OCD Best Practices
& Treatment Recommendations

Jon Hershfield, MFT
Director, The OCD and Anxiety Center of Greater Baltimore
September 12, 2019

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Overview

- OCD 101: Defining and diagnosing
- Treating OCD: CBT, Mindfulness, Medication
- The Role of the Family: Nature/Nurture and working with family members
- Q & A
- Resources

OCD Basics

- Lifetime prevalence of 2.3% in adults, and about 1% in children
- Biopsychosocial origins including learned behavior, structural differences in the brain, and genetics
- 4th most commonly diagnosed psychiatric condition
- In the top 10 of WHO's most debilitating disorders
- Runs in families
- Slight female predominance

OCD Basics

Obsessions – unwanted intrusive thoughts, images, or urges that are associated with discomfort, often repetitive, typically ego dystonic

Compulsions – physical or mental behaviors engaged in for the purpose of seeking certainty and relieving distress associated with obsessions

Obsessions

- **Often represent a threat to identity or safety**
- **May come in the form of:**
  - What if xyz happens?
  - What if I did something wrong/irresponsible?
  - What if others would be horrified by this?
  - What if this is the wrong thing to think, feel, or sense?
  - What if I never stop thinking/experiencing this?
  - Or as spontaneous presentations of disgusting, offensive, unwanted content.

Compulsions

- **Physical OR mental behaviors in response to obsessions**
  - Designed to increase certainty about the content of thoughts
  - Viewed as prerequisite for moving on
  - Time consuming
  - Temporarily reduces anxiety, disgust, or other distress

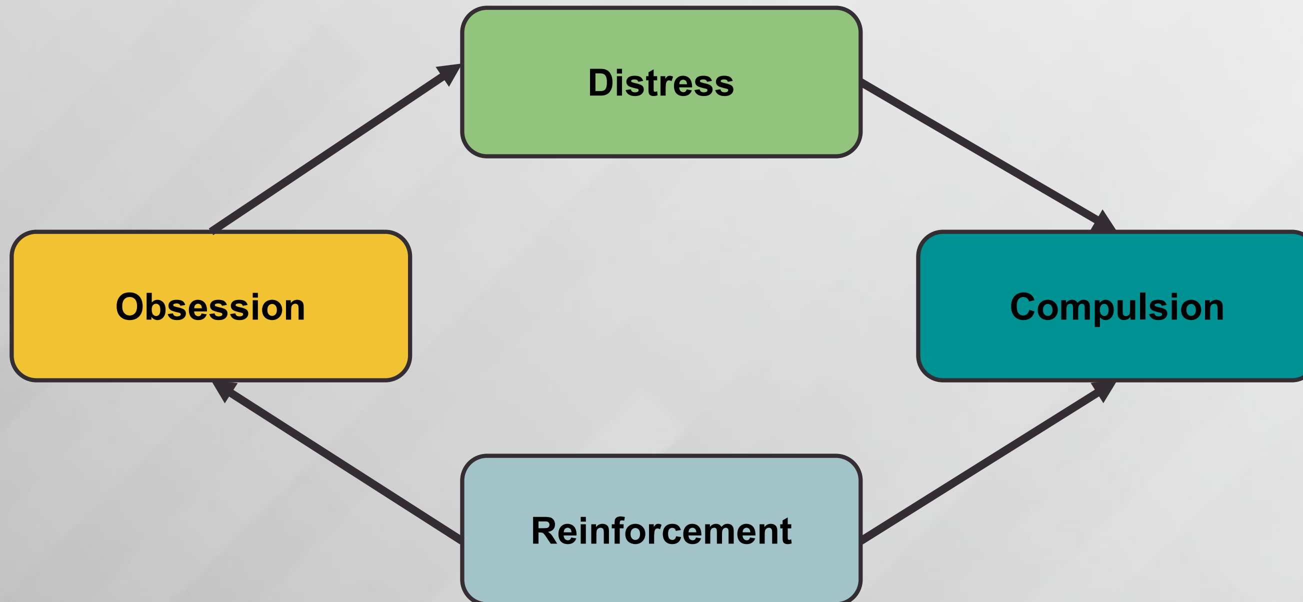
Genetics, Biology, & Chemistry

- Overactive orbitofrontal cortex (thinking center of the brain)
- Affected neurotransmitters include serotonin, dopamine, glutamate, and potentially others. Effectiveness of serotonin reuptake inhibitors suggest serotonin plays a key role
- Genetics – risk of having OCD goes up considerably when first degree relative has OCD or related disorder (Steinhausen et al, 2013)
- Specific genetic markers being narrowed down but no single gene identified, suggesting complex combination of genes influencing predisposition

Family Environment

- Children whose parents are authoritarian more likely to have OCD sxs (Timpano et al, 2000)
- Over-interfering, over-protective parenting possible contributor (Yoshida et al, 2005)
- High expressed emotion (EE) correlates with higher rate of sxs (Przeworski et al, 2012)
- Chicken or Egg? Parenting causing sxs or sxs causing parenting style?
- Little evidence identifying family directly causing OCD, but some relationship of reciprocation between parenting, symptoms, and the family system

Learned Behavior



Assessment

- Clinical interview
- Yale Brown Obsessive Compulsive Scale (I or II)
- Family Accommodation Scale (FAS) can also be useful

Common Obsessions

- Contamination (fear/disgust with bodily fluids, germs, chemicals, etc.)
- Checking/responsibility (fear of causing catastrophes through failure to lock, shut, turn off or otherwise check things)
- Harm obsessions (fear related to intrusive thoughts of a violent nature toward self or others)
- Sexual obsessions (fear of losing sexual orientation or of having inappropriate sexual impulses)

Common Obsessions

- Scrupulosity (fear of violating religious or moral guidelines)
- Just Right/Symmetry obsessions
- Relationship-themed obsessions
- Hyper-awareness/sensorimotor obsessions
- Existential obsessions

OCD Manifestations in Children

- Often same content as with adults even when age inappropriate (e.g. sexual obsessions in a 9-year old)
- Fears may involve superstitious beliefs
- May have greater concern for safety of parents or fear of being unloved
- Significant reassurance seeking and family accommodation likely

Common Compulsions

- Mental rituals (mental review, thought neutralization, compulsive prayer, etc.)
- Repeating
- Evening up/arranging
- Staring
- Counting
- Ritualized daily routines

- Washing/cleaning rituals
- Checking/repeating
- Avoiding triggers/triggering tasks
- Reassurance seeking (in person, research, or self)

Mental Rituals

- Thoughts as contaminants of the mind
- Some people wash their hands, some people wash their minds
- Previously believed some people were not doing compulsions and this led to misnomer “pure o” which is now understood to be inaccurate
- Covert compulsions
- Often un-noticed by others
- Often overlooked by treatment providers
- Sufferer may be unaware or believe mental behavior to be non-compulsive

Mental Rituals

- Mental review, rumination
- Mental checking/testing
- Mental rehearsal
- Mental repeating
- Thought neutralization
- Rationalizing and self-reassurance
- Self-criticism/self-punishment
- Compulsive prayer
- Counting compulsions

Core Elements of CBT for OCD

- Psycho-education on the disorder and its treatment conceptualization
- Cognitive restructuring – challenging distorted thought processes
- Behavioral therapy – exposure with response prevention (ERP)

Psychoeducation

- O-C cycle and negative reinforcement
- Habituation
- Inhibitory Learning
- Basic Mindfulness concepts and fostering understanding of the nature of thoughts, feelings, and sensations

Cognitive Therapy

- Identifying ways thinking about an experience can be modified to bring about healthier results
- Cognitive distortions: ways of thinking about an experience that encourage compulsive behavior

Cognitive Therapy

- All-or-nothing, black-and-white, absolutist: viewing things as all in one category or its opposite
- Catastrophizing: predicting a negative future and assuming it can’t be coped with
- Magnifying: identifying something as larger than its evidence
- Emotional reasoning: assuming something must be true primarily because of associated feelings
- Discounting/disqualifying the positive: refusing to take in information that contradicts an obsession
- Selective abstraction/tunnel vision: only taking in information that supports an obsessions

Cognitive Therapy

- Thought-Action Fusion: assigning probability to frequency of thoughts or assigning morality to the presence of thoughts
- Magical thinking: attributing supernatural/superstitious powers to thoughts
- Mind reading: assuming you know what someone else is thinking
- Should/must thinking: assuming an idea is true primarily because it fits a rigid rule or expectation

Cognitive Therapy

- Automatic thought record can be used for cognitive restructuring
- Reframes do not challenge content directly, only process
- Goal is to get back to zero, to the objective, to the state where compulsions are choices, not mandates
- Not for reassurance or putting positive spin on things, but to challenge assumptions and discourage compulsions

Exposure with Response Prevention (ERP)

- Interaction with triggers and associated discomfort paired with elimination of compulsive behavior
- “first-line psychosocial intervention” for OCD (March et al, 1997), efficacy supported by meta-analysis (Abramowitz et al, 2002)
- Habituation, inhibitory learning, and improved uncertainty tolerance as the goal
- Rules: never ask to do something harmful, never ask to do something that violates religion/morals, never ask to do something not capable of doing, never ask to do something therapist won’t do

Exposure with Response Prevention (ERP)

- In vivo exposures
  - Making direct or real-time contact with discomfort-inducing stimuli (e.g. touching something dirty, holding a knife, interacting with a triggering person)
- Imaginal exposures
  - Using ideas/stories to generate ERP experience (e.g. writing or reading about a triggering story)
- Interoceptive exposures
  - Generating body sensations/states associated with triggers

Exposure with Response Prevention (ERP)

- ERP hierarchies?
  - Good for functional analysis
  - Establishes a tolerable place to start and buy-in for the process
  - However, inhibitory learning ultimately more effective when exposure intensities are varied

Mindfulness

- Paying attention to the present moment
- Non-judgmental observation of internal experiences
- Letting go of resistance to discomfort

Thoughts as Mental Health Events

- Thoughts are thoughts, not threats (not "*JUST* a thought" – which implies value)
- Value is unknown, not intrinsic
- To be acknowledged, observed
- Be curious about them, not avoidant

Feelings as Raw Data

- Feelings are feelings, not facts
- Not evidence, significance is unknown
- Appraisals of physical sensations
- To be experienced in the moment, not sought after or checked for
- Pain (a present experience) vs. suffering (same experience plus resistance)

Physical Sensations as Nerves Firing

- Not mandates to act
- Also not evidence, personal significance uncertain (i.e. groinal response as fear or arousal)
- Cause unknown
- To be experienced, not explained unless medically impairing

Medication & OCD

- Most commonly prescribed meds for OCD are a class known as selective serotonin reuptake inhibitors or SSRI's
- Higher doses to achieve therapeutic response

Accomodation

- Direct participation in compulsive behavior (washing, checking, etc.)
- Giving time for compulsions
- Protecting sufferer from triggers (e.g. hiding triggering objects, being careful not to use trigger words)
- Providing reassurance
- Promoting analysis

Accomodation

- “Family accommodation refers to ways in which family members assist the proband in the performance of rituals, avoidance of anxiety provoking situations, or modification of daily routines to assist a relative with obsessive-compulsive disorder.” (Lebowitz and Bloch, 2012)
- associated with greater severity, disruption, worse treatment outcomes (Lebowitz, 2013)
- 60% of family members are involved in some way with a ritual being engaged in by an individual with OCD (Shafran et al, 1995)
- Family inclusive treatment that addresses accommodation is correlated with improved treatment outcomes (Thompson et al, 2014)
- Frequent event in families, positively correlated to symptom severity and parent-rated impairment but not child-related impairment, meaning child with OCD may not identify accommodation as part of compulsive process/problem (Storch et al, 2007)

Reassurance

- One reality check may be ok, but reassurance = poison
- No, you can’t get HIV from a doorknob. No, I don’t know if you touched the door knob.
- Tendency for one person to become the arbiter of truth
- Same O-C cycle for family member: reassurance-question (obsession) leads to discomfort observing pain leads to reassurance-answer leads to short-term quiet from sufferer/relief from guilt for family member leads to negative reinforcement of reassurance responses leads to worsened obsessions/increased reassurance-seeking leads to increased guilt/frustration leads to more reassurance

Reassurance Contracting

- OCD sufferer writes a document specifically giving permission to respond to reassurance attempts with denial and some other response.
- Family further needs specific permission to determine for themselves what is or is not reassurance and OCD sufferer must accept the assessment.
- Important that responses are collaborated on and agreed upon before intervening
- Essential that responses are done without hostility or exasperation because otherwise they are disregarded by the OCD and lead to more questions

Reassurance Responses

- That’s a reassurance question and I can’t answer that.
- I would totally answer that but your therapist won’t let me.
- Anything’s possible, but you knew I would say that.
- Sorry you’re struggling. What else can we talk about?
- Gee, people seem really concerned about Star Wars spoilers.
- Meow.

Partners

- Heavy emphasis on reassurance contracting
- Encourage open dialogue about gradual removal of accommodations
- Reduce criticism and hostility
- Do not triangulate others (especially children)
- Promote understanding of intimacy issues (especially with sexual obsessions)

Children

- Incentivizing (sticker charts and other reward systems) success, not punishing “failure”
- Emphasis on externalizing OCD (let’s not let the Booger tell us what to do)
- Reduce criticism and hostility
- Both parents must be unified in approach to accommodations
- Be conscious of attention given to siblings and spouse

Tips for Therapists

- Inquire early in treatment about family accommodation
- Collaborate with individual clients on when to bring involved family members into session
- Early intervention is associated with improved treatment outcome (Gomes et al, 2014)
- Expect resistance to reducing accommodation from some
- Both family and OCD sufferer may feel they need it to maintain homeostasis, may credit it with getting along or reducing severity of symptoms

Case examples

- 38-year old male with contamination OCD
  - fear of contracting and spreading illness via fecal matter
  - compulsions include excessive and ritualized handwashing, avoidance of public restrooms, reassurance-seeking, mental review of hand washing routine, requesting accommodation from family members
- 27-year old mother with Harm OCD towards newborn
  - fear of stabbing infant
  - compulsions include avoidance of knives or other sharp objects, reassurance-seeking from husband, researching moms who kill, avoidance of being alone with child, thought neutralization and rationalization rituals

Contact Information

www.ocdbaltimore.com

jon@ocdbaltimore.com

(410) 927-5462

The OCD and Anxiety Center of Greater Baltimore

11350 McCormick Rd., EP3, LL4

Hunt Valley, MD 21031

Resources

- International OCD Foundation www.iocdf.org
- Anxiety and Depression Association of America www.adaa.org

Upcoming CTAC Events

Why Youth Peer Advocates? Part One

- Tuesday, September 17th | 1:00PM
- In Part One of this two-part presentation, we will explore what research and data tell us about Youth Peer Advocates.

Why Youth Peer Advocates? Part Two

- Tuesday, September 24th | 1:00PM
- In Part Two of this two-part presentation, we will hear directly from a panel consisting of Youth Peer Advocates, young adults who have received YPA services, a family member, and program managers who will share with you their unique experiences engaging with and providing Youth Peer Support Services.

As part of a statewide training initiative to improve the quality and access to care for individuals with Obsessive Compulsive Disorder, The Center for OCD and Related Disorders and The Center for Practice Innovations at Columbia Psychiatry and the New York State Psychiatric are collaborating with the New York State Office of Mental Health (NYS-OMH) through an initiative called **I**mproving **P**roviders' **A**ssessment, **C**are **D**elivery **A**nd **T**reatment -Of OCD (**IMPACT - OCD**). IMPACT-OCD has a number of training offerings available for mental health professionals employed at OMH- licensed, OASAS-certified or NYS VA program enrolled in the Center for Practice Innovations Learning Management System. These offerings reflect our goals to raise awareness of the disorder and develop and test the effectiveness of online training resources for OCD treatment.

IMPACT-OCD webpage: https://practiceinnovations.org/I-want-to-learn-about/IMPACT-OCD

Contact Us!

Jon Hershfield, MFT

The OCD and Anxiety Center of Greater Baltimore

jon@ocdbaltimore.com

Jayson Jones, LMSW

Community Technical Assistance Center

jayson.jones@nyu.edu