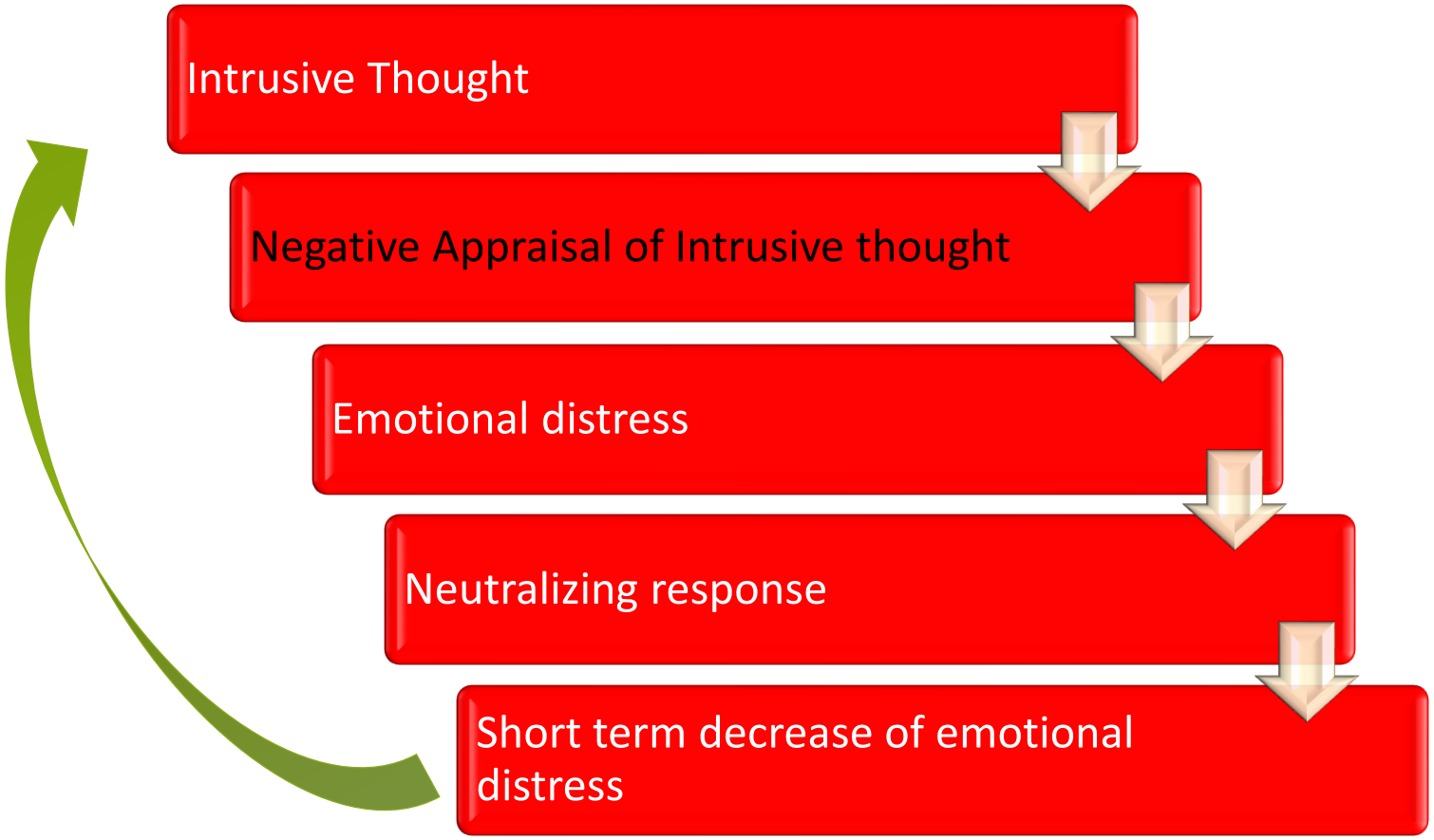


HIGH ENERGY USE IN THE BRAIN OF A TYPICAL PERSON WITH OCD

OCD: A BIOLOGICAL BRAIN-BASED BULLY

http://hope4ocd.com/

CBT MODEL OF OCD



THE FILTER

DIAGNOSIS: SUBTYPES AND CO-MORBIDITY

DIAGNOSIS OF OBSESSIVE-COMPULSIVE DISORDER:

Obsessions are unwanted and uninvited **thoughts, images, feelings,** and **urges** that trigger strong fears or substantial distress.

Compulsions are repetitive behavioral or cognitive counter-measures that the individual employs to **ignore, suppress,** or **prevent** the distress-triggering thoughts, images and urges and/or potential consequences.

COMMON OBSESSIONS AND COMPULSIONS

Obsessions	Compulsions
Harming	
Contamination	Checking
Sexual	Washing
Religious	Cleaning
Symmetry / exactness	Repeating
Somatic	Ordering/arranging
	Counting

CONTAMINATION OCD

Core Fear: I might touch or see or think something that may make, me sick, kill me, make me bad, make someone else suffer, or may make me feel yucky.

Common Neutralizers:

washing avoiding reassurance seeking mental review checking excessive discarding

HARM AND MORBID OBSESSIONS

Core Fear: I might think or do something that might cause harm to someone else. The presence of the thought makes it true. (e.g, "I'm evil")

Common Neutralizers:

reassurance seeking	mental review (Did I do it/enjoy* it?)	checking	avoidance	mental/behavioral un-doing

EXAMPLES OF TRIGGERING THOUGHTS AND IMPULSES

- I’m a pedophile
- I’m homosexual
- I’ll stab someone
- I’ll jump off a bridge
- Image of an airplane crash
- Impulse to curse in church

SECURITY OBSESSIONS: CHECK-MATE

Core Fear: the house may burn down, my family will be attacked, the house will flood

Common Neutralizers:

checking	reassurance seeking
delegated checking	mental review

SCRUPULOSITY: SPIRITUAL OBSESSIONS AND COMPULSIONS

SCRUPULOSITY

Core Fears: I might think or do something blasphemous. I might commit a sin that will send me or someone else to Hell. I might offend God by something I do, don't do, or don't do well enough.

Common Neutralizers:

Reassurance seeking over-participation in forgiveness rituals	mental review ritualistic prayer	self-mortification avoidance of religious objects or activities

EXAMPLES OF TRIGGERING THOUGHTS AND IMPULSES

My prayer wasn't good enough

LUKE 12:10; MARK 3:29, MATTHEW 12: 31-32

I had a blasphemous visual image

Placing my fork down crooked means I love the devil

I've sold my soul to the devil

I might cheat on my taxes.

OCD AND DEPRESSION

Over 2/3 of adults with OCD will suffer from depression and 85% of the time the OCD symptoms appear first.

If the depression is interfering with the patient's ability to perform CBT, then it must be targeted first for intervention psychiatrically and psychologically.

OCD AND BIPOLAR DISORDER

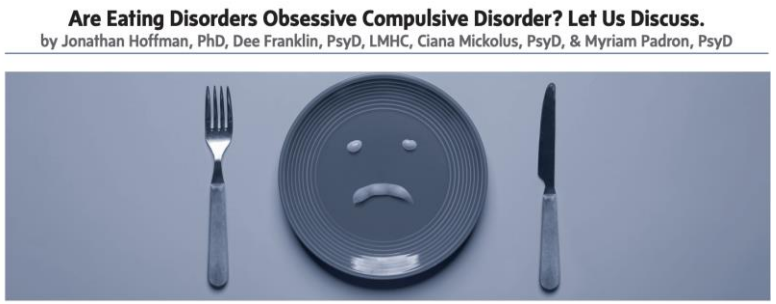
Angst et al (2004), 53% of OCD patients had hypomanic symptoms with 30% diagnosed with Bipolar II.

OCD more prevalent with Bipolar II than Bipolar I.

(Raja, 2005) Using nation-wide sample, 21% of subjects with either Bipolar I or II, had co-morbid OCD.

CO-MORBID OCD AND BIPOLAR VS. OCD

- Some evidence that for those with co-morbid bipolar and OCD, the OCD appears first.
- Higher risk for co-occurring substance abuse disorders.
- Less compulsions but equal volume of obsessions.
- Obsessions more likely to be “existential, superstitious, or philosophical” (Masi et al 2004).
- Medication to treat the mood disorder is essential.



OCD AND EATING DISORDERS

Ritualized behaviors may manifest in schedules, eating habits, portion sizes, or ways food is ingested. Some people excessively count calories throughout the day and have specific numbers they try to meet or avoid which often leads to hours and hours spent researching the caloric value of various food items.

Studies of patients in intensive eating disorder programs suggest rates of OCD in their patients range from 24 to 41%. (Godart et al 2006 and Kaye et al 2004).

https://iocdf.org/download/winter-2022-vol-36-num-4/

OCD AND EATING DISORDERS

Early onset OCD a risk factor for ED.

Individuals with anorexia show more compulsive tendencies, whereas individuals with binge eating difficulties struggle with impulsive behaviors.

PSYCHOSIS AND OBSESSIVE-COMPULSIVE SYMPTOMS

The rate of obsessive-compulsive symptoms (OCS) in individuals with schizophrenia range from 10%-50% and the rate of OCD ranges from 7.8% to 26%.

OCS can also be experienced by individuals who have psychotic symptoms due to mood disorders (e.g., bipolar disorder, major depressive disorder)

OCD AND SCHIZOPHRENIA

In patients with Sc and OCS there is evidence for greater levels of cognitive deficits, negative and positive symptoms, neurological soft signs, depression, suicidal ideation, and suicide attempts.

There is emerging data from neuro-imaging and neuro-psychological studies that indicate differences between patients with combined Sc and OCS and patients with either OC or Sc.

Most problematic area is distinction between obsession and delusion.

CO-MORBIDITY IN CHILDREN AND ADOLESCENTS WITH OCD

In pediatric samples, co-morbidity rates as high as 74% (Storch et al., 2008)

OCD AND ADDICTIONS

27 percent of OCD treatment seeking patients found to have substance use disorders

70 percent of these patients reported OCD symptoms one year prior to onset of substance use disorder

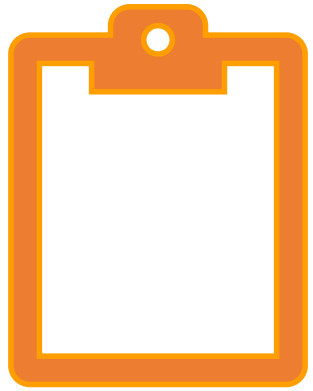
Individuals with childhood onset of OCD at greatest risk

Mancebo et al., J Anxiety Disord. 2009 May; 23(4): 429–435.

ASSESSMENT OF OCD

LINDSEY CONOVER, PHD

ASSESSMENT



- Don’t ask “Do you have obsessions and/or compulsions?
- SI/HI ? --> ask more questions (ego syntonic vs ego-dystonic)
  - E.g, “When you have that thought, how do you feel? Is this consistent with your mood and other thoughts? How do you respond?”
- Checklists!
- Clues
  - If someone worries about only one content area
  - If they are engaging in significant mental or physical actions in response to fears
  - If they describe feeling “not just right” or incomplete

QUESTIONS TO ASK

Instead of:

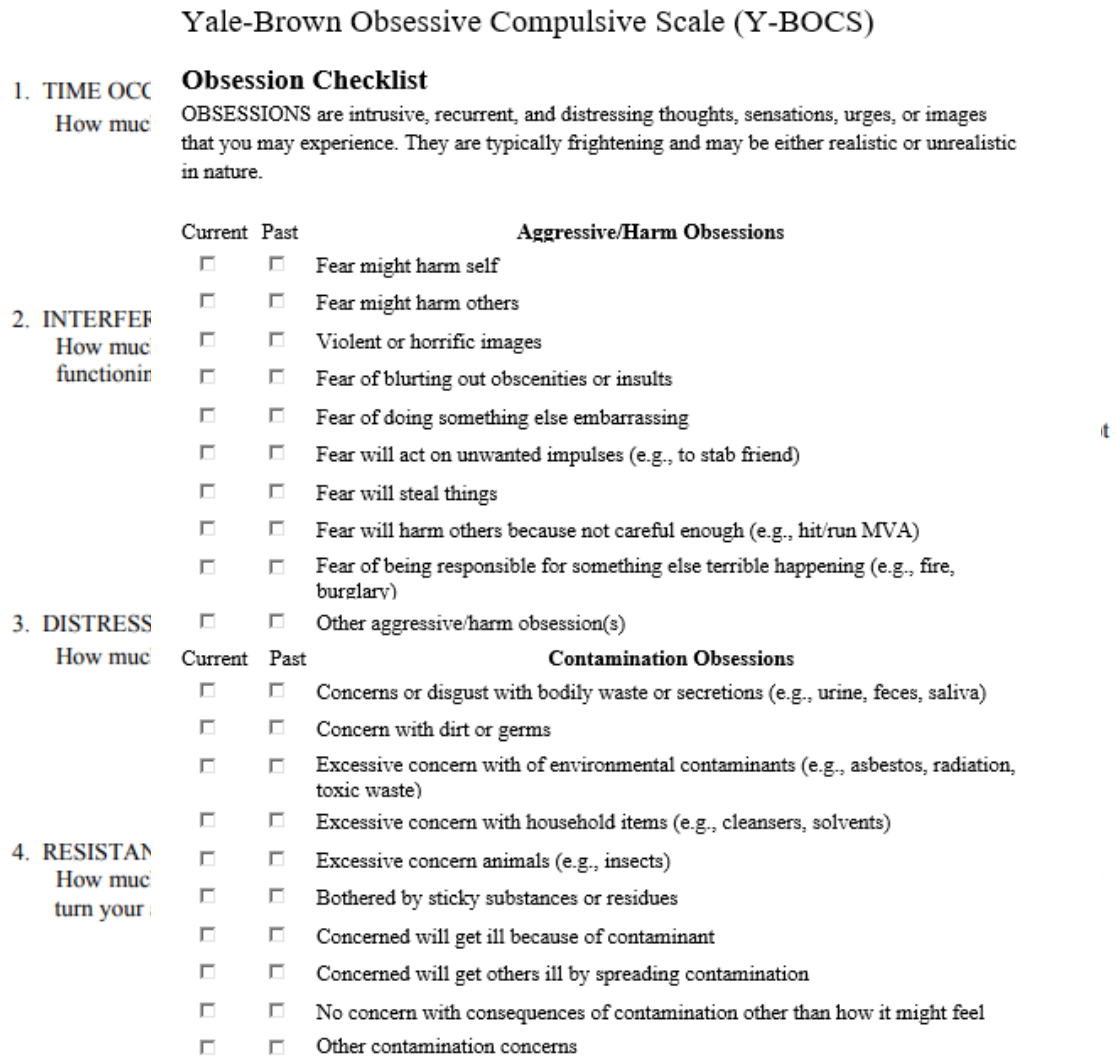
- Do you have obsessions?
- Do you have compulsions?

Ask this:

- Any repetitive thoughts, images, or impulses that you can't get out of your mind? Do you think about anything repeatedly that causes anxiety?
- Do you engage in any repetitive or ritualized behaviors ? Do you feel like any of these behaviors don't make sense or take up more time than is necessary?

ASSESSMENT MEASURES

- **Yale-Brown Obsessive-Compulsive Scale (Y-BOCS)**
- Obsessive Compulsive Inventory
- Structured/Semi-structured clinical interviews
- Children
  - Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS)
  - Obsessive Compulsive Inventory-CV
  - Child Behavior Checklist OCD scale
- Family impact
  - Children's Obsessive-Compulsive Impact Scale (COIS)
  - Family Accommodation Scale
  - OCD Family Functioning (OFF) Scale



Yale-Brown Obsessive Compulsive Scale (Y-BOCS)

1. TIME OCC
How muc

2. INTERFEI
How muc
functionir

3. DISTRESS
How muc

4. RESISTAN
How muc
turn your

Obsession Checklist

OBSESSIONS are intrusive, recurrent, and distressing thoughts, sensations, urges, or images that you may experience. They are typically frightening and may be either realistic or unrealistic in nature.

Current	Past	Aggressive/Harm Obsessions
☐	☐	Fear might harm self
☐	☐	Fear might harm others
☐	☐	Violent or horrific images
☐	☐	Fear of blurting out obscenities or insults
☐	☐	Fear of doing something else embarrassing
☐	☐	Fear will act on unwanted impulses (e.g., to stab friend)
☐	☐	Fear will steal things
☐	☐	Fear will harm others because not careful enough (e.g., hit/run MVA)
☐	☐	Fear of being responsible for something else terrible happening (e.g., fire, burglary)
☐	☐	Other aggressive/harm obsession(s)

Current	Past	Contamination Obsessions
☐	☐	Concerns or disgust with bodily waste or secretions (e.g., urine, feces, saliva)
☐	☐	Concern with dirt or germs
☐	☐	Excessive concern with of environmental contaminants (e.g., asbestos, radiation, toxic waste)
☐	☐	Excessive concern with household items (e.g., cleansers, solvents)
☐	☐	Excessive concern animals (e.g., insects)
☐	☐	Bothered by sticky substances or residues
☐	☐	Concerned will get ill because of contaminant
☐	☐	Concerned will get others ill by spreading contamination
☐	☐	No concern with consequences of contamination other than how it might feel
☐	☐	Other contamination concerns

TREATMENT PLANNING

- Identify obsessions and compulsions
- Identify family accommodation and avoidance
- Identify triggers
- Identify core fears
- Identify patient goals and values

*Doubles as psycho education and insight building!

IDENTIFYING MENTAL COMPULSIONS

- Pure "O"?
- Ask: What do you do when obsessions come into mind?
- Mental acts that could be compulsive
  - Thought replacement or blocking
  - Distraction
  - Avoidance
  - Confirming the negative
  - Mental review/analyzing
  - Self-reassurance

IMPORTANT TO IDENTIFY CORE FEARS

- **Obsessions:**
  - -I may have just touched/saw/thought of something contaminated
- **Core fears:**
  - -It might make me sick
  - -It might make me bad
  - -It might make someone else suffer
  - -It might make me feel yucky.
- **Common Neutralizers:**
  - Washing
  - Avoiding
  - Reassurance seeking
  - Mental review
  - Checking
  - Excessive discarding

DOWNWARD ARROW TECHNIQUE

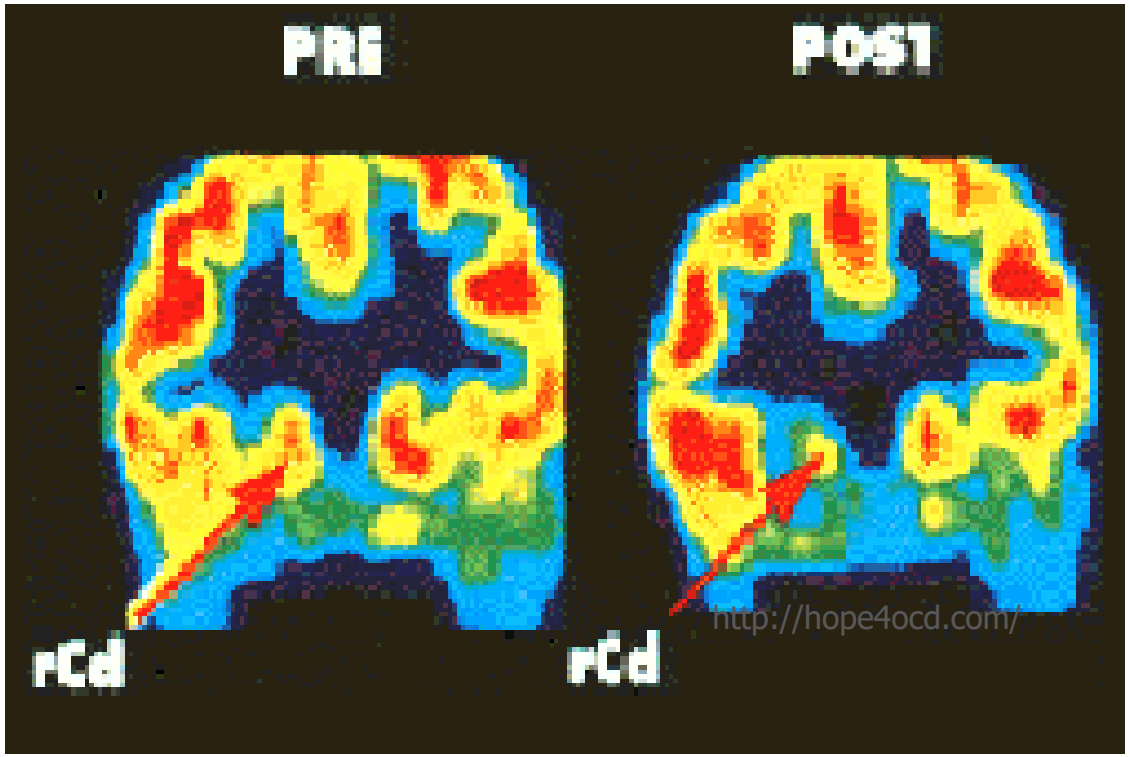
TREATMENT APPROACHES

MEDICATION TREATMENT OF OBSESSIVE-COMPULSIVE DISORDER: ADULTS

Medication Efficacy

- 50-60% Patients achieve full response to medication alone.
- Average full response to medication is 40-50% symptom reduction.
- Approximately 20% of patients do not respond to medication.
- Discontinuation leads to relapse rates of greater than 80% if medication is sole treatment.

PRE AND POST MEDICATION PET SCANS



COGNITIVE BEHAVIORAL THERAPY FOR OCD: EFFICACY

- ✓83% of OCD patients improve significantly due to CBT.
- ✓Brief intensive CBT reduces OCD and concurrent depressive symptoms 50-60%.
- ✓Post–treatment relapse rate for CBT is 20-30%
- ✓CBT reduces activity in the orbital cortex, the caudate nucleus, the cingulate gyrus, and the thalamus; regions known to be excessively active in untreated OCD.

COMPONENTS OF CBT FOR OCD

Exposure

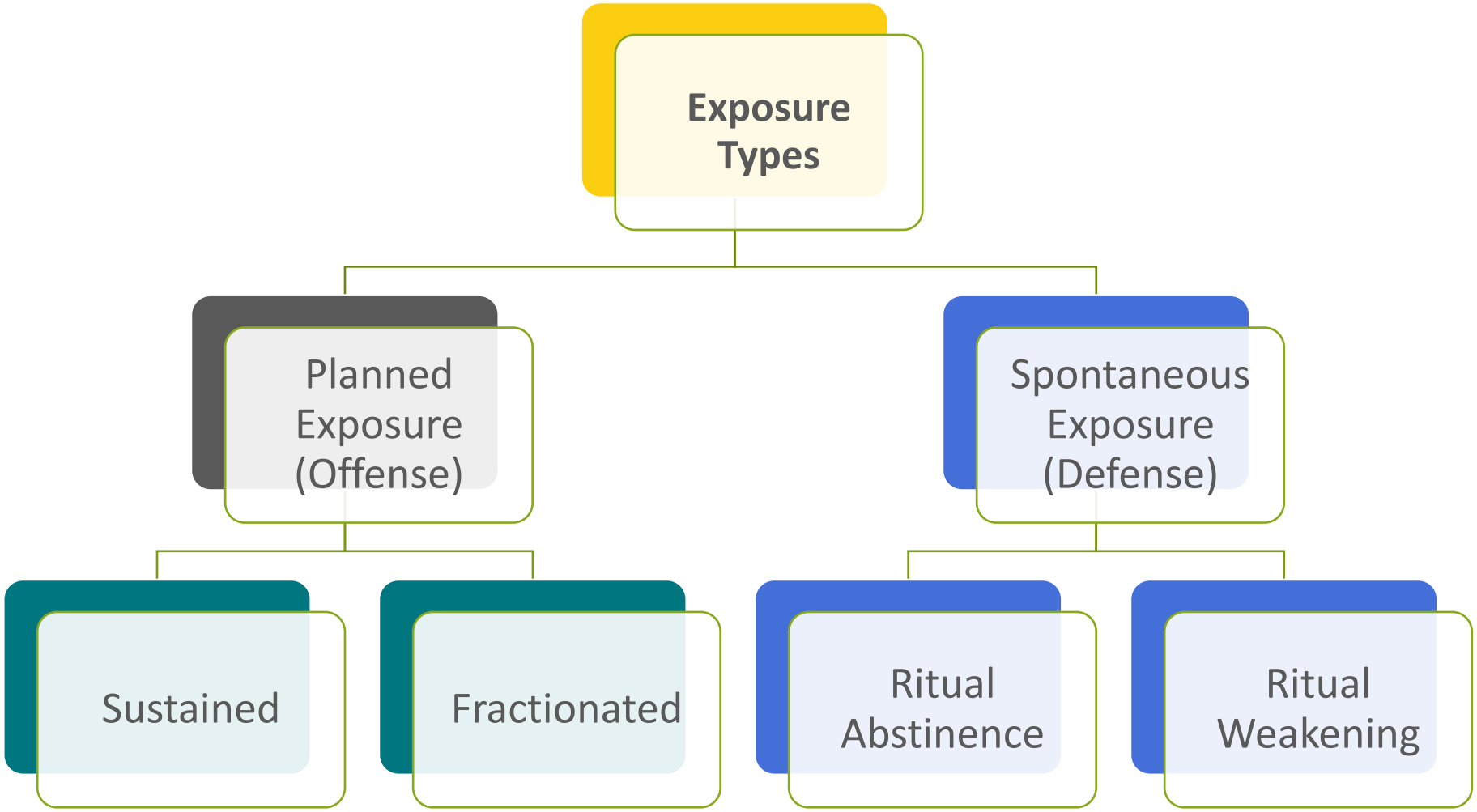
- purposeful confronting and maintaining contact with feared objects, thoughts, or images to allow the anxiety to rise, peak, and subside.

Response Prevention

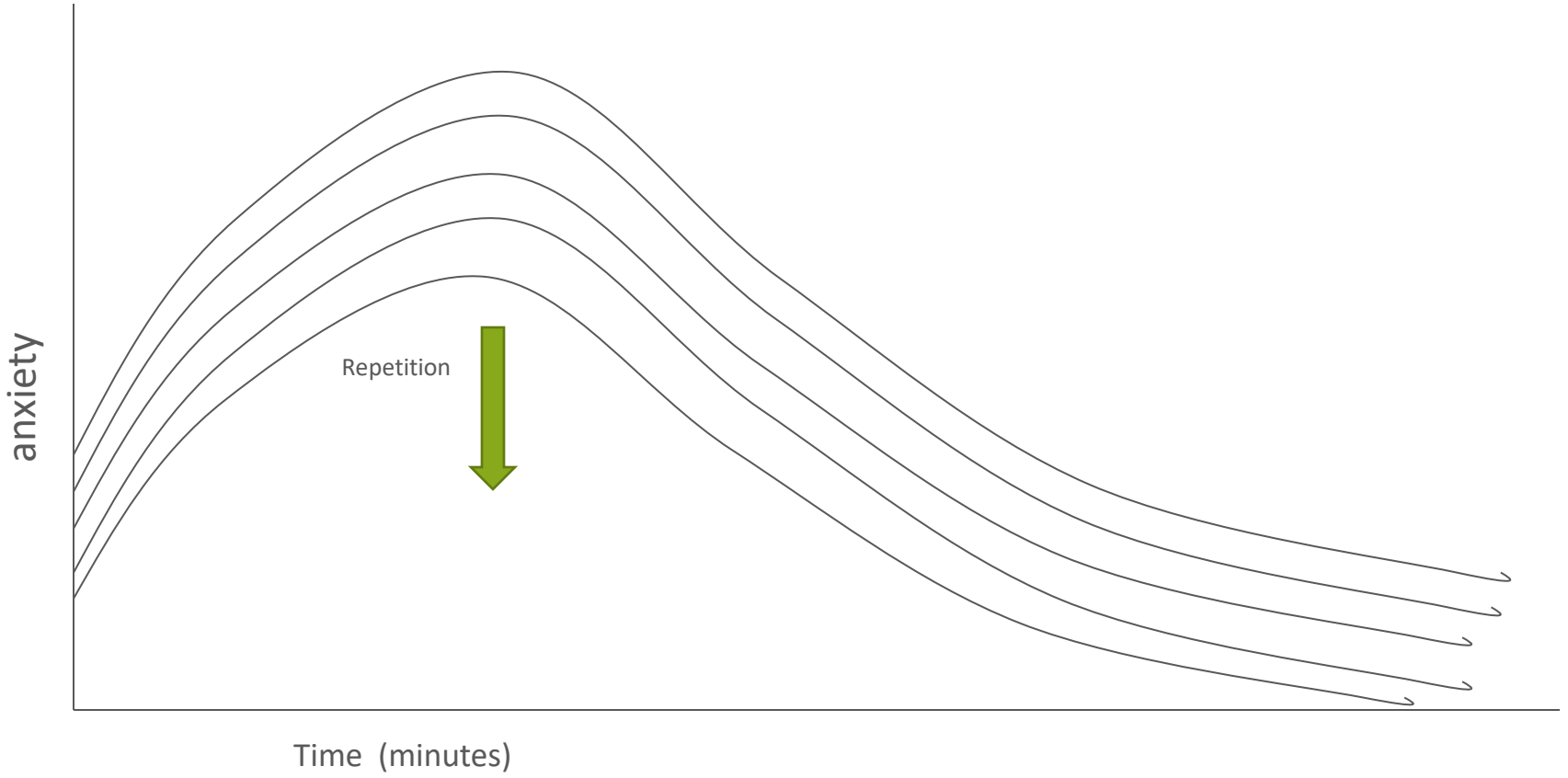
- the reduction and halting of neutralizing actions and/or thoughts (i.e., compulsions) to allow habituation to a feared stimulus (e.g., not washing after touching a doorknob)

Cognitive Therapies

- strategies designed to help the individual change their relationship with faulty, fear-fueling beliefs.


Exposure Types
Planned Exposure (Offense)
Spontaneous Exposure (Defense)
Sustained
Fractionated
Ritual Abstinence
Ritual Weakening

HABITUATION



INHIBITORY LEARNING MODEL

ABRAMOWITZ, J. S. (2018). *GETTING OVER OCD* (2ND EDITION). NEW YORK: GUILFORD PRESS

- **In order to be optimally effective, ERP needs to help people learn safety in such a way that it is strong enough to block out (or *inhibit*) the original fear — and this is where the term *inhibitory learning* gets its name.**
- Fear extinction is maximized when a person uses ERP to learn new safety information that *inhibits* existing obsessional fear.
- The goal of ERP is therefore to learn safety in a way that permanently inhibits obsessional fear.

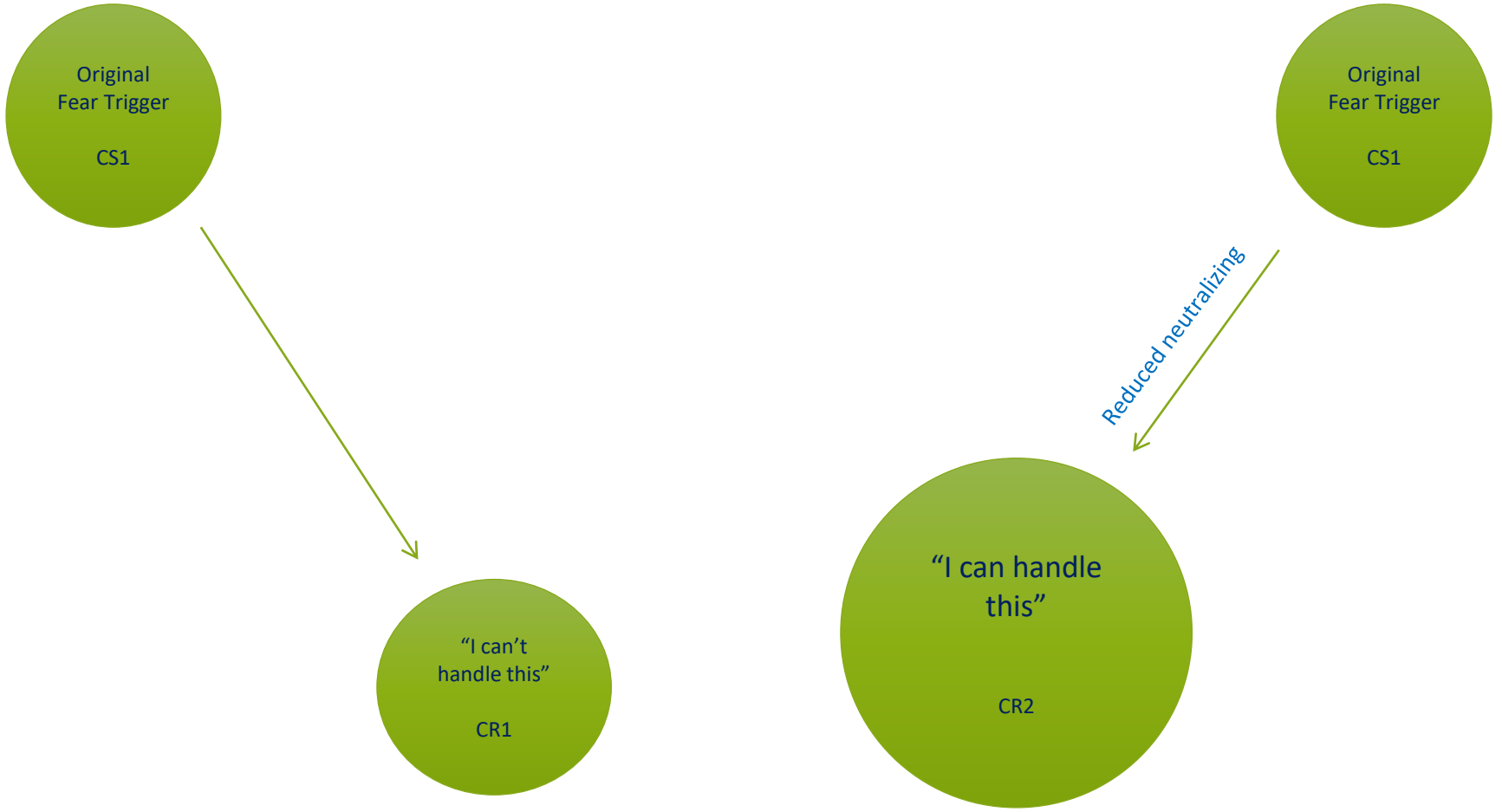
INHIBITORY LEARNING MODEL

ABRAMOWITZ, J. S. (2018). *GETTING OVER OCD* (2ND EDITION). NEW YORK: GUILFORD PRESS

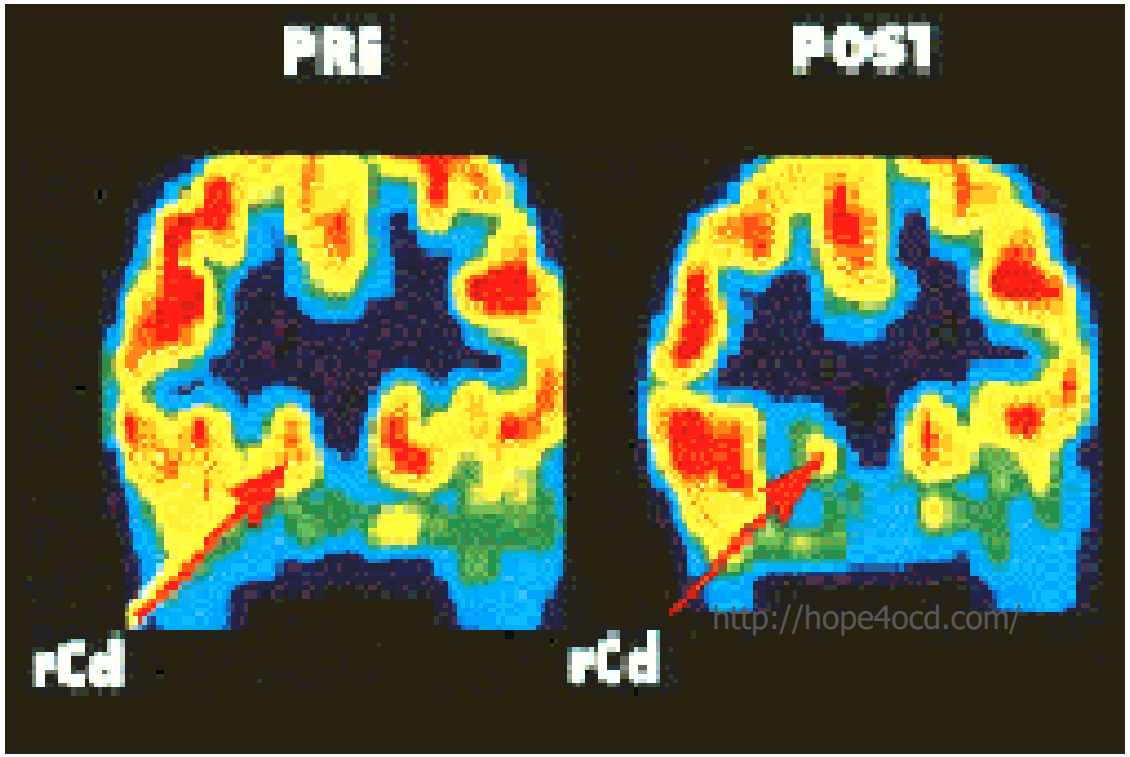
- People with OCD tend to over-predict negative outcomes, such as becoming sick, being responsible for harm, acting immorally, and not being able to tolerate anxiety or uncertainty.
- Within the inhibitory learning framework, ERP is designed to teach what “needs to be learned” to disconfirm these feared outcomes.
- For example: if I let my son play at an indoor play ground he will 100% get the stomach bug. The ERP is designed to disconfirm the prediction.
- To facilitate extinction learning, each exposure practice is focused on determining whether or not the expected negative outcome occurred (rather than waiting for anxiety to habituate).

INHIBITORY LEARNING: LEARNING BASIS OF RECOVERY

CRASKE, ET. AL. (2008). OPTIMIZING INHIBITORY LEARNING DURING EXPOSURE THERAPY. *BEHAVIOUR RESEARCH AND THERAPY*, *46*(1), 5-27.



PRE AND POST CBT PET SCANS



FIRST LINE TREATMENT FOR OCD

Adults		Adolescents		Children	
Mild* OCD	**Moderate to Severe OCD**	**Mild OCD**	**Moderate to Severe OCD**	**Mild OCD**	**Moderate to Severe OCD**
CBT **	CBT + SRI** SRI first	CBT	CBT + SRI	CBT	CBT

* Little to no help from others to manage daily life and symptoms
** Cognitive Behavior Therapy with Exposure and Response Prevention (E/RP)
*** SRI (serotonin reuptake inhibitor)

COGNITIVE BEHAVIORAL THERAPY FOR OCD: TREATMENT LEVELS

Standard Outpatient:

- **individual or group**
- weekly or bi-weekly with E/RP homework
- in office or "on-site"

Intensive Outpatient/Partial Hospital

- individual or Group
- **3 to 5 days per week**
- self-directed and therapist-assisted exposure for 3-6 hours

Intensive Residential:

- individual and group treatment
- **6 to 10 hours daily**

Family involvement in OCD

OCD is a family affair!

COMPULSION OR ACCOMMODATION?

compulsion

symptom

- behavior or mental acts aimed at preventing or reducing anxiety or distress , or preventing some dreaded event or situation...

accommodation

noun

- the act of accommodating someone or something **:** the state of being accommodated
- the providing of what is needed or desired for convenience

COMPULSIONS: GENERALLY A DIRECT REQUEST/ DEMAND FROM THE INDIVIDUAL WITH OCD IN AN ATTEMPT TO NEUTRALIZE THE DISTRESS OF THEIR OBSESSIONS

- Answering reassurance seeking questions
- Taking responsibility for decisions, checking, or reassurance seeking compulsions
- Observing actions at loved one's request for reassurance
- Doing loved one's laundry, washing, or cleaning compulsions
- Performing actions that loved one is avoiding/refusing

ACCOMMODATIONS: GENERALLY STARTED AS AN ADAPTATION WITH THE INTENTION OF MAKING LIFE EASIER FOR THE INDIVIDUAL WITH OCD (OR FOR THE PEACE OF THE FAMILY SYSTEM)

- Waiting/ changing plans due to interference from compulsions
- Taking over chores or household responsibilities
- Doing loved one's laundry, washing, or cleaning responsibilities
- Purchasing more expensive or higher quantity of products than preferred
- Tolerating unusual conditions around the house (leaving clothes in the dryer, stacks of papers that cannot be touched or discarded)
- Making concessions about movie and TV choices to avoid triggering content

WHY DO FAMILY MEMBERS GET INVOLVED IN THEIR LOVED ONE'S OCD?

MANY OF THE SAME REASONS THAT THE INDIVIDUAL ENGAGES IN COMPULSIONS:

- They fall for the "content" and believe that addressing it will help
- They think that it will be different this time
- They want to provide immediate relief/ peace
- They have been worn down
- They love the individual
- They have a difficult time tolerating the distress of their loved one's distress

DO FAMILY ACCOMMODATIONS MAKE IT WORSE?

Maybe, Maybe not

When room is made for something, that room tends to get filled. We don't want there to be room for OCD in the family, but that is not to say that accommodations are making the loved one's OCD "worse."

The individual with OCD may be more motivated to engage in their treatment if they are not getting relief through family members accommodations.

HOW SHOULD COMPULSIONS AND ACCOMMODATIONS BE ADDRESSED?

COMPULSIONS:

If the individual is in treatment: Rate the level of distress on their hierarchy and address through their ERP as appropriate in therapy.

If the individual is not in treatment: Depersonalize their OCD as the problem and compulsions as the reinforcing factor in their OCD. Encourage treatment and invite collaboration about pulling away from compulsions. Slowly break the cycle by pulling yourself out of the compulsions.

REMINDER:

- The individual with OCD is responsible for their own ERP. Ideally, involvement in compulsions by others will be extinguished systematically and willingly as part of their ERP.

ACCOMMODATIONS:

- Are they being requested by the individual with OCD? If so, they are compulsions and should be addressed as such.
- Are they new ideas/ behaviors? Identify them as accommodations. Be compassionate about your desire to help your loved one but refrain from allowing yourself to make more room for their OCD.
- Have they evolved over time and become ingrained? Identify and systematically plan on eliminating them with a clear plan and without threats. Plan can involve slowly but progressively pulling back or eliminating one at a time.

EXAMPLES:

- “When I sit in the bathroom with you while you take a shower, I have been giving your OCD the incorrect message that it is actually dangerous and that you need my supervision. I want you to start proving to your OCD that you can handle the distress of doing the steps of the shower without my presence for reassurance. Starting next week, would you prefer that I remain sitting in the bathroom but while reading a book or sit outside the bathroom door with the door cracked open?”
- Starting next week, when I pick you up from work, I will only wait 10 minutes after the end of your shift. If you are not at the car by then, I will leave without you. Before then, I will show you how to use the Uber app and you will have to spend your own money getting a ride home.

SUPPORTIVE VS REASSURING

- "You can handle it!"
- "It will pass."
- "You are stronger than your OCD!"

- "It won't hurt you."
- "You didn't do anything wrong."
- "I am not mad at you."

FAMILY ACCOMMODATION SCALE FOR OBSESSIVE-COMPULSIVE DISORDER SELF-RATED VERSION (FAS-SR)

https://nwanxietysolutions.com/assets/FAS.pdf

QUESTION AND ANSWER: ROUNDTABLE

- Led by Dr Brady