25TH ANNUAL

OCD CONFERENCE

WASHINGTON, D.C. | July 27–29, 2018

Organized by:

International OCD Foundation

Presented by:

McLean
HARVARD MEDICAL SCHOOL AFFILIATE

PRESENTATION BOOKLET

2019

26th Annual OCD Conference

AUSTIN

July 19-21, 2019

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Talks are listed chronologically.

Some speakers have also made these handouts available electronically on our website here:

www.iocdf.org/2018Handouts

Friday

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Share what you learned — don't forget to tag any Conference posts or tweets with #OCDcon!

DISCLAIMER: Please be aware that some of the content included in this presentation booklet contains material appropriate for a mature audience. It is up to the discretion of parents and guardians to allow children to view this material.

HOW TO ARTICULATE EMOTIONS TO GET NEEDS MET

Teen/Parent Summit

Identifying, Describing and Expressing Feelings

- We are not living in an OCD vacuum
  - Other stressors occur as well
  - If OCD takes up all our attentional resources and relational opportunities, it gets fueled at the expense of all other aspects of life and relationships
- Fostering EQ – Emotional Intelligence – to communicate the need for support
  - take a step back from emotions,
  - look at the feeling, and
  - examine the effect that the emotion has

Identifying, Describing and Expressing Feelings

- Emotion Differentiation
  - Moving from "bad" and "fine" or "OCD ALL THE TIME" to more specific, descriptive emotion words that help "prescribe" and tailor our action
    - If I'm feeling remorse, I might want to figure out a way to make amends.
    - If I'm feeling lonely, I might need to reach out for support.
    - If I'm feeling overwhelmed, I might need to break down the task into smaller parts.
    - If I'm feeling ashamed, I might need to talk kindly to myself.
  - Emotional awareness and clarity help to focus our attention on coping rather than on suppressing or dwelling

HOW DO WE ATTEND TO EMOTIONAL NEEDS WITHOUT ACCOMMODATING?

Providing emotional support vs.
Providing reassurance

Helpful Emotional Regulation Strategies

- **Name it to tame it**
- **Validation (by self or others)/Acceptance**
- **Approaching the problem/problem solving**
- **Cognitive reappraisal**

- Unhelpful emotional regulation strategies
  - Suppression
  - Invalidation/non-acceptance (by self or others)
  - Lack of emotional awareness or clarity
  - Avoidance
  - Impulse control difficulties

Name It To Tame It

- Lieberman (2007) study: Act of naming negative emotions actually reduces the brain arousal associated with them
  - Acknowledging the emotion (accurately) helps to down-regulate the sympathetic nervous system (fight or flight response system)
- Helps the brain to "make sense" of the experience
- Can be verbal/written

- "You feel XXX." (period….nothing more)
  - Sounds like…; I'm wondering if…; I imagine you might…

Building your emotional vocabulary and empathy skills

1. Answer the empathy question
   How would I feel if I were in his/her shoes?
   -OK to access physical sensations and cognitions to help guide the identification of the emotion
2. Identify general feeling category (happy, angry, sad, disgusted, surprised, scared)
3. Identify intensity of feeling (high, medium, low)
4. Use the feeling wheel to guide your response
5. PRACTICE!

Validation/Acceptance

- **Validation allows for self/other compassion to be experienced**
- **Feeling heard and understood fosters healing and well-being**
- **"It makes sense that you feel XX." "I understand." "This is hard/tough"**
- **NOT "it's okay" "you'll get through this" "don't be so…" "you're over-reacting" "it's no big deal"**

Cognitive Reappraisal

- **Once we are able to name the feeling and understand it, we can better evaluate whether it's**
  - **True**
  - **Helpful**
  - **Inspiring**
  - **Necessary**
  - **Kind**
- **If not, how might we modify the interpretation of the thought/event?**

Approaching/Problem Solving

- **Once we feel heard and understood, we are more motivated and physiologically/emotionally prepared to face our challenges**
- **"How can I support you in preparing to face XX?"**
- **"I'm here to encourage you to face XX"**
- **Note: Problem solving is NOT modifying schedules/doing extra cleaning to solve OCD's problem; instead, it's identifying strategies to APPROACH the feared situation/thought/event**

THROUGH APPROACHING OUR PROBLEMS/FEARED STIMULI (I.E., EXPOSURES), WE ARE ABLE TO LEARN _____.

HOW DOES THIS HAPPEN IN REAL LIFE?

Relationship-Driven Support

- Intentional scheduling of predictable support opportunities;
  - Not on OCD's time!!
- To say:
  - Tell me more
  - That's so hard
  - I love you
  - Can I give you a hug
  - Sounds like you are feeling XX (Feelings wheel)
- Not to say
  - But
  - You should
  - At least

Establish OCD-Free Touchpoints

- Collaboratively plan predictable enjoyable outings or "innings"
- Develop rituals for talking through highlight and lowlight of the day
- Be taught
- Participate (without judgment) in teen-selected hobby or show/podcast/youtube etc
- Think in ratios so we are fueling the dirt road not the well paved highway

Interactive "Think-Aloud" Exercises

- "I can't go to school because I've missed so much."

Interactive "Think-Aloud" Exercises

- "My brother's such a jerk for yelling at me because of my OCD."

Maximizing the Effectiveness of Exposure Therapy by Optimizing Inhibitory Learning

Jennifer L. Buchholz, MA
Jonathan S. Abramowitz, PhD

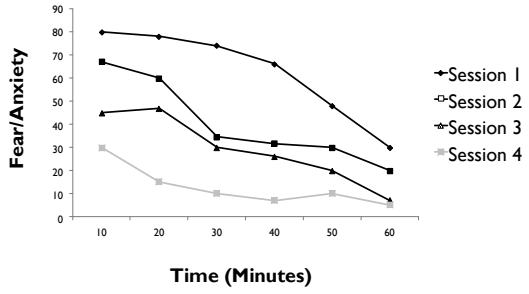
University of North Carolina at Chapel Hill

Explanatory Models of Exposure Therapy

Emotional Processing Theory

Break the association between a conditioned stimulus ("trigger") and conditioned response (fear/anxiety)

- Activation of a fear structure
- Habituation
  - Within sessions
  - Between sessions



Does Habituation Matter?

- Habituation is *not* a reliable predictor of long-term outcome
- Successful outcomes occur *despite* lack of habituation
- Habituation is nice, not necessary
  - Can emphasizing habituation backfire?

Hijacking Habituation

- Exposure used to control anxiety
  - "It's okay because I know my anxiety will go down…"
- Implicit message that anxiety is unsafe or intolerable
- Inevitable future experiences of anxiety may be misinterpreted as a sign of danger or relapse

Inhibitory Learning Theory

Develop safety-based associations that *inhibit* retrieval of fear-based associations

Inhibitory Learning Theory

Develop safety-based associations that *inhibit* retrieval of fear-based associations

- Violate negative expectancies
- De-contextualize inhibitory associations
- Promote distress tolerance

Revisiting Response Prevention

Compulsive rituals interfere with exposure

- Lead patients to misattribute safety
- Bypass the *natural* decline in fear/anxiety
- Interfere inhibitory learning
  - Prevent maximal violation of negative expectancies
  - Contextualize new learning
  - Impede development distress tolerance

Emotional Processing vs. Inhibitory Learning: Critical Differences

- Goal of exposure
  - Remain in situation until anxiety naturally subsides
  - Remain in situation until patient no longer expects catastrophe
- Relation to anxiety
  - Anxiety is supposed to go down over time
  - Patient can *tolerate* anxiety, no matter the duration or intensity

Optimizing Inhibitory Learning during Exposure

Maximizing Exposure

Therapeutic strategies to generate and strengthen inhibitory associations

1. Frame exposures to violate negative expectancies
2. Introduce variability wherever possible
3. Combine multiple fear cues
4. Discriminate safety aids and retrieval cues
5. Augment learning with affect labeling

1. Frame Exposures to Violate Negative Expectancies

- Set the stage for a "mismatch"
  - Therapeutic value of surprise
- Help patient learn through direct experience that he/she was mistaken with regard to anticipated outcome
  - Not as likely as I thought
  - Not as awful as I thought
  - Anxiety/uncertainty are safe and tolerable

Clinical Application: Expectancy Tracking

- Set up the exposure to violate expectancies, not reduce SUDS
- Before exposure
  - Identify nature and strength (%) of negative expectancy
  - Level of anticipated distress tolerance
  - Length of time patient can persist and/or resist safety behaviors
- After exposure
  - Consolidate new learning by asking patients to summarize what they learned
  - **Explicitly contrast predicted and actual outcome**

Jenn: Case Example

- 31 year-old accountant
- Married with two kids and otherwise healthy
- OCD – fear of developing schizophrenia
  - Main fear: I will have a "psychotic break" after reading about someone with schizophrenia
  - Safety behaviors: Avoidance, distraction, arousal reduction
- Difficulty concentrating at work, having nightmares about "going crazy"

Jenn: Framing exposure to promote distress tolerance

- Session 3 (Jon is the therapist)
- Setting up exposure: Reading about someone with schizophrenia
- What to look for:
  - De-emphasis on habituation
  - Emphasis on distress tolerance
  - No cognitive restructuring (we'll get back to this)

No Cognitive Restructuring!?

- What's the goal of CR when used with exposure?
  - Challenge and correct mistaken beliefs about exposure stimuli
- Why is this inconsistent with inhibitory learning?
  - It spoils the surprise (minimizes violation of expectancies)
- But what about too much anxiety?
  - Anxiety is safe and manageable
  - We're teaching fear *tolerance* over fear *reduction*

2. Introduce Variability Wherever Possible

- Varying ("mixing up") the exposure makes short-term learning more difficult, but enhances long-term retention and generalization of new learning
  - "Desirable difficulties"

Clinical Application 1: Vary the Exposure Context

Extend inhibitory associations to new contexts by de-contextualizing

- Stimuli and locations (visually distinct types of trash bins, same type of trash bin on different blocks)
- Others present (therapist, loved ones, strangers)
- Session time (time of day, day of week)
- Internal state (when alert, when tired, when happy, when anxious)
  - Medication

Clinical Application 2: Vary the Practice Interval

- Spacing out learning trials over time enhances long-term retention
- More opportunities to strengthen inhibitory associations by forgetting and re-learning associations
- Expand therapy sessions near end of treatment
  - 2x per week → 1x per week → Every other week → etc.

Clinical Application 3: Vary Exposure Intensity

- What are some limitations of traditional "hierarchy" (gradual approach)?
  - Over-reliance on habituation
  - Sets up the expectation that lower anxiety is safer or easier than high anxiety
  - Anticipation of high items reinforces fear of anxiety
- How might varying the exposure intensity help the patient?
  - Tolerate exposure across a variety of emotional states
  - Preparation for "real world" settings
  - More opportunities for "surprise" and life after treatment finishes

Clinical Application 3: Vary Exposure Intensity

- An alternative: The exposure "to-do list"
  - Set of tasks to be attempted over the course of treatment
  - Select at random (pulling pieces of paper from a bowl)
  - Can be modified to meet patient where they are at
    - First half of treatment follows hierarchy
    - Second half of treatment progresses randomly through the remaining tasks

FEAR ↑

Exposure Task	Predicted SUDS
1. The word "stab"	40
2. The word "puncture"	45
3. Fork	55
4. Scissors	60
5. Kitchen knife	65
6. Read news stories of stabbings	70
7. Write a story about stabbing husband	75
8. View pictures of people with stab wounds	80
9. Write husband's obituary	90

FEAR ↑

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FEAR H

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3. Fork	55
4. Scissors	60
5. Kitchen knife	65
6. Read news stories of stabbings	70
7. Write a story about stabbing husband	75
8. View pictures of people with stab wounds	**80**
9. Write husband's obituary	90

FEAR H

Exposure Task	Predicted SUDS
1. The word "stab"	40
2. The word "puncture"	**45**
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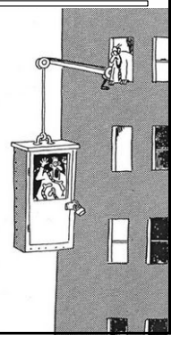
4. Scissors	60
5. Kitchen knife	65
6. Read news stories of stabbings	70
7. Write a story about stabbing husband	75
8. View pictures of people with stab wounds	80
9. Write husband's obituary	90

3. Combine Multiple Fear Cues

- Inhibitory learning is greater when anticipated negative outcomes do not occur despite *multiple* fear cues present
  - "Deepened extinction"
  - Can also be thought of as increased (additive) negative expectancies
- Fear cues to consider
  - External (contaminants, weapons)
  - Mental (obsessive thoughts and images)
  - Physiological (racing heart, dizziness, sexual sensations)



4. Augment Learning with Affect Labeling

- Verbally expressing the emotions one is experiencing facilitates the development of new associations
  - Different from cognitive restructuring, in which appraisals are challenged

Clinical Application: Put Feelings into Words

- Have patients include "emotion words" when describing their experience
  - "I'm afraid that reading about Jerry Sandusky's despicable behavior will cause me to become a pedophile"
  - "I'm disgusted by touching the bathroom floor because I don't know what sort of diseases might be lurking on the tiles"
  - "I'm worried that if the odometer reads '666' I will be condemned to hell"

Limitations of the Inhibitory Learning Model

Things to Consider

- Does the inhibitory learning model just use new words to describe established constructs?
  - "Negative expectancies" and "irrational beliefs"
- How well does this model apply to the treatment of OCD?
  - Habituation-based exposure therapy works very well
- Do the purported mechanisms of change actually mediate outcome?
  - How should negative expectancy violation, de-contextualization, and distress tolerance be measured in these studies?

Questions?

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http://jonabram.web.unc.edu/recent-conference-presentations

BULLYING IN A PEDIATRIC BDD SAMPLE

Fugen Neziroglu, Ph.D., ABBP, ABPP
Tania Borda, Ph.D.

DSM 5 CRITERIA FOR BDD

- Categorized as an obsessive compulsive disorder consisting of a preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others.
  - Engage in repetitive behaviors aimed at camouflaging or improving the perceived defect
  - Excessive grooming, mirror checking, mirror avoidance
- Research suggests diathesis stress model - neurocognitive deficiencies, family history of BDD

CONTRIBUTING & ASSOCIATED FACTORS

- Negative early traumatic environmental experiences
  - Higher rates of sexual and emotional abuse compared to OCD
- Suicide:
  - Ideation approximately 80%
  - Attempts 24% to 28%
  - Death by suicide 45 times higher than for the general population

TEASING AND BULLYING IN BDD

- BDD individuals experience increased social teasing and rejection
  - Greater peer victimization (being ignored, excluded, made fun of, and gossiped about) posed a risk for the escalation of symptoms congruent with BDD
  - Children with BDD symptoms report more negative perceptions of peer acceptance over time
  - Those with BDD may self-perpetuate social difficulties over time

TEASING AND BULLYING IN BDD CONT.

- Biased attention processes are influenced by life experiences (teasing, bullying, family values, physical changes in adolescence), along with personality traits, and neurobiological factors.

THE CURRENT STUDY

- Purpose:
  - To investigate the presence of bullying and victimization in a population of elementary school children
  - To better identify the possible connections between bullying and BDD symptomology
- Hypotheses:
  - Children with emerging BDD would be victims of bullying to a higher degree than healthy controls.
  - Children with OCD and other diagnoses would be victims of bullying, but significantly less than those with BDD

METHOD: PARTICIPANTS

- Participants
  - 219 children ages 7 to 10 (M= 7.95, SD= 1.024)
  - Recruited from 3 regular elementary private schools in Buenos Aires
  - Screened for BDD & other psychopathology
  - Exclusionary criteria: Diagnosis of Autism Spectrum Disorder, Psychotic Disorder, or Eating Disorders

METHOD: PARTICIPANTS CONT.

- 72.2% (N= 158) no diagnosis
- 27.8% (N = 61) screened positive for psychiatric conditions
- Out of (N=61)...
  - 10.5 % (N = 23) of children had BDD
  - 4.5% (N = 10) experienced OCD symptoms

OTHER CLINICAL DIAGNOSES

- Remainder 12.7% (N = 28) of clinical children fell into the clinical control category comprised of:
  - Depressive disorders (4.9%)
  - Attention deficit hyperactivity disorder (ADHD; 6.2%)
  - Oppositional defiant disorder (ODD; 4.9%)
  - Anxiety disorders not otherwise specified (anxiety NOS; 17.3%)

METHOD: MEASURES

The Peer Interaction in Primary School Questionnaire: (PIPS)

- 22-item measure
- Assesses indirect & direct forms of bullying & victimization for elementary school children
- Allows for identification of bullies and victims
- Good internal consistency (α = .90) & test-retest reliability

METHOD: MEASURES CONTIN.

The Mini International Neuropsychiatric Interview for Children and Adolescents

- Designed to diagnose the 30 most common mental disorders and subtypes observed in pediatric mental health
  - Spanish version has been validated
  - It's sensitivity and specificity to the most common mental illnesses has shown to be adequate
- *The Body Dysmorphic Disorder Questionnaire* (BDDQ)
  - Self-report measure used to screen BDD
  - High sensitivity (100%) and specificity (89%)
  - Effective for screening BDD in both general & psychiatric populations

RESULTS: CLINICAL VS. NONCLINICAL

- Comparison between clinical (n=61) and nonclinical population (n=158) on PIPS:
  - Clinical children (M=7.85) were significantly more likely to be bullies than nonclinical children (M= 4.02)

RESULTS FOR BULLYING USING NONRANDOMIZED NONCLINICAL CONTROLS

- BDD group (M=10.65) engaged in the most bullying
- Clinical control group (M=7.00) had second highest mean
- OCD (M=3.80) and nonclinical control group (M=4.02) reported least amount of bullying behaviors; did not differ

RESULTS FOR VICTIMIZATION USING NONRANDOMIZED NONCLINICAL CONTROLS

- OCD group (M=15.90) experienced more victimization than clinical controls (M=13.21), and BDD (M=10.17)
  - Clinical controls and BDD groups do not differ
- Nonclinical control group (M=6.16) experienced least amount of victimization

RANDOM SELECTION OF NONCLINICAL CONTROLS

- 25 non clinical controls randomly selected for analysis to control for group differences
  - BDD (N=23)
  - OCD (N=10)
  - Clinical controls (N= 28)
  - Nonclinical controls (N=25)

BULLYING USING RANDOMIZED NONCLINICAL CONTROLS

- For bullying:
  - BDD still had highest mean (M= 10. 65)
  - Followed by clinical control group (M = 7.00)
  - OCD (M=3.80) and nonclinical control group (M=3.28) (did not differ)
- OCD group were least likely to be bullies within the entire clinical population
- **BDD group were more likely to be bullies than everyone else**

VICTIMIZATION USING RANDOMIZED NONCLINICAL CONTROLS

- For victimization:
  - OCD group were the most victimized (M=15.90), followed by:
  - Clinical controls (M=13.21)
  - BDD (M= 10.17)
  - Nonclinical controls (M=6.16)

OCD individuals were more likely to be victims than everyone else
BDD individuals least likely to be victims within the clinical population

RESULTS: BODY DYSMORPHIC DISORDER

Bullying means and victimization means of those with BDD (N = 23);

- No significant difference in scores for bullying (M= 10.65) and victimization (M= 10.17)
- Indicates that the sample of individuals with BDD were ***equally as likely*** to be bullies and victims (p=.81)

RESULTS: OBSESSIVE COMPULSIVE DISORDER

Bullying means and victimization means of those with OCD (N = 10);

- Victimization (M=15.90) significantly higher than bullying (M=3.80)
- Indicates that OCD individuals were ***more likely*** to be victims than bullies (p=.000)

RESULTS: CLINICAL CONTROLS

Bullying means and victimization means for clinical controls (N = 28);

- Victimization (M=13.21) significantly higher than bullying (M=7.00)
- Indicates that clinical control group were ***more likely*** to be victims than bullies (p= .001)

RESULTS: NONCLINICAL CONTROLS

Bullying means and victimization means of nonclinical controls (N = 158);

- Victimization (M=6.16) significantly higher than bullying (M=4.02)
- Indicates that nonclinical control group were ***more likely*** to be victims than bullies (p= .000)

Table 1. Mean scores and Paired Sample T-tests on the Peer Interaction in Primary School Questionnaire (PIPS) (N= 219).

Group	Bullying Subscale	Victimization Subscale	P
BDD	10.65 ± 4.71	10.17 ± 5.10	.81
OCD	3.80 ± 3.23	15.90 ± 4.20	.000
Clinical Controls	7.00 ± 4.33	13.21 ± 5.19	.001
Nonclinical Controls	4.02 ± 1.93	6.16 ± 3.94	.000

DISCUSSION

- BDD sample were the most likely to be bullies, least likely to be victimized
- However, amount of bullying and victimization in BDD sample was not statistically different when compared against each other
    - Suggesting a unique pattern in BDD: they seem to be both bullies and victims

DISCUSSION

- OCD group were least likely to be bullies, most likely to be victimized
- Children with OCD at high risk of being bullied
    - Followed by clinical controls

DISCUSSION CONT.

- Bullying in BDD may be externalized reaction to their own victimization
  - self-consciousness and body image concerns in childhood prompting externalizing behavior
    - as opposed to internalizing behavior typical in adolescent BDD

DISCUSSION CONT.

- Anger associated with interrupted rituals
  - Frustration externalized
- Bullies often victims of abuse and other forms of violence
  - Externalizing behavioral problems
  - Internalizing behavior problems in some cases

FUTURE RESEARCH

- Future studies on early BDD pathology and characteristics may lead to more promising outcomes and help identify at risk youth
- Identifying warning signs needs to be better established
- Instituting prevention techniques as a means to decrease later social isolation
- Additional academic support and interventions for children with OCD and other psychopathology to reduce long term impact of bullying

From Home-Based Care To Residential Treatment: What Level is Right for You or Your Loved Ones?

C. Alec Pollard, Ph.D.
Throstur Bjorgvinsson, Ph.D.
Tim DiGiacomo, Psy.D.
Jon Hershfield, MFT
Patrick B. McGrath, Ph.D.

Overview

- Thank you for coming to this presentation
- We have gathered several experts in the treatment of OCD to discuss the various levels of OCD Treatment that are available to patients.
- We will each spend time reviewing the assigned level of care, and then we can take any general questions and then can split up in the room and do some small group discussions about each level of care.
- Please note, at the end of the assigned time for the talk, we will have to go as most of us have some meetings or other talks to do after this talk. Thanks you for understanding this.
- If your question does not get answered, feel free to email me at:
- Patrick.McGrath@amitahealth.org and I can direct your questions to the requested panel member.

Jon Hershfield, MFT: What does outpatient mean?

- https://www.merriam-webster.com/dictionary/outpatient: a patient who is not hospitalized overnight but who visits a hospital, clinic, or associated facility for diagnosis or treatment — compare inpatient

What is the goal of outpatient?

- Collaborate with the patient on treatment plan to reduce symptoms and improve functioning/quality of life
- Facilitate smooth transition from higher level of care, if applicable
- Ultimately, train the patient to internalize the tools, generalize them to new experiences, become the expert, and fire me

Assessing for level of care

- YBOCS score alone not sufficient
  - Belief in lack of control over compulsions and insight into what is compulsive makes a difference
  - Score can be very high while level of functioning is also high
- Practical accessibility
  - Can patient make it to office weekly?
  - How much therapeutic attention is actually required?
- Expectations for both therapist and patient
  - How long will this take?
  - What real or imagined deadlines are there?

Advantages

- Less time away from home or work
- Can be more affordable
- Relationship with individual therapist vs team
- Majority of the work is done outside of treatment in living environment
- Great for high insight/high motivation clients

Less effective with…

- Very low insight
- Evidence of psychotic process
- Unmanaged comorbid depression
- Other psychiatric complications that warrant team approach
- Self-harm risk
- Substance abuse
- Overall level of functioning and ability to care for self at age-appropriate level

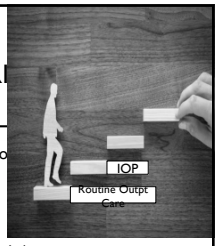
INTENSIVE OUTPATIENT PROGRAMS

C. ALEC POLLARD, PH.D.

SAINT LOUIS UNIVERSITY & SAINT LOUIS BEHAVIORAL MEDICINE INSTITUTE

FOR SYMPOSIUM ENTITLED, *FROM HOME BASED CARE TO RESIDENTIAL TREATMENT: WHAT LEVEL IS RIGHT FOR YOU?*, IOCDF, 2018, WASHINGTON, DC.

IOP: DEFINITION & DESCRI



- The next level of intensity up from routine o
- 2-4 hours per day
- 3 or more days per week
- 4-6 weeks (range = 1 week to multiple months)
- May include individual, group, & family therapies

IOP: CONDITIONS TO CONS FOR ADMISSION

- Patient has failed to respond to outpatient care
- Treatment is not feasible with a routine outpatient format (ie., needs more support/structure, higher dose of ERP)
- Treatment cannot be conducted safely with routine outpatient care

IOP: ADVANTAGES

- Relative to routine outpatient care: provides more support, structure & a higher dose of treatment
- Relative to higher levels of care (PH, Residential): less expensive, less interference with other life activity/obligations.

IOP: LIMITATIONS / SPECIFIC ISSU

- May not be useful for individuals who have dificulty getting to the clinic
- Does not provide the support, structure, or dosage of higher levels of care

Patrick B. McGrath, Ph.D. Other types of care available

- AMITA Health Foglia Family Foundation Residential Treatment Center, Chicago IL.
- Consider finding or starting a GOALS group in your area.
- Consider finding or starting a Parent Support Group in your area.
- Utilize your local affiliates for resources for OCD. They are listed on the IOCDF website.

Residential Treatment for Co-Occurring OCD and SUD

- As discussed, Residential Treatment is a 27/7 level of care. All needs are met for ADL's and food. Treatment begins in the morning and can go through the evening. Depending on the facility, treatment can occur on the weekends as well, or there may be a lighter schedule. AMITA has therapy 7 days a week.
- This level of care is for people who struggle both with a mental health and a substance use disorder.

Conditions Under Which to Consider Residential for Co-Occurring OCD and SUD

- There is presence of OCD and SUD
- Neither is being managed well at a lower level of care. As treatment for one problem helps to improve that area, the other area worsens (i.e., as ERP is introduced, substance use increases).
- It is hard to find a specialist for both the OCD and SUD at the same clinic or even in the same town.

Advantages to This Level of Care

- Safety – very decreased chance of dying from an overdose or by suicide.
- Both problems can be addressed at the same time – Riley's story.
- Can get a person to start working a 12-step or rational recovery program.
- Build a sense of community – you are not alone in this journey.
- A person is always available to work with you and support you 24/7 is a helpful, but not reassuring, way.

Advantages to This Level of Care

- Learn to fight OCD without using substances.
- Learn to deal with the initial increase in OCD when substance use stops.
- Mitigate seizure potential when coming off certain substances by 24/7 nursing and appropriate anti-seizure medications.
- Can begin Medication Assisted substance use treatment.

Limitation and Special Issues

- Away from friends, family, and supports (which can be a plus and minus in these circumstances)
- Does the treatment at an RTC transfer to the home environment?
- There can be issues with other residents that can complicate treatment.
- Many residentials state they treat OCD, but do not have anyone there who specializes in it.
- There are many scams in addiction treatment on the internet currently, so much so that Google took it off of their search terms.

Training Family Members to Become ERP Coaches

An Experiential Workshop
July 27, 2018
Gerald Tarlow, Ph.D.
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Become Educated about OCD and the Family's Role

- Read the self help book assigned to the patient.
- Read a self help book directly written for a family member.
- Join the International OCD Foundation and read their monthly newsletter.
- Attend conferences where OCD treatment is discussed.

How to Understand the Assignment and the Role You Play

- If possible sit in on the sessions.
- Review the assignments after each session with the patient.
- If it is not possible to sit in on the sessions it may be helpful to set up times to talk to the therapist directly.

Exposure and Response Prevention (ERP) The Gold Standard

Exposures

- Make sure patient is willing to do the assigned exposure.
- Exposures are designed to elicit anxiety. If the patient reports no anxiety it may not be useful to continue the exposure.
- At times it might be helpful to model the exposure.
- Monitor anxiety using a SUDS scale (0-100) about every 10 minutes.

- Continue the exposure until the anxiety drops at least 50%.
- Make sure the patient is not engaging in avoidances during the exposure.
- Repeat the exposures until the anxiety starts at very low levels.

Response Prevention

- Encourage the patient to not do any behavioral, or mental, rituals after the exposure.
- Never get angry if the patient is unable to do response prevention.

Other Guidelines for Family Members

- Try to never reassure a patient that the thing they fear will not occur.
- Be aware of repeated questions.
- It is okay to reassure a patient that if they do not do the rituals that the anxiety will eventually decrease.

Role Play #1

- Obsession: Fear of contamination
- Compulsion: Hand washing and cleaning of objects and avoidances.
- ERP Assignment: Shake hands with strangers.

Role Play #2

- Obsession: Fear of harming others.
- Compulsions: Avoiding sharp objects. Asking for reassurance. Checking to see if others have been harmed.
- ERP Assignment: Hold plastic knife up against a person you care about.

Role Play #3

- Obsession: Something bad might happen if I don't do certain behaviors correctly.
- Compulsion: Repeat behavior. Mental counting.
- ERP Assignment: Get up from being seated in a chair.

Essential Components in the Treatment of Body Dysmorphic Disorder

Optimizing Exposure and Response Prevention

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WHAT IS BODY DYSMORPHIC DISORDER?

- DSM-5 Criteria
  - Preoccupation with an imagined defect in appearance
    - Excessive concern over small anomalies
  - Distress or impairment in social, occupational, or other areas of functioning
  - Not better accounted for by another disorder
  - Repetitive behaviors or mental acts that reduce distress

AFFECTIVE COMPONENTS

- Depression
- Anxiety
- Anger
- Disgust
- Shame

ANXIETY

- Anxiety and fear over appearance flaws
  - Reinforcement of avoidant and compulsive behaviors
- BDD anxiety may impair relationships and employment
- 37-38% of those with BDD also have social anxiety disorder
- BDD anxiety is related to shame, disgust, and guilt
- Similar to social anxiety

ANGER

- Often called anger-hostility
- Frustration/stress from high levels of distress and symptoms
  - Frustration that others don't understand the severity
- Also fueled by
  - cosmetic treatments
  - skin irregularities
  - stressors that heighten negative thoughts
- BDD patients experience higher levels of anger and hostility than healthy controls

(Phillips, Siniscalchi, & McElroy, 2004)

DISGUST

- Salient emotional factor in BDD
- Often loathe perceived appearance
- Appraisal of self disgust can make individual depressed or anxious
- May lead to isolation, low self esteem, lack of interest, suicidal thoughts, etc.

(Hickey , Neziroglu, McKay; 2009)

SHAME

- Deeply painful self-conscious emotion
- Experienced when a person judges him or herself as wholly negative (e.g., defective, bad)
- Damages interpersonal relationships & motivates social withdrawal
- Linked with depression and suicide
- BDD may be under recognized due to individual's shame and embarrassment
  - Buhlmann et. al., 2014 study (N=172)
  - 50% felt they will be judged when disclosing their irrational thoughts to clinicians and others
  - 55.6% felt shame was their biggest barrier to receiving treatment along with the desire to self treat the situation.

PERCEPTUAL AND COGNITIVE COMPONENTS

- Perceptual distortions
- Somatosensory Disturbances
- Global/Idealized values
- Faulty beliefs
- Information processing biases
- Neurobiological Defect

BEHAVIORAL COMPONENTS

- Mirror checking/avoiding
- Excessive grooming
- Ritualized or excessive make-up application
- Excessive usage of skin or hair products
- Hair removal
- Reassurance seeking
- Camouflaging
- Skin picking
- Repeated checking of body part
- Do it yourself surgery (DIY)

FACTORS THAT MAY INTERFERE WITH TREATMENT

- Overvalued Ideation
- Personality Disorders
- Extent of avoidance behaviors
- Comorbidity
- Severity of depression
- Lack of support system
- Family psychopathology
- Readiness for change

OVERVALUED IDEATION

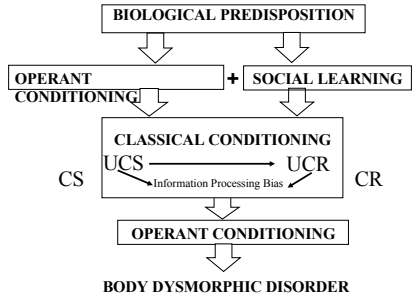
- This diagnosis is dependent on the degree of insight
- Overvalued ideation
  - An unreasonable and sustained belief with less than delusional intensity
  - Held with very strong conviction, even in spite of contrary feedback and evidence
- Patient has difficulty recognizing senselessness of obsession
- It's argued that OVIs become associated with idealized values
  - Develops into overriding "self" or identity of individual

OVI AND ERP

- OVI predicted treatment outcome in BDD patients who received Exposure and Response Prevention.
- The higher the OVI the poorer the prognosis.

(Neziroglu et al., 2001)

CBT WORKING MODEL



CBT WORKING MODEL

BIOLOGICAL PREDISPOSITION

- Genetic Factors
- Visual Processing Problems
- Somatosensory problems
- Faulty Neuroanatomical Circuitry

CBT WORKING MODEL

BIOLOGICAL PREDISPOSITION

OPERANT CONDITIONING

- Person is Positively and/or Intermittently Reinforced for:
  - Overall Appearance
  - Particular Body Part
  - Height
  - Cuteness
  - Poise
  - Weight
  - Body Shape

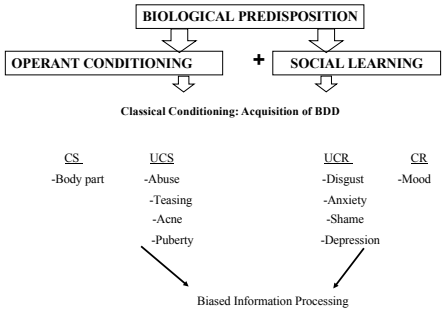
CBT WORKING MODEL

BIOLOGICAL PREDISPOSITION

OPERANT CONDITIONING + **SOCIAL LEARNING**

- Social Learning
  - Modeling
  - Vicarious Learning
- Social learning and operant conditioning
  - Develop
    - values and beliefs about attractiveness
    - self value based on body image

CBT WORKING MODEL



CBT WORKING MODEL

OPERANT CONDITIONING: MAINTENANCE OF BDD

Mood/CR **Avoidance Behaviors**

Negative Reinforcement

- Negative reinforcement
  - CR is removed through avoidance behaviors (e.g. camouflaging, mirror checking, excessive make-up)
- Positive intermittent reinforcement
  - Maintains avoidance behaviors

COGNITIVE BEHAVIORAL THERAPY FOR BDD

- **ERP Alone**: Reduces Compulsions
- **CBT Alone**: Reduces Obsessions
- **ERP & CBT**: Reduces Obsessions & Compulsions

EXPOSURE AND RESPONSE PREVENTION PROCESS

ERP is:

- Prolonged and repeated exposure to feared stimuli with simultaneous prevention of rituals
- Reduction in emotional arousal (habituation) to feared stimuli
- Optimizing exposure via inhibitory learning
- Exposure can be conducted in-vivo or imaginal (typically a combination is used)

HOW HABITUATION OCCURS

- Fatigue as a result of constant neuronal stimulation.
- Habituation of cellular activity occurs in the brain stem reticular formation (Grove & Lynch, 1972)
  - Particularly the mesencephalon

INHIBITORY LEARNING THEORY (ILT)

- Patients' fears return after exposure, so maybe the process of extinction needs to be enhanced.
- ILT is distinguished from a 'fear habituation' approach and 'belief disconfirmation' approach.

INHIBITORY LEARNING THEORY

- CS has two associations after extinction: original excitatory (CS-US) and additional inhibitory (CS- no US)
- Partial retention of original excitatory association in various contexts

INHIBITORY LEARNING: THEORY RETENTION OF THE ORIGINAL LEARNING

1. CR shows **spontaneous recovery**. Strength of the CR increases in proportion to the amount of time since the end of extinction.
2. **Renewal** of CR if **context is changed** between extinction and retest.
3. **Reinstatement** of CR if unpaired or **US is present after extinction.**
   1. Eg. Fear of asking question at work returns if rejected at cocktail party
4. Rapid **Re-Acquisition** of the CR if **CS-US pairings are repeated** after extinction.
   1. Eg. reacquire after trauma

INHIBITING OLD LEARNINGS WITH NEW ONES

- Learned associations remain in memory even with disuse.
- Associations don't fade over time, only access to them does
- Encoding and long term recall of newly learned non-threat connections inhibit fear based learning.
- Both associations remain in memory, and compete for retrieval when prompted by an outside trigger.

OPTIMIZING EXPOSURE VIA INHIBITORY LEARNING

- expectancy violation
- deepened extinction
- variability
- retrieval cues
- multiple contexts
- affect labeling
- occasional reinforced extinction
- removal of safety signals

CASE EXAMPLE: BOBBY

- 30 year old male presenting with BDD
- Preoccupation with forehead/ hairline: "too large and protruding; hairline receding"
- Behaviors included:
  - Camouflaging
  - Mirror checking
  - Avoidance of social situations that included same aged/ opposite sex individuals

EXPECTANCY VIOLATION

- The mismatch between expectancy and outcome is significant for new learning
- Develops inhibitory expectancies that will compete with excitatory ones.
- The more the expectancy can be violated by experience, the greater the inhibitory learning.
  - Bobby: "Women will never be attracted to me, men with laugh"
  - When Bobby is exposed to social situations, he never experiences ridicule
  - Hypothesis testing: most women found him attractive

DEEPENED EXTINCTION

- Multiple fear CSs are separately extinguished before being combined during extinction
  - (Bobby going into the community without socially interacting, talking to one female before hypothesis testing)

OR

- A previously extinguished stimulus is paired with a new CS
  - (Bobby passes a mirror without checking, or focuses on other features when looking)

VARIABILITY

- Pairs the new information with more retrieval cues or generates a rule
- Renders the information more retrievable at a later point in time.
  - Bobby goes to a bar and interacts with men and women, goes to work and talks with female coworkers while forehead is exposed, talks with a female cashier at a convenient store

RETRIEVAL CUES

- Including retrieval cues during extinction training enhances extinction learning and offsets context renewal
  - Bobby learns to associate various social situations with lack of danger
- Retrieval cues differ from safety signals in that they retrieve the CS-no US relationship

MULTIPLE CONTEXTS

- Conducting interoceptive, imaginal, and in vivo exposures in various contexts to prevent context renewal
  - Bobby imagining the feared situation, paying attention to bodily sensations
  - Interacting with others while forehead exposed while experiencing habitutation
- Context renewal involves the return of fear to a phobic stimulus when encountered in a context (internal or external) that differs from the context in which exposure therapy was conducted

AFFECT LABELING

- Labeling emotions disrupts distressing emotional states and attenuates fear response
  - "I am going to be laughed at due to my forehead, people will notice" replaced with "I feel anxious that/ I feel embarrassed"

OCCASIONAL REINFORCED EXTINCTION

- Involves occasional CS-US pairings during extinction
- Expectancy violation effect in which participant is less likely to expect the next CS presentation to predict the US
  - Because CS-US pairings have been associated with both further CS-US pairings and CS-no US pairings
  - Bobby noticing when a person is staring at him vs. noticing a person not stare at his forehead when talking to him

REMOVAL OF SAFETY SIGNALS

Safety signals alleviate distress in the short term, but when they are no longer present, the fear returns

- Prevent avoidance, stop mirror checking, stop wearing hats

EXPOSURE AND RESPONSE PREVENTION OVERVIEW

- build a hierarchy
- gradual exposure to areas of concern
- exposure with distortion
- mirror retraining
- goal is reduce impulsive behaviors
  - prevent rituals

BUILDING A HIERARCHY

- Targeting avoidance
- Targeting distressing situations
- Question patient about a typical day to elicit hierarchy items

BUILDING A HIERARCHY

COMMON DISTRESSING SITUATIONS

- Mirrors/Shiny surfaces
- Outdoors and bright lighting
- Crowded situations with little personal space
- Shopping centers
- Haircuts
- Summer time activities
- Shopping for clothes
- Classroom environment
- Sports activities (swimming)

SAMPLE HIERARCHY

- 10 Watching self on sister's wedding video
- 20 In session with therapist without hat for 1 min.
- 25 Driving in car with combed hair without hat
- 30 Sitting in last row of movie theater without hat
- 40 In session with therapist without hat for 15 mins
- 50 Dining in dimly lit restaurant without hat

SAMPLE HIERARCHY

- 60 Sitting in clinic waiting room without hat
- 70 Taking a walk outdoors on a windy day
- 80 Going out with friends without hat
- 80 At home with extended family with messy hair
- 90 Shopping in a supermarket with messy hair
- 100 Physical activity in a crowded park without hat

GRADUAL EXPOSURE

- Response Prevention
  - Initially patient may be asked to cover all mirrors in home.
  - Give up all cosmetic products.
  - Give up special "tools" for skin picking.
- Gradually expose area of concern

EXPOSURE WITH DISTORTION

- Use of make-up, clothes etc. to highlight or exaggerate defect
- Pair with gradual exposure to anxiety provoking situations

MIRROR RETRAINING

- Teaching patient to describe appearance in less subjective language
- Teaching patient how to scan appearance without spending too much time on one body part
- Teaching patients not to focus and examine details of appearance

MIRROR RETRAINING

- Identify motivation and criteria for termination
- Goals for agreed function
- Use large mirror at slight distance & non-judgmental
- Minimal or no makeup
- Focus attention on external reflection
- Scan whole of face or body
- Use a variety of mirrors & lights
- No magnifying mirrors
- No ambiguous surfaces
- Delay response when urge

CONCLUSION

- Affective, cognitive and behavioral components of BDD can be mitigated through ERP
- Enhancing exposure through inhibitory learning will result in better prognosis

Families Unite! Integrating Behavioral Contracting and Motivational Strategies to Overcome OCD

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Learning Objectives

1. Understand the impact of family responses on OCD
2. Learn some basic motivation strategies
3. Rate your level of Family Accommodation.
4. To develop a family contract incorporating motivation strategies

Themes and the Rationale For Including the Family in Treatment:

The Facts!

Family Accommodation

Family behavior that reinforces and perpetuates OCD

"My daughter, Mary, is scared that I might have brought home germs from my job. I spend at least an hour every night letting her ask me questions about what I did and where I went today to help relieve her anxiety. It makes her anxiety go away for a little while."

Obsession: Germs might get me and my family sick

↓

Anxiety! → **Compulsion:** Seek reassurance from parent that there is no danger

↓

Anxiety reduced!

Family Accommodation

Obsession: Germs might get me and my family sick

↓

Anxiety

↓

Compulsion: Seek reassurance from parent that there is no danger

↓

Anxiety reduced

What has Mary learned?

"If I am feeling anxious about germs, I can ask my mom about it for an hour. After that hour, my anxiety goes away."

1 **I NEED TO KEEP ASKING MY MOM ABOUT GERMS!**

2 **MOM KEEPS ANSWERING ME. SO, MY FEAR MUST BE IMPORTANT!**

Family Accommodation

Forms

- Providing reassurance (Tell patient everything is okay)
- Participate (Excessive washing own hands)
- Assist (Help patient avoid germs)
- Facilitate (Buy patient soap)
- Modify family routine (Drive patient to avoid bus)
- Take on extra responsibilities (Cleaning room)
- Modify leisure activities (Vacation in "clean" places)
- Modify work responsibilities (Calling patient during work hours)

What Relatives Say

- 88% relatives of OCD patients reported FA
- Over 80% considered OCD symptoms unreasonable
- 60% experienced mild to extreme
- 52% reported FA not personally helpful or satisfying
- ***60% reported accommodation did not help alleviate OCD symptoms***

(Calvocoressi et al. 1995, 1999)

Family Accommodation Effects

- FA associated with less response to behavioral therapy in adults and children (Amir et al., 2000 Freeman et al, 2014)
- FA in OC and Anxiety Disorders: A five year update (Leibowtiz, Panza and Bloch, 2015)
  *Review of 57 relevant articles between 2010-15 pediatric and adult
  *Almost 90% FA, significantly and positively associated with OCD sx severity and impairment
  *FA predicts poorer tx outcome and worse naturalistic trajectories
  *FA positively correlated caregiver burden, functional interference

How FA Interferes with Treatment

Lasting effects of treatment gains with CBT are through exposure coupled with response prevention

How FA Interferes with Treatment

Situation: Touching countertop

Obsession: Germs might get me and my family sick

↓

Anxiety

↓

Compulsion: Seek reassurance there is no danger

↓

Parent provides reassurance = Exposure but No Response Prevention

↓

Anxiety reduced
Patient learns the obsession is important
and the compulsion is the way to reduce anxiety!

How FA Interferes with Treatment

Situation: Touching countertop

Obsession: Germs might get me and my family sick

↓

Anxiety

↓

Compulsion: Seek reassurance there is no danger

↓

No Reassurance

↓

Anxiety reduces and/or is tolerated

1. Patient learns that compulsion is not necessary
2. Obsession is not so important
3. Parent has time to do other activities! Family is happier!

Family Accommodation A Review

- FA is a "well intentioned" attempt to reduce ritual involvement, reduce distress and reduce OCD impact on family
- FA reinforces obsessions and compulsions
- FA only temporarily reduces anxiety and prevents:

1. Experiencing naturally occurring anxiety reduction
2. Learning that anxiety can be tolerated while acting in a way that is consistent with values
3. Learning natural consequences of OCD behavior

SOLUTION:
Families Unite!!
Behavioral Contracting and Working Together

Behavioral Contracting

- Ideally, person with OCD selects exposure
- Clear and direct discussion about ERP homework and the role of family- how family changes behavior to gradually reduce FA
- Limits of responsibility are clarified
- Consequences and expectations are defined
- What is meant as family "support" is negotiated (hold hand vs. ask)
- Gradual withdrawal of FA (similar to working up an exposure hierarchy)

Family Contract Examples

- Instead of opening doors, person with OCD agrees to place hand over relative's and open door together until gradually person with OCD touches knob/handle fully then opens the door themselves
- Person with OCD has whispering compulsion, agree that until family can hear what they are saying they won't respond
- For reassurance, respond with a cue: "scooby snacks," "time to walk the dog," or a question: "What do you think I will say? What have I told you before?"

Integrating Motivation Strategies

Why Motivation?

Family contracts involve change

Change can be hard!

What Changes are Needed?

1. OCD sufferer needs to change their response to obsessions

2. Family members need to change their response to compulsions

Motivation Strategies

Motivation Script

Looking Back: What was life like before OCD?

Looking Forward: What could life be like if I choose to make a change?

Values: What is important to you? How is the change going to bring you closer to your values?

Adult Contract Example

Jodie

Obsessions: Worried about harming others

Compulsions: Asking for reassurance, avoiding contact, removed sharp objects from house

Contract: Cooking dinner targeted (knives, close contact)

Patient really liked cooking with family in past

Jodie's role

1. Be in kitchen when others cooking, no sharp objects
2. Be in kitchen when others using knives
3. Jodie uses knives

Family's role

1. No reassurance provided while cooking
2. Gradually reintroduce knives
3. Move physically closer to Jodie over time

Jodie's Motivation Script

I am tired of letting OCD run my life. Before OCD, I spent time with my family doing things I love. I hugged my husband and children and cooked dinner with them. I love these things. If I choose to accept obsessions and resist the urge to do compulsions, there is a chance that I'll get back to these things I love. I value my relationship with my family. Compulsions interfere with my relationships and I am not going to allow them to interfere any longer.

Motivational Strategies

Token Economy

Incentive program for brave behaviors

Small reward (earn 1-2 days)

Medium reward (earn 1-2 weeks)

Large reward (3-4 weeks)

1. Patient and parents come up with rewards together so truly motivating items for patient
2. Patient earns stickers/points/chips for brave behaviors.
3. Patient cashes in the stickers to “buy” an item from their reward list

Pediatric Contract Example

Amy (5 year-old)

Obsessions: Worried about contamination/getting sick

Compulsions: Asking for reassurance (~50 times per day)

Contract: Reassurance targeted. Made agreement (contract) that these behaviors have not stopped OCD, so let’s “boss back OCD” by not giving into reassurance seeking

Amy's role

1. Tolerate discomfort, rate on fear thermometer

Family's role

1. Not rescue, cheerleader, respond: “We have reached the agreed upon limit of questions, I can not answer any more”

Motivation Strategy

Token Economy

First Goal

Reassurance Seeking

50 questions per day ⟶ 30 questions per day

Amy gets 30 tokens at start of each day

Gives away one token each time she wants reassurance
Mom: "Are you sure you want to give up a token?"

Tokens remaining at end of day are used to purchase rewards

PART II:
Behavioral Contracting
Administer FAS-SR
(Pinto, Van Noppen, Calvocoressi, 2013)

SMALL GROUP CONTRACTING

1. I reassured my relative that there were no grounds for his/her OCD-related worries.

- *Examples: reassuring my relative that s/he is not contaminated or that s/he is not terminally ill.*

0 = None/ Never
1 = 1/week
2 = 2-3/week
3 = 4-6/week
4 = Everyday

2. I reassured my relative that the rituals he/she already performed took care of the OCD-related concern.

- *Examples: reassuring my relative that s/he did enough ritualized cleaning or checking.*

0 = None/Never
1 = 1/week
2 = 2-3/week
3 = 4-6/week
4 = Everyday

3. I waited for my relative while he/she completed compulsive behaviors.

0 = None/Never
1 = 1/week
2 = 2-3/week
3 = 4-6/week
4 = Everyday

4. I directly participated in my relative's compulsions.

- *Examples: doing repeated washing or checking at my relative's request.*

0 = None/Never
1 = 1/week
2 = 2-3/week
3 = 4-6/week
4 = Everyday

5. I did things that made it possible for my relative to complete compulsions.

- *Examples: driving back home so my relative can check if the doors are locked; creating extra space in the house for my relative's saved items.*

0 = None/Never
1 = 1/week
2 = 2-3/week
3 = 4-6/week
4 = Everyday

6. I provided my relative with OCD with items s/he needs to perform rituals or compulsions.

• *Examples: shopping for excessive quantities of soap or cleaning products for my relative.*

0 = None/Never
1 = 1/week
2 = 2-3/week
3 = 4-6/week
4 = Everyday

7. I did things that allowed my relative to avoid situations that might trigger obsessions or compulsions.

•*Examples: touching public door knobs for my relative so s/he would not have to.*

0 = None/Never
1 = 1/week
2 = 2-3/week
3 = 4-6/week
4 = Everyday

8. I helped my relative make simple decisions when s/he could not do so because of OCD.

•*Examples: deciding which clothes my relative should put on in the morning or what brand of cereal s/he should buy.*

0 = None/Never
1 = 1/week
2 = 2-3/week
3 = 4-6/week
4 = Everyday

9. I helped my relative with personal tasks, such as washing, grooming, toileting, or dressing, when his/her ability to function was impaired by OCD.

0 = None/Never
1 = 1/week
2 = 2-3/week
3 = 4-6/week
4 = Everyday

10. I helped my relative prepare food when s/he couldn't do so because of OCD.

0 = None/Never
1 = 1/week
2 = 2-3/week
3 = 4-6/week
4 = Everyday

11. I took on family or household responsibilities that my relative couldn't adequately perform due to OCD.

• *Examples: doing bills, shopping, and/or taking care of children for my relative (when, except for OCD, I wouldn't have done so).*

0 = None/Never
1 = 1/week
2 = 2-3/week
3 = 4-6/week
4 = Everyday

12. I avoided talking about things that might trigger my relative's obsessions or compulsions.

0 = None/Never
1 = 1/week
2 = 2-3/week
3 = 4-6/week
4 = Everyday

•

13. I stopped myself from doing things that could have led my relative to have obsessions or compulsions.

- *Examples: not moving items that my relative has carefully lined up.*

0 = None/Never
1 = 1/week
2 = 2-3/week
3 = 4-6/week
4 = Everyday

14. I made excuses or lied for my relative when s/he missed work or a social activity because of his/her OCD.

0 = None/Never
1 = 1/week
2 = 2-3/week
3 = 4-6/week
4 = Everyday

15. I didn't do anything to stop unusual OCD-related behaviors by my relative.

- *Examples: tolerating my relative's repetitive actions such as going in and out of a doorway or touching/tapping objects a certain number of times.*

0 = None/Never
1 = 1/week
2 = 2-3/week
3 = 4-6/week
4 = Everyday

16. I put up with unusual conditions in my home because of my relative's OCD.

- *Examples: leaving the home cluttered with papers that my relative won't throw away.*

0 = None/Never
1 = 1/week
2 = 2-3/week
3 = 4-6/week
4 = Everyday

17. I cut back on leisure activities because of my relative's OCD.

- *Examples: spending less time socializing, doing hobbies, exercising*

0 = None/Never
1 = 1/week
2 = 2-3/week
3 = 4-6/week
4 = Everyday

18. I changed my work or school schedule because of my relative's OCD.

0 = None/Never
1 = 1/week
2 = 2-3/week
3 = 4-6/week
4 = Everyday

19. I put off some of my family responsibilities because of my relative's OCD.

- *Examples: I spent less time than I would have liked with other relatives; I neglected my household chores.*

0 = None/Never
1 = 1/week
2 = 2-3/week
3 = 4-6/week
4 = Everyday

When the Going Gets Tough- Managing Reactions From Your Child When Saying "No" to OCD

When the Going Gets Tough:

Managing Difficult Reactions From Your Child When Saying "No" to OCD

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2018 IOCDF Conference Washington, DC

Goals

- Understanding family accommodation and it's role in maintaining OCD
- **Emotion Regulation skills for parents: putting your own oxygen mask on first**
- How to respond to difficult reactions (anger, aggression, self-harm)

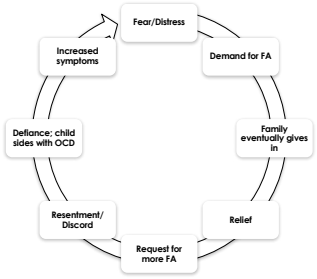
Family Accommodation Defined

- The way families act to reduce symptoms of distress and anxiety in their loved one
- Two main types:
  - **Participating in symptoms** (compulsions/rituals) and modifying family routine
  - **Providing reassurance** and **facilitating avoidance** (most common)
- Exercise

Examples of FA

- Hiding or removing potential triggers
- Facilitating avoidance
- Taking responsibility for something so your child doesn't have to (e.g. being the last one to lock up, go to bed, throw away trash)
- Allowing extra time for ritual completion
- Not making appointments/demands during certain times of the day
- Purchasing supplies that will help with rituals
- Not disciplining behaviors you otherwise would
- Providing REASSURANCE

The Family Accommodation Cycle



Why we know we shouldn't accommodate…

- Family accommodation is linked to:
  - **Greater symptom severity** (on standardized measures; medication)
  - **More impairment in functioning**: FA mediates relationship between symptom severity and functional impairment (e.g. social, academic, family)
  - **Poorer response to treatment** and lower insight about disorder
  - **Higher rates of distress** and poorer quality of life for relatives

And why we do it anyway

- It's instinctive
- It's easier in the short term
- It's an attempt to minimize distress (your own* and your child's)
- It might seem harmless
- We lose perspective and forget that **anxiety is not dangerous** and we do not need to protect our child from their own emotions

It's hard not to rescue your child from distress…

- "Ray" Clip

Yet, we need to stay committed to change

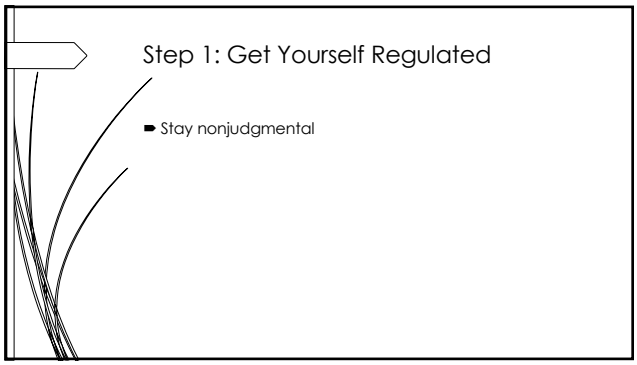
- Desert Island metaphor

Step 1: Get Yourself Regulated

- Understand it as a fight response (fun clip) https://www.youtube.com/watch?v=ffiktN4SVPs

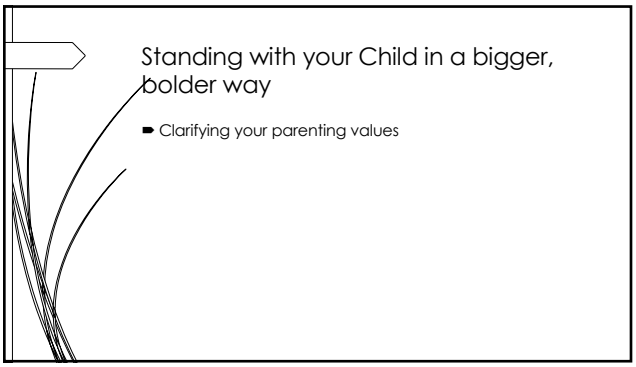
Step 1: Get Yourself Regulated

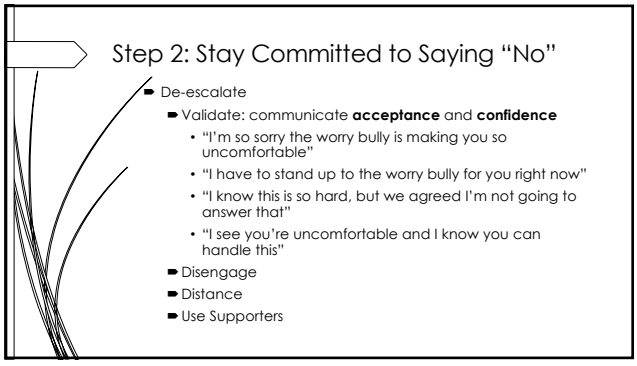
- Surf the urge exercise

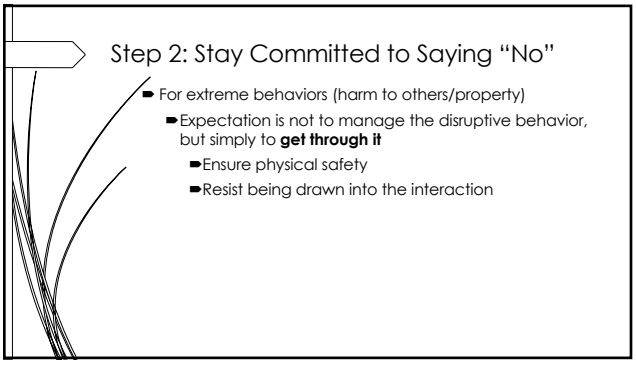

Step 1: Get Yourself Regulated
Stay nonjudgmental

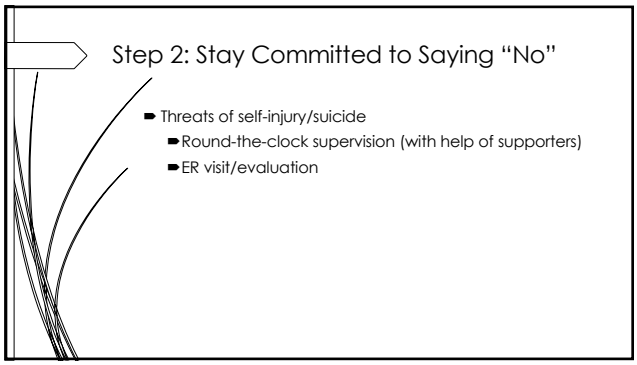

Step 1: Get Yourself Regulated
Self-compassion exercise

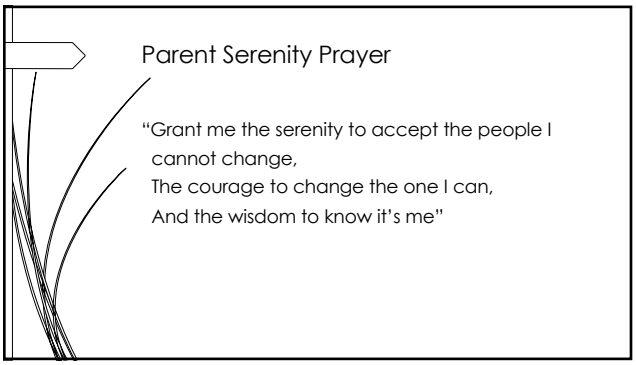

Step 1: Get Yourself Regulated
Use your attention superpower


Standing with your Child in a bigger, bolder way
Clarifying your parenting values


Step 2: Stay Committed to Saying "No"
De-escalate
Validate: communicate acceptance and confidence
"I'm so sorry the worry bully is making you so uncomfortable"
"I have to stand up to the worry bully for you right now"
"I know this is so hard, but we agreed I'm not going to answer that"
"I see you're uncomfortable and I know you can handle this"
Disengage
Distance
Use Supporters


Step 2: Stay Committed to Saying "No"
For extreme behaviors (harm to others/property)
Expectation is not to manage the disruptive behavior, but simply to get through it
Ensure physical safety
Resist being drawn into the interaction


Step 2: Stay Committed to Saying "No"
➨ Threats of self-injury/suicide
➨Round-the-clock supervision (with help of supporters)
➨ER visit/evaluation


Parent Serenity Prayer
"Grant me the serenity to accept the people I cannot change,
The courage to change the one I can,
And the wisdom to know it's me"

Helping Your Loved One with OCD: A Step by Step Plan

Noah Weintraub, Psy.D.
Lisa Levine, Psy.D.
Behavior Therapy Center of Greater Washington
Fri, July 27th, 4:00 PM - 5:30 PM

Overview

Step 1: OCD Re-Orientation

Step 2: Self-Assessment

Step 3: Self-Care

Step 4: De-Accommodation and Support

Step 1: OCD Re-Orientation

Understand how OCD operates and change how you respond to it

Understanding OCD: How OCD is born and grows

Predisposition + Creative & Alarming Idea = False Alarm (OCD seedling)

OCD seedling

This “false alarm” comes in different forms…

Uncertainty (“What if [scary outcome]?”)

Disgust and/or Fear of Contamination

Disturbing, Unwanted Thought or Image

Bodily/Sensory Discomfort, Feeling "Wrong"

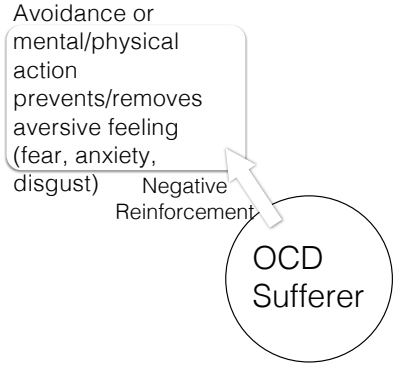
How OCD thrives: OCD exploits the sufferer's instinct

Sufferer **responds** to this initial false alarm in the intuitive way. By **listening to their feelings**.

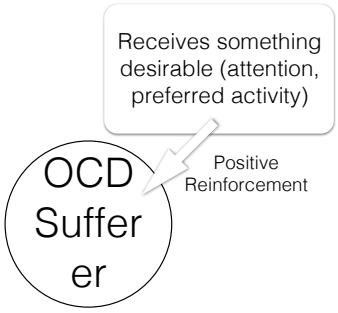
By **escaping (compulsions) and avoiding**.

Escaping and avoiding maintains and strengthens OCD over time.

How OCD Thrives: Negative Reinforcement



There's Inadvertent Positive Reinforcement Too!



Just as OCD exploits a sufferer's instinct to run from the "false alarm" of danger and discomfort…

…it equally exploits your instinct to protect and comfort your loved one.

Essential in overcoming OCD

Remaining in the presence of the stimulus (including thoughts) that automatically elicit negative emotions (**Exposure**) without escaping from unwanted emotions (**Response Prevention**)

Duration and repetition are essential to success

Exposure must be **strong enough to induce an emotional response** (the more senses involved, the better!)

Allows for **habituation and violation of predictions**

Why Face Your Fears?

Emotional Processing Theory (Foa & Kozak, 1986)

Successful treatment requires the sufferer to remain in the presence of the anxiety-provoking stimuli (including thoughts). This allows **habituation** (getting used to, bored of stimuli).

Inhibitory Learning Theory of OCD (Craske, et al., 2008)

Exposure to feared stimuli strengthens multiple non-fear structures to override the OCD fear-structures. The sufferer **violates her own predictions** of what they can tolerate. This builds **self-efficacy** (confidence) in coping.

(Strauss, et al., 2015)

Change Your **Attitude** Toward and **Relationship** with Your Loved One's OCD

Goal **not to comfort (provide relief) and protect (help avoid)**, rather to **support brave behaviors**

Without escape (rituals/compulsions) **or avoidance, OCD cannot survive**

Change Your **Attitude** toward and **Relationship** with Your Loved One's OCD

Any way you change your behavior that makes avoidance or escape (compulsions) easier is helping to feed OCD

Anything you do to help your loved one confront what they are avoiding is helpful (starves OCD)

Doing the helpful thing for the sufferer will often feel wrong and will go against your instincts

Just as your loved one will experience distress on the path toward recovery, *you will experience distress in response to your loved one's distress*

Step 2: Self-Assessment
How are you helping or hurting?

Loved ones commonly **vacillate between** extremes of

Accommodating behaviors

and

Expression of **anger/frustration**

Family Accommodation

What is Family Accommodation (FA)?

Changes in loved ones' behaviors with the ***intent of*** reducing OCD sufferer's distress/rituals and facilitating sufferer's functioning

Do you behave differently as a family/spouse than you would if your loved one did not have OCD?

Accommodation is Common

- Accommodation is an intuitive response
- Comes from parental instinct to nurture, protect, soothe
- Paradoxically, leads to poorer coping ability and decreased functionality long-term

Ways Loved Ones Accommodate

1. **Modifying the family's routines/daily way of life:**

a. Change in loved one's activities

b. Change in loved one's work schedule

c. Waiting for ritual completion

Wu, et al., 2016; Benito, et al., 2015

Ways Loved Ones Accommodate

2. **Engaging in sufferer's compulsions:**
   a. Provision of supplies (cleaning, etc)
   b. Reassurance-giving
   c. Observing actions at sufferer's request

(Cont.)

Wu, et al., 2016; Benito, et al., 2015

Ways Loved Ones Accommodate

(Cont.)

d. Performing "magical"/or fix-it rituals (verbal or actions) at sufferer's request

e. Checking for sufferer (locks, lights, making sure trigger not present, etc)

f. Cleaning self/environment for sufferer

Wu, et al., 2016; Benito, et al., 2015

Ways Loved Ones Accommodate

3. **Facilitating avoidance of OCD triggers**

a. Avoiding presentation of media with triggers (TV shows, pictures, books)

b. Avoiding saying trigger words, ideas

c. Avoiding going to specific trigger places, activities

d. "Running interference" with other people

(Cont.)

Wu, et al., 2016; Benito, et al., 2015

Ways Loved Ones Accommodate

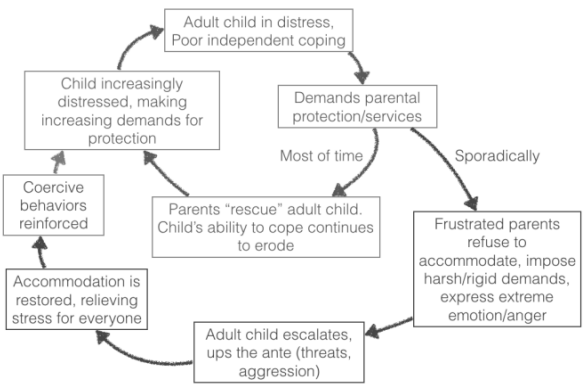
(Cont.)

e. Reducing expectations, household responsibilities

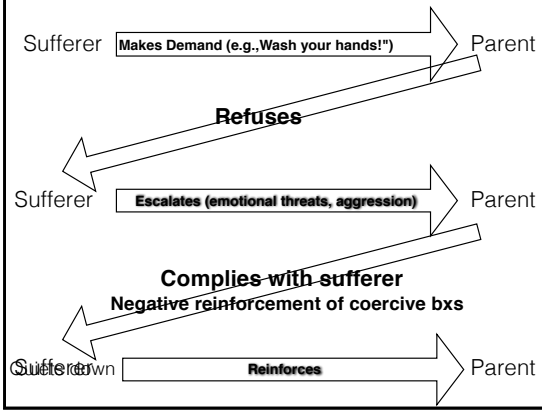
f. Avoiding contact with "contamination" at sufferer's request

g. General subsidizing of adult child (free electricity, internet, food, money, shelter, etc). "*Dependency Trap*" (Lebowitz & Omer, 2013)

Dependency Trap (Lebowitz & Omer,



Coercive Behavioral Cycles (Patterson)



Extinction Bursts: An expected sign of healing from OCD

When a typical reward* does not occur, we intensify our behavior to try to get the desired outcome

**In OCD, the reward is relief as a consequence of escape/avoidance behaviors*

Self-Assessment

Complete Family Accommodation Scale

modation Scale for Obsessive Compulsive Disorder - Self-Rate
by Anthony Pinto, Ph.D., Barbara Van Noppen, Ph.D., & Lisa C

Frustration/Anger Response

- Imposing harsh/rigid demands/expectations
- Expressing extreme emotion/anger ("I've had enough of this!!!")
- Criticism, judgment ("You're lazy," "You must like being sick")
- Minimizing sufferer's difficulties in changing

Self Assessment

Do you engage in the following out of anger, frustration, and/or extreme concern?

-Lecturing

-Nagging

-Criticizing

-Shaming

-Threatening

-Yelling

-Pressuring

-Physically coercing your loved one

Reasons a sufferer isn't working on overcoming OCD

Fear and **"Incentive Deficits"** (Alec Pollard)

Behaviors are functional (there's always a reason behaviors are maintained)- Viewing behaviors this way helps remove personalizing and judgment

How to help?!

It's going to involve walking the middle road, validating and understanding, while refusing to participate in your loved ones OCD behaviors and rewarding brave behaviors

but first…

Step 3: Apply your own oxygen mask first

Rationale for Self Care

- You Will Be Better Able to Help Your Loved One
- Caretakers who take care of themselves are more likely to feel hopeful and less likely to be depressed (Geffkin, Storch, et al.)
- Excessive functioning for the OCD sufferer (accommodation) is doing the opposite of helping anyway.
- Taking care of yourself is modeling healthy coping skills. It also models following your values rather than allowing anxiety/fear to guide you.

Behavioral Antidepressants

- **Pleasurable** (e.g., taking bath, solving crossword, sitting in sun)
- **Mastery** (fixing something in house, learning an instrument, completing a task)
- **Novelty** (listening to new music, trying new restaurant, new activity)
- **Exercise**/Open Air/Sunlight
- **Social** (joining a support group, talking with friend, going to party)
- **Mindfulness Meditation**

Step 4: De-Accommodation and Support

Prepare for Change

- Prepare to be a united front
- Have a clear plan for every change
- Consistency is key
- Educate other family members
- If needed, recruit a support system (Lebowitz & Omer, 2013)

Start Changing Your Own Behaviors

Write week-by-week list of gradual de-accommodation plan

If Cooperative

De-accommodation:

Include your loved one in creating hierarchy of de-accommodation based on their level of distress and level of importance to loved ones

ERP:

In coordination with behavior therapist, involve family members in planned/unplanned exposures

If Uncooperative

De-accommodation

In unilateral way, stick to **gradual** weekly de-accommodation plan.

When you stick to this plan, expect that you will need to weather a storm before it gets calm again (extinction bursts).

Extinction Bursts

- Be responsible for **your responses. It is not cruel to refuse to help with rituals or avoidance. It is *loving.***
- Make sufferer 100% responsible for his/her OCD symptoms (Penzel, 2000)
- On surface, when you're doing the right things, it will appear as if you're doing something wrong

Extinction Bursts

- Pause, delay your responses (Lebowitz & Omer, 2013)
- Model for your loved one regulating emotions
- Just because it looks and feels like a crisis doesn't mean you need to respond like it's a crisis
- Practice *tolerating distress over your loved one's distress*

Incentive Plans

Remember, you're competing with the extremely powerful reward (negative reinforcement) of immediate avoidance/escape

Incentive point charts/reward systems: All children, some failure to launch adults and at times with consenting adult sufferers

With failure to launch young adult living in home or being subsidized by loved ones: Setting up contingencies

Identify OCD-Related Behavior and "Positive Opposite" Behaviors

OCD Related Behavior	Positive Alternative
Changing clothes multiple times in the morning to get the "right outfit"	Wearing the first outfit that you put on in the morning
Refusing to eat sandwich without reassurance that it hasn't been contaminated	Eating 1 bite of sandwich
Washing hands for 10 minutes after restroom	Washing hands for 60 seconds after restroom
Turning light switch on and off multiple times	Turning light switch off once
Erasing and re-writing words multiple times when doing homework	Competing a page of homework without erasing

Reassurance-Seeking Behaviors

- Reassurance-seeking- A **common ritual** in which the sufferer questions/makes statements for the purpose of reducing anxiety and/or discomfort.
- Examples:
  - Are my hands clean?
  - Are you OK?
  - Are we safe?
  - Was that a sin?
  - Does God love me?
  - Was it OK that I saw (something sexual) on that website
  - I didn't want to think about hitting dad (confessing)
  - I love mom, I don't want anything to happen to her.

How to Respond to Reassurance-Seeking Questions

Respond by saying (hierarchical):

- "I think you know how I would answer that"
- "You don't really need me to answer that. I know you can handle that"
- "Maybe, perhaps, I'm not sure"
- "I can't answer that question. That would be helping OCD."
- "Yeah, it probably could happen."
- Ignore

Active Ignoring

- Removing the unintentional rewards for your child's anxious behavior
- Attention from parents is incredibly reinforcing to most kids... even negative attention!
- Called active ignoring because it is not easy!
  - Things sometimes feel like they get worse before they get better (i.e., extinction bursts)

Other Issues: Failure to Launch

All my adult child will do all day is sleep, watch TV, go on the Internet and play video games. She is not engaging in life or working on her treatment.

Common "Status Quo" Beliefs

- We've tried before to get him to get up and do something and it was no use.
- He will get worse (emotionally or in functioning).
- He is suffering enough. It's my job to make him comfortable. Watching TV is the only time he is free from worrying or stress.

I can't take these things (wifi, television, etc) away.

If you think your adult child is not already on a reward

think again!!

The rewards are just accidental- not contingent on any expectations or movement toward recovery.

Other Issues: Impact on Siblings

- Lack of attention to sibling due to OCD
- Involvement of sibling in family accommodation
- Anger/frustration

Remember, There's a Lot You *Can* Do

Two Terrible People Teach You How to be Good Without Being Certain
A Moral Scrupulosity Workshop

My OCD Says I'm a Bad Person

Tackling Moral Scrupulosity

The Two Very Horrible, Despicable, Gross, Disgusting, and all around Bad Hombres delivering this talk (that we hope you enjoy but fear that we may be wasting your valuable time and money that you spent to come to the conference)

Jon Hershfield, MFT
Patrick McGrath, Ph.D.

What is Moral Scrupulosity in OCD?

- "Excessive concern with right/wrong" (from YBOCS-II, Rasmussen et al., 2006)
  - Worries about always doing "the right thing" ←Why is that in *quotes?*
  - Unfounded worries about lying or cheating ←What does *unfounded* mean??

What is Moral Scrupulosity in OCD?

- Common manifestations
  - Excessive concern with being 100% honest
  - Excessive concern with the idea of being good or of not being bad
  - Excessive concern that a past act was immoral
  - Excessive concern that a thought about an immoral act is not a memory
  - Excessive concern that adultery or some disloyal act took place
  - Excessive concern that a thought does not reflect an immoral identity

What is Moral Scrupulosity in OCD?

- Common compulsions
  - Reassurance seeking about morality
  - Confessing perceived immoral acts or thoughts
  - Mentally reviewing acts to determine moral integrity
  - Mental rituals (e.g., repeating neutralizing "good" thoughts, ruminating on hypothetical moral scenarios to test responses)
  - Avoidance of morally ambiguous situations
  - Self-punishment to prove moral concern
  - Washing and checking behaviors connected to moral concerns
  - Excessive donating or other acts of exaggerated altruism/generosity

Cognitive errors in moral scrupulosity

- All or nothing, absolutist thinking (Jesus vs Hitler)
- Catastrophizing about moral failures
- Magnifying moral significance
- Discounting the positive/selecting the negative
- Emotional reasoning (e.g. guilty feelings = guilty behaviors)
- Moral perfectionism (should and must statements)

The big bad enemy

- I have to be certain
- If I am not certain, it may mean that I did something
- I should tell others that I may have done something since I cannot be certain
- Others can reassure me that I did not do something I think I may have done
- I do not believe what others tell me, so I have to confess to more people
- I do not believe them either
- I should just turn myself in for this possible act and see if the professionals can find proof
- Even if they say no, I do not believe them, and still believe that I may have done something

ERP for moral scrupulosity

- Goals
  - Improve uncertainty tolerance
  - Violate the expectation that uncertainty about morality is intolerable
  - Improve ability to commit to value-based behaviors despite unwanted thoughts/feelings

ERP for moral scrupulosity

- Rules
  - Work within client's moral framework, not violate it
    - Identify the lines not to be crossed
    - Do exposure to walking near the line without checking
    - Risk the potential that line could or even has been stepped on or crossed
  - Only do what therapist is willing to do (no need to overly test yourself)

ERP for moral scrupulosity

- Hierarchy development
  - Inventory avoidance
  - Reduce accommodation
  - Explore both mental and physical moral exposures
  - Start as small as necessary (e.g. exposure to a trigger word without compulsions)

ERP for moral scrupulosity

- Imaginal exposures
  - Scripts articulating that uncertainty will be accepted about morality
  - Scripts describing the outcome of moral failures
  - Scripts that are in and of themselves moral exposures (e.g. writing that you hope someone gets sick)

moral scrupulosity alongside other obsessions

- Relationship obsessions
  - It would be wrong to let my partner stay in a relationship with someone who has my thoughts, or who might suddenly have developed a differing sexual preference
- Religious scrupulosity
  - It would be wrong to be flexible with religious doctrine on moral issues
- Pedophilia obsessions
  - It would be wrong not to go to the police and tell them something that I might have done to an unsuspecting child

moral scrupulosity alongside other obsessions

- Contamination
  - It would be wrong to touch this with dirty hands
- Checking
  - It would be wrong to risk the door being unlocked, etc.
- Harm
  - It would be wrong to be careless in a way that could lead to harm (leaving a sharp object exposed = involuntary manslaughter)
- Sexual obsessions
  - It would be wrong to deceive others about my attractions

Case Examples

Approximately 55 year old Male

"What if…" based fears.

"What if an action I did 25 years ago has now caused someone to be addicted to drugs."

"What if, while driving after I had a drink, I caused an accident"

Fears involved harm, scrupulous issues, and self blame and guilt.

Approximately 20 year old Female

"What if…" based fears

"What if the hit and run accident I just heard about on the news was me?"

"Why did I get a ticket on the highway? I was only going 35 miles per hour."

Fears involved disappointing family and going to jail.

Case Examples

Approximately 35 year old Male

"What if…" based fears.

"What if me talking to the barrista was actually flirting and I just cheated on my wife?"

"What if failure to disclose this cause my wife to be trapped in a marriage with a bad guy she does not really know?"

Fears involved causing emotional harm to others and being in denial. Primary compulsions include mental review, avoidance, and confessing.

Approximately 40 year old Female

"What if…" based fears

"What if moving to this neighborhood causes my son to grow up to be a criminal?"

"What if my failure to be vigilant results in him being molested?"

Fears involved harm to son and scorn from society/being a "failure" of a mom. Compulsive checking, over-monitoring child, reassurance-seeking.

Exercises to do this weekend

- Throw away a recyclable item in the trash.
- Throw away a non-recyclable item into the recycling.
- Take a non-recyclable and put it inside a recyclable and then throw that in the recyclable
- Borrow a pen and do not return it.
- Do not say hello back to someone who greets you.
- Tip someone 14.5%
- Do not share your french fries with a person who asks to try one (unless you have contamination fears too and then totally share with them and their unclean hands)
- Touch several coffee cozies and stirrers before selecting one

Exercises to do this weekend

- Let an explicit pop song play with the kids in the car
- Move a grocery item to the wrong shelf
- Bring 16 items to the 15-or-less aisle at the supermarket
- Return an item of clothing after wearing it out on the town
- Compliment a friend on a bad haircut (make them feel good but know that you're a liar)
- Take a freebie from an exhibit table and walk away before hearing the pitch
- Come back later and take another one
- Do not apologize for doing any of these exercises.

So what are some of YOUR "bad" ideas?

- e.g. email the following people with the subject "I KNOW WHAT YOU DID AT IOCDF" and nothing in the actual email

- Jon Hershfield, MFT – jon@ocdbaltimore.com
- Patrick B. McGrath, Ph.D. - Patrick.McGrath@amitahealth.org

Scrupulosity Support Group: When OCD Gets Tangled in Religious and Moral Matters

IOCDF – Washington, DC 2018

Ted Witzig, Jr. Ph.D. – www.scrupulosity.org
Apostolic Christian Counseling and Family Services
877-370-9988 -- office@accounseling.org

Scrupulosity? What's that?

The word "scruple" is derived from the Latin "scrupulus," a rough or hard pebble that causes discomfort if trodden on; a later meaning was a minute apothecaries' weight, one twenty-fourth of an ounce, so small as to affect only the most sensitive scales. The term in English acquired a moral interpretation of a thought or circumstance so insignificant as to affect only a very delicate conscience. In religious terminology a scruple is an "unhealthy and morbid kind of meticulousness, which hampers a person's religious adjustment."

Weisner & Riffel, 1960

Clinical Definition of Scrupulosity

- Obsessions and compulsions containing religious themes, hypermorality, pathological doubt/worry about sin, and excessive religious behavior.

Abramowitz, Huppert, Cohen, Tolin, & Cahill, 2002

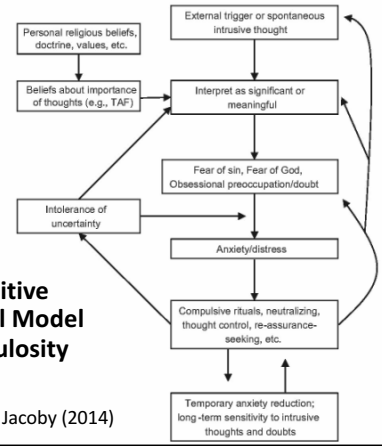
Does Religion Cause OCD?

- Scrupulosity has been identified among followers of all of the major world religions.
  - The OCD will take on the characteristics of the person's religious and cultural beliefs.
- *"There is no evidence that religion causes OCD. However, your religious background and experience can influence the type of obsessional concerns that develop in people with OCD."*

Purdon & Clark (2005). Overcoming Obsessive Thoughts, p. 94

The Nature of the Problem

- Please remember it is possible for anyone to struggle with a spiritual issue.
- Sometimes these struggles can lead to anxiety.
- Going through such a spiritual struggle *does not* necessarily mean a mental disorder is present.



A Cognitive Behavioral Model of Scrupulosity

Abramowitz and Jacoby (2014)

Normal Religious Practice
vs
Scrupulosity

What differentiates the two?

Healthy Faith vs. Scrupulosity

1. **Fear:** A healthy faith is not associated with debilitating worry and fear.
2. **Entangling:** The more you focus on scrupulosity, the more entangling it is, and the worse it gets. It creates stress.
3. **Non-responsive:** Scrupulosity is not responsive to spiritual interventions.
   - For example, for the scrupulous person spiritual interventions (e.g., confession) may produce momentary relief, but the symptoms will return.

Ciarrocchi, 1998; Greenburg, 1984; Abramowitz et al., 2002

Healthy Faith vs. Scrupulosity cont'd

4. **Distress:** People enjoy and want to engage in normal religious practices, whereas people with scrupulosity perform the rituals to reduce anxiety/distress due to some feared consequence.
5. **Overdoing:** The individual's practices far exceed what is required by the particular religious group.
6. **Interferes:** Scrupulosity interferes with normal religious practice (e.g., the person does not attend church, does not partake of communion because of obsessional worries, etc.).

Ciarrocchi, 1998; Greenburg, 1984; Abramowitz et al., 2002

Healthy Faith vs. Scrupulosity cont'd

7. **Narrow:** The individual's beliefs and practices become very narrowly focused on "getting it right" and he or she loses sight of deepening their relationship with God.
8. **Overlooking:** The individual may focus so much time and energy on perfectly performing rituals that he or she overlooks more important aspects of faith (e.g. doing good toward others).

Ciarrocchi, 1998; Greenburg, 1984; Abramowitz et al., 2002

Healthy Faith vs. Scrupulosity cont'd

9. **OC-Cycle:** Scrupulosity closely resembles other subtypes of OCD in that there is an overt focus on compulsions (repeating prayers, checking, multiple confessions, reassurance seeking) in response to distressing intrusive, unwanted and repetitive thoughts, images or impulses.
10. **Other OCD:** People with scrupulosity often have other symptoms and/or subtypes of OCD.

Ciarrocchi, 1998; Greenburg, 1984; Abramowitz et al., 2002

A Team Approach
to Treating Scrupulosity

Desired Characteristics of the Core Treatment Team

1. Family member or close friend
- Willing to learn about OCD.
- Willing to stop accommodating the OCD.
- Willing to stop giving in to reassurance seeking.
- Willing to attend sessions, as needed.

2. Physician/Psychiatrist
- Willing to listen to your situation and treat you kindly.
- Understands medication dosing for SSRIs with OCD.
  - Note: primarily obsessional forms of OCD often require higher dosages.

3. Clergy
- Willing to learn about OCD/scrupulosity.
- Willing to not accommodate the OCD or give into reassurance seeking.

The Core Treatment Team cont'd

4. Counselor
- Who knows how to treat OCD using cognitive-behavior therapy with ERP and ACT.
- Willing to communication and collaborate with your family, clergy, etc.
- Understands that OCD/scrupulosity is a mental health condition and does not simply blame your spirituality.

- **Note:** It is important that Release of Information forms are signed so these individuals can talk to each other, as needed.

Family Involvement

- Research shows that emotional over-involvement and criticism from family members *negatively affect* treatment and lead to higher relapse rates.
  - Family members need to identify and stop *reassurance giving* and compliance with the patient's compulsions.
  - Family members need to become educates about OCD so they can be both supportive and firm.
  - Be ready and willing to attend counseling sessions with the person with OCD.

Coping Statements for Scrupulosity

Dealing with Doubt and Uncertainty

1. Faith is not the absence of feeling uncertain. Faith is going forward through the uncertainty.
2. OCD wants me to believe that uncertainty and doubt are dangerous. While uncertainty is uncomfortable, it is not dangerous, and I can tolerate it.
3. My faith is what I believe, not what I feel.
4. Feelings are not facts.
5. OCD will always bring up another *What if . . . ?* Trying to nail down all of the *What if . . . ?* questions will lead me down a path of never feeling good enough or certain enough.

Dealing with Doubt and Uncertainty Cont'd

6. I can have faith and still feel uncertain. *Mark 9:24, "…Lord, I believe; help thou mine unbelief."*
7. God loves me completely, even when my feelings are uncertain and clouded by doubt.

Dealing with Intrusive Thoughts

1. Even though they feel real, intrusive thoughts (i.e., distressing thoughts or images with violent, sexual, or blasphemous content) say nothing about my true character.
2. The goal of the intrusive thoughts is to shock and scare me so I try to suppress or "fix" them. My goal is to identify them as "intrusive thoughts" and move on instead of fighting with them.
3. Having an intrusive thought does not make it more likely for me to act on it.
4. God understands that intrusive thoughts are distressing to me. He understands OCD better than anyone!

Dealing with Intrusive Thoughts Cont'd

5. OCD wants me to believe that worry, anxiety, and compulsions will protect me spiritually. That is all part of the trick OCD wants me to believe.
6. OCD wants me to fight with my thoughts and try to control and suppress them. OCD knows that by getting distressed and fighting with the thoughts I will refill the "gas tank" in the obsessional engine and keep it running.
7. Trying to prevent myself from ever having certain thoughts, images, and feelings only makes them worse.

Tips on Moving Forward

1. One of OCD's biggest tricks is asking me the question, "What if this fear isn't from OCD and it really is a serious issue?" Whenever this thought (or one similar) comes, I will treat it as OCD and not try to figure it out.
2. I will pray to God for grace and strength to accept/move on from intrusive thoughts without figuring them out and fight doing compulsions, neutralizing, or avoiding.
3. My goal is to "starve" OCD by not giving meaning to intrusive thoughts or doing compulsions.

Tips on Moving Forward Cont'd

4. I have two choices: (1) to chase after a feeling of certainty that never comes or (2) to choose to move forward through the uncertainty.
5. My goal is to focus on doing the tasks that I need to be doing in the present moment (studying, cooking, talking to a friend, working) instead of focusing on trying to figure out the uncertainty or fear.
6. I need to focus on the present moment and allow my thoughts to come and go.
7. Trying to figure it all out only makes it worse.
8. God understands that I don't understand.

Online Resources on Scrupulosity

- **Ted Witzig Jr. - OCD/Scrupulosity Info**
  - www.scrupulosity.org
- **Ian Osborn, MD**
  - http://ocdandchristianity.com
- **Peace of Mind Foundation – Videos**
  - http://www.peaceofmind.com/education/types-of-ocd/immoral-or-scrupulous-thoughts/
- **Two-Screen Method of Mindfulness**
  - https://www.youtube.com/watch?v=H3FEMbMXv6Q

Helpful Books for Treatment

- Harris, R. (2014) The Illustrated Happiness Trap: How to Stop Struggling and Start Living. Shambhala
- Hyman, B., & Pedrick, C. (2010). The OCD Workbook. 3rd Ed. New Harbinger.
- Knabb, J. (2016). Acceptance and Commitment Therapy for Christian Clients: A Faith-Based Workbook. Routledge. [Therapist Guide Available]
- Osborn, I. (2008). Can Christianity Cure OCD?: A Psychiatrist Explores the Role of Faith in Treatment. Brazos
- Purdon, C., & Clark, D. (2005). Overcoming Obsessive Thoughts. New Harbinger.

Parents: How to Proceed When Your Child with OCD Refuses Treatment

Allen H. Weg, Ed.D.
Stress & Anxiety Services of New Jersey, Inc.
Springfield, NJ East Brunswick, NJ

www.StressAndAnxiety.com

So, your child is refusing treatment:

- You are being challenged with one of the toughest situations parents have to endure.
- Use your resources
- Have a plan
- Stay hopeful

Agenda: What we will be covering:

Variables that might affect the situation

Boundaries

What and how to share with your child

What if he gets angry/upset?

What if his anger/depression escalates?

Designing, setting, instituting consequences

Other complicating factors

Questions

Variables affecting the situation:

- Age of child
- Intact vs blended/separated family
- Co-morbid mental health conditions (Depression, Autistic Spectrum Disorder)
- Danger or risk- to self and/or others
- Dual diagnosis (drug/alcohol issues)

Boundaries

This is at the core of everything- This serves as your major guideline determining your responses to your OCD child with treatment-refusal:

You are NOT to attempt to control your child and his OCD by forcing treatment or pressuring your child to work on the OCD problem.

Your child, on the other hand cannot, through his OCD, control YOU.

Boundaries, cont.

- You are each responsible for yourselves.
- You are not trying to fix your child by changing his behavior.
- You are fixing YOU by changing YOUR behavior.
- This dramatically increases your power and control over the task at hand…

Boundaries, cont.

Immediately discontinue all efforts to get your child into treatment.

Setting Boundaries

- You are working towards no longer accommodating anything having to do with your child's OCD.
- By not doing a task for him:
- 1) He will do it himself, and challenge his OCD
  or
- 2) He won't do it, his life will become more miserable, and he will be more likely to be motivated to work on the problem himself…

Setting Boundaries, cont.

By not engaging with him in his rituals…
:
- 1) He will have to cope without the ritual
  or
- 2) Will have to develop a new way of responding to his anxiety (which excludes you)

Where to start?

DON'T start by all of a sudden discontinuing all the ways you have been accommodating your child up to this point.

Start by informing your child that, moving forward, you will be doing nothing NEW for him that he requires help with because of his OCD, and that you will not engage with him in any NEW rituals that have not been previously requested of you.

DRAW A LINE IN THE SAND!

What do we do next?

Identify how you are presently accommodating your child's OCD.

Start by filling out the Family Accommodation Scale for OCD by Karen J. Landsman, Ph.D. & Kathleen M. Rupertus, Psy.D (Google the instrument name and these authors)

Then *decide together* which areas of accommodation you are going to begin reducing.

How do we tell our child our plan?

- Present as a unified front. If possible, both parents should be there together every time you discuss these issues with your child.
- Schedule the meeting at the right time and place
- Expect to take very, very small steps, especially to start.
- Attempt to engage child to participate in the process
- If possible, implement immediately

* Follow through! (you WILL be tested!)

Caveats and Guidelines…

- Do not threaten
- Do not take a punitive tone
- Speak calmly
- Remember that you are doing this because you love and are concerned for your child- communicate this to him
- Explain that while you understand you cannot make HIM, you need to begin to stop letting HIM make YOU.

* Resist his attempts to engage you in an argument

More Caveats and Guidelines…

- Keep the focus away from your child, and keep it on yourselves. You will not be instituting these changes to manipulate him, but rather for your own self protection and mental health.
- Also, explain that you now understand that your attempts to help him in the past have really hurt him (like if you obeyed your alcoholic son's demand that you go out and get him a beer) and you don't want to be part of that anymore.

What if he gets angry?

- Empathize: "Join" first with his emotions- " We know this is upsetting/scary, etc" "We are sorry that this is so hard for you"
- Anger management: Do not force or lecture, but offer to provide assistance and ideas if he is open to it.

Anger Management Ideas

- Leave the room
- Breathe
- Get physical (run/exercise)
- Wash your face
- Journal
- Distract with music, video, or video games
- Hold ice exercise
- Draw
- Call/text a friend to talk

What if his anger escalates?

- Explain at the time of your first meeting that, whether he wants to work on his anger or not, there will be consequences if he:

  Curses at you
- Threatens to hurt someone (including either of you)
- Threatens to hurt himself
- Engages in violent behavior to property
- Any other inappropriate behavior that you would never tolerate had he not had OCD

Consequences?

Choose consequences that are:
- Appropriate to your child's age and interests
- Easily carried out
- Immediate in your ability to execute them
- As appropriate to age, very short term
- Easily managed by you

Deliver information about consequences:
- Before there is an incident
- Again, as a unified front, at a low-intensity time and place
- Play with the idea of asking him to be involved in the process

Consequences for extreme behaviors?

- You must be ready to call 911, the local ER, the police, or specialized mental health home visit teams if you are concerned about safety of any kind.
- You must be *physically* prepared (have the telephone numbers beforehand- call in advance to ask about procedures should you need to call in the future)
- You must be *mentally* prepared (you have to decide that you will take this action if your child threatens violence of any kind to anyone).

Other complicating factors

- Siblings in the home are also accommodating the child with OCD (forbid utilizing them, set consequences for utilizing them or threatening them if they don't)
- Child is persistent- is not threatening, but whines and follows you around (again, any inappropriate behavior should have consequences- if you would not allow this normally if there were no OCD, do not allow it now)
- Withdrawn- in room, no friends, no school, no employment (withdraw all accommodations, set consequences for not taking household responsibilities)

If he does agree to go to therapy

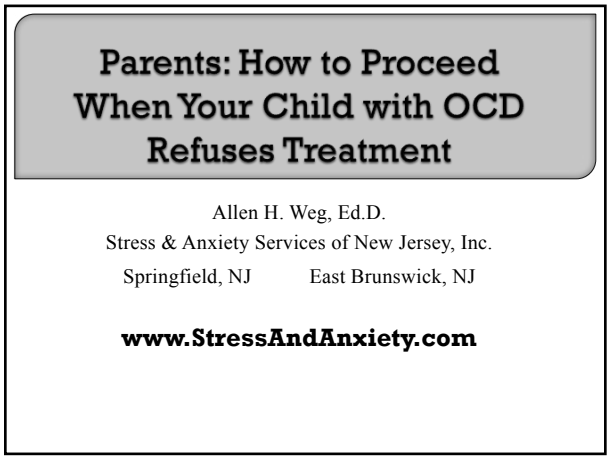
Share that you are proud that he is willing to investigate this process.

Tell him that you are relieved that he giving this a chance.

Tell him that, given the state of the art in OCD treatment, and what you know of him, that you are hopeful he will make significant progress.

Keep your distance, don't push, let him define your role in treatment (again, somewhat depending on age and maturity).

Questions and Follow up issues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How Far is Far Enough: Maximizing EX/RP with Taboo Content in Adults and Children

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Overview of Taboo Content in OCD

- Aggressive thoughts and impulses
- Sexual content
- Bathroom behavior

Aggressive Obsessions

- **Fears of harming others or yourself**
  - Accidentally
  - From being careless
  - By losing control and acting on an impulse
- **Fear of becoming/being evil**
  - A criminal
  - A sociopath

Common Compulsions with Aggressive Obsessions

- **Fears of harming others or yourself**
  - Checking for signs of violence
  - Mentally reviewing interactions
  - Seeking reassurance
  - Thought suppression
  - Avoiding "dangerous" items (knives, poison, cars, subways, high places, oven, getting drunk/high when more likely to lose control)
- **Fear of becoming/being evil**
  - Checking for pleasure/remorse
  - Reviewing interactions
  - Seeking reassurance
  - Researching (usually on the internet)
  - Avoiding triggering content in news, TV, movies, etc.

Sexual Obsessions

- **Sexual orientation**
  - Fear of being gay or straight (HOCD)
  - Fears of being unable to "know" orientation
- **Inappropriate sexual thoughts**
  - Pedophilia
  - Incest
  - Sexual violence
  - Bestiality

Sexual Obsessions

- **Scrupulous concerns**
  - Thoughts/images of sex with religious figures
  - Thoughts/images of sex in places of worship
- **Pregnancy concerns**
  - Thoughts of unintentionally impregnating others
  - Thoughts of accidentally becoming pregnant

Common Compulsions with Sexual Obsessions

- **Sexual orientation**
  - Checking for arousal (or the ***lack*** of arousal) when exposed to triggering content
  - Excessive researching
  - Seeking reassurance
  - Thought suppression
- **Inappropriate sexual thoughts**
  - Checking for arousal (or the ***lack*** of arousal)
  - Reviewing/rationalizing using past behavior
  - Ritualized "prayer" or mantras

Common Compulsions with Sexual Obsessions

- **Scrupulous concerns**
  - Thought suppression
  - Reassurance seeking/excessive confession with trusted religious authorities
  - Excessive prayer
  - Avoiding places of worship
- **Pregnancy concerns**
  - Checking (pregnancy tests, small amounts of semen)
  - Excessive contraception
  - Avoiding sex and masturbation
  - Avoiding contact with opposite sex
  - Excessive cleaning, especially unisex places/items (public bathrooms, bath towels at home, etc.)

Common Obsessions Related to Bathroom Behavior

Cleanliness Concerns

- Showering sufficiently/completely
- Wiping sufficiently/completely
- Fears of feces or urine
- **Concerns about completeness:**
  - Doubt about fully emptying bladder/bowels
- **Concerns about having an accident**
- **Concerns about spreading contamination**

Common Compulsions Related to Bathroom Behavior

- Excessive wiping, hand washing
- Cleaning bathroom before/after using
- Shower routine to ensure cleanliness, prevent contamination
- Shower routine to maintain order, symmetry
- Frequent going to the bathroom
- Frequent body scanning for sensations indicating "need to go"
- Excessive pushing to ensure complete evacuation

Aggressive Obsessions in Children

- Aggressive obsessions are less common in children compared to adolescents and adults
- Aggressive thoughts may be related to cursing or being aggressively disrespectful
- Obsessions may be more fantastical

Example: "I'll become like Darth Vader if I touch something red"

Sexual Obsessions in Children/Teens

- Obsessions related to emerging sexuality
  - Am I sinning or being immoral by having sexual thoughts? Or by masturbating?
  - What if I am not sufficiently well-endowed?
- Fear of becoming pregnant or impregnating someone may be influenced by emerging knowledge regarding sex
- Must take into account normal developmental processes of sexual identity formation

Cleanliness Obsessions in Children

- Content is similar to adults
- Parents often involved in compulsions:
  - Requiring parents to wipe them after toileting
  - Seeking reassurance from parents regarding cleanliness

Assessment with Adults

- **Goal = Full functional analysis of symptoms**
- **Obsessions**
  - External cues (children, knives)
  - Internal cues (graphic images, sexual arousal, urges to act)
- **Compulsions**
  - Physical (checking, seeking reassurance, repeating)
  - Mental (reviewing, praying, rationalizing)
- **Avoidance behavior**
  - Places, people, tasks, situations
- **Feared consequences**
  - The ultimate consequence of not doing compulsions
  - Often either dying or living meaningless, worthless existence

Assessment with Adults

- Ask yourself "Why am I asking this question?"
  - Each question should add to functional analysis
- Establish a "bank of knowledge" about obsessional content
  - History of violence or impulsivity
  - Driving record
  - Sexually exciting stimuli (pornography, fantasy)
  - Realistic chance of pregnancy
- "I'll say this once and only once"
- Ego syntonic vs. dystonic

Assessing Aggressive Content

- Do you ever have thoughts you don't want to have about hurting other people? About hurting yourself?
- Do you ever get scared that you might hurt someone?
- Do you often check that you didn't hurt someone? Ask if you hurt someone?
- Do you have to do anything to convince yourself you're not a bad person?
- Do you avoid being near knives, fires, or other dangerous things? If so, why?

Assessing Sexual Content

- Do you worry that you might be gay? Straight?
- Do you feel uncertain about your sexual orientation?
- Do you worry you're aroused when you see men/women/kids?
- Do you avoid touching your crotch/near your crotch when you're not going to the bathroom?

Assessing Bathroom Content

Details, details, details …

Want to have accurate pictures of what OCD makes patient do when using toilet, shower, etc.

Assessing Bathroom Content

- Do you worry that the toilet/shower is dirty before you use it?
- Do you ever feel like you might not have "gotten everything out" after going to the bathroom?
- How long do you spend pushing when you go to the bathroom?
- Do you worry that you're not clean enough after going to the bathroom? After defecating?
- How many arm lengths of toilet paper do you use to wipe? Have you clogged toilets from using too much toilet paper? Do you flush several times to avoid clogging toilets?

Assessing Bathroom Content

- Do you ever worry about having an accident away from home?
- Do you ever check your underwear for signs of an accident?
- Do you have a specific shower routine? How long does a typical shower take? How often do you shower?
- How many times a day do you wash your hands?

Assessing Taboo Symptoms with Children

- Normalize! Normalize! Normalize!
- What does the child know/understand about the topic?
  - Exposures ***should*** cover all material covered in child's obsessions
  - Exposures ***should not*** introduce unfamiliar content to child
- Sometimes necessary to work backward from compulsions

Assessing Taboo Symptoms in Children and Teens

- Obtain information from ***both*** youth and parents
- Preferable to assess youth and parents separately
- Helpful to review discrepant reports with youth and child (if they can handle it!)

Assessing Aggressive/Violent Obsessions in Children/Teens

- Learn from children and parents about any history of violence
  - Was child victim of violence?
  - Did child witness any violence?
  - Is child actually violent toward others?
- As with adults, important to distinguish between obsessions and ego-syntonic urges/desires

Aggressive/Violent Obsessions in Youth: Questions to Ask

- Are you afraid to be alone with your little brother/sister?
- Do you ever worry that you will become a bad guy?
- Do you tell your parents or someone else about any violent thoughts you have?

Assessing Sexual Obsessions in Children/Teens

- Learn as much as possible about child's understanding of sexuality; have child explain what he knows
- For teens, learn if he is sexually active; if so, get necessary details
- If the child has misinformation about any topic, he should be properly educated, ***once***

Assessing Sexual Obsessions in Children/Teens: Questions to Ask

- I know this is awkward to talk about … but do you have thoughts about sex/boys or girls/private parts that you don't want to have?
- For teens: Do you worry that you might be gay/straight/bisexual and you don't know it?

Assessing Sexual Compulsions in Children/Teens: Questions to Ask

- Do you have to do anything to get rid of yucky/bad/upsetting thoughts you have?
- Do you look up lots of information online about what's normal for a teenager?
- Do you check feelings in your body a lot to try and figure out if you are …
  - Attracted to certain people?
  - Pregnant?

Assessing Cleanliness Obsessions in Children/Teens

- Preface with understanding that it is embarrassing to discuss toileting/showering
- Adolescents are often more concerned about hygiene than kids or adults. And sometimes much ***less*** concerned!

Assessing Cleanliness Obsessions in Children/Teens: Questions to Ask

- Do you ever need your mom or dad to help you clean up after using the bathroom?
- Do you need to clean the toilet/shower/sink before using it? After using it?

Keys to Conducting Exposures Involving Taboo Topics

- Follow path of obsessional content, not necessarily reality, to fully address symptoms
- Exposure should encompass the feared consequence
- Gradually move up hierarchy
  - Sit in room with scissors
  - Sit in room with knife
  - Hold knife while sitting across room from therapist
  - Hold knife while sitting next to therapist
  - Hold knife while sitting behind therapist
  - Point knife at therapist's back

Exposures Targeting Violent/Aggressive Obsessions

Fear of Hurting Self/Others

- Read about suicides
- Walking up to strangers with fists clenched
- Watch videos of "nice" people acting violently (e.g., *Misery*, *The Hand That Rocks the Cradle*)
- Hold weapon and brandish toward self or another person
- Holding knife to therapists chest, neck, or back
- Walk near subway platform or busy street so that patient could potentially push someone nearby

Exposures Targeting Violent/Aggressive Obsessions

Fear of Harming Others Unknowingly

- Driving in crowded or poorly lit areas with bumpy roads
- Prepare food near unsafe items and share with others
- Leave out unsafe items (e.g., bleach, rat poison, matches, broken glass, water on tile floor)
- Telling vivid stories of harming others because of not checking, not seeking reassurance, or otherwise being "reckless"

Exposures Targeting Violent/Aggressive Obsessions

Fear of Becoming Evil

- Read biographies of "evil" people, noting similarities
- Play violent video games
- Develop plans to manipulate or con others
- Hold ceremony intended to give your soul to the devil

Exposures Targeting Sexual Obsessions

Fear of Becoming Pregnant/Impregnating Others

- Read about life span of sperm; accidental pregnancies
- Sit on chairs where member of opposite sex was sitting, or will sit soon
- Use unisex bathrooms

Females

- Sit in sperm-bank waiting room
- Handle men's dirty laundry

Males

- Touch genitals and then touch items in public areas
- Masturbate, then use unisex bathroom

Exposures Targeting Sexual Obsessions

Fear of Having Sexual Identity Wrong

- Look at pictures of people of the "wrong" sex and note attractive features
- Read "coming-out" stories
- Spend time in a gay bar
- Go to bars, stores, drop-in centers that cater to LGBT community
- Watch seductive videos involving the "wrong" sex

Exposures Targeting Sexual Obsessions

Fear of Being a Pedophile

- Read about pedophiles, noting similarities
- Watch videos of children at the beach or taking baths
- Spend time at playground or children's store
- Babysit a family member or friend's child

Exposures Targeting Sexual Obsessions

Fear of Committing Incest

- Read/watch material involving incest
  - *Flowers in the Attic*
  - *Game of Thrones*
- Note attractive features of siblings, cousins
- Sleep over at family members' homes

Exposures Targeting Cleanliness Obsessions

Fear of Being Unclean After Toileting

- Wipe insufficiently
- Wipe with your non-dominant hand
- Dab "used" toilet paper on clothes, skin
- Wear same underwear for more than one day

Exposures Targeting Cleanliness Obsessions

Fear of Being Unclean After Showering

- Skip parts of your body in the shower
- Contaminate "clean" parts of body with "dirty" parts in shower
- Poop spray

Imaginal Exposures

- Very helpful in targeting fears that are impossible or inappropriate to simulate
- Imaginal exposure should guide the patient through a feared consequence in as much detail as possible and should follow the functional assessment of OCD symptoms
- No happy endings

Imaginal Exposure: How I Stabbed My Mother

"… my mother is standing in our kitchen with her back turned to me as she boils water for dinner. As I watch her cook, I suddenly feel an urge of rage toward her that I cannot control. I am unable to think about anything except stabbing her with the knife that is laying next to her on the kitchen counter … the next thing I know, I am being forcibly handcuffed by two police officers who are shouting at me. There is blood all over the kitchen floor. I see my father huddled in the hallway, crying and screaming at me … each night in prison is like an eternity, and I am forced to reimagine the horrible thing I did …"

Exposures with Children and Teens

- Exposures should still fully target obsessional fears
- In most cases, therapist should review exposure plans with parents before proceeding
- Therapists should use judgment when sharing with parents of teenagers regarding private topics
  - Exposures involving sex, masturbation
  - Exposures involving bathroom behavior

Addressing Taboo Topics with Children

Include parents in the process

- Particularly for content involving sexual, aggressive, or blasphemous content, exposures should be previewed with parent/guardian before introduced to child
- Parents may need psycho-education about exactly why exposures are crucial to treatment

Initial Exposures with Children

- Saying "taboo" words out loud
- Playing word games involving "taboo" words
  - Curse-word Memory
  - Sex-word Hangman
  - Violent-word Wordsearch

Drawing the Line Between Thorough and Gratuitous

- Exposures ***should*** fully target all fears underlying an individual's obsessions
- ***But***, exposures ***should not***:
  - Place individual at higher risk than other people
  - Exploit other people (e.g., asking people of same sex on dates as exposure)
  - Be gross for gross' sake
  - Be morally questionable or illegal

Example

- **Situation:** Man fearing he will harm others with knife
- **Thorough Exposure:** Holding knife to therapist in office
- **Gratuitous Exposure:** Brandishing knife on crowded subway
- **Curveball Exposure:** Placing pocket knife in pocket while on crowded subway

Example

- **Situation:** Woman fearing she will carelessly hit people while driving
- **Thorough Exposure:** Driving near pedestrians while having conversation with radio on
- **Gratuitous Exposure:** Driving near pedestrians while playing game on smartphone
- **Curveball Exposure:** Turning slightly toward pedestrians while being distracted during driving

Example

- **Situation:** Man experiencing obsessions that he may be a pedophile
- **Thorough Exposure:** Changing his nephew's diaper
- **Gratuitous Exposure:** Viewing child pornography
- **Curveball Exposure:** Spending time in child area of swimming pool

Example

- **Situation:** A teenage girl who self-identified as heterosexual having obsessions that she is attracted to women
- **Thorough Exposure:** Watching seductive videos involving women
- **Gratuitous Exposure:** Connecting with a girl on Tinder
- **Curveball Exposure:** Viewing pornography involving women

Example

- **Situation:** Woman having obsessions about not being sufficiently clean following urination
- **Thorough Exposure:** Placing toilet paper lightly dabbed with urine in pants
- **Gratuitous Exposure:** Pouring urine on clothes
- **Curveball Exposure:** Avoiding all wiping after urinating

Example

- **Situation:** Man fearing he will impregnate strangers
- **Thorough Exposure:** Rubbing a drop of semen on hands, then touching women's underwear
- **Gratuitous Exposure:** Masturbating onto a unisex toilet
- **Curveball Exposure:** Touching items in the waiting room of a gynecologist or fertility clinic after masturbating

Know Where It's Hard for You to Go

- Many of us have certain symptoms that we personally find hard or challenging to treat
- Taboo topics can often elicit strong feelings from all of us
- Recommendations for treating symptoms challenging for you:
  - Self-exposure!
  - Refer to another therapist
  - Use self as coping model for patient

Conclusions

- Addressing taboo topics is part of treating OCD in both adults and children
- Proper and thorough assessment of symptoms is crucial to appropriately plan and execute exposures
- Taboo topics can be adequately treated with both in vivo and imaginal exposure
- Special considerations should be taken when treating taboo topics in children and teens

Thank you!

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Kate Brett

Trastorno Obsesivo Compulsivo:
conceptos básicos y TCC

PCC Liz Basanez

MÉXICOSINDISTRESS by LIZ BASAÑEZ

Preocupación vs. Obsesividad

- **PREOCUPACIONES**
  - Pensamientos insistentes que generan aflicción y ansiedad.
  - Cambian de un día a otro
  - Pueden llegar a ser insistentes, según la circunstancia
- **OBSESIONES**
  - Pensamientos, ideas, imágenes o impulsos intrusivos, recurrentes y persistentes que provocan ansiedad, miedo, culpa, vergüenza o enojo.
  - No son simples preocupaciones excesivas
  - Entre más se ignorarlos, más evidentes son.
- **COMPULSIONES**
  - Actos abiertos -conductuales- o mentales
  - Buscan bajar la ansiedad, miedo, culpa, vergüenza o enojo
  - Y eliminar las obsesiones

El TOC y sus porcentajes

- **Prevalencia**
  - Se presenta del 2.3 al 2.5% de la población
  - Población mundial aprox. = 7,600 millones de personas
  - Personas con TOC en el mundo = 190 millones

EE.UU

  - Población aprox. en EE.UU = 330 millones de personas
  - Personas con TOC en EE.UU = 8.25 millones

MÉXICO

  - Población aprox. en México = 131 millones de personas
  - Personas con TOC en México = 3.17 millones

El TOC y sus porcentajes

- **Incidencia en cada sexo**
  - NIÑOS: varones 2:1 mujeres
  - ADULTOS: 1:1
- **Primer contacto con un especialista**
  - 6-9 años en encontrar el tratamiento adecuado

El TOC y sus porcentajes

- **Edad de inicio**
  - NIÑOS: alrededor de los 6 años
  - ADOLESCENTES: alrededor de los 12 años
  - ADULTOS: en la adultez temprana.
    - Los **hombres** tienden a manifestarlo antes (19.7 años ± 1.7)
    - Las **mujeres** inician promedio 24 años ± 1.4
      - Algunas mujeres debutan con TOC en el embarazo o en el parto

La responsabilidad en el TOC

- Ningún acontecimiento específico en la infancia distingue a un adulto con TOC de los demás.
- Casi todos los niños desarrollan por poco tiempo rituales de "protección" para sí mismos y sus padres.

Años finales de la adolescencia e inicio de los 20

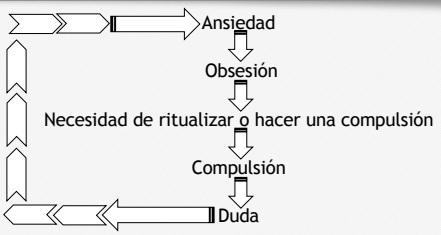
Más responsabilidades

Más posibilidad de cometer errores con consecuencias serias

Características de las OC

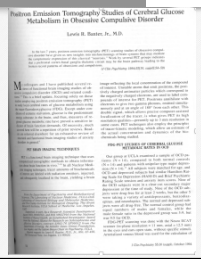
- Sus preocupaciones y obsesiones implican ansiedad por las catástrofes temidas.
- Llegan a reconocer que sus obsesiones son absurdas, ilógicas, exageradas o irracionales pero no pueden evitar la angustia que les provocan.
- Entre más resisten sus obsesiones más se agravan.
- Incapacidad para impedir o retardar sus conductas repetitivas.
- Suelen pedir ayuda de otro para sus compulsiones o rituales.

Relación entre Obsesiones y Compulsiones



Alteraciones cerebrales en el TOC

- Alteración en la corteza prefrontal:
  - Ganglios basales
  - Corteza Prefrontal Orbital
  - Giro del cíngulo
- Anormalidades en la Serotonina
- La TCC es la ÚNICA que modifica niveles serotoninérgicos en dichas áreas, al igual que los medicamentos.


Positron Emission Tomography Studies of Cerebral Glucose Metabolism in Obsessive Compulsive Disorder

Lewis R. Baxter, Jr., M.D.

Tipos más comunes de TOC

- Lavadores y Limpiadores
- Verificadores
- Repetidores
- Ordenadores
- Ritualizadores Mentales
- De daño
- Sexual
- Agresión
- HOCD (Homosexual OCD)
- ROCD (Relationship OCD)

Lavadores y Limpiadores

- Obsesiones relacionadas a la **contaminación** a través de objetos o situaciones.
- Suelen lavarse por horas, inclusive con cloro y usar hasta 1-2 rollos de papel de baño por cada ocasión que defecan.
- Contaminaciones más temidas:
  - suciedad
  - enfermedades (SIDA/Herpes)
  - mala suerte
  - gérmenes

Verificadores o Checadores

- Inspeccionan de manera excesiva con el propósito de evitar una "catástrofe"
- Revisan ⇨ Dudan ⇨ Re-Verifican
  ⇩
  pueden durar horas
- Compulsiones comunes de verificar:
  - estufa ° que no haya errores
  - aparatos eléctricos ° trabajo realizado
  - ventanas ° que no olviden algo

SATURDAY

Repetidores

- Se empeñan en la ejecución de acciones repetitivas.
- Al igual que los verificadores, tratan de evitar catástrofes.
- Pero a diferencia de ellos, NO pueden identificar una conexión lógica entre obsesiones y compulsiones.
- Está presente una **cualidad mágica**.

Ordenadores

- Exigen que las cosas estén dispuestas con ciertas pautas rígidas, incluyendo la simetría y colores.
- Dedican mucho tiempo asegurándose de que las cosas están en el "lugar correcto".
- Advierten de inmediato si algún objeto ha sido movido.

Ritualizadores Mentales ½

- A consecuencia de las **Obsesiones** acostumbran apelar a pensamientos o imágenes repetitivas:

Compulsiones

Mentales

- Pueden confundirse con los Obsesivos Puros pero los R.M. realizan ceremoniales de pensamiento para disminuir su angustia.

Ritualizadores Mentales 2/2

- Las compulsiones mentales más comunes son:
  - rezar
  - repetir frases o palabras
  - cantar
  - pensar en eventos o números buenos
- Suelen tratar de recordar acontecimientos con todo lujo de detalles o de hacer listas mentales para tranquilizarse.

ROCD TOC de Relaciones

- Tienen obsesiones con respecto a su **relación de pareja.**
- Obsesiones más frecuentes:
  - Preguntarse si es la persona indicada
- Si las características que no les gustan de él/ella van a mantenerse si se casan
  - "Cuántas parejas sexuales tuvo antes de mí"
  - "Y si en verdad no me gusta"
  - "Y si le soy infiel"
  - "Y si en verdad no me la paso bien con él/ella"

HOCD: TOC de Miedo a ser Homosexual

- Sus obsesiones y compulsiones se centran en saber o constatar que no es homosexual.
- Evitan contenidos en películas, canciones o personas que contengan material homosexual.
- Muchas de sus compulsiones son mentales, al tratar de buscar evidencias –mentales- de que les gustan personas del sexo opuesto.

Características Cognitivas del TOC

1. **Riesgo - Peligro**
   - Sobreestimación del riesgo – peligro
   - Subestimación de las propias capacidades
2. **Duda – Incertidumbre – Indecisión**
   - Percepciones erradas sobre su memoria
   - Necesidad de certezas
   - Dificultad para tomar decisiones o confiar en ellas
   - Necesidad de Garantías
   - Dificultad para categorizar y discriminar

Características Cognitivas del TOC

3. **Severidad – Probabilidad**
   - Si sucede, no es malo, es TERRIBLE
   - Confusión entre lo posible y lo probable
4. **Perfeccionismo**
5. **Culpa – Responsabilidad - Vergüenza**
   - Excesivos sentimientos de responsabilidad, culpa o vergüenza sobre pensamientos y conductas
6. **Rigidez – Moralidad**
   - Actitudes moralistas
   - Reglas rígidas

Trastorno Obsesivo Compulsivo

- Evitación del daño.
- Aversión al riesgo.
- Ansiedad anticipatoria.
- Mediación cognitiva ante sus conductas.
- Actitudes perfeccionistas.
- Duda-incertidumbre-indecisión.
- Culpa, vergüenza

-Basañez, et al., 1997)

¿Qué empeora mi TOC?

1. **EVITACIÓN**: huir de lo que me da ansiedad
2. **COMPULSIONES**
   - intensifican los síntomas ansiosos y
   - previenen la incomodidad del pensamiento en las cogniciones de peligro.
   - Lo cual perpetua la subestimación de habilidad de afrontamiento personal.

TOC: Autoestima baja

- Es MUY común que la educación haya recaído en extremos:
  - Estricta
  - Sobreprotectora
- El mensaje implícito indica:
  - Como no eres nadie...no vales...
  - Tengo que tratarte "con la punta del zapato"
  - Tengo que sobre-cuidarte, porque tú no lo haces bien
- La AUTOESTIMA resultante es BAJA

TOC: Autoestima baja

- Autoestima Baja:
  - Se siente abrumado por sus propios errores
  - Gran esfuerzo por <u>evitarlos</u> en el futuro
- Autoestima Alta:
  - Mejor preparado para soportar las consecuencias de sus errores
  - No dedica energía a evitarlos
  - Errores ≠ catástrofes

TCC Terapia Cognitivo Conductual y TOC

FACTORES DE BUENA RESPUESTA

- Habilidad del terapeuta
- Motivación y colaboración del paciente
- Diseño y desarrollo del programa.

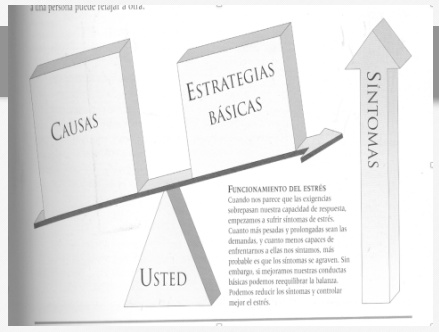
Características esenciales de la TCC para el TOC

- Buena y estrecha relación terapéutica.
- Sentido del humor.
- Explicación detallada de la **EPR Exposición / Prevención de Respuesta / Habituación**
- Participación de co-terapeuta por parte del paciente

EPR Exposición y Prevención de Respuesta

Habituación

- Lograr estar frente a lo que me da ansiedad y no tener la respuesta de ansiedad.
- Es el indicador de éxito
- Es por lo que necesito luchar
- Por eso, necesito ENFRENTAR, ENFRENTAR y ENFRENTAR
- Y hacer equipo con mi Terapeuta Cognitivo-Conductual



Componentes en la TCC para el TOC

- Identificar qué dicen mis **OBSESIONES** (…"y si…")
- ¿Cuáles son mis **MIEDOS?**
- ¿Qué hago para **EVITARLOS?** → **COMPULSIONES** (**Fiuff**)
  - Directamente
  - Indirectamente
- Estar dispuesto a ENFRENTARLOS
  - Imaginería
  - In vivo

E-PR

Componentes en la TCC para el TOC

• Exposición Directa	• Modelamiento	• **Habituación**
Imaginería	Implosión	Impedimento del ritual (pavo frío)
Inundación	Desensibilización Sistemática	**EPR**
		EPR

A - B - C

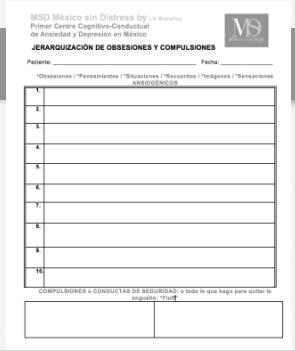
A= situaciones que te provocan angustia o te impulsan a ritualizar.

B= pensamientos, imágenes o impulsos que te provocan angustia (obsesiones).

C= consecuencias temidas que llevan a evitar o ritualizar.

Preparación para la TCC

- **Redistribución de compromisos.**
- **Preparar a familiares y amigos.**
  - No ayuden en rituales
  - No admitan demandas de seguridad
- **Selección de personas colaboradoras para tus tareas**
  - Cálidas y alentadoras
  - Que estén dispuestas a sugerir y participar en actividades para distraer rituales
  - No burlas ni críticas


MSD México sin Distress by Liz Basañez
Primer Centro Cognitivo-Conductual de Ansiedad y Depresión en México

JERARQUIZACIÓN DE OBSESIONES Y COMPULSIONES

Paciente: _____ Fecha: _____

*Obsesiones / *Pensamientos / *Situaciones / *Recuerdos / *Imágenes / *Sensaciones ANSIOGÉNICOS

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

COMPULSIONES o CONDUCTAS DE SEGURIDAD: o todo lo que haga para quitar la angustia. *Huir

TCC en TOC

- Un tratamiento Cognitivo-Conductual efectivo requiere una intervención intensiva por parte del terapeuta y
- Una fuerte motivación por parte del paciente.
- El progreso no se da en línea ascendente, tiende a fluctuar: existen días malos.

TCC en TOC

- Tu participación ante tu enfermedad será activa:
- Eres el principal responsable de la implementación apropiada de las técnicas y por lo tanto de los éxitos (o fracasos).
- Todo el proceso será en cooperación con tu terapeuta.
- Tendrás que realizar tareas fuera de la consulta.
- Pero ojalá seas proactivo para proponer acciones que ataquen tu TOC

Tareas y Seguimiento

- Es responsabilidad del paciente la continuidad del programa
- La tarea prolonga los beneficios del tiempo con tu terapeuta, quien es solo un guía y soporte.
- Una vez finalizado el programa, sabrás cómo enfrentar tu enfermedad y no ésta a ti
  - Este es un objetivo que suele lograrse.
- Es recomendado estar en contacto con tu terapeuta por 12 meses más de manera esporádica.

Beneficios de la TCC

- En la TCC la tasa de recaída es sólo del 20 al 25%.
- En un estudio realizado en el Center for the Treatment and Study of Anxiety del Medical College de Pennsylvania, el 90% de los pacientes mostraron mejoría con la TCC
- Un año después, el 80% mantenía su nivel de mejoría.

(Foa, 1992)

"Creo que cualquiera puede vencer el miedo

haciendo las cosas que teme hacer, siempre que siga realizándolas hasta obedecer un buen número de experiencias exitosas".

-- E. Roosvelt (1884-1962)

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How to Raise your Parents When you have OCD (to help or get out of the way)

Allen H. Weg, Ed.D.
Stress & Anxiety Services of New Jersey, LLC
Florham Park, NJ East Brunswick, NJ

www.StressAndAnxiety.com

Raise your hand if this statement is true for you...

What about *your* parents?

What are your goals?

How do you want your parents to change?

SATURDAY

Some goals we've heard before from teens who have OCD:

My parents will understand me better

My parents will be more patient with me

My parents will believe me more

My parents will stop micro-managing me so much

My parents will stop yelling at me/punishing me for OCD

My parents will treat me with more respect

My parents will back off and leave me alone!

How do you get the changes you want in your parents?

You can change your parents' behavior ~~by changing *your* behavior.~~

If you want your parents to treat you more like an adult, you can't act like a like a little kid- you have to act more like an adult yourself.

You can learn to better understand *them* even when *they* don't understand *you*.

You need to "parent" your own parents!

How?

A simple 4 step approach:

E
V
C
R

1. E Empathize-

"To empathize is to understand and share the feelings of another"

When your parents do the things that you have complained about, what are *they* feeling?

- Parents of children with OCD might be experiencing some of the following feelings:

Anger
Frustration
Anxiety/Worry
- Hopelessness
- Embarrassment
- Guilt

What might be an example of an empathizing statement someone with OCD might say to a parent?

Examples of Empathizing Statements:

I'm guessing you're feeling pretty *frustrated* right now because you have explained why I don't need to be washing so much but I do it anyway.

I'm sorry that I make you *angry* keeping you up so late at night with all my questions.

I know that when you see me not being able to go to friends' houses or out to restaurants with you, that you *worry* about me, and get *anxious* about where this is all heading.

2. V Validate- "I *get* you"

"Validation is the recognition and *acceptance* of another person's thoughts, feelings, sensations, and behaviors *as understandable*."

What might be an example of a validating statement someone with OCD might say to a parent?

(defend your parents' actions)

Examples of Validating Statements:

It's generally *hard to be a parent*, and I am sure my OCD makes it even more challenging for you, as it would for any parent.

I know that you love me and care about me, and *all you are doing and saying comes from that.*

I know that you are suffering with this as much as I am. You are a victim of my OCD as much as I am.

3. C *Challenge* the current strategy

"Do you think what you have been doing has been helping me?"

"When you do the things that you have been doing to stop my OCD behaviors, we just get angry with each other."

"Is this getting you want you want?"

This sets them up to be more open to changing to *new* strategies…

4. R Redirect

"To Redirect is to change the course of direction."

Examples of Redirecting Statements:

"I need to work on my OCD with your *support,* but *not* with your *control."* *

"I need to be in control of my own recovery." *

"We need to work on you pulling out of your involvement with my rituals, and I need to work on challenging my OCD directly, and on my own." *

*…and it would probably be very helpful to get a good mental health professional to guide us in this process"

Examples of Redirecting Statements continued…

"Tell me that you know that I am doing the best I can."

"Tell me that you are sorry that I am struggling so with this problem."

"Tell me that you believe in me, that I can fight this thing and win."

"Ask me how you can be of help, and what I need from you (but this does not mean accommodation)."

What NOT to do:

DON'T:

Scream/Yell
Threaten
Behave violently
Over apologize
Verbally attack your parents
Use curse words
Shut down and withdraw
Defend yourself
(instead, empathize/validate)

A simple 4 step approach:

Empathize
Validate
Challenge
Redirect

Questions/Comments

How to Raise your Parents When you have OCD (to help or get out of the way)

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Power Up Your OCD Recovery!

Reid Wilson, PhD; Jon Hershfield, MFT; Shala Nicely, LPC; Jeff Bell
IOCDF Conference 2018

HOW ARE WE GOING TO POWER IT UP?

- Adopt a game-changing, paradoxical attitude
- Experience fully living in the now with mindfulness
- Discover how empowering self-compassion can be
- Build motivation to do your maintenance exposures with joy (yes, joy!)

Power Up Your OCD Recovery with ATTITUDE

Reid Wilson, PhD

Want It

This is aggressive sport

Push into Disorder's territory

Get determined

Find your "I want this" stance

4

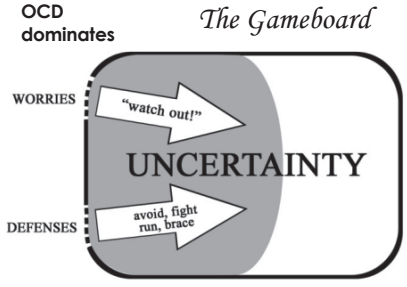
Want It

How does (& doesn't) amygdala change during exposure?

prefrontal cortex

Worried VS *Supportive*

5



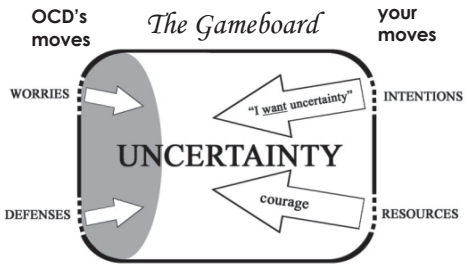


FIGURE 2

Want It

The Science of Habituation

Frequency

Intensity

Duration

8

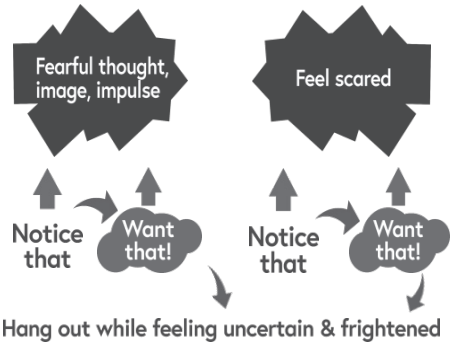
Want It

Honest Stance toward symptoms/worry/uncertainty…

9

Purposely, voluntarily, choose…

- ✓ "I want it"
- ✓ "If it lasts, I want it to last"
- ✓ "If it gets strong, I want it to be strong"



Want It

2 VERY important concepts...

- ✓ Transforming your fear response
- ✓ Taking advantage of the Working Memory

11

Want It

Dr. Barb Frederickson

- Pull up **+** emotion on heels of negative → dismantle mental & physical preparation to run
- Generate **+** meaning for why you are generating feelings of threat

12

Want It

- Then step forward, voluntarily, because know why – because you can see it in broader context of life's goals

Then intentions can transform experience

13

Want It

Dr. Les Greenberg

Transform fear reaction: become afraid, then call up competing emotion

- NOT by thinking, reasoning, allowing, or letting go of, or facing feeling. NOT by exposure, extinction, habituation

14

Want It

- But by activating competing emotion that expresses a competing point of view

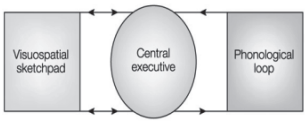
Elevate willingness to embrace doubt & discomfort while feeling afraid

15

Want It

Working Memory

- Roughly 4 thoughts, images or feelings…
- Central Executive pushes away distractions



16

Want It

Self-talk DIRECTS Working Memory
Therefore, apply strategy…

When you're anxious → ask for exactly what you're experiencing now

But you have to ask for it
– signals working memory to retrieve resource of "acceptance" from past

18

Apply strategy…

20

Attach self-messages to exposure

Keep repeating process

Your long-term working memory will link it all together

Then…

call up message → cue working memory

retrieves internal resources associated with message

21

Want It

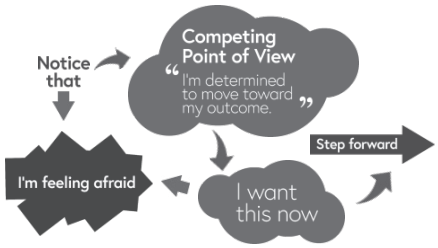
It's an ATTITUDE!

"If I have to take what you're dishing out in order to get stronger, then give me 2 servings, now"

22

Protect & Defend	*Step Forward & Risk*
Be sure everything is okay	Seek out doubt
Get comfortable	Provoke your discomfort
Treat fearful thoughts seriously	Treat fearful thoughts absurdly
Stay safe	Aggress into new territory
Feel confident before acting	Scare yourself
If you do this ⇧	*Then do this* ⇧

It's an Attitude Shift



Power Up Your OCD Recovery with Mindfulness

Jon Hershfield, MFT

What are you talking about?

- Mindfulness is not a tool that you USE. It is a state of awareness. I am wide awake right now. I am not "using wakefulness" to give this talk. But the less I am asleep, the better this talk will go.

No, seriously, what are you talking about?

- Mindfulness is paying attention to the present moment without judgment.
- Observing what IS instead of getting lost in what COULD be
- Understanding that THINKING is a thing that you are DOING (like eating or dancing) and not the same thing as BEING

Mindfulness is…

- Remembering that no matter how scary or disturbing sharks may be, you are not actually in the tank with them. You are always in the aquarium.
- Each shark is an object of attention, whether a thought, feeling, or sensation
- Each object of attention can be watched with curiosity or not, but always swims by when not disturbed.

Yeah, but…

- What if the glass breaks and I drown in a stew of broken glass and shark feces while the infernal beasts eat my face?

There's always one of you.

Meditation: What gives?

- What are the two areas we struggle with the most in regards to our attention?
  - Knowing when the mind has become distracted by an obsession
  - Returning from the distraction without condition (i.e. compulsion)

Meditation: what gives?

- Meditation is the practice of only these two skills:
  - Recognizing when the mind has wandered from the anchor (e.g. the breath)
  - Beginning again with the anchor without judgment

Meditation: Let's Do This

1. Getting a clear picture of what you are in this moment.
2. Finding the anchor of your breath.
3. Watching, wandering, noticing, and beginning again.
4. Letting go.

Powering Up Recovery

- You don't have to get into Buddhism, enlightenment, or anything philosophical if you don't want to. But get into the technical act of daily meditation.
- Find an app or two that you like and run through course after course. Explore different teachers.
- Never expect to be "good" at it. There is no such thing as being good at mindfulness. You either notice what's going on or you don't.

Powering Up Recovery

- You always have ten minutes (unless you have kids, then you have 5).
- Attach your practice to another activity (e.g. between getting to work and checking your first email, upon arriving home in your car, etc.)
- Practice micro-versions of your meditation throughout the day (occasional body scan, resting attention on a part of the body, etc.)

Powering Up Recovery

- Seek out mindful moments (e.g. drive without the radio on for a few minutes, notice the flavor of your food, etc.)
- Make the mindless mindful (watch tv without your phone on, notice the performances and notice your thoughts about them)
- What are some ways you could practice being meditative throughout the day?

Power Up Your OCD Recovery with Self-Compassion

Shala Nicely, LPC

Three Components of Self-Compassion

- Mindful awareness of feelings
- Community humanity
- Self-kindness

MINDFUL AWARENESS OF FEELINGS

- "I'm feeling frustrated because my OCD is bothering me again."

COMMON HUMANITY

- "I bet other people in recovery from OCD get frustrated, too."

SELF-KINDNESS

- Notice what's right: "My OCD is bothering me a lot less than it used to!"
- Give yourself permission: "I'm allowing myself to have an imperfect (and realistic!) recovery."
- Do something kind and helpful: "I'm going to use what I learned in Power Up Your OCD Recovery! to remind my OCD who's in charge, and then [do something enjoyable]."

SELF-COMPASSION STATEMENT

"I'm feeling frustrated because my OCD is bothering me again. I bet other people in recovery from OCD get frustrated, too. But I'm going to give myself a break, recognizing my OCD is bothering me a lot less than it used to! I'm allowing myself to have an imperfect (and realistic) recovery. I'm going to use what I learned in Power Up Your OCD Recovery! to remind my OCD who's in charge, and then [do something enjoyable]."

SHORT VERSION

"I'm feeling frustrated, just like many people in recovery from OCD. But I'm going to use my new tools, remind my OCD who's in charge, and get back to enjoying my life!"

Now it's your turn

- Using the worksheet in the handout book, briefly jot down an overview of a situation where you've been self-critical.
- Take a few moments to write a self-compassion statement using the prompts on the worksheet.

Power Up Your OCD Recovery with MOTIVATION: The Greater Good Perspective Shift

Jeff Bell

Claim and exercise your freedom to choose

ON SERVICE AND PURPOSE

"The best way to find yourself is to lose yourself in the service of others."
Mahatma Gandhi

"The purpose of our lives is to give birth to the best which is within us."
Marianne Williamson

FEAR-BASED DOUBT (FBD) FRAMEWORK

- Only black-and-white choices
- These default choices are typically framed as "good" versus "bad," based on the anxiety they cause
- To FBD "good" choices appear to offer relief from anxiety; "bad" choices are those that require us to sit with anxiety

FEAR-BASED DOUBT (FBD) FRAMEWORK, CONT.

- Compulsions reduce our anxiety (if only temporarily), so they are almost always seen as "good" choices
- Within this FBD framework, decisions are based on two motivators: fear and doubt.

THE GREATER GOOD FRAMEWORK

- While stuck in Doubt, our choices remain limited to two options
- This framework acknowledges the perceived (though distorted) "good" of acting on compulsions to relieve anxiety
- This framework also introduces a Greater Good choice — one that enhances our own sense of purpose and/or is of service to others.
- Within the Greater Good framework, decisions are based on two motivators: purpose and service

CHOOSING GREATER GOOD MOTIVATION

- In this moment how I can use my free will and choose to ....
  - be of SERVICE to someone else?
  - enhance my own sense of PURPOSE?

TURN TO YOUR GREATER GOOD PERSPECTIVE WORKSHEET

- We'll work through an example together.

Resources

- *Stopping the Noise in Your Head* by Reid Wilson, PhD
- *The Mindfulness Workbook for OCD* by Jon Hershfield, MFT
- *Everyday Mindfulness for OCD* by Jon Hershfield, MFT and Shala Nicely, LPC
- *When in Doubt, Make Belief* by Jeff Bell

Briefly jot down an overview of a situation where you've been self-critical:

Now, take a few moments to put the three elements of self-compassion about this situation into your own words. We've given basic examples of each of the three in quotes.

1. Mindful awareness of feelings: "I'm feeling frustrated because my OCD is bothering me again."

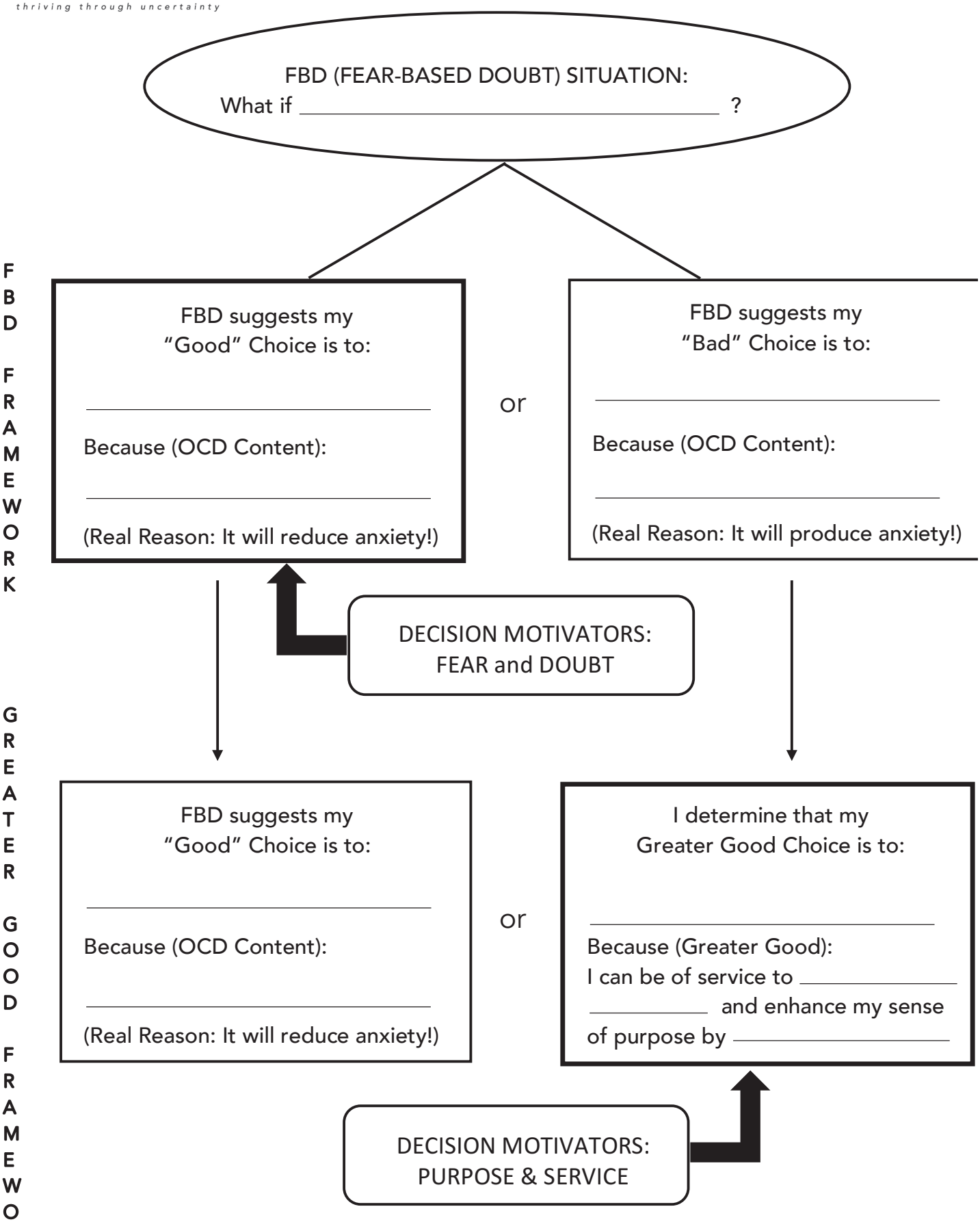
2. Common humanity: "I bet other people in recovery from OCD get frustrated, too."

3. Self-kindness:
    a. Notice what's right: "My OCD is bothering me a lot less than it used to."

    b. Give yourself permission: "I'm allowing myself to have an imperfect (and realistic!) recovery."

    c. Do something kind and helpful: "I'm going to use what I learned in Power Up Your OCD Recovery! to remind my OCD who's in charge, and then [do something enjoyable]."

Put it all together to create your self-compassion statement. You can shorten it up, too, so it's easy to remember: "I'm feeling frustrated, just like many people in recovery from OCD. But I'm going to use my new tools, remind my OCD who's in charge, and get back to enjoying my life!"


FBD (FEAR-BASED DOUBT) SITUATION:
What if _____ ?
FBD FRAMEWORK
FBD suggests my "Good" Choice is to:
_____
Because (OCD Content):
_____
(Real Reason: It will reduce anxiety!)
or
FBD suggests my "Bad" Choice is to:
_____
Because (OCD Content):
_____
(Real Reason: It will produce anxiety!)
DECISION MOTIVATORS: FEAR and DOUBT
GREATER GOOD FRAMEWORK
FBD suggests my "Good" Choice is to:
_____
Because (OCD Content):
_____
(Real Reason: It will reduce anxiety!)
or
I determine that my Greater Good Choice is to:
_____
Because (Greater Good):
I can be of service to _____
_____ and enhance my sense
of purpose by _____
DECISION MOTIVATORS: PURPOSE & SERVICE

Family Affair: Involving a Partner or Spouse in Exposure and Response Prevention for OCD




Jonathan S. Abramowitz, PhD
University of North Carolina at Chapel Hill

Outline

- OCD from an interpersonal perspective
- Conceptual model → effective treatment
- Couple-based treatment strategies

The Experience of OCD

- Obsessions trigger anxiety and fear
- Compulsive rituals and avoidance behavior produce an immediate reduction in anxiety
- Rituals and avoidance become habitual because they are reinforced by the reduction in distress they engender (negative reinforcement)
- Rituals and avoidance prevent the natural correction of obsessional fear

OCD in an Interpersonal Context

- Person with OCD acts to structure their environment to minimize obsessions and anxiety
- Partners often become part of "OCD World"
  - Partner helps person **avoid** anxiety
  - Partner **participates in compulsive rituals**
  - Partner provides ongoing **reassurance**
  - Partner may **argue** with their loved one

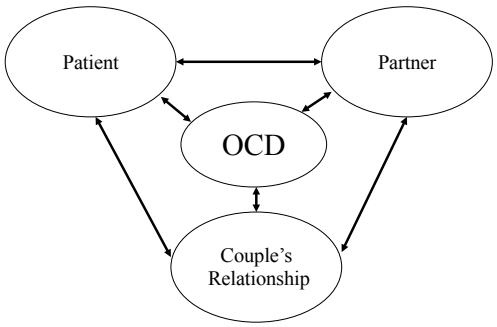
Partner Accommodation in OCD: "Symptom-System Fit"

OCD domain	Avoidance	Compulsions
Contamination	Sources of contamination	Reassurance, cleaning/washing (showering before sex)
Responsibility	Assume liability	Checking, reassurance
Symmetry	Order-related tasks	Arranging, reassurance
Unacceptable thoughts	Obsessional triggers	Reassurance

OCD ⇄ Relationship Functioning

- The patient's fears, avoidance, and rituals create interpersonal conflict which exacerbates OCD
- Accommodation by partner maintains OCD symptoms
  - Performed out of love to protect loved one from anxiety
  - Couple might appear relationally distressed *or* happy
  - Often frustrating for the healthy partner
- Chronic relationship stress unrelated to OCD (e.g., finances) increases OCD symptoms

Why Include a Partner in Treatment?



7

Elements of Couple-Based CBT for OCD

- Assessment
- Education about OCD in relationship context
- Communication training
- Partner assisted exposure and response prevention
- Alter couple's relationship relative to OCD
  - No accommodation
  - Healthy ways to show care and concern
  - Broaden couple behaviors as OCD improves
- Focus on general relationship distress *or* relationship enhancement

Individual Assessment of OCD

- Fear cues
  - External, internal, thoughts
- Avoidance
- Compulsive rituals
  - Behaviors and mental rituals
- Cognitive distortions

Couples Assessment

- Presence of symptom-system fit?
  - Are there support behaviors that reinforce symptom expression?
  - How is relationship impacted by OCD?
  - How would life be different without OCD?
- What have the two of you done as a couple to try to manage OCD?
  - How well has it worked?

Couples Assessment (cont'd)

Relationship – general

- Satisfied vs. distressed?
  - Clinical interview
    - Relationship history
    - Strengths & weaknesses
  - Behavioral observation of communication
    - Problem-solving; provision of support; listening
  - Can supplement with self-report measures (e.g., Dyadic Adjustment Scale; Spanier, 1976)

Psychoeducation

- Understanding OCD
- Symptom accommodation
- CBT: Why and how?

Communication Training

- Sharing thoughts and feelings
- Problem solving & decision-making

Emotional Expressiveness Training (EET)

- State your views **subjectively.**
- Express your **emotions, not just ideas.**
- When expressing concerns, also include any **positive feelings** you have about the person or situation.
- Make your statement as **specific** as possible.
- Speak in "paragraphs."
- Express your feelings and thoughts with **tact** and **timing.**

Listening Skills

Ways to respond while your partner is speaking

- Through facial expressions, etc., show that you **understand** your partner's thoughts and feelings.
- Look at the situation from your partner's perspective.

Ways to respond after your partner finishes speaking

- **Summarize** your partner's most important feelings, desires, conflicts, and thoughts- reflect.

Problem Solving/Decision Making

- State the issue
- Discuss why it's important and what you would like
- Discuss possible solutions
- Decide on a solution that both can agree to
  - Compromise
- Trial period and evaluate

Exposure and Response Prevention

A set of techniques designed to help patients engage with feared situations and stimuli and resist urges to perform compulsive rituals and avoidance behaviors to control the anxiety

Partner Assisted Exposure

- Target Problem: Anxiety and fear within the identified patient
  - The couple's relationship is not directly addressed
  - Symptom accommodation is not directly addressed
- Role of the partner: Coach
- When to use:
  - Relationship distress is not part of OCD
  - Partner is not engaging in excessive accommodation

Is the Partner Suitable?

- Characteristics of a good exposure partner
  - Considerate, sensitive, optimistic about treatment
  - Warm and thoughtful, nonjudgmental
  - Willing to challenge or confront the patient in a *constructive* way
- Characteristics of a poor exposure partner
  - Pessimistic, sarcastic
  - Highly critical, antagonistic
  - Smothering, overbearing, overly involved in treatment

Role of the Partner

- Be present at the treatment sessions, but gradually withdraw from involvement in treatment
- Positive reinforcement of non-OCD behavior
- Share thoughts and feelings about doing exposure
- Gentle but firm reminders not to avoid or ritualize
- Emotional support during exposure and response prevention

Partner-Assisted Exposure

- Stage 1- Preparing for the exercise
  - Clarify the exposure exercise
  - Discuss how each partner feels about the exercise
    - Teach them to use EET
  - Clarify what might be difficult for each person and what they need from the other person
  - Clarify how they will handle it if person with OCD wants to stop the exposure exercise

Partner-Assisted Exposure

- Stage 2- Confronting the feared stimulus
  - Patient expresses thoughts & feelings (EET)
  - partner asks patient how he/she is doing
  - Partner compliments patient on handling the situation
  - If the patient is experiencing distress, the partner (a) acknowledges his/her difficulty and (b) reinforces his/her efforts
  - No distraction or providing reassurance

Comments for Partners to use During Exposure Therapy

- "I love you, but I can't give you that guarantee"
- "I know you can get through this! How can I help you without doing rituals for you?"
- "I know you're strong. If I did that for you it would only be making your OCD worse. How else can I help you."
- "I know it is difficult. Let's talk with the therapist about the problems your having getting through this"

Partner-Assisted Exposure

- Stage 3- Coping with high anxiety
  - If the patient is feeling very anxious, use EET
    - Patient expresses feelings and partner reflects
  - The partner reminds patient that they can get through the anxiety
    - Anxiety is safe and temporary

Partner-Assisted Exposure

- If necessary, take a brief time-out
  - Break from the exposure or perform a limited ritual
- Use EET to discuss thoughts and feelings
- Partner provides support ("you can do it")
- Discuss what happened and how to approach the situation when exposure resumes
- If patient insists on stopping exposure, partner reminds him/her of importance of continuing but leaves decision up to patient

Partner-Assisted Exposure

- Stage 4- Evaluation of the exposure
  - After exposure discuss the experience (EET)
    - Patient's and partner's experiences
    - What did partner do that helped or did not help?
    - What might he/she do differently next time?
  - Discuss communication during the exposure
    - clarify what could be different in the future

Interventions Targeting Accommodation

- Target Problem: Maladaptive relationship dynamics focal to OCD that reinforce symptom expression in anxious partner
  - The couple's relationship outside of OCD (e.g., money, in-laws) is NOT directly addressed
- Role of the partner: Client
- When to use:
  - Relationship distress is NOT part of the presenting complaint
  - Partner IS engaging in excessive accommodation

Targeting Accommodation

- Alter symptom-system fit/accommodation
  - Education & alliance-building
  - Develop an exposure list/hierarchy
  - Help couple develop new ways of relating that facilitate exposure rather than avoidance and symptom expression

Steps To Target Accommodation

- Psychoeducation & alliance-building
  - Have partners share thoughts & feelings about the effect of OCD on each of them
  - Pull from client & partner that avoidance and rituals decrease anxiety short-term but maintain it long-term
  - Help client and partner to "buy into" rationale for exposure and response prevention

Steps to Target Accommodation

- Develop an exposure plan
  - Create specific exposure situations
  - Stress importance of remaining in situation until new learning has occurred ("e.g., I can do it!")
  - Teach couple to problem-solve around client's anxiety in a given situation
  - Be specific about who will do what / when
  - Instruct in how to debrief after exposure & continue consolidating gains

Targeting Accommodation

- Develop new ways of relating that facilitate exposure to feared situations rather than symptom expression
  - Gradually eliminate signals that promote OCD-related behaviors
  - Shape towards target behaviors

Characteristics of Couple Therapy

- Target Problem: Problematic relationship dynamics that serve as chronic stressors (e.g., mutual hostility)
  - The couple's relationship, not specific to OCD is directly addressed
- Role of the partner: Client
- When to use: Relationship distress & communication deficits ARE part of the presenting complaint

Couple Therapy

- Create more mutually respectful, harmonious environment for both partners to decrease ambient stress and increase collaboration
  - Increase pleasurable events & support behaviors
  - Challenge negative cognitive biases (e.g., selective attention for negative events, negative attributions)
  - May need explicit focus on communication skills
- See Epstein & Baucom (2002) as an example of manual for cognitive-behavioral couple therapy

Treatment Schedule

- **Sessions 1-3** – assessment, education, treatment planning, coping with anxiety as a couple
- **Sessions 4-7** – partner-assisted ERP and communication training
- **Sessions 8-11** – decision-making skills, reducing accommodation
- **Sessions 12-16** – enhancing communication, non OCD-related stressors

Considerations

- How might addressing interpersonal relationships optimize treatment?
  - Teamwork when using treatment strategies
    - Enhances motivation for change
  - Healthy partner learns skills to help patient get through anxiety and stay on task
  - Reducing accommodation broadens the couple's repertoire with non-OCD activities

Considerations

- What promotes maintenance of gains?
  - Couples learn ways to relate to each other that allow them to use exposure in daily routine
  - Partners learn to recognize and stop accommodation behaviors
  - Learning communication strategies helps lower general relationship stress

Considerations

- We have an effective treatment for OCD, but it does not work equally well for everyone
- Importance of identifying and understanding prognostic indicators such as interpersonal factors
- Fine-tuning existing treatments for OCD vs. developing new ones
- Need to examine long-term follow-up

Thank you!

How Do I Stop Thinking About This?
What To Do When You're Stuck Playing Mental Ping-Pong

Talk 1
Lisa Levine, Psy.D.
Behavior Therapy Center of Greater Washington

Talk 2
Michael Greenberg, Ph.D.
New York, California

Talk 1

Lisa Levine, Psy.D
Behavior Therapy Center of Greater Washington

Internal dialogue:

I can't stop thinking about when I worked at the yogurt place and I gave that baby a moldy strawberry. I mean, I think it was moldy! I really think it was because I definitely dug down deep to get the ones on the bottom- I had to have WANTED to get a moldy one- I had to have wanted to make that baby sick. But I didn't even know if the mom got the yogurt for the baby or for herself! But when I saw her give it to the baby, I could've said something- I SHOULD have said something. But I was so embarrassed-how do you tell someone you just gave their baby a moldy strawberry? And I wasn't even sure if it was moldy! But maybe I did really know, and even so, how could I have taken that risk? I was only thinking of myself and my own pride rather than that baby…that means I'm a bad person. I need to know if something happened to that baby! I mean, I bet she totally could've gotten sick- or died! Yeah I googled the effects of eating mold and it DID NOT say death….but this was a baby! What if she was allergic to mold?? But wait, then the mom probably wouldn't have let her eat strawberries from a toppings bar… Oh my gosh, I am so desperate to STOP THINKING ABOUT THIS, but my brain just won't stop…

IS THIS AN OBSESSION OR A COMPULSION?

Obsessions

- Recurrent, persistent, unwanted thoughts, impulses, and/or images that intrude, preoccupy, and distress.
- Experienced as intrusive and inappropriate/ excessive, at least some of the time.

Compulsions

- Physical or mental actions intended to reduce or eliminate anxiety.
- compulsions are BEHAVIORS= internally coordinated responses-actions or inactions- to internal or external stimuli.
- compulsions involve STRIVING; there is a goal/objective.

"Pure O"

- Historically, this refers to a type of OCD that involves only obsessions, in which no compulsions exist.
- We know now that all OCD involves compulsions- but some compulsions are covert="mental compulsions."

Mental Compulsions

- Neutralizing/Undoing
- Mental ping-pong=compulsive rumination

What is Compulsive Rumination?

- purposeful action engaged in to reduce anxiety
- always involves some kind of STRIVING
- can involve analyzing, attributing meaning, reviewing/remembering, predicting, rationalizing/reassuring oneself, looking for evidence

Compulsive Rumination

- Obsessive thoughts are embedded within the compulsive process, but it is an active, goal directed behavior, undertaken and intended to alleviate anxiety.
- Compulsive rumination often occurs during an exposure. When this happens, the exposure is undermined- response prevention is not happening. While there are other ways exposures can be undermined, this may be the most subtle-it disguised as an obsession.
- Compulsive rumination happens in response to naturally occurring triggers. Some people engage in compulsive rumination for hours each day, or even for most or all of the day.

So what do you do about it? How do you stop your brain from figuring things out, especially when you are desperate for an answer?

Before this question is answered, we need to understand:

- Why it is virtually impossible to will yourself to just stop thinking about it.
- Why it is critical to stop.
- Some basics about the Escape/Avoidance Cycle.
- Some basics about Exposure and Response Prevention.

Why Can't I Just Stop Thinking About This?

The Thought Suppression Paradox
(Wenger,1987)

- rebound effect
- more importance=more difficult
- attribution of meaning of failed thought suppression

The Escape/Avoidance Cycle

- When a person feels intensely anxious, often (and understandably) attempts at escape or avoidance occur.
- While much of the time, this intuitive, natural reaction serves a protective function, in OCD it traps the sufferer into an endless cycle of striving.

Why is it So Important to Stop?
The Escape/Avoidanvce Cycle

Compulsive Rumination is destructive because, like any compulsion, it will ultimately backfire by:

- allowing the anxiety to last indefinitely
- trapping you into compulsing even more
- eroding your self efficacy beliefs and preventing you from seeing what might happen without trying to escape the anxiety.

But don't people need to figure things out sometimes? Isn't it normal to consider all the ins and outs when you have to make an important decision about something?

Yes- sometimes. But NOT in the presence of:

- URGENCY
- DESPERATION

How Do I Stop?

Exposure and Response Prevention

- In Vivo and Imaginal Exposure
- Non-Engagement Responses

Exposure and Response Prevention (ERP)

- Emotional Processing Theory (Foa & Kozak, 1996) =**gradual exposure and habituation**
- Inhibitory Learning Theory (Craske, et al., 2008)=**self-efficacy and new learning**

Components of Successful Exposure

- repetition
- duration
- response prevention

Imaginal Exposures

- exposure scripts
- exposure statements/phrases
- scenes/images
- trigger words

Non-Engagement Responses (NERs)

- based on "Dead Man's Rule"
- NER= a statement that affirms UNCERTAINTY (about the fear or worry) and/or affirms the presence of ANXIETY (about the fear or worry).
- Instead of trying to dispute the worry, you're affirming/agreeing that anything is possible.*
- The most essential purpose of NERs is to shut down (response prevention) the compulsive ruminating process, but NERs also involve components of exposure.* Some NERs involve elements of coping as well.
- hierarchical
- NER is used until its no longer needed**

Types of NERs

- Affirmation of Anxiety
- Affirmation of Uncertainty
- Affirmation of Possibility
- Affirmation of Difficulty
- Combinations

Affirmation of Anxiety

- The "gentlest" NER; different variations.
- Involves observing and acknowledging that you're feeling anxious, rather than striving to reduce the feeling.
- Involves components of Mindfulness, Exposure, and Response Prevention.

Affirming Anxiety

- Feeling anxious.
- Feeling anxious about that.
- Feeling anxious that….
  the curling iron is still on.
  (fill in the blank)
- Feeling anxious that….
  the curling iron is still on and will cause a fire.
  (fill in the blank)

Affirmation of Uncertainty

- States that you simply do not know the answer at this time, that you will not reach an answer at this time- there is missing information.
- Based on the idea that no matter how long you spend weighing the possibilities, without the missing information, you cannot and will not reach a conclusion.

Affirming Uncertainty

- I don't know for sure (right now).
- I'm not going to know for sure (right now).
- I don't know (right now).
- I'm not going to know (right now).

Affirmation of Possibility

- OCD insists that you that you must know, you must know NOW, and you must know FOR SURE.
- The pursuit of certainty is inherently doomed to failure, but when you're desperate, it can be hard to stop your mind from trying.
- Affirming that anything is possible shuts down the pursuit.
- Affirming that anything is possible shuts down OCD's attempts to continue baiting you.

Affirming Possibility

- Anything is possible (in this world)- include remote examples.
- Its unlikely/extremely unlikely**, but anything is possible (in this world).
- Its possible.
- Maybe so (maybe not).
- Could be/you never know.
- Probably/very well could be*

Affirmation of Difficulty

- Response to the feared thought that involves an element of condescension- duh!
- Can be said in a glib, nonchalant manner- be an actor.
- Answers the question "but what if?"

Affirming Difficulty

- TWS
- TWS, but I'll handle it.
- other variations

Combinations

- Become familiar with using them individually first.
- Some may work better for you than others.
- Using combinations helps keep you focused and less likely to slip into the rote repetition of meaningless words.

How to Use NERs

- prolonged/planned:
  -use with triggers for prolonged practice
  -use as an unplanned, prolonged exposure (rather than waiting for compulsive rumination to take over)
  -use as planned exposure statement (affirming possibility)
- on the spot

Troubleshooting

- I'm zoning out!
- My worry just keeps switching to something else!
- embedded Compulsive Rumination

Tips

- personify OCD
- get angry
- be open
- want the burn
- be an actor
- give yourself credit

How do I stop thinking about this? Talk 2

Michael Greenberg, PhD
New York & California

Some personal background

Separating Obsession from Compulsion in Compulsive Rumination

- What you might think
- The problem with that
- A different perspective
- Arguments for a different perspective
  - A practical argument
  - A theoretical argument

  (The word "obsession" adds to the confusion.)

My Controversial Claim

- You *can* actually stop
- But what about thought-suppression?
- What it means to accept the obsession without attending to (actively thinking about) the obsession
  - A cognitive perspective
  - A mindfulness perspective

Why is it so hard then?

- First, because it's still a compulsion, and stopping compulsions is hard
- May get stuck trying to follow the rules by not "pushing away" thoughts, thus *justifying and even encouraging* compulsion
- Accepting without attending isn't a natural ability
- Lack of self-efficacy
- **Ambivalence** about stopping
  - May seem invalidating but is same as compulsions
  - May prevent a person from stopping at all or lead to **back-and-forth**
  - May be outside awareness
- **Lack of awareness**
  - Of compulsive rumination
  - Of ambivalence about stopping
  - Of back-and-forth

Ambivalence

- What do I mean?
  - Definition
  - May sound invalidating, but really no different from any other compulsion in terms of not being 100% sure you want to stop
- **Not inherently an issue, unless it prevents the person from making the choice to stop the compulsion, and to do so consistently**
- Can be outside awareness
- If outside awareness, try asking yourself, "Why is it important that I think about this right now?"
  - Anticipating, planning, preparing, preempting, preventing a problem
  - Preventing a problem from getting worse, catching something early
  - Problem-solving
  - Figuring something out, answering a question, needing to know/accept something
  - Feeling on the verge of figuring something out or knowing/accepting something
  - Trying to prevent future anxiety (different from avoiding current anxiety)
  - Needing to be honest or authentic
  - Needing to be a good person
  - Needing to maintain an identity
  - Needing to remain in control
  - And the ever-popular:
    What if it's not OCD and this approach is the wrong one or denial?

Back-and-Forth

- Definition
- Very different from physical compulsions because in compulsive rumination, you might not be aware you're going back-and-forth
- Can undermine treatment while the patient and/or therapist thinks they're doing everything right
- No matter what strategy you use to eliminate the compulsion, you have to commit to eliminating it
- Build awareness by self-monitoring and address underlying ambivalence about compulsion

Lack of Awareness

- Sometimes people don't *notice* that they are engaged in compulsive rumination
- Sometimes people don't *identify* their thought process as compulsive rumination
  - If they are used to a certain thought process and never thought of it as compulsion
  - If there's no anxiety preceding or during it
- Educate and build awareness by self-monitoring

Okay, I notice I'm doing it, I understand I can stop if I choose to, and I'm committed to doing so consistently.

How do I do it?

Strategies: Models and Metaphors

Try them on for size and pick one that fits

- Refusing and moving on
  - "No comment"
  - "I have no thoughts about that"
- Remaining aware of the urge without giving in
  - Like a pet in your bag that you must not play with right now
  - Like a curious place you must not explore
  - Like sexual attraction you must not act on
- Affirming the risk involved in not thinking about it
  - Leaving the kitchen with the gas on
  - If X happens as a result of not compulsing, so be it
- Affirming the harm involved in actively thinking about it
  - Like breaking a diet or eating a food you're allergic to
  - Like acting on sexual attraction in a harmful way

Summary of Key Points

A Few Extra Notes…

My Old Strategy and Why I Stopped Using It

- I used to have patients actively refute every reassuring thought that came up while they were compulsively ruminating
- This works if the person is able to preserve focus on their anxiety, uncertainty, or core fear, so it will work for some people sometimes
- Often it just keeps them playing ping-pong

Is this Mindfulness?

- Definition of mindfulness
- How mindfulness is relevant to what was discussed in this presentation
- How mindfulness could also be used in ways that are inconsistent with what was discussed and would not be helpful

You can find more information at:
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For questions or feedback, you can reach me at:
michael@drmichaeljgreenberg.com

Development of Inclusive Demographic Forms

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Disclosures

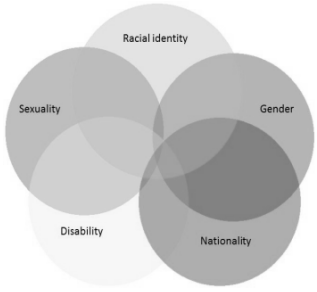
I, or an immediate family member, including a spouse or partner, have no financial relationships or any other relationship which could reasonably be considered a conflict of interest relevant to the content of this CE activity

What does "Identities" Refer to?

Age (years, cohort)
Disability status (e.g., physical health)
Diagnosis status (e.g., mental health)
Religion & Spirituality
Ethnicity & Race
Socioeconomic & occupational status
Sexual orientation
Indigenous heritage
Nation of origin & Citizenship Status
Gender & gender expression

Hays, 2008

Intersectionality



Hays, 2008

Demographic Forms

- Often the first form a person interacts with in the lab or the office
- A fast, efficient way to get a sense of someone's sociocultural identities
- A way to signal that you value and consider these aspects (or a way to signal that you do not)

Typical Demographic Form

What is your gender?
□ Male
□ Female

What is your age? _____

What is your Race/Ethnicity?
□ American Indian or Alaskan Native
□ Asian
□ Black or African-American
□ White
□ Native Hawaiian or Pacific Islander
□ Caribbean Islander
□ Latino/a
□ Multiracial (Specify) _____
□ Choose not to answer
□ Do Not Know

Have you ever been homeless?
□ Yes
□ No

If you are a Latino/a, where is your place of ancestry?
□ Dominican Republic
□ Puerto Rico
□ Cuba
□ Central America
□ South America
□ Mexico
□ Other (Specify) _____

Marital status:
□ Never married
□ Separated/divorced
□ Widowed
□ Married
□ Living with partner

SATURDAY

Missing Identities

Age (years, cohort)
Disability status (e.g., physical health)
Diagnosis status (e.g., mental health)
Religion & Spirituality
Ethnicity & Race
Socioeconomic & occupational status
Sexual orientation
Indigenous heritage
Nation of origin & Citizenship Status
Gender & gender expression

Hays, 2008

Difficulties of collecting inclusive demographics

- Balance between efficiency and accuracy
- Most studies measuring sexual orientation (and other demographics) use an unrepresentative check-box approach
- Example:
  - Sexual Orientation
    - __ Heterosexual
    - __ Gay or Lesbian

Leaving those who identify as bisexual, queer, asexual, or other sexual orientations with the option of:
- Leaving the item blank
- Checking a box that does not accurately reflect them

Problems with using non-inclusive demographic forms

- Collect inaccurate data
  - Missing data
  - People checking boxes that do not accurately capture their identity/lived experience, resulting in queer/bi/etc. experiences being analyzed as "lesbian/gay"
- Signaling that identities outside of those listed are not worth the time or attention to include on our forms
  - Can alienate participants
  - Gives an impression of the degree to which the field of psychology values them

Importance of inclusive demographics

- Some forms use an "other" or write-in response for identity items
- Example:
  - Sexual Orientation
    - __ Heterosexual
    - __ Gay or Lesbian
    - ___ Other (please describe): _____

Importance of inclusive demographics

- Some forms use an "other" or write-in response for identity items
- Example:
  - Sexual Orientation
    - __ Heterosexual
    - __ Gay or Lesbian
    - ___ ~~Other~~ (please describe): _____
- *Tip: instead call this category "write-in" or "not listed"*

Recommended Demographic Form

UMB COMPREHENSIVE DEMOGRAPHICS QUESTIONNAIRE

Suyemoto, K. L., Erisman, S. M., Holowka, D.W., Fuchs, C., Barrett-Model, H., Ng, F., Liu, C., Chandler, D., Hazeltine, K. & Roemer, L. (2016). UMass Boston comprehensive demographic questionnaire, revised. As cited in *Wadsworth, L. P., Morgan, L. P., Hayes-Skelton, S. A., Roemer, L., & Suyemoto, K. L.* Ways to boost your research rigor through increasing your cultural competence. *the Behavior Therapist, 39, 83-89.*

University of Massachusetts Boston (UMB) Demographic form, included in:
"Ways to Boost your Research Rigor through Increasing your Cultural Competence" *Behavior Therapist*

1. What is your current age? *(please write in answer)* _____

2. What is your biological sex?

☐ Male ☐ Female ☐ Intersex ☐ Not listed (Specify if you choose____)

3. What is your gender identity?

☐ Male	☐ Female	☐ Transgender	☐ Nonbinary/fluid queer/gender queer	☐ Not listed (please specify if you choose_____)

4. What is your sexual orientation?

☐ Asexual	☐ Bisexual	☐ Gay or Lesbian	☐ Heterosexual	☐ Queer	☐ Pansexual

☐ Not listed, please specify if you choose _____

5. With what religion or spiritual practice (if any) do you identify?

_____

Racial and Ethnic Background

We're interested in getting a complete picture of your racial and ethnic background. Because this information can be so complex, we are going to ask you several questions about your race and ethnicity in order to get as complete a picture as possible.

19. Racial categories are based on visible attributes (often skin or eye color and certain facial and bodily features) and self-identification. These groupings have social meanings that affect how people see themselves and are seen and treated by others. Race is not the same as ethnicity or culture. **In your own words, what is/are your racial identification(s)?**

_____

20. Although the categories listed below may not represent your full identity or use the language you prefer, for the purpose of this survey, please indicate which group below most accurately describes your **racial identification**? (check all that apply)

☐ Native American/American Indian/Alaska Native/Indigenous
☐ Asian
☐ Black
☐ Latinx/Hispanic (Non-White)
☐ Middle Eastern/North African (Non-White)
☐ Pacific Islander/Native Hawaiian
☐ White
☐ Multiracial (*please specify*):_____
☐ Not listed *(please specify):* _____

[For multiracial participants:]

21. Multiracial people can identify in various ways, sometimes in relation to specific racial heritage, sometimes as "multiracial," or in various other ways. Which of the following best captures how you racially identify? Please choose one.[1]

☐ Mixed/both/multiple—you'll have a chance to tell us about your specific background next.
☐ Multiracial generally—without reference to any particular race or races.
☐ Primarily Alaskan Native/Native American/Indigenous
☐ Primarily Asian
☐ Primarily Black
☐ Primarily Latinx/Hispanic (Non-White)
☐ Primarily Middle Eastern/North African (Non-White)
☐ Primarily Pacific Islander/Native Hawaiian
☐ Primarily White
☐ Primarily in a way not listed *(please specify):* _____

[1] These options are responsive to the multiple ways that racial identity may be experienced by multiracial people and to the historical marginalization experienced by multiracial people in research. They also enable the researcher to make decisions about whether or how to include multiracial people within racialized groupings.

24. Ethnicity or ethnic culture refers to patterns of ideas and practices associated with a group of people sharing a common history, geographic background, and/or language, rather than their racial background. It might include things like values, patterns of interacting, food, dress, holidays, or ways of seeing the world, yourself, or other people.

There are hundreds of different ethnic culture backgrounds within the people in the United States. (such as Cuban, Haitian, Cambodian, African-American, American, Ukrainian, etc.). We are interested in the ethnicity that affects your daily experience, which may be the heritage of your ancestors if you continue to practice and be affected by that heritage, but it may also be a more pan-ethnic or pan-American ethnicity. **In your own words, with which ethnic group(s) do you identify?**[3]

_____

Running Analyses/NIH Report

- Collapsing groups
  - Relatively fast
  - Learning opportunity- expanding your vocab
- Adding additional items to use for NIH reports (even if it's repetitive)

Additional Clinical Step

- Are there any other aspects of your identity, such as disability statuses, religion, socio economic status, nation of origin, etc. that you would like to share with me, or think it is important for me to know to better understand you and your experiences?

Thank you. For many people, aspects of identity are directly related to, or play a role in, the things they are coming to the BHP to work on. In therapy with me, I invite you to bring up any ways in which identity plays a role in your symptoms or goals, at any time.

What might an approach like this do?

- Create an affirming experience for those who hold marginalized identities
- Signal (relative) safety for trans/GNC folks
- Bring identities into the room
  - Signals to patients/participants/clients that you and/or your team appreciate and consider whole people, not just symptoms
  - Makes some space, opens a door for person to share how their identities may impact their symptoms/therapy or your research question

What might an approach like this do?

- Create the opportunity for additional research, ask the under-asked questions
  - Help pave the way forward by doing demographic related preliminary analyses for group differences
  - Help pull discussions around identities into top tier journals and integrate it into your work
  - Help fill the gap of knowledge of all psychological research as it applies (or doesn't) to marginalized groups

Additional Suggestions

- Do your homework
  - Expand the articles/journals you read
    - Read Dr. Monnica Williams and Dr. L Kevin Chapman's work on OCDI in racial and ethnic minorities
  - Do occasional web searches to learn about new ways people are describing their gender and sexual orientations
  - Not a big fan of reading more? Checkout YouTube for videos exploring recent discussions of identity
    - E.g. Trans101; Chescaleigh Ramsey

Additional Suggestions

- Approach clinical work and research with
  - Curiosity
    - Bring up the topic of identities, ask how identities might be interacting with symptoms/treatment/research question
  - Openness
    - Be open to (and expect) people to not match stereotypes or the group "norms" from your homework
  - and Humility
    - Understand that this work comes with making mistakes, being wrong, and being uncomfortable. Considering identities and aiming to become more culturally competent means a commitment to lifelong learning of ever changing constructs

Acknowledgements

- UMB Clinical Psychology Department
- OCD Institute, McLean Hospital/Harvard Medical School
- McLean's Multicultural Psychology Consultation Team

Questions?

Contact: Lauren.p.wadsworth@gmail.com

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DFW Center for OCD & Anxiety

Study and Organizational Skills for Middle and High School Students with OCD

Mary Kathleen Norris, LPC

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Bedford, TX 76022

Office 817-237-9889
Appointments 940-242-0501
Fax 817-545-8417

www.dfwocd.com

* There are no financial affiliations, manufacturer relationships, or off-label / investigational usage of pharmaceuticals used in this presentation.

1

Scientific studies define and explain these deficits in OCD

- Strategic processing errors
- Frontal striatal dysfunction during planning
- Episodic memory impairment

2

Scientific Research Break Down

OCD Kids Tend to:

- Focus on details without appreciating the larger picture
- Have difficulty shifting mental sets
- Have difficulty trying alternative strategies

Furthermore, there is a negative impact on the ability to encode, organize and retrieve information

3

Which Symptoms of OCD Impact Academic Performance?

- Need to know or remember
- Need to do something until it "feels" better
- Need to do something until it "looks" right
- Waiting for the "right time"
- Doubting whether something was done correctly, or done at all

4

Which Symptoms of OCD Impact Academic Performance? (cont.)

- Needing to make an A, 100 or the best
- Magical Thinking
  - Related to Academic outcome
  - Unrelated to Academic outcome
- Doubts whether it is honest

5

Which Symptoms of OCD Impact Academic Performance? (cont.)

Neutralizations (Compulsions):

- Checking
- Rereading
- Rewriting
- Asking for reassurance
- Confessing or disclosures
- Trying to memorize everything, totally cover the subject

6

Common Behaviors Resulting from OCD Symptoms

For the Student:

- Not getting started on assignments
- Not completing assignments
- Pathological slowness
- Procrastination on projects
- Academic meltdowns

7

What Can Be Done?

Study Skills Are Learned!

OCD students can be taught to compensate for deficits with cognitive re-training in organizational and study strategies

8

Most Schoolwork is Adverse

Need a skill set of:

- Distress tolerance
- Facing adversity

9

The Four Goals for Students

1. Easiest
2. Fastest
3. Least Problematic (hassles)
4. Most fun

** Kids need to post these up*

10

Organizational Skills

11

Technology for Organization

Remind – 100 character limited text based information

*** Skyward** – Grade book and class management software

*** Canvas** – Student assignment, online testing, student and teacher collaboration program

Google Classroom – Assignment and student collaboration software

Apple Classroom – Classroom control for technology and learning

12

Technology for Organization

Google Drive – Document sharing, collaboration and storage

Moodle – Education learning and assignment platform

Blackboard – Course management and assignment platform

Edmoto – Assignment management program

*** Skyward** – Most used e-gradebook

*** Canvas** – Personal favorite collaboration between teacher and student

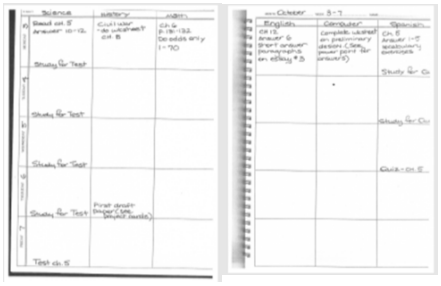
13

The Planner
Manual Strategies May Be Best

- Buy a simple planner to view one day and one week at a time
- You may use green dots in the planner to show work is completed
- Put a green dot on completed work
- Computer planners may not be as effective – kinesthetic learning

14

Sample Planner



15

The Green Dot Notebook

A method to remember to turn completed work in

- Put green dots on completed work
- Place in **ONE** green notebook to turn it in
- **Green** means finished
- May need "Gatekeeper" help (before/after school)

16

Time Management

17

Time Estimate Worksheet

Homework:	Estimate	Actual
Read chapter 10 (8 pgs)	40 min	
Make 5 Study Cards	15 min	
Math – 10 problems	30 min	
Check in/corrections	15 min	
Total:	100 min	
	1 hr 40 min	

18

Procrastination

There are many reasons for OCD students to put off schoolwork.

A few rules to remember-

- If you don't like it, get it done!
- If you do like it, take your time and enjoy it!
- **OHIO – Only Handle It Once!**
  Each time you handle it:
  - Inefficient – takes more time
  - More chances for human error (ex: losing it)
  - Takes away time from preferred activities

19

Learning On Computer

20

Computer Homework and Tests vs. Pen and Paper

There may be many benefits to the student.

However, studies are finding challenges:

- A sense of isolation from students and teacher
- Teacher may not actually grade the work
- Therefore, miss possible learning challenges
- Technical and mechanical frustration
- Overdependence on computer – less creativity

21

Computer Homework and Tests vs. Pen and Paper (Cont.)

- Reduced effort with unlimited guessing
- No urgency to keep on going (a teacher can redirect)
- Unmotivated students do even worse
- Poor writing skills by using drop downs etc. to select
- The temptation to get off task
  ex: solitaire

22

Using E-Textbooks

Certainly

- Are cheaper
- Use less paper
- More portable than backpack of heavy books

However studies are finding:

- Lower reading comprehension and recall
- Excessive screen time can lead to cognitive problems

23

Using E-Textbooks (Cont.)

- Many students find it harder to follow along and not lose your place
- ERP for re-reading may be harder to do
- Students may need the kinesthetic aspects of a paper book
- By turning physical pages one can see what's done and left to read
- Technical and mechanical frustration
- Reading before bed may increase stress whereas paper books tend to relax

24

Computer Dependence

What should we do?

https://medium.com/social-spartans/positive-negative-effects-of-education-in-the-classroom-533daa5fa376

25

Homework

26

Setting Up for Success

Routine is critical (avoid set shifts)

- Continuity
- Consistency

Study Environment

- Sit up at a desk or table
- Easy parent access in an open area
- Least amount of distractions

27

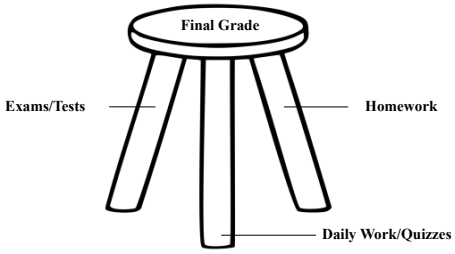
Why Homework is Important to Your Grade

The three legged stool

- Homework
- Daily work/quizzes
- Tests/exams

28

Why Homework is Important to Your Grade



29

Why Homework is Important to Your Grade

Homework is:

- The only "legal cheat"
- Supposed to be:
  An easy A or completion grade

For Most Students:

- Tests are their lowest grades with homework high to support their average

30

Study Cards

Better and more efficient than:

- Annotating
- Underlining
- Studying the study guide

Fastest way:

- Train to write cards as you read the chapter
- Manual or computer

31

Making Study Cards (SC's)

- Determine if this is an SC class
- Include all definitions
- All italicized
- All answers to chapter questions
- Make as you go (manual or computer)

32

Study Cards (Front)

What are the four characteristics of nerve cells?

33

Study Cards (Back)

1. Conduct electrical signals
2. Extreme longevity
3. Do not divide
4. High metabolic rate

34

Diagnosing Zeros

- Zeros can kill your grade
- Check online gradebook daily
- Fill in reason for missing paper
- Fill in date for student action
- If not resolved, parent action

35

Missing Paper Forensics

Today's Date	Assignment/Due Date	Reason for 0	Student Deadline to Fix	Action Taken
4-9-19	Chapter 6 Worksheet/ 4-2-19	L	4-16-19	√ RN

Reason Codes:

F I forgot to do it
L I lost it
T I turned it in?
U I didn't understand the assignment
N I didn't want to do it

36

Taking Breaks

- Good idea for most brains
- OCD brains may have set-shifting pr
- Brain always training, it is used to it
- Short breaks of 1-2 minutes
- Every 20-30 minutes of focused work

37

Taking Breaks

- Allow brain to relax, sort out, uncoil, and adjust
- Kinesthetic – using other parts of your brain
  - Stand up and stretch
  - Move around
  - Play with a "Switch and Scramble"
- There are Brain Breaks websites 30 sec – 1 minute

38

Projects

39

Project Cards

- Calendar of dates
- Components List

40

Project Cards
Calendar of Dates

41

Project Cards
Components of My Project

1. Write my components list
2. Supplies to buy:
   1. 1" 3 ring binder
   2. One piece poster board
   3. Check computer ink
3. Library:
   1. Check out 3 book resources
   2. Find 2 journal articles
   3. Copy articles
4. Online: find 3 citings, print and highlight

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Project Cards
Components of My Project (cont.)

5. Read/skim over 3 books, type notes or make cards*
6. Read/highlight 2 journal articles
7. Make outline for paper
8. Put my notes in order of my outline
9. Type rough draft*
10. Review with an advisor/corrections
11. Type final draft*

* *Divide into smaller parts*

Project Cards
Components of My Project (cont.)

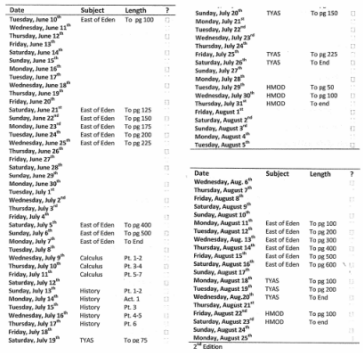
12. Complete bibliography
13. Download pictures and titles for poster
14. Cut and arrange pictures
15. Glue down pictures
16. Final check & return books

Project Card (sample)

Card 4 Sunday Oct. 26

- Read and Highlight 2 journal articles
- Make outline for paper
- Put my notes in order of my outline

Sample Summer Study Guide



Date	Subject	Length	?
Tuesday, June 10th	East of Eden	To pg 100	
Wednesday, June 11th			
Thursday, June 12th			
Friday, June 13th			
Saturday, June 14th			
Sunday, June 15th			
Monday, June 16th			
Tuesday, June 17th			
Wednesday, June 18th			
Thursday, June 19th			
Friday, June 20th			
Saturday, June 21st	East of Eden	To pg 125	
Sunday, June 22nd	East of Eden	To pg 150	
Monday, June 23rd	East of Eden	To pg 175	
Tuesday, June 24th	East of Eden	To pg 200	
Wednesday, June 25th	East of Eden	To pg 225	
Thursday, June 26th			
Friday, June 27th			
Saturday, June 28th			
Sunday, June 29th			
Monday, June 30th			
Tuesday, July 1st			
Wednesday, July 2nd			
Thursday, July 3rd			
Friday, July 4th			
Saturday, July 5th	East of Eden	To pg 400	
Sunday, July 6th	East of Eden	To pg 500	
Monday, July 7th	East of Eden	To End	
Tuesday, July 8th			
Wednesday, July 9th	Calculus	Pt. 1-2	
Thursday, July 10th	Calculus	Pt. 3-4	
Friday, July 11th	Calculus	Pt. 5-7	
Saturday, July 12th			
Sunday, July 13th	History	Pt. 1-2	
Monday, July 14th	History	Act. 1	
Tuesday, July 15th	History	Pt. 3	
Wednesday, July 16th	History	Pt. 4-5	
Thursday, July 17th	History	Pt. 6	
Friday, July 18th			
Saturday, July 19th	TYAS	To pg 75	
Sunday, July 20th	TYAS	To pg 150	
Monday, July 21st			
Tuesday, July 22nd			
Wednesday, July 23rd			
Thursday, July 24th			
Friday, July 25th	TYAS	To pg 225	
Saturday, July 26th	TYAS	To End	
Sunday, July 27th			
Monday, July 28th			
Tuesday, July 29th	HMDD	To pg 50	
Wednesday, July 30th	HMDD	To pg 100	
Thursday, July 31st	HMDD	To end	
Friday, August 1st			
Saturday, August 2nd			
Sunday, August 3rd			
Monday, August 4th			
Tuesday, August 5th			

Date	Subject	Length	?
Wednesday, Aug. 6th			
Thursday, August 7th			
Friday, August 8th			
Saturday, August 9th			
Sunday, August 10th			
Monday, August 11th	East of Eden	To pg 100	
Tuesday, August 12th	East of Eden	To pg 200	
Wednesday, Aug. 13th	East of Eden	To pg 300	
Thursday, August 14th	East of Eden	To pg 400	
Friday, August 15th	East of Eden	To pg 500	
Saturday, August 16th	East of Eden	To pg 600	
Sunday, August 17th			
Monday, August 18th	TYAS	To pg 100	
Tuesday, August 19th	TYAS	To pg 200	
Wednesday, Aug.20th	TYAS	To End	
Thursday, August 21st			
Friday, August 22nd	HMDD	To pg 100	
Saturday, August 23rd	HMDD	To end	
Sunday, August 24th			
Monday, August 25th			

2nd Edition

Study for Tests

Active Vs. Passive Learning

Passive Learning is:

- Underlining
- Taking notes in lecture
- Reading chapter, study guide or notes
- Fairly relaxed

Active Vs. Passive Learning

Active Learning is:

- Challenging
- Involves encoding information into memory
- Takes repetition
- Quizzing by helper or alone
- Discussing the concepts orally

Passive learning is the main reason for doing poorly on a test.

49

Study Assist Programs

- Quizlet
- Cornell Notes
- Learn Smart

50

Problems Relying on the Study Guide

- Given at the last minute as a class assignment
- May get the wrong answers
- Learn by proxemics and other cues
- Recognition only

51

Use Study Cards

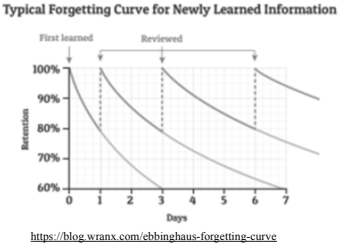
52

The Leitner System of Study

- German Psychologist Ebbinghaus found we forget 75% of what we learn after 48 hours
- We need repetition for our neural networks to learn
- We retain more with less effort with spaced reviews

53

Recalling Ability



https://blog.wranx.com/ebbinghaus-forgetting-curve

54

Eat an Orange – Seriously!

During intense study or a test, your brain uses more power than the rest of your entire body

Brain runs on sugar – special cells feed the neurons

Too much of wrong sugar (carbs) = Brain crash, brain mush, sleepy, sluggish

Perfect food:

Orange –pectin- complex sugar takes 4-8 hours to digest. Will hit the perfect peak of enough, not too much sugar

Overall ↑Protein ↓Low Carbs

55

Facing Problems

56

Facing Problems: Pathological Slowness

- Hallmark neuropsychological symptom
- Can be improved
- **ERP** involves:
  - Time estimate and pacing
  - Learning "the end" – Plan ahead
  - 91% vs. 125%
  - Practice and patience

57

OCD Perfection Traps

- "Always try your hardest"
- "If you are going to do it, do it right"

58

Assessing Importance

Overall Goal:

To align our investment with the actual demand

Worksheet helps us:

- Determine how much it counts (weighted significance)
- Match the detail needed
- Estimate intellectual demand
- Estimate need for accuracy (error ratio)

Summary of data helps us determine how much energy to expend

59

Assessing Importance Worksheet

Overall Goal: To align our investment with the actual demand

How much does this count towards my grade? __%__

(weighted significance)

How much detail is required?

High Medium Low

What is the level of accuracy required?

High Medium Low

What is the intellectual demand?

(how difficult) High Medium Low

Summary of the data = how much energy to expend

60

Chunking and Time Pacing

A process which is actually **ERP** to address:

- Pathological slowness
- Perfection
- Doubt

61

Chunking and Time Pacing

You will need:

Teacher Time Estimate Sheet

- List each assignment
- Provide estimated time to complete for average student

To Multiply by Accommodation Factor

- May be 2x in beginning
- Reduce to 1.5x with mastery
- Goal – to complete in average time

62

Chunking and Time Pacing

Take Assignment and Chunk

- Start with 10 minute chunks
  - Use a highlighter
  - Cut the paper
- Allow 10 minutes **ONLY**
- When time is up, **TURN IN**
- Regardless of quality or finished
- Continue to completion

63

Chunking and Time Pacing

Remember:

A finished paper, turned in on time, with a few errors or omissions is **BETTER** than one that is 20% completed (turned in?) and no errors (perfect).

As a student's skill improves, time is increased and chunks are larger.

64

Chunking and Time Pacing

Two factors

- Improvement by using **ERP**
- Neurological improvement

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Sample Teacher Time Estimate Sheet

English

Lesson 1	Assign. 2 -120 min.	**Lesson 4**	Quiz 1 – 20 min.
	Assign. 3 -30 min.		Quiz 2 – 20 min.
200 min.	Quiz 2 – 20 min.		Essay – 60 min.
	P – 30 min.	*160 min.*	Quiz 3 – 20 min.
			Assign. 2 – 20 min.
Lesson 2	Assign. 3 – P 30 min.		Quiz 4 – 20 min.
Lesson 3	Quiz 1 – 20 min.	**Lesson 5**	Assign. 1 Evaluation
	Quiz 2 – 20 min.		Response - 60 min.
60 min.	Assign. 1 – 20 min.		Assign. 2 – 60 min.
			Quiz 1 – 20 min.
		340 min.	Assign. 3 – 20 min.
			Assign. 4 Poem - 60 min.
			Assign. 5 Commercial -120 min.

66

ERP – Forced Writing Practice

Goal: To practice timed writing exercises

- Start with 1-2 minutes (assigned time)
- Paper has a limited box size
- Pencil/pen to paper and immediately start writing from your head to hand
- Pencil/pen doesn't leave paper – keep writing
- Not about quality, about skill
- Can provide prompts
  Ex: Why are squirrels better than opossums?
  Reasons blue is better than orange?

67

ERP – Bottom Lining or Summarizing

- Can be difficult for students with **OCD**
- Challenge: Leave out extraneous details
  Include only the "big picture"
- Increasing requirement in school at the end of class
- Check for understanding
- Called: exit ticket, take home points, etc.
- Practice writing main idea in one sentence
- Helps to provide limited box to write in

68

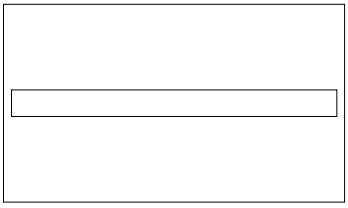
Facing Problems: Rereading as a Ritual

- Trigger is doubt – ritual is checking
- All readers use induction and deduction
- **ERP** involves:
  - Reading Card I Use
    - Read aloud
    - Read quietly
    - Read silently
  - Reading Card II Use
  - Fade to finger guide
  - Practice and rewards

69

Facing Problems: Rereading as a Ritual

Reading Card #1



* Cut hole the size of one line, about midway on the index card.

70

Facing Problems: Rewriting as a Ritual

- Trigger is the need for "just so"
- Can include erasing
- **ERP** involves:
  - Use of pen only
  - Cross-out reduction
  - Paradoxical mistakes
  - Practice, humor and rewards

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Summary

Although kids with OCD may display deficits related to planning, organizational and study skills, they can learn ways to compensate by adding structure, and using specific study skill tools.

This allows an OCD student to feel more comfortable and successful in the academic setting.

72

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Do's and Don'ts When Treating OCD with Multicultural Families

DO'S AND DON'TS WHEN TREATING OCD WITH MULTICULTURAL FAMILIES

JENNY C. YIP, PSY.D., ABPP
SARAH HAIDER, PSY.D.
CINDI GAYLE, PH.D.
JAMILAH R. GEORGE, M.DIV.
JESSICA PARLOR, M.A.

WHEN HELPING HURTS TYPES OF ENABLING & ACCOMMODATIONS

- Reassuring senseless fears.
- Waiting while child performs rituals.
- Doing rituals for child or participating in it.
- Providing supplies for rituals.
- Doing things for child s/he can do.
- Allowing child to avoid situations.
- Not talking about things that provoke anxiety.
- Putting up with unusual demands.
- Showing fear.
- Giving up self-care time.
- Not setting limits/consequences.

FAMILY TREATMENT GOALS NORMAL VS. OCD ACCOMMODATIONS

Normal, Healthy Family	OCD Family Accommodations
Parents meet child's needs	Parents provide basic necessity only if unrelated to OCD.
Parents comfort child	Parents provide space for children to tolerate discomfort.
Parents protect child	Parents keep children safe from real dangers and NOT from OCD
Parents care for child	Parents encourage self-sufficiency
Parents encourage & support children	Parents support child w/o supporting OCD
Parents reassure child	Parents foster uncertainty

CASE VIGNETTE: 16YO HENRY WITH OCD

Obsessions	Compulsions
Being punished by God	Repeating to good thoughts & numbers
Bad words, numbers, songs	Completing any action & ending the day to good thoughts
Losing appearance, athletic skills	Mental phrases & prayers to undo bad thoughts

- A/B grades in school
- Athletic and competitive
- Refuses to complete household chores
- Argumentative and verbally combative with parents
- Hostility & aggression toward father
- Pleasant and likeable by peers and other authorities
- Police have been to the house many times for property destruction
- Has caused $8k in property damages
- Has missed school for 5 mos

CASE VIGNETTE: 16YO HENRY – CULTURAL FACTORS

- Mother is 1st generation minority (i.e., African- , Latino- , Asian-American).
- Father is 3rd generation Irish-Caucasian.
- Older sister (+3yrs) is away at college and is resentful of how IP treats their parents.
- Mother is motivated & committed toward treatment.
- Father tags along, though is skeptical, unmotivated, & not committed.
- IP is motivated, yet lacks commitment when exposures become challenging.

CASE VIGNETTE: 16YO HENRY – CULTURAL FACTORS

- Mother is a homemaker, has undiagnosed contamination OCD that isn't talked about, and accommodates to IP's OCD demands to maintain peace.
  - ✓ Avoids watching or listening to anything with bad words without headphones.
  - ✓ Must remain quiet while IP completes mental rituals to good numbers & thoughts.
  - ✓ Avoids doing things to bad numbers (i.e., meal prep, waking IP up, etc).
- Father is a litigation attorney who is partner to a firm, works 80+hrs/wk, and is rarely home.

CULTURALLY RELEVANT FEATURES

TREATING AFRICAN-AMERICAN FAMILIES WITH OCD

JAMILAH R. GEORGE, M.DIV.
JESSICA PARLOR, M.A.

UNDERSTANDING AFRICAN-AMERICAN FAMILIES & ROLES

Culturally Relevant Features

- ➢ Historical influences & Adversity
  - ✓ Legacy of slavery & mistrust of medical institutions
- ➢ AA and mental health professionals
  - ✓ Current trend in treatment-seeking population
  - ✓ Continued barriers to treatment access
- ➢ Nuanced family boundaries

Accommodating Patterns

- ➢ Stigma
- ➢ Perceived Weakness
- ➢ Religion* (accommodation or support)

TREATING AFRICAN-AMERICAN FAMILIES

- ➢ Continuing Education: Seeking & applying information on cultural competency and flexibility
- ➢ Strategies to strengthen hierarchies
  - ✓ Invitation to create and implement safe space
    - Assessing daily cultural and race/ethnicity based experiences
    - Ex: Do you ask pts about their experience with race/ethnicity?
  - ✓ Introduce cultural components of anxiety presentation into case conceptualization & tx planning
  - ✓ Psycho-ed :
    - Addressing absence of healthy behavior modeling
    - Hx of over diagnosing → Importance of trained & culturally competent clinicians

TREATING AFRICAN-AMERICAN FAMILIES

- ➢ Strategies to strengthen boundaries
  - ✓ Offering family / care giver inclusive tx plans
  - ✓ Community collaboration
    - Ex: Spiritual/religious leaders
  - Reframing of Mental Health Services as empowering

CULTURALLY RELEVANT FEATURES

TREATING LATIN-AMERICAN FAMILIES WITH OCD

CINDI GAYLE, PH.D.

CULTURALLY RELEVANT FEATURES

TREATING ASIAN AMERICAN FAMILIES WITH OCD

JENNY C. YIP, PSY.D., ABPP

UNDERSTANDING ASIAN-AMERICAN FAMILIES & ROLES

- Relationships with and across generations are effected by beliefs in caste and karma.
- Obedience, discipline toward success, and high work ethic are valued.
- Spirituality and simplicity are applauded, and family-centeredness take priority over individual needs.
  - ✓Respect = obedience to the family and culture.
  - ✓Love includes loyalty and control.
- Men exert enormous social and economic power over women and children.
- Women realize power by exerting control over women of lesser status.

UNDERSTANDING ASIAN-AMERICAN FAMILIES & ROLES

- Fathers are responsible for the education, economics, and values of their male children, and care of their elderly parents.
- Mothers expect sons to control their wives re: money, work, socially.
- First-born males are preferred and enhances parents' status within the family.
- Sons have strong ties with mothers; connectedness with fathers involve obedience.
- Daughters are given excess adult responsibilities.
- Young children are overprotected by grandparents.
- Men are often torn between supporting their wives vs. respecting their mothers.
- Children are taught to avoid direct eye contact and disagreements with their elders.
- Elderlies are respected for their wisdom.

TREATING ASIAN-AMERICAN FAMILIES

- Strategies to Enhance Healthy Hierarchies:
  - ✓Inquire gently with respectful persistence into family's beliefs about caste and karma.
  - ✓Strengthen the parental role of mothers and fathers as equal partners and disciplinarians.
  - ✓Empower women, so they do not need to rely on the in-law system for power and control.
  - ✓Minimize in-law intrusiveness from parental roles.

TREATING ASIAN-AMERICAN FAMILIES

- Strategies to Strengthen Boundaries:
  - ✓Help family members reframe tx success as that of IP's individual achievement vs. family accommodations.
  - ✓Help men find constructive solutions that will enhance nurturance of their partners while maintaining loyalty toward families of origin.
  - ✓Help grandparents utilize their "wisdom" with grandchildren rather than overprotect them.
  - ✓Since emotions are neither identified nor acknowledged, encourage families to speak about their problems within the context of their cultural heritage.

CULTURALLY RELEVANT FEATURES

TREATING VARIOUS CAUCASIAN FAMILIES WITH OCD

SARAH HAIDER, PSY.D.

UNDERSTANDING VARIOUS CAUCASIAN-MULTIRACIAL FAMILIES & ROLES

Caucasian Families

- Assess for family background and ethnicity specifically within Caucasian population. Determine family's awareness of their own cultural background.
- Families with an immigrant parent may primarily identify with country of origin
  - ✓Language may be a barrier. Idioms may be a barrier.
  - ✓IP may take on adult responsibilities on behalf of parents
  - ✓May be trauma/grief/loss from from leaving behind country of origin, even if by choice.
  - ✓Parents may not have support/presence of extended family
  - ✓May be less awareness of OCD, severe anxiety disorders
- Some Caucasians may primarily identify with religion (e.g., being Jewish may be more core to someone's ethnic identity than their skin tone)
- Religious considerations: Muslim*Catholicism*Judaism*Protestant

UNDERSTANDING VARIOUS CAUCASIAN-MULTIRACIAL FAMILIES & ROLES

Multicultural Families - The New "Modern Family"

- In 2010, 15% of marriages were between partners of different ethnicities/races (Pew Research Center, 2014)
- Multicultural families may pride themselves on doing things their own way
- Within multicultural families, choosing to adhere to core values from each culture may be deliberate vs inherent
- Conversely, parents may enter therapy room with very different approaches and expectations.

TREATING CAUCASIAN-MULTIRACIAL FAMILIES

- During evaluation, inquire into ethnicity of spouse, and family members who are not present. Inquire into ethnicity of step-parents who may not be present.
- Determine communication patterns within the family system
- Look to the cultural norm for a guideline, yet determine how each family communicates within their own system
- Brief gene-o-grams during evaluation can shed light on family dynamics relevant to that particular culture/ethnicity.
- Within a multicultural family, determine mechanism that contributed to multiculturalism: adoption, immigration prior to meeting spouse, escaping family of origin, love, extended family history of multicultural marriages
- IP may identify with one parent's religion or ethnic background more so than the other. Must consider this when creating treatment plan and in approach to treatment.

UNDERSTANDING VARIOUS CAUCASIAN-MULTIRACIAL FAMILIES & ROLES

TREATING CAUCASIAN-MULTIRACIAL FAMILIES

Q&A

The Bergen 4-day Treatment (B4DT): A novel, Concentrated Treatment for Long-Term Change

Gerd Kvale, PhD
Professor, Department of Clinical Psychology, University of Bergen; Head of The National 4-day Clinic; Head of the OCD-team, Haukeland University Hospital

Bjarne Hansen, PhD
Associate Professor, Department of Clinical Psychology, University of Bergen; Deputy of The National 4-day Clinic; Deputy of the OCD-team, Haukeland University Hospital

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Behav. Res. & Therapy, 1966, Vol. 4, pp. 273 to 280. Pergamon Press Ltd. Printed in England

MODIFICATION OF EXPECTATIONS IN CASES WITH OBSESSIONAL RITUALS

V. MEYER
Academic Department of Psychiatry Middlesex Hospital Medical School, London

(*Received* 6 *May* 1966)

Summary—Some theoretical issues in relation to the nature of obsessional rituals and th
adopted method of behaviour therapy for this disorder are critically considered. On the
siderations, a different method—"modification of expectations" or "reality testing" is p
successful application to two patients described and discussed.

Treatment of OCD – What is the state of art?

- CBT and related treatments: Highly effective
- CBT=CT=ERP > medication
- Robust in several formats

Haukeland University Hospital BERGEN

The Bergen OCD-clinic

Evidence based treatment + quality assessment + research= True

- Established in 2011 as an initiative from the UoB
- A genuine combination of academia + health services
- **"Combine all we expect might work without letting infrastructure be a limitation"**
- Not compromise on quality - quality assessment integrated
- Start with OCD – aim for a clinic for anxiety disorders
- Always address dissemination (certification of teams, not individuals)

The Bergen OCD-clinic

- Specialist health care r**equired to offer treatment to all severe OCD patients** in the catchment area of 420.000
- **No selection based on comorbidity** (but do not start treatment if suicidal, psychotic, active bi-polar, active substance abuser)
- 4-day format now standard
- Quality assessment integrated – online since Sept 2015
- Independent raters post treatment and follow up
- Re-referred if relapse

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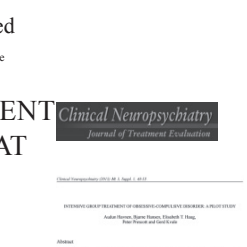
The Bergen 4-day treatment (B4DT)

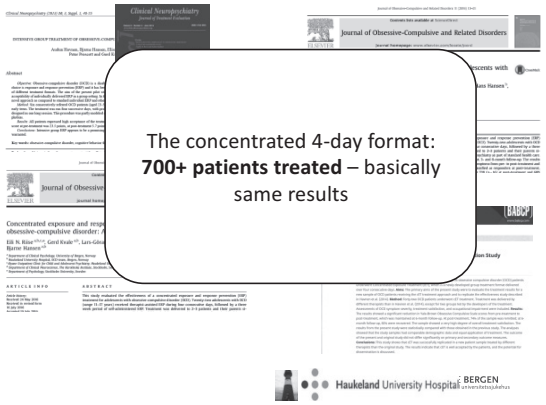
- Developed for the most severe anxiety disorders
- Basically no drop-out
- Better than «gold standard»
- Improves depression
- Get patients back to work
- 50% less resources allocated to the actual treatment
- **So far more than 700 treated with very good results**

The 4-day format introduced as pre-treatment…. and became

INDIVDUAL TREATMENT IN A GROUP FORMAT



Haukeland University Hospital BERGEN



The concentrated 4-day format: **700+ patients treated** – basically same results

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COMORBIDITY IS NOT EXCLUSION CRITERIUM

But patients are not offered treatment if they are:

- Suicidal
- Bipolar in a manic phase
- Substance abuser
- Psychotic
- BMI too low to be able to gain from psychological interventions

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Patients want and like the treatment

(Patient Satisfaction Questionnaire)

Client satisfaction questionnaire	1	2	3	4
1. Quality of treatment		3 %	27 %	70 %
2. The treatment you wanted?			40 %	60 %
3. Satisfied your needs?		3	46 %	51 %
4. Recommend to a friend?			16 %	84 %
5. Satisfied with the extent of treatment?			27 %	73 %
6. Helped to deal with problems?			24 %	76 %
7. Overall, how satisfied are you?		3 %	21 %	76 %
8. Return to our clinic?			16 %	84 %

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The B4DT works regardless of

- Severity of the disorder
- Comorbidity
- Duration of the disorder
- Indications of personality disorder

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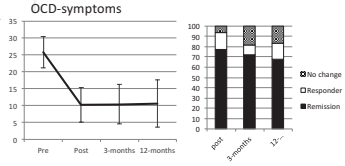
REPLICATION

OCD-symptoms

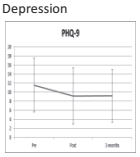


One week after treatment: 90% show clinically significant changes

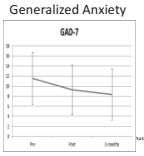
At follow up (3 months, 6 months, 12 months) Nearly 70% are recovered

Improves depression and generalized anxiety

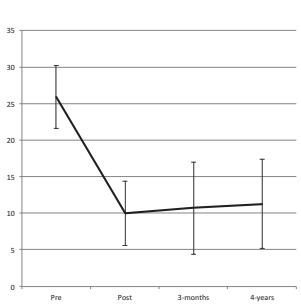
Depression

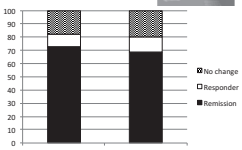


Generalized Anxiety



Four years later 68% are recovered!





International consensus criteria from Cols et al., 2016

Hansen, B., Kvale, G., Hagen, K., Havnen, A., & Öst, L-G. (In press) The Bergen 4-Day Treatment for OCD: Four years-follow-up of concentrated ERP in a clinical mental health care setting. Cognitive Behaviour Therapy

THE ULTIMATE TEST OF THE FORMAT

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Haukeland universitetssjukehus

"Erasing waiting lists at Oslo University Hospital "

100 patients with OCD treated in two separate weeks

50 therapists trained in delivering the treatment


Medisin

Kutter ventelister på dugnad

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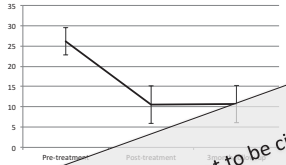
Haukeland universitetssjukehus

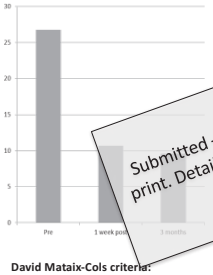
8 parallel groups - 50 patients treated during 1 week in Oslo x 2! Same results



Submitted – not to be cited until in print. Details will be presented at the meeting

Y-BOCS

Replication, new site…. SAME RESULTS



Submitted – not to be cited until in print. Details will be presented at the meeting

Status 1 week	Percent
Unchanged (not 35% change)	6,3 %
Improved (35% or more change)	93,7 %
Recovered (35% change & Y-BOCS ≤ 12	75,0 %

Status 3 months	Percent
Unchanged (not 35% change)	20,7 %
Improved (35% or more change)	79,3 %
Recovered (35% change & Y-BOCS ≤ 12	69,0 %

David Mataix-Cols criteria:
Improved= Min 35% change
Recovered: Y-BOCS of 12 or lower

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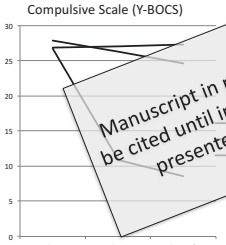
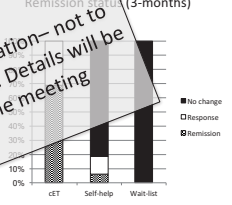
Randomized controlled trial completed – excellent results

Yale Brown Obsessive Compulsive Scale (Y-BOCS)



Manuscript in preparation– not to be cited until in print. Details will be presented at the meeting

Remission status (3-months)



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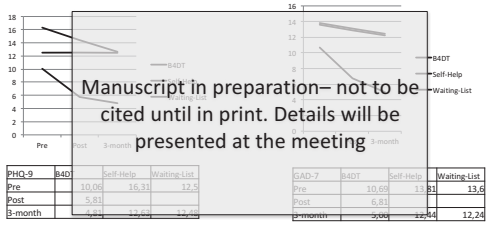
Randomized controlled trial: With significant effects also for depression and anxiety

Depression (PHQ-9)

Generalized Anxiety (GAD-7)



Manuscript in preparation– not to be cited until in print. Details will be presented at the meeting

PHQ-9	B4DT	Self-Help	Waiting-List
Pre	10,06	16,31	12,5
Post	5,81		
3-month	4,81	12,63	12,48

GAD-7	B4DT	Self-Help	Waiting-List
Pre	10,69	13,81	13,6
Post	6,81		
3-month	5,06	12,44	12,24

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GOING ABROAD

ICELAND

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Implementation of the Bergen 4-day treatment (B4DT) for OCD in Iceland

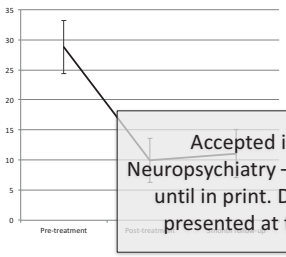
Sóley D. Davíðsdóttir, Ólafía Sigurjónsdóttir, Sigurbjörg Jóna Ludvigsdóttir, Bjarne Hansen Inger Lill Laukvik, Kristen Hagen, Throstur Björgvinsson og Gerd Kvale

HELSE BERGEN Haukeland University Hospital

KVÍÐAMEÐFERÐARSTÖÐIN

HELSE BERGEN Haukeland universitetssjukehus

Iceland: SAME RESULTS



Accepted in Clinical Neuropsychiatry – not to be cited until in print. Details will be presented at the meeting

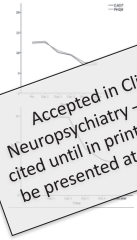
K-BOCS	M	SD	d
Pre-treatment	23.29	4.42	
Post-treatment	9.95	3.67	4.26
3-month follow-up	11.05	5.89	4.01

KVÍÐAMEÐFERÐARSTÖÐIN HELSE BERGEN Haukeland universitetssjukehus

Results from Iceland: Significant improvement on anxiety and depression

Significant decrease in depression and generalized anxiety symptoms

Significant decrease in OCD symptom severity on the secondary measure, DOCS-SF



Accepted in Clinical Neuropsychiatry – not to be cited until in print. Details will be presented at the meeting

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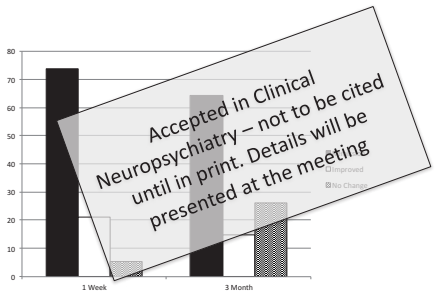
Results from Iceland: THE SAME



Accepted in Clinical Neuropsychiatry – not to be cited until in print. Details will be presented at the meeting

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The patients: "One word describing the results"

- Unbelievable
- Freedom
- Life Changing
- Difficult but worth it
- Unbelievable
- Great
- Awesome
- Amazing

All patients would recommend the treatment to other

KVÍÐAMEÐFERÐARSTÖÐIN HELSE BERGEN Haukeland universitetssjukehus

Comments from the Icelandic team

- A fun and educative format to work as a psychologist
- We really get to be hands on and get to dig into the most important issues the patients has
- Much better insight into the problem since you get to see the patient in action
- It combines qualities of individual treatment sessions and group treatment in a very good way
- It gives the therapists good support and restraints and minimizes therapist drift
- …..And it is much more fun!

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Comments from the Icelandic team, continued

- The focus on teaching and training a technique and doing -not just talking
- The focus on letting the patient take responsibility for finding the best exposures and the therapist being there to guide and encourage
- The treatment makes sense for the patient – the metaphors hit the nail on the head
- We manage to do more in 2 days with the patient than in many weeks, even months of doing treatment as usual

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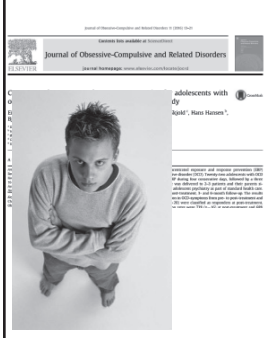
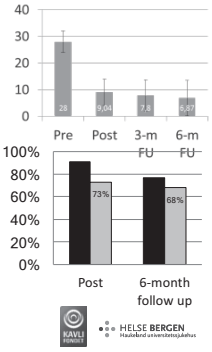
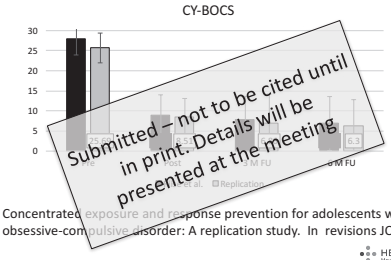
What about children and adolescents? Amazing results – even better than adults





KAVLI TRUST HELSE BERGEN Haukeland universitetssjukehus

Bergen 4-day treatment for children and adolescents, OCD: Replication, 2018. SAME RESULTS

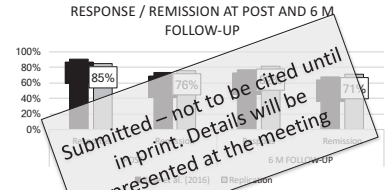


Submitted – not to be cited until in print. Details will be presented at the meeting

Concentrated exposure and response prevention for adolescents with obsessive-compulsive disorder: A replication study. In revisions JOCRD.

HELSE BERGEN Haukeland universitetssjukehus

Bergen 4-day treatment for children and adolescents, OCD: Replication, 2018. Same results!



Submitted – not to be cited until in print. Details will be presented at the meeting

Concentrated exposure and response prevention for adolescents with obsessive-compulsive disorder: A replication study.

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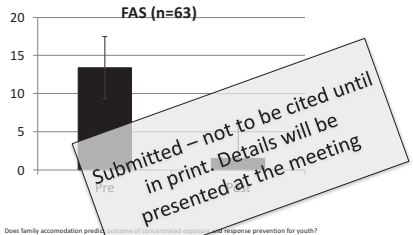
THE FAMILY CHANGE – FOR THE BETTER – AFTER B4DT

Family accommodation



Submitted – not to be cited until in print. Details will be presented at the meeting

Does family accomodation predict outcome of concentrated exposure and response prevention for youth?

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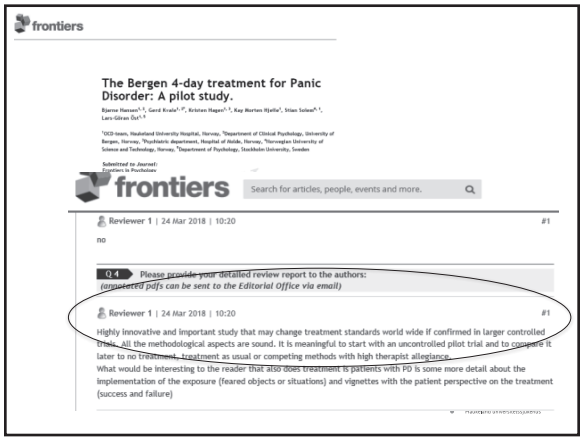
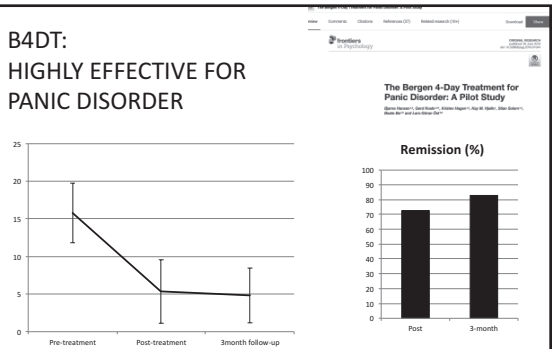


B4DT:
HIGHLY EFFECTIVE FOR PANIC DISORDER



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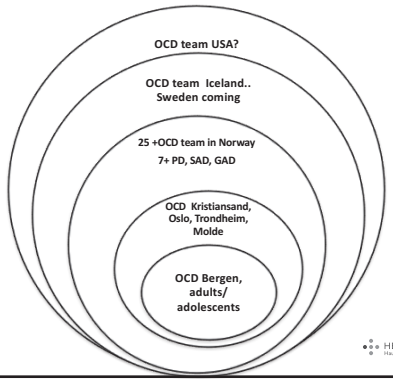
Patients, relatives, clinicians, clinics.. want the B4DT



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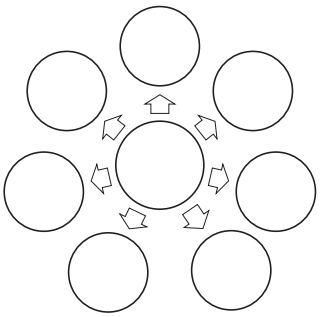
The research



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Can psychological treament induce changes in the brain?

PI: Gerd Kvale, co-PI Bjarne Hansen, Haukeland University Hospital, Norway; Partner Odile van den Heuvel, VUMC, Amsterdam. FINANCED BY REGIONAL SPECIALIST HEALTH, WESTERN NORWAY. DATA COLLECTING COMPLETED SPRING 2018)

OPEN

ORIGINAL ARTICLE

Mechanisms of cognitive-behavioral therapy for obsessive-compulsive disorder involve robust and extensive increases in brain network connectivity

ARCHIVAL REPORT

The Effects of Pharmacological Treatment on Functional Brain Connectome in Obsessive-Compulsive Disorder

Da-Jung Shin, Wi Hoon Jung, Yong Ho, Jinhui Wang, Geumsook Shim, Min Soo Byun, Joon Hwan Jang, Sung Nyun Kim, Tae Young Lee, Hye Youn Park, and Jun Soo Kwon

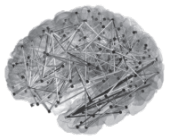
Multivariate resting-state functional connectivity predicts response to cognitive behavioral therapy in obsessive–compulsive disorder

Nicco Reggente, Tonia D. Moody, Francesca Morfini, Courtney Sheen, Jesse Rissman, Joseph O'Neill, and Jamie D. Feusner

Psychiatry Research: Neuroimaging

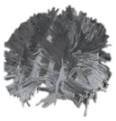
Neuroimaging of psychotherapy for obsessive-compulsive disorder: A systematic review

Functional and structural MR

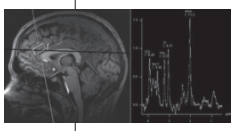


Functional networks

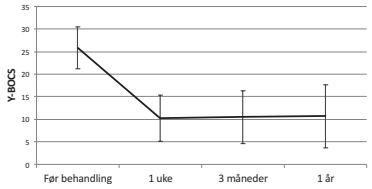
Cognitive end emotional functions



Structural changes



Neurochemistry



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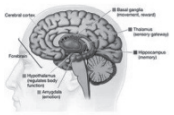
Haukeland universitetssjukehus

The difficult to treat anxiety patient: New treatment approaches

A randomized placebo controlled multi-center study

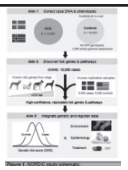


PI: Gerd Kvale, co-PI Bjarne Hansen, Haukeland University Hospital, Norway; Partners: Gunvor Launes,Sørlandet Sykehus; Unn beate Kristensen, OUS; Svein Haset, St. Olavs Hospital; Kristen Hagen, Molde Sykehus

International partners: Michael Davis, University of Atlanta (emeritus); Michelle Craske, UCLA; Jonathan Abramowitz, University of North Carolina; Martin Franklin, University of Philadelphia; Joseph A. Himle, University of Michigan, Lars-Göran Öst, University of Stockholm (emeritus).
NATIONAL STUDY, NORWAY. FINANCED BY BODY FOR NATIONAL RESEARCH, HEALTH REGIONS.

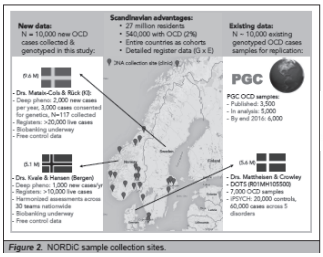
Dear Gerd, Bjarne and all involved in the DCS-study,
Congratulations to all of us for completing the largest (as far as I know) study, both of difficult to treat OCD-patients and of DCS. And doing this in 20 months instead of the projected 24 months! I have never heard of a therapy RCT of this size being completed ahead of time, and without any drop-outs and very little loss of data! This would be an enormous achievement in a university setiing and it was carried out in community settings across Norway! I am really impressed and look forward to breaking the blind after the 1-year follow-up assessment.

Best wishes,
Lars-Göran



Predisposing genes? (NIMH-funded)

OCD: Novel Comparative Genomic Approaches to Identify Disease and Treatment Mechanisms
***PI:** Jim Crowley, University of North Carolina; **PI Norway**: Gerd Kvale; **PI Sweden**: David Mataix Cols, **PI Denmark**: Mads Mathiesen.* FINANCED BY NIMH, DECEMBER 2016 – 2021 →).



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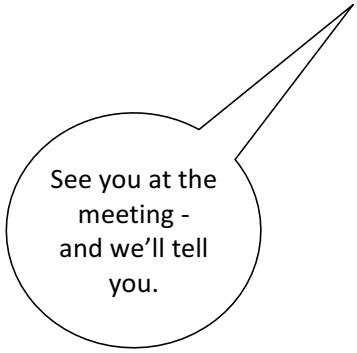
The Bergen 4-day treatment

- Highly attractive for patients, relatives and clinicians
- Low selection of patients
- Basically no drop-out
- After 4 years: 68% recovered + 15% clinical change
- Improves depression and generalized anxiety
- Gets patients back to work
- Works equally good for children and adolescents
- More than 700 treated
- Works in new sites
- Completed a randomized trial
- Works in a new culture

So what are we actually doing..?



USING OCD TO FIND YOUR VOICE! SLAM POETRY FOR TEENS WITH OCD

Zoe Homonoff and Megan Abramyk

TONIGHT'S AGENDA

- Ground rules for this activity
- Video/Demonstration: How can someone use OCD as a topic for poetry?
- Tips and Tricks for writing poetry
- Writing time! (prompts will be given, too)
- The Performance

DA RULES

1. Don't pressure others into sharing--and don't pressure yourself, either! This is a fun and safe environment.
2. Don't laugh at or make rude remarks about anything that a person shares; it takes courage to share.
3. Do push yourself to create a work that is meaningful both yourself and others. Read it over. Stylize it. Make it your own.
4. It's okay to take a breather, or to leave at any time.

NEIL HILBORN'S POEM, "OCD"

Thoughts on "OCD" (by Neil Hilborn)?

TIPS AND TRICKS FOR WRITING POETRY:

- You don't have to rhyme, but you DO have to think about your ***rhythm.***
  - I.e. think about the syllables and the sounds that the words make.
- If you're stuck, just write about something that you're thinking about--worry about form and formalities later!
- Avoid using cliche terms and phrases. Try to talk about your topic in a new way.
- Collaboration is always welcome, as is looking online for ideas.
- Use imagery and have a vision.
  - e.g. picture an image in your head, and try to describe it.
- Think about how you'd talk to a person about your topic. Be conversive!
  - Remember, MOST OF YOU will be sharing!

AND NOW… WE WRITE!
HERE ARE 2 IDEAS TO GET YOU STARTED:

"Morning, and evening,
It's you and me
But I'm more than my--
the--OCD . . ."

"A Letter to OCD"
If you could write to OCD, what would you say?

THE PERFORMANCE!

Reflections!

- **Add depth**
- **Take your time**
- **Remember guidelines (Da Rules)**

THANK YOU!! ☺

DBT and ERP for Treatment Refractory OCD

Fugen Neziroglu, Ph.D., ABBP, ABPP
Brittany Bonasera
Casey Ferri
Nathaniel Lewis

Bio Behavioral Institute
935 Northern Blvd, Suite 102
Great Neck, NY, 11021
www.biobehavioralinstitute.com/

Overview

- Treatment-refractory (resistant) OCD
- When to use DBT
- ERP
- Suicidal Ideation
- Good Candidates for DBT

Meeting Treatment-Refractory OCD Criteria

- Patient must have tried & received no benefit from each of the following:
  - Min. of 3 different SSRIs at max dosage for at least 3-6 months
  - Along with 30 hours behavioral therapy in conjunction with 2 individual atypical antipsychotics
- Inadequate response defined by International Treatment-Refractory OCD Consortium as a less than 25% reduction in Y-BOCS score after treatment

CBT-Refractory OCD

Sookman and Steketee (2007) defined CBT resistance as:

- Patient does not fully engage in exposure
- Incomplete response prevention
- Behavioral and cognitive rituals persist
- Symptoms (beliefs, behaviors) are not reduced to non disruptive levels
  - "I experience [obsession], which makes me want to engage in [compulsion], but I learned in therapy the thoughts are harmless."
- Evaluated after treatment ends

Why are some patients treatment refractory?

- Patient
  - Disease severity
  - Medical comorbidity
  - Psychiatric comorbidity (mood, personality, and/or substance use disorders)
  - Treatment nonadherence
  - Cultural factors
- Environment
  - Childhood stressors (trauma, abuse)
  - Long-term persistent stressors (psychosocial, occupational, financial)
  - Life stages
  - Lack of knowledge in primary care (brief treatment duration, subtherapeutic dosing)
  - Limited doctor-patient relationship (eg, availability/cost of treatment)

(Khalsa, 2011)

Why are some patients treatment refractory?

- Pathology-related
  - Underlying disease pathophysiology (largely unknown)
  - Multiple neurotransmitter system interactions
  - Polygenetic influences (genetic load)
  - Gene-environment interactions
  - Neural circuits (cortical and subcortical feedback loops)
  - Diagnostic variance (dimensional vs categorical vs target symptom approach)
  - Syndromal variation (differing presentations over time)
  - **Treatment limitations (limited empirical studies, nonrepresentative study samples)**

(Khalsa, 2011)

Considerations for Treatment Refractory OCD

Primary considerations when OCD case appears to be treatment-refractory:

- Review accuracy of diagnosis
- Was the first-line treatment given for the right amount of time (or dosage for medication)
- Are there comorbidities that may affect treatment response
- Are there other prescribed drugs that may interact with OCD regimen

A Call for New Treatment Options

- When an OCD sufferer fails to respond to treatment, we as professionals offer:
- More sessions of cognitive therapy
- More intense or frequent ERP
- Higher dosages or different SSRIs

Current strategies for treatment-refractory OCD

Few studies look at nonresponse to CBT (Albert et al., 2013)

- CBT often an augment for adolescents who do not respond to initial SRI treatment (Bloch & Storch, 2015)

For SSRI treatment:

- Best to maintain treatment in case of a delayed response
- Also evidence for increasing dose of SSRI
- Evidence for adding atypical neuroleptics to standard SSRI regimen

ERP: Elements of Effective ERP

First line treatment for OCD

- Total ritual prevention
- Intensive sessions with constant homework
- More in-session exposure than homework exposure
- Combined In-vivo and imaginal exposure
- Prevention of reassurance seeking

Best Candidates for ERP

- Patients who are willing to confront their fears and compulsions
- If the anxiety which follows refraining from a compulsion can be managed
- If medication or other forms of therapy are ineffective
- Patients who are prepared & committed to devote extensive time to homework and weekly exposures

St. Louis Model

Intensive outpatient ERP for treatment refractory-OCD Used when:

- first run of ERP is unsuccessful
- patient shows treatment interfering behaviors Involves:
- 2-6 hours of ERP per day
- therapist-monitored ERP
- fading of therapist involvement in ERP
- brief group sessions
- Accompanied by therapy using other CB interventions (e.g. cognitive restructuring)

When ERP Doesn't Work Alone

- Patients with high OVI
  - Denial of the problem
- Unwilling to confront their fears and compulsions
- Anxiety becomes too much to manage
- Compulsions and stressors increase with treatment

DBT and ERP

DBT strongly emphasizes acceptance & non-judgement to one's thoughts

- Used to cope with OCD-related anxiety
- does not directly address obsessions and compulsions.
- ERP directly addresses obsessions and compulsions.
- Focused on making measurable behavioral changes
- Does not have an emphasis of unconditional acceptance of one's thoughts

When to Use DBT for OCD

- Adjunct treatment; ERP is first line
- Partial or little response to standard ERP
- For those with low tolerance for anxiety
  - Difficulty tolerating anxiety/distress associated with ERP
- For those with thought-action fusion
- For those who exhibit therapy interfering behaviors
  - frequent cancellations, conflict with therapist, difficulty completing therapy HW, etc.

When to Use DBT for OCD

- When medication or CBT fail to reduce symptoms of OCD
- Patients who seek to control their overwhelming emotions.

DBT comprised of building four basic skills:
- Distress Tolerance
- Emotional Regulation
- Interpersonal Effectiveness
- Mindfulness

- Therapist must build and maintain trust with patient
  - Patient then more likely to take risks and pursue change in therapy

Applying DBT Modules

Distress Tolerance:
- Self soothe disturbing thoughts or emotions.

Emotional Regulation:
- Manage anxiety related to obsessions and/or fear
- Realize anxiety will decrease without giving in to the compulsion

Interpersonal Effectiveness:
- Manage feelings related to interactions with others. (i.e. reassurance seeking)

Mindfulness:
- Be present in the moment
- Realize thoughts are not right or wrong
- Redirect thoughts when intrusive or repetitive

Suicide in Treatment Refractory

- Patients with OCD have been reported to be at a greater risk of suicide than the general population
- Suicidal thoughts in patients with OCD can be an obsession of self-harm that is distinct from factual suicidal ideations

DBT: Suicidal Behavior Management

- Identify trigger
- Explore problem NOW
  - Focus on problem solving the immediate behavior
  - Assess immediate environmental/behavioral high risk factors
- Reinforce progress, extinguish suicidal responses
- Troubleshoot
  - Identify factors interfering with effective plan of action
- Commit to plan of action
- Anticipate and cope ahead for recurrence of crisis situation
- Re-assess suicide risk

(Linehan, 2012)

Current strategies

- Cognitive therapy targeting dysfunctional beliefs may improve effectiveness of ERP for resistant OCD
- Other groups have also reported outcomes for intensive residential treatments (IRTs) aimed at patients with refractory OCD.
- Stewart, Stack, Farrell, Pauls, and Jenike (2005) reported on the efficacy of IRT in a sample of 403 patients.
  - Treatment consisted of 2 to 4 hours daily of CBT, combined with pharmacotherapy.

Conclusions

- Dr. Nez..... not sure what you want us to put here.....

OCD: ERP and DBT

Skills learned
for my very first ERP and how I maintain these over **4 years now**.

GLASS KETCHUP BOTTLES

- **OBSESSIVE** part was my irrational fear and intrusive thoughts playing over and over again, about glass ketchup bottles.
- **COMPULSIVE** part was; Avoidance, freezing, repetitive counting and other ritualistic behaviors.

- irrational fear since childhood

2014/2015

- 2014; First stay at OCDI at McLean.
- 2015; Second stay at OCDI at McLean.
- Touch & carry, and use glass ketchup with me EVERYWHERE without, or at least lessen behavioral patterns of RITUALS.

- EXPOSURE THERAPY
- DEEP BREATHING;

MINDFUL, PRESENT MOMENT

. 1) observe the BOTTLE & scary thoughts

2)Describe my thoughts, feelings physical/emotional.

3) Participate in daily ERP no matter how I felt, EMBRACE the exposure and accept my thoughts without being judgmental.

- DBT SKILLS

Mindfulness; observe-describe-participate.

DEEP BREATHING.

DISTRESS TOLERANCE

- Distracting
- Self-soothing
- Acceptance
- Willingness VS. Willfulness

- Surviving crises and with accepting life as it is in the present **MOMENT**.

Self-soothing was helpful right before the ERP and DIRECTLY after touching and using it. (not to "get rid of" the feelings/thoughts/emotions, but to **ENGAGE** in activity, etc. (stress ball or tangle, frozen orange, scented oils, weighted blanket, etc)

While experiencing them as anxiety will lessen. Accepting how I felt FULLY, negative or positive. Being willing to engage in ERP over and over.

- ERP AND ART THERAPY!!!!

FIRST BOTTLE FINISHED

-I finished this and brought it to life in art therapy, this is Sally!

2018 AND A SMILE

What helped me the most

ERP was about two full years for this specific irrational fear.

ERP included;

Going to restaurants
Walking around public
Eating in therapy sessions
Looking at pictures online
Touching/looking at all bottles

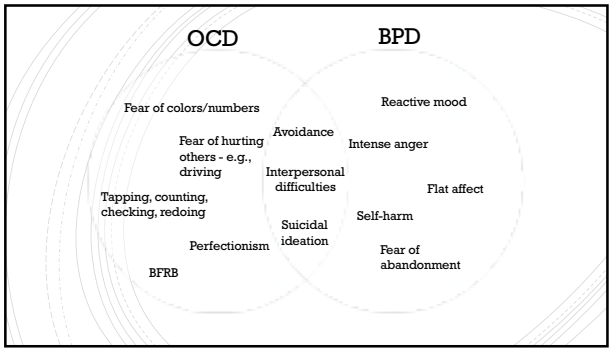
WITHOUT my OCD behaviors.

My Story

- OCD since childhood
- Diagnosed with OCD at 19
- Began ERP
- ERP for two years including a residential program
- OCD well controlled

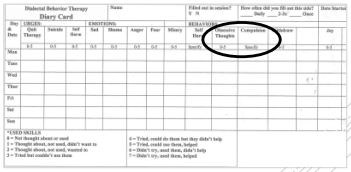
My story

- Difficulty regulating emotions
- Referred to DBT
- Diagnosed with BPD
- Several hospitalizations
- Graduated DBT!
- Feeling great!



Combining DBT and ERP

- Therapist with a working knowledge of both
- Diary card
- Mindfulness of thoughts
- Opposite action aka exposing


Dialectal Behavior Therapy
Diary Card

Name

Filled out in session? Y N

How often did you fill out this side? Daily 3-5x Once

Date Started

Day & Date	URGES: Self Harm	Suicide	Self Hate	EMOTIONS: Shame	Anger	Fear	Misery	BEHAVIORS: Self Hate	Obsessive Thoughts	Compulsions	Avoidance	Joy
	0-5	0-5	0-5	0-5	0-5	0-5	0-5	Num'd	0-5	Num'd	0-5	0-5
Mon												
Tues												
Wed												
Thur												
Fri												
Sat												
Sun												

*USED SKILLS
0 = Not thought about or used
1 = Thought about, not used, didn't want to
2 = Thought about, not used, wanted to
3 = Tried but couldn't use them

4 = Tried, could do them but they didn't help
5 = Tried, could use them, helped
6 = Used them without trying, help
7 = Didn't try, used them, helped

Building a Life Worth Living

the ERP "lifestyle" & DBT skills

DBT & RO-DBT for ERP Treatment Non-Responders

Magda Rodriguez, Psy.D.
CPE Clinic, LLC

Outline

- Adoption vs Adaption of Treatment Model
- DBT Dialectical Balance (Secondary Targets)
- DBT Strategies of Treatment
- Radical Openness-DBT (RO-DBT) for OC (Dialectical dilemmas & skills)
- Case Examples
- Questions and considerations for the future research

Adopt the Standard or Modify DBT to fit setting and client needs

- Fidelity Matters:
  - May or may not retain active ingredients for success so…
  - adapt the standard model in all its form and functions of DBT so "enough" of the effective elements are active in your setting.

Problems: Informed Consent, Reimbursement, & Consumer Opinion

- Offering an untested modification of DBT complicates the process of…
  - informed consent due to ethical obligations: Risks and benefits
  - Reimbursement limitations
  - Consumer Opinion about DBT Outcomes
  - Risk and Liability

Tips for Managing Problems

- Radically accept the Dialectical Tension and Search for Synthesis throughout the implementation process
  - Personal Examples: Assessment, Phone coaching, and Consultation Team.
- Clearly identify if you plan to Adopt of Adapt (principles, strategies, and modes).
- Start with a small, tightly focused pilot program (Measure)
- Think throughout Typical questions and Problems using: Functions, DBT principles, and adherence.

The Dialectic in Self-Control: DBT or RO-DBT

- **Under-Control (UC):** Emotion Dysregulation and Impulsivity
  - Examples: Borderline PD, Bipolar, ADHD, etc.
- Tx: DBT

- Over-Control (OC): Emotionally Restricted and Risk-Avoidant
  - Examples: Treatment Resistant Anxiety, OCPD, Anorexia, etc.
- Tx: RO-DBT

DBT Strategies of Treatment

- Therapist is both: Teacher and Consultant to the client
- ALWAYS ALWAYS DANCE : Dialectic of Acceptance and Change
  - The Core Treatment Strategies are *Problem Solving* (change) and *Validation* (acceptance).

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Change Pole: Problem Solving

- Use Target Hierarchy and tie to treatment goals
- Traditional CBT Problem Solving Skills are used
- Assess and operationalize problem
- Chain Analysis

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Change Pole: Problem Solving Cont.

- Solution Analysis:
  - Skills deficit (teach, generalize)
  - Unwarranted affect (exposure, mindfulness, check the facts)
  - Problematic cognitive interference (cognitive modification)
  - Effective skill is low in response hierarchy (contingency management).
- Rehearse implementation of solution in-session
- Troubleshoot possible obstacles

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Acceptance Pole: Validation

- Find behavior presented by the client and reflect it back to the client. Only validate the valid.
- Present counterpoints to the invalidating environment via modeling and teaching the client how to validate their personal response.
  - Example: A client cuts when they feel anxiety. Cutting is valid in that it relieves anxiety and most people look for ways to reduce their anxiety. Cutting is invalid in that it gets in the way of the client reaching their goal of increasing their self-esteem and feeling better overall.

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Levels of Validation

1. Staying awake and paying attention
2. Accurate summary of what was stated
3. Reading between the lines by stating what has not been said
4. Highlighting how their experience makes sense given their PAST
5. Acknowledge the Valid given the CURRENT facts
6. Radical Genuineness: Respond to client as you would to a loved one

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Major Treatment Techniques

- Attend to relationship
- Stylistic Strategies
- Dialectical Strategies

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Stylistic Strategies

- Reciprocal: Warmth and genuineness with self-disclosure.
- Irreverence: Used when a client is stuck or polarized to nudge out of current stance.
  - Examples: Matter-of-fact or confrontational tone to discuss taboo topics

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Dialectical Strategies

- Movement and flow between dialectics of change and acceptance.
  - Validate the valid, invalidate the invalid, push for change, highlight the effects the solution may have on other issues, bring in what is missing, add a different perspective, accept what can't be changed, and so on
- Metaphors, make lemonade out of lemons, devil's advocate, extending, etc.

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DBT Dialectical Dilemmas

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Behaviors Relating to Self that are Biologically Based

- Active Passivity
  - Approaches problems passively & helplessly INSTEAD of actively and with determination.
    - "You decide, I don't know." "I will ask my mom, she knows better than me."
- Emotional Vulnerability
  - High emotional intensity, slow return to baseline, and sensitive to emotional triggers
    - "I hate feeling this way and can't stand it anymore."

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Behaviors Relating to Self that are Biologically Based Continue

- Unrelenting Crisis
  - Repeated stressful events & challenges in fully recovering fully
    - "I can't deal with this. I'm going to my room."

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Behaviors Relating to Others that are Socially Based

- Apparent Competence
  - Appears able to cope with day to day life
    - "I got this, I don't need any help."
- Self-Invalidation
  - Taking on the "voice" (characteristics) of the invalidating environment
    - "I'm so weak, I should be able to handle this."

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Behaviors Relating to Others that are Socially Based Continue

- Inhibited Grieving
  - Experiencing repeated loss or trauma couples with the challenge of not fully experiencing the associated loss or emotions nor ability to resolve painful events.
    - "I'm numb right now, I will deal with it later." OR "It hurts too much to deal with."

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Skills To Use for Secondary Targets

- All Secondary Targets with the exception of Apparent Competence can use the Core DBT Mindfulness skills
  - What Skills: Observe & Describe while Participating in noticing if left present moment.
  - How Skills: One-mindfulness, Nonjudgmentalness, & Effectiveness
    - Other Skills to be used by Target Area…

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Active Passivity

- Remember times you have coped well and experienced positive events
- Ask self:
  - What skills have led to effectiveness and can I use them now?
  - What others skills can I use from my workbook?
  - What do I need?
  - What can I change that will influence me (antecedents and consequences)?

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Apparent Competence

- Interpersonal Effectiveness
  - Objective Effectiveness: DEAR MAN, Describe, Express, Assert, Reinforce, Mindful, Appear confident, Negotiate
  - Relationship Effectiveness: GIVE, Gentle, Interested, Validate, Easy Manner
  - Self-Respect Effectiveness: FAST, Fair, No Apologies, Stick to Values, Truthfulness
  - Communicate with precision (state limits, willingness, and needs)

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Emotional Vulnerability & Self Invalidation

- Emotion Vulnerability:
  - Emotion Regulation
    - Label emotions both Primary and Secondary
- Self-Invalidation:
  - Dialectical Thinking
    - Getting to Wise Mind and listening to it
    - What else is being left out? What would X think?
    - Work toward the middle path (synthesis)

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Unrelenting Crisis & Inhibited Grieving

- Unrelenting Crisis
  - Distress Tolerance skills to increase Willingness such as Radical Acceptance, Turning the mind, and awareness/focus on Long-Term Goals.
  - Effective Decision Making Skills via use of Wise Mind and Evaluating Pros/Cons

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Unrelenting Crisis & Inhibited Grieving Continue

- Inhibited Grieving
  - Distress Tolerance Skills: TIPP, Temperature Change, Intense exercise, Paced Breathing and Progressive Muscle Relaxation
  - Exposure: Approach, Do not Avoid, and formal or informal exposure.

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The Dialectic in Self-Control

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Radical Openness DBT (RO-DBT) for OC

- Radical Openness DBT is an evidenced based treatment that was developed by Thomas R. Lynch, Ph.D..
- Targets excessive self-control AKA Overcontrol (OC)
- Primary issue with OC is <u>not</u> emotion dysregulation but instead EMOTIONAL LONELINESS

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RO-DBT for OC Continue

- RO-DBT Manual and skills training book both were published Feb 2018
- A collectivists model where emotional health is believed to be continuously influenced by the community's feelings and responses.
  - External emotion regulation is more important than changing internal emotional regulation.

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Transactional experience with the environment

- Environment can exacerbate deficits by…
- Reinforcing OC:
  - Perfectionism, order, following rules, and appearing unphased.
- Punishing UC:
  - Emotional display, request for nurturance, and letting lose.

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Core Deficits in OC 1

- <u>Low receptivity and openness</u>: Resist change, hypervigilance for potential threat, discount critical feedback, and does not take in rewards.

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Core Deficits in OC 2

- Pervasive inhibited emotional expression and low emotional awareness: incongruent emotional expressions, under report of distress, and low awareness of body sensations

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Core Deficits in OC 3

- Low social connectedness and intimacy with others: aloof and distant relationships, feeling different from others, social comparisons, reduced empathy, and high envy and bitterness.

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RO-DBT Skills Target

Feel Safe and Secure via:
Open Expression → Trusted → Social Connectedness

- External Emotion Regulation
- Social Signaling
- Openness to New Experiences
- Target factors maintaining isolation, loneliness, and physiological distress.
  - Forgiveness
  - Acceptance of self and others

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Skills Training and Targets to Decrease

- Core Mindfulness (2 weeks) Targets: Rigidity and rule governance, extreme concern for correctness, and high compulsivity.
- Interpersonal Effectiveness (6 weeks): Aloofness and distance & inability to appear vulnerable
- Emotion Regulation (6 weeks): Masking inner feelings & high levels of envy and bitterness

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Skills Training and Targets to Decrease Continue

- Distress Tolerance (1 week): Low self-care and high need for structure.
- Radical Openness (8 weeks): Low openness, avoidance of risk and new experiences, disregard feedback from others, intense level of distrust & suspicion of others, inability to validate others, and poor forgiveness and compassion.

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Case Examples

- Suicidal client
- Low tolerance for distress
- BPD and/or MDD and OCD
- Interpersonal and life chaos
- Intense emotion

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Commonly Asked…answers…

- How to determine when to start ERP?
  - More stability in their lives (less interpersonal conflicts and non-OCD related crisis)
  - Increased confidence in managing emotions
  - Use of mindfulness skills
  - Not active suicidal behaviors
  - Tolerates low levels of distress

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Commonly Asked…answers…Continue

- How to incorporate DBT skills in ERP
  - Skills training and individual coaching
  - If co-morbid MDD or Personality Disorder is present then consider comprehensive DBT model

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Considerations for the Future Research

- Adaptation of Standard DBT Model for OCD
- Adaptation of RO-DBT for OCD
- Pilot Studies
- Create measures for Pilot Studies looking at OC
- RO-DBT and DBT Skills with ERP vs Standard ERP Treatment in OCD Population

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504 and IEP Teamwork: Establishing Collaborative Relationships between Mental Health Providers and Educators

Andrea Guastello, PhD, Amanda Merkwae, JD, MEd,
Danielle Cooke, MS,
Brian Olsen, PhD, & Melissa Munson, PhD

Overview

- 504s and IEPs: What the Law Says
- What to Ask For: Possible Accommodations for Students with Anxiety
- Integrating Educational Accommodations and Psychological Treatment
- Managing Transitions
- Communication Strategies
- Discussion and Questions

Managing Transitions

Danielle Cooke, M.S.

The Transitional Approach

- Transitions are an ongoing conversation between patients, families and stakeholders (school administrations, teachers, school counselors)
- Occurs in the context of the family
- Transitions should start early, and continue throughout childhood and adolescence
- Parents should task children with **developmentally appropriate** responsibilities

(Betz, 2004)

Transitional Shifts

- High School:
  - Schools are primarily responsible for identifying and evaluating disabilities
  - Parents and guardians are the primary advocates
  - Schools are responsible for developing and providing personal services
- College:
  - Students are expected to self-identify their concerns, and provide their own documentations
  - Prior IEP and 504 documentation may not be sufficient
  - Students are expected to advocate for their needs with the disability offices and teachers
- This is a big jump!

(Gil, 2007)

Why is transition important?

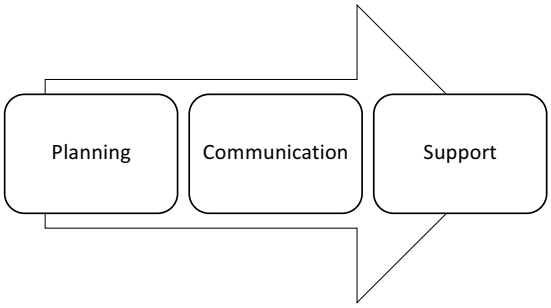
- Transferring to adult care and self-management can leave patients feeling overwhelmed, anxious, and underprepared
- Transitions are intended to make this process easier on the patients and families by encouraging the development of a repertoire of skills
- Responsibilities should change, and build over time until autonomy is reached

(Gil, 2007)

Factors for Consideration

- Age and developmental level
  - These two do not always line up!
- Cognitive abilities
  - Children with neurodevelopmental disorders will need more scaffolding.
- Support Structures
  - Will your child be leaving home? If so, are they living in a dorm or living independently? What supports are or are not in place? What additional stressors will they have to manage in addition to their healthcare (laundry, cooking, paying bills, school)?
- Timelines
  - Are there particular milestones or events coming up? What challenges will they pose? Will they need to start with all new providers? Will your child be starting new schools, new responsibilities?

Good transitions include…



Younger than 12 years

- Keep in mind middle school stressors:
  - Peer relationships, more classes, increased academic responsibilities
- Model appropriate healthcare and academic interactions (letting your child know when and why you're scheduling appointments with teachers and providers)
- Ensure your child is completing age and developmentally appropriate chores and responsibilities

(Quann et al., 2015)

13 to 14 Years

- Continue previous work
- Begin conversations with healthcare providers and educators about office and school policies regarding transitions from youth to adult care
- Begin a conversation with your child about their academic accommodations and how/why they are provided

(Quann et al., 2015)

Freshmen: 14-15 years

- Continue all previous work
- Explain the importance of self-advocacy
- Encourage your child to attend IEP meetings and ask questions
- Discuss academic and career goals with your child, and discuss how best to reach these goals

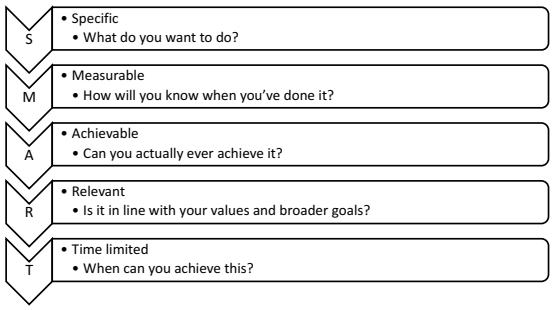
(Quann et al., 2015)

Sophomore: 15-16 years

- Continue all previous work
- Role play: help your child develop a script to communicate with their instructors what their experiences are, and what they need to succeed
- Include your child in IEP meetings, and encourage them to speak up
- Set short-term and long-term goals: make sure your child knows how to reach them

(Quann et al., 2015)

Goal Setting



Junior: 16-17 years

- Continue all previous goals
- Transition to independence
- Encourage your child to lead their IEP meetings, and step in only when necessary
- Have your child meet with their instructors individually and explain their needs and accommodations
- Discuss how to balance new responsibilities, such as driving, with school assignments, part-time work, and extracurricular activities

(Quann et al., 2015)

Senior: 17-18 years

- Continue all previous work
- Update goals
- Reward and encourage independence and autonomy
  - With increased responsibility should come increased privileges
- Monitor progress to graduation
- Accessing external resources
- Connect to post-school services
- Discuss impending expectations

(Quann et al., 2015)

18 years +

For the parent:

- Take a step back – provide support and encouragement
- Encourage your child to use self-advocacy skills, research available resources
- **Do not contact your child's instructors or employers for them or on their behalf**
- The Family Educational Rights and Privacy Act (**FERPA**) (20 U.S.C. § 1232g; 34 CFR Part 99) is a Federal law that protects the privacy of student education records.

(Gil, 2007)

College: 18 years +

For the student:

- Get registered with your school's disability office as quickly as possible
- Discuss with a disability resource officer what accommodations you are and are not entitled to
- Contact your professors early on, and establish ongoing communication
- Take a **proactive**, not **reactive** approach: if you're having a rough semester make sure to talk to them before your grades suffer!

(Chan, 2016)

The Workforce: 18 years +

For the employee:

- Get informed on what you're entitled to via the Americans with Disabilities Act and through state laws
  - "reasonable accommodations"
- Discuss concerns and collect documentation from mental health providers
- Understand that not all workplaces understand or are equipped to meet all accommodations

(Brandes, Ormsbee, & Haring, 2007)

Workplace Resources

- The Job Accommodation Network (JAN) is a free consulting service from the U.S. Department of Labor's Office of Disability Employment Policy that provides individualized accommodation solutions and information on the ADA and services related to employment for people with disabilities. JAN can be accessed at 1-800-526-7234 (V/TTY).
- The Center for Psychiatric Rehabilitation's Reasonable Accommodations page includes specific tips for employers on developing and implementing accommodations.
- Ten regional ADA National Network Centers, sponsored by the U.S. Department of Education's National Institute on Disability, Independent Living, and Rehabilitation Research, provide ADA information, training and technical assistance across the nation. They can be contacted at 1-800-949-4232 (V/TTY).
- The Equal Employment Opportunity Commission's *Enforcement Guidance on the ADA and Psychiatric Disabilities* answers some of the most common questions about the ADA and persons with psychiatric disabilities.

This list was obtained from US Department of Labor's Office of Disability Employment Policy website

"Do's" and "Don'ts"

- **Do** start early and small: building each step will make the next one easier
- **Don't** expect too much, too quickly
- **Do** make a task list and discuss expectations
- **Don't** get frustrated if they struggle, it's a part of the process!
- **Do** discuss fears and concerns with your child's mental health provider – they can help set up a plan for the whole family
- **Don't** be afraid to let your child experience the consequences of their actions (missed assignments, failed tests), but be prepared intervene when necessary (tutoring, gentle reminders, appropriate support)
- **Do** offer age appropriate rewards for successful self-advocacy
- **Don't** assume your child will always be eligible for their accommodations! Talk to their evaluator and therapists about whether your child
- **Do** remember when it is and is not important to get involved – high school teachers may only respond to an adult, no matter how good your child is at advocating for themselves!

Communication Strategies

Danielle Cooke, M.S.

Developing a Script (High School)

1. Introduce yourself
2. Briefly explain why you have and IEP/504 (diagnosis, and what it means for your daily life)
3. Identify your areas of strength
4. Ask stakeholders (teachers, parents) to identify concerns about your academic performance
5. Identify your needs
6. Identify your goals and ask instructors to review them
7. Check that you are on track for your goals (re: graduation)
8. Ask to stakeholders review and explain your accommodations

Developing a Script (College)

Sample email:

Dear ____,

My name is ____. I will be taking your course, XXX0000, this semester. I am excited to begin. Attached you'll find my accommodation letter from the disability office. You'll see that I am entitled to _____. I find that I do well in courses when ____. Please let me know if there is anything you feel that I should keep in mind in order to be successful in your course, and let me know if you have any tips or suggestions for success in your course.

Thank you!

_____

College Communication

- It may be helpful to communicate more specifically if you believe your diagnosis may impact your class performance.
  - EX: I think it is important for you to know that I have been diagnosed with ___. This means that I _____.
- Make sure you're connecting with care providers early (psychiatrist, mental health counselors) to continue care.
  - They can also provide documentation of any mental health concerns if necessary
- Communicate early if you run into problems
  - If you're given extensions, make sure to set up new deadlines and meet them
- Cultivate a relationship – go to office hours and ask questions!
- Be aware of what services your school may offer in addition to disability resources (such as medical withdrawals, and deadlines associated with them.

Concerns in Communication

Disclose

- Explain, to the limits of your comfort, what you need to succeed and why
- Start a dialogue early: you are not entitled to accommodations until you provide documentations
- Maintain communication with your instructors and disability resource officer

Understand

- Understand what your disabilities are
- Know what accommodations you are and are not entitled to
- Understand that you are entitled to confidentiality and what processes are in place should that be violated
- Research your school and state's policies

Boundaries

- Utilize appropriate boundaries when necessary – your health information is yours to keep private
- Answer only questions you feel comfortable answering
- Keep a paper trail

Things to remember…

- Professors and teachers are human
  - The more they know (so long as it is appropriate) the better than can help you
- Know what you are legally entitled to, and know how to get it
- Research your school and state policies and discuss any concerns with your disability resource provider, parents, school administrators and other stakeholders when appropriate
- Self-advocacy is a powerful tool, but knowledge is the most important!
- **Communication is an ongoing process**

(Gil, 2007)

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Treating Sleep Problems Associated with OCD

James M. Claiborn Ph.D. ABPP ACT

Disclosures

- I have many interests, including some financial interests but none are worth much and none will influence this presentation.
- No pixels were harmed in the making of this presentation.
- Many of the slides present research results, but statements here represent my interpretation of those results.
- A complete reference list is available from the presenter
- Contact me at CBT4OCD@maine.rr.com or Anxietyshrink@gmail.com

Acronyms used in this presentation

- CBT Cognitive Behavioral Therapy
- CBTI Cognitive Behavioral Therapy for Insomnia
- DSPS Delayed sleep phase syndrome
- EDS Excessive daytime somnolence
- OCD Obsessive-Compulsive Disorder
- REM Rapid Eye Movement sleep
- SE Sleep efficiency (ratio of time asleep to time in bed usually as %)
- SOL Sleep onset latency
- SRP Sleep related problems
- WASO Wake after sleep onset
- YBOCS Yale-Brown Obsessive-Compulsive Scale

Basic Sleep Concepts

- Stages of sleep
- Stage 1
- Stage 2
- Stage 3-4
- REM
- Sleep architecture
- Common sleep disorders: Insomnia, RLS, PLMS, SRBDs, Nightmares

Sleep Disturbance and OCD Comorbidity

- A national comorbidity study assessed sleep disturbance, OC symptoms as well as depression, anxiety disorders and substance abuse
- Participants with sleep disturbance had significantly greater OCS severity than those without sleep disturbance
- The link between sleep disturbance and OCS severity is not limited to insomnia but extends to even minor sleep disturbance
- The link is not accounted for by cooccurring depression or anxiety disorders
- It may be that the effect of sleep disturbance is to lead to increased OCS or that OCS may lead to increased sleep disturbance

Cox & Olatunji, 2016

Sleep Problems in Pediatric OCD

- Nightmares
- Sleep onset insomnia
- Difficulty sleeping away from home
- Refusal to sleep alone
- Nighttime fears (Generalized)
- Decreased SE
- Increased SOL
- Over tired and or EDS
- 92% of sample had SRP, 27% had 5 or more
- Severity of sleep problems correlated with severity of OCD and anxiety
- CBT for OCD resulted in reduced rate of SRP and in reduction of several specific sleep problems

Storch et al 2008

Sleep Problems Reported by Parents of Swedish Children and Adolescents with OCD

- Samples were taken from general child and adolescent psychiatric clinics (CAP), a specialized OCD treatment program (OCD), and a non-clinical school population (GP)
- The OCD and CAP samples had significantly more sleep problems than the GP sample
- OCD subjects had less sleep while CAP subjects had more problems with sleep walking and talking, nightmares were about equal
- Results are comparable to Storch et al (2008)

Ivarsson & Larsson, 2009

Sleep Problems and CBT in Pediatric OCD Bidirectional Effects

- A sample of 296 children and adolescents with OCD were treated with exposure based CBT with 75 min sessions for 14 weeks. Parents were involved in treatment.
- No specific interventions were directed to sleep problems, but obsessions and compulsions that interfered with sleep were addressed
- 68% of the sample had at least a minor sleep problem and over 25% had a frequent or severe sleep problem
- All sleep problems except sleeps more than other kids were reduced after CBT, and this problem was rare
- Non-responders had at least one severe or frequent sleep problem
- Sleep problems and OCD tend to respond together although many still had some sleep problems at the end of treatment

Ivarsson & Skarphedinsson, 2015

Delayed Sleep Phase in Patients with Severe Resistant OCD

- Patients were treated at a specialized unit for severe resistant OCD
- Patients with comorbid major depression or other serious mental illnesses were excluded
- DSPS patients had more severe OCD than non DSPS patients
- Sleep phase problems persisted after CBT, and treatment with medications(SSRIs) and augmentation with antipsychotic medications and mood stabilizers
- Most patients had bedtime rituals
- DSPS is a common problem in people with OCD

Turner et al 2007

Case Study CBT and Chronotherapy for Insomnia and OCD

- Ritual of morning & evening prayers perfectly
- YBOCS=35
- Poor response to previous trials of SSSIs and OCD focused psychotherapy
- Typical sleep period 6:00 to 13:00, SOL ≤ 5 min, duration 6.5-7.5 hr/night
- Treatment CBT including ERP and cognitive restructuring and chronotherapy involving advancing sleep time requiring call in to enhance compliance
- Results sleep time shifted to 00:00, wake up time to 10:00, YBOCS decrease 15 points (43%)

Coles and Sharkey 2011

Delayed Bedtime and OCD

- People with OCD tend to have delayed bedtimes and indications of DSPS
- In a non-clinical sample, (college students) delayed bedtime correlated with OCD symptom severity
- Total sleep time was not correlated with OCD symptom severity
- Delayed bedtimes were not related to OCD symptom subtypes
- Delayed bedtimes were not related to SOL or overall sleep quality
- Results from this non-clinical sample parallel reports from case studies of OCD

Coles & Schubert, 2012

Obsessive Compulsive Symptoms (OCS) and Sleep Difficulties

- Two studies of non-clinical student populations
- Insomnia but not sleep quality, delayed bedtime, or nightmares are related to severity of OCS severity (contrast Coles et al 2012)
- Obsessions are related to insomnia but compulsions are not
- Obsessions at bedtime without daytime distractions appear to interfere with sleep onset
- Compulsions may have more impact on sleep quality and delayed sleep in clinical samples but are not apparent in this non-clinical sample
- While depression is independently related to insomnia, it does not account for the relationship between OCS severity and insomnia

Timpano et al, 2014

Sleep, Arousal, Circadian Rhythms in Adults with OCD Meta-analysis

- Sleep in individuals with OCD differs from healthy controls in ways not explained by psychotropic medication or depression
- There are large differences in the prevalence of DSPD in people with OCD vs healthy controls
- DSPD correlates with severity of OCS and rate of diagnosis of OCD
- Treatments that address delayed bedtime and subjective sleep disruption may reduce OCS
- People with OCD have shorter average sleep duration, and longer SOL
- People with OCD have increased WASO as do people with anxiety disorders
- Sleep deprivation is related to difficulties with attention and emotion regulation

Nota et al, 2015

OCD, Insomnia and Anxiety Sensitivity

- Study used survey data from non-clinical online sample
- Unacceptable thoughts but not contamination, harm, or symmetry obsessions were correlated with insomnia
- Cognitive dimensions of anxiety sensitivity were related to insomnia but physical and social dimensions of anxiety sensitivity were not
- Anxiety sensitivity has been shown to be responsive to CBT like interventions
- Interventions directed toward cognitive aspects of anxiety sensitivity may prove useful in treating OCD and associated insomnia

Raines et al, 2015

Case Study Non-Pharmacological Treatment of Insomnia in Individual with OCD

- Patient was 25 y.o. male with long history of OCD, with primary concerns with contamination obsessions and cleaning rituals
- OCD and depression had been treated with medication
- Patient developed acute problem with insomnia following job change
- Complaints included difficulty falling asleep, nighttime awakening, difficulty with concentration, EDS, and daytime hypersomnia
- Intervention combined feedback of actigraphy information, education on sleep hygiene and recommendation to reduce alcohol and smoking near bedtime

Abe et al, 2012

Sleep and OCD a Metanalysis

- This paper reports a metanalysis of studies of sleep in people with and without OCD, primarily involving polysomnography
- People with OCD have significantly lower total sleep time, sleep efficiency, time in stage 2 sleep and significantly more time awake
- Interpretation of results is complicated by the effects of depression on sleep and the fact that depression is highly comorbid with OCD.
- Additional complicating factors include use of medication, and age both of which typically affect sleep

Diaz-Roman et al, 2015

Sleep and OCD

- This paper is a review of the research on sleep and OCD and includes some of the papers discussed individually in this presentation
- Sleep quality (total sleep time, SE, WASO, subjective ratings) is typically impaired in people with OCD and impairment is correlated with severity, and comorbid depression
- DSPS is common in people with OCD and correlated with severity and earlier age of onset, but not related to comorbid depression
- People with OCD may show more stage 1 and 3 sleep and less stage 2, these changes are correlated with severity of OCD
- People with OCD may show early onset and increased total REM sleep and REM density, correlated with severity, and some reports of sleep onset REM
- Similar changes in REM are seen in depression

Paterson et al, 2013

Sleep in Children and Adolescents

- This paper presents a review of the literature on sleep and OCD. The research on sleep and OCD in children is very limited and often depends on adults reports which may be biased
- Studies using objective measures including actigraphy show reduced total sleep time, SE, increased SOL, and WASO
- Parents report high rates of general sleep problems, (54-90%), including difficulty waking in the am, daytime tiredness, or non-specific trouble sleeping
- These findings in children may suggest that sleep problems are directly linked to OCD, in the absence of comorbid depression, which is much less common in children than adults
- While not yet well researched CBT may be an effective intervention for treatment of sleep problems in children and adolescents with OCD

Reynolds, Gradisar & Alfano, 2015

Sleep Problems in Patients Seeking Treatment for OCD Response to Exposure

- Sample of 36 people seeking intensive treatment for OCD
- Nearly 70% had insomnia problems, 2/3 had severe or extreme OCD and almost 40% had one or more comorbid anxiety or depression diagnoses
- Treatment was 4 consecutive days of intensive therapist assisted ERP
- Patients with sleep problems had a significant reduction in symptoms maintained at follow-up independent of changes in depression
- Patients with sleep disturbance had larger changes in OCD than those without
- While sleep disturbance was not directly addressed in treatment the treatment of OCD may have led to generalization of the response to concerns about sleep

Nordahl et al, 2018

Clinical Examples of OCD Impacting Sleep

- Compulsions that have to be completed before going to bed
- Compulsions directly involving the bed or getting into bed
- Obsessions about ordinary tasks that may not have been done
- Obsessions about getting enough sleep or effects of sleep deprivation
- Obsessions about contamination of the bed
- Obsessions about actions or activities occurring during sleep
- Obsessions about lack of vigilance while asleep
- Obsession and compulsions related to elimination before sleep
- Fear of nightmares with obsessive content
- Beliefs about not being able to sleep if thoughts can't be stopped

Cognitive Behavioral Therapy for Insomnia

- First choice treatment for insomnia (American College of Physicians)
- Sleep hygiene (weak)
- CBT to address beliefs about sleep
- Stimulus control (strong)
- Sleep restriction (Very strong)
- Assessment Insomnia Severity Index, Pittsburg Quality of Sleep Index, Epworth Sleepiness Scale, Sleep log or diary,
- Calculation of sleep efficiency
- Efficacy, impact on depression
- Training opportunities

Treating Nightmares

- Historical Definition
- Nightmare was the original term for the state later known as waking dream (cf. Mary Shelley and Frankenstein's Genesis), and currently as sleep paralysis, associated with rapid eye movement (REM) sleep. The original definition was codified by Dr Johnson in his A Dictionary of the English Language and was thus understood, among others by Erasmus Darwin and Henry Fuseli,[4] to include a "morbid oppression in the night, resembling the pressure of weight upon the breast."

Nightmare are often confused with other experiences

- Night terrors which are a stage 3-4 sleep parasomnia not associated with coherent dream content
- Nocturnal panic attacks which typically occur in transition between sleep stages not in REM sleep
- Sleep paralysis (Hagridden) which involves incomplete waking from REM sleep and may be associated with visual hallucinations

A Modern Definition of Nightmares

Nightmare is the term currently used to refer to a dream which causes a strong unpleasant emotional response from the sleeper, typically fear or horror, or the sensations of pain, falling, drowning or death. Such dreams can be related to physiological causes such as a high fever, psychological ones such as psychological trauma or stress in the sleeper's life, or can have no apparent cause. Sleepers may waken in a state of distress and be unable to get back to sleep for some time.

Medications and Nightmares

- Nightmares have been associated with a number of medications including
- Amphetamines, other stimulants and cocaine
- Sedative Hypnotics or discontinuation of these drugs (sleeping pills, benzodiazepines and alcohol)
- Beta blockers
- Opiates and related drugs
- Sympathomimetic drugs

Treatment for Nightmares

- Medications including Prazosin (Risk and benefits)
- Insight oriented psychotherapy
- Relaxation training
- Exposure based treatment similar to imagery exposure for OCD
- PTSD treatments such as Prolonged Exposure
- Imagery Rehearsal

Imagery Rehearsal

- Often provided in a limited number of sessions
- Psychoeducational component on dreams, emotional processing and memory
- Re-scripting the nightmare
- Clinical example

Questions and Answers

- In the remaining time I would like to take questions from the audience about OCD and sleep problems and discuss possible solutions

Workplace Issues and Legal Rights for Individuals with OCD

Michael V. Gigante, MA, JD
July 29, 2018

Disclaimer: This presentation is for general informational purposes only and does not create an attorney-client relationship.

Introduction

Opening Remarks

Introduction: Brief Bio

- Work in employment/discrimination area of law
- Education:
  - J.D., New York University School of Law
  - M.A., Columbia University
  - B.A., University of Notre Dame
- Email: mvgigante@gmail.com

Introduction

My Experience with OCD

Outline for Today's Presentation

- I. Workplace Issues for Individuals with OCD
- II. Legal Rights under the ADA
  - A. What is the ADA?
  - B. Protection from Discrimination
  - C. Accommodations/Interactive Process
- III. *Humphrey* Case
- IV. *Earl* Case
- V. Conclusion

I. Workplace Issues for Individuals with OCD

What Types of Difficulties Do Individuals with OCD Face in the Workplace?

- Being late to work due to time spent performing rituals, such as compulsive handwashing/showering, checking locks and stoves

What Types of Difficulties do Individuals with OCD Face in the Workplace?

- Difficulty concentrating; making errors due to intrusive, obsessive thoughts

- Source: *EEOC Enforcement Guidance on the Americans with Disabilities Act and Psychiatric Disabilities*, available at <https://www.eeoc.gov/policy/docs/psych.html >.

What Types of Difficulties do Individuals with OCD Face in the Workplace?

- Missing deadlines due to time spent performing rituals while at work, such as constantly rechecking one's work for fear of making mistakes

II. Legal Rights under the ADA

A. What is the ADA?

What is the ADA?

- Stands for the "Americans with Disabilities Act"
- Federal law = Law of the Land (applies everywhere in USA)
- Generally applies to employers with 15+ employees
  - Check your state and local laws!!

  - Source: *Facts About the Americans with Disabilities Act*, available at <https://www.eeoc.gov/eeoc/publications/fs-ada.cfm>.

What Does the ADA Do?

- Protects individuals with disabilities in employment

- Source: *Facts About the Americans with Disabilities Act*, available at <https://www.eeoc.gov/eeoc/publications/fs-ada.cfm>.

What is a "Disability"?

- Physical or mental impairment
- Substantially limits a major life activity, such as concentrating and working
  - Examples: blindness limits the ability to see; paralysis limits the ability to walk

- Source: *Facts About the Americans with Disabilities Act*, available at <https://www.eeoc.gov/eeoc/publications/fs-ada.cfm>.

Is OCD Considered a "Disability" Entitled to Legal Protection?

- Absolutely!!
- Mental and psychological disorders are impairments that limit life activities
- According to federal regulations, it should easily be concluded that OCD substantially limits brain function

- Source: 29 C.F.R. § 1630.2(h) (1) and (2); *Id.* at (j)(3)(iii).

"Qualified" Individuals

- To receive protection under the ADA, you must be "qualified," meaning:
  - You have the experience/education needed for the job
  - You can perform the essential functions of the job with or without "reasonable accommodation"

- Source: *The ADA: Questions and Answers*, available at <https://www.eeoc.gov/facts/adaqa1.html>.

Who Enforces the ADA?

- U.S. Equal Employment Opportunity Commission (EEOC)
- Headquarters: 131 M Street, NE, Washington, DC 20507
- Search for field offices at: https://www.eeoc.gov/field/

- Source: *EEOC Office List and Jurisdictional Map*, available at <https://www.eeoc.gov/field/>.

B. Protection from Discrimination

ADA's Protection from Discrimination

- Very broad protection
- Employer can't discriminate against you in hiring, firing, advancement, compensation, training, and other employment matters
- Examples: Employer can't fire you simply because you have OCD; employer can't pay you less simply because of your OCD

Source: *Facts About the Americans with Disabilities Act*, available at <https://www.eeoc.gov/eeoc/publications/fs-ada.cfm>.

C. Accommodations / Interactive Process

Right to "Reasonable Accommodation"

- If you are qualified for the job, you are entitled to "reasonable accommodation" for your OCD

Source: *The ADA: Questions and Answers*, available at <https://www.eeoc.gov/facts/adaqa1.html>.

What is a "Reasonable Accommodation"?

- An adjustment to your job that enables you to perform the job

Source: *The ADA: Questions and Answers*, available at <https://www.eeoc.gov/facts/adaqa1.html>.

What is a "Reasonable Accommodation"?

- Examples:
  - Making facilities accessible
  - Job restructuring or modifying work schedules
  - Acquiring or modifying equipment
  - Providing readers or interpreters

Source: *Facts About the Americans with Disabilities Act*, available at <https://www.eeoc.gov/eeoc/publications/fs-ada.cfm>.

Accommodations Vary with the Person's Needs

- Examples: employee with diabetes may need breaks to monitor blood sugar and insulin levels; employee with cancer may need leave for chemotherapy treatments
- Not all people with disabilities (even with the same disability) require the same accommodation

Source: *Facts About the Americans with Disabilities Act*, available at <https://www.eeoc.gov/eeoc/publications/fs-ada.cfm>

Limitations on Employer's Duty to Accommodate

- Employers must accommodate known disabilities if they would not impose an "undue hardship" on the employer's business

- Source: *Facts About the Americans with Disabilities Act*, available at <https://www.eeoc.gov/eeoc/publications/fs-ada.cfm>.

What is an "Undue Hardship"?

- An action requiring significant difficulty or expense in light of factors such as:
  - An employer's size;
  - Financial resources; and
  - Nature and structure of its operation

- Source: *Facts About the Americans with Disabilities Act*, available at <https://www.eeoc.gov/eeoc/publications/fs-ada.cfm>.

Additional Limitations on Duty to Accommodate

- Employer does not have to lower quality or production standards to make an accommodation
- Employer does not have to provide an accommodation unless a person has asked for one

- Source: *Facts About the Americans with Disabilities Act*, available at <https://www.eeoc.gov/eeoc/publications/fs-ada.cfm>.

How Do Employees and Employers Decide on a Suitable Accommodation?

- Via the "Interactive Process"

- Source: *Enforcement Guidance: Reasonable Accommodation and Undue Hardship Under the Americans with Disabilities Act*, available at <https://www.eeoc.gov/policy/docs/accommodation.html>.

What is the "Interactive Process"

- Process between person and employer that identifies:
  - Limitations resulting from the disability, and
  - Potential accommodations to overcome them
- First step in interactive process = person requests accommodation from employer

- Sources: *Enforcement Guidance: Reasonable Accommodation and Undue Hardship Under the Americans with Disabilities Act*, available at <https://www.eeoc.gov/policy/docs/accommodation.html>; 29 C.F.R. § 1630.2(o)(3).

Employer's Rights

- Employer not necessarily required to provide the requested accommodation
  - Employer may choose among accommodations provided that the chosen accommodation is effective
- During interactive process, employer may offer alternative suggestions for accommodations

- Source: *Enforcement Guidance: Reasonable Accommodation and Undue Hardship Under the Americans with Disabilities Act*, available at <https://www.eeoc.gov/policy/docs/accommodation.html>.

Duty to Accommodate is Ongoing

- Some people need only one accommodation, while others need multiple
- Some people need one accommodation for a period of time, then another type of accommodation later

- Source: *Enforcement Guidance: Reasonable Accommodation and Undue Hardship Under the Americans with Disabilities Act*, available at <https://www.eeoc.gov/policy/docs/accommodation.html>.

Duty to Accommodate is Ongoing

- Employer must consider each request for accommodation
- If an accommodation turns out to be ineffective, employer must consider whether there is an alternative accommodation
  - Employer can't say "one and done"

- Source: *Enforcement Guidance: Reasonable Accommodation and Undue Hardship Under the Americans with Disabilities Act*, available at <https://www.eeoc.gov/policy/docs/accommodation.html>.

Duty to Accommodate is Ongoing

- If there is no alternative accommodation, employer must attempt to reassign you to a vacant position for which you're qualified

- Source: *Enforcement Guidance: Reasonable Accommodation and Undue Hardship Under the Americans with Disabilities Act*, available at <https://www.eeoc.gov/policy/docs/accommodation.html>.

What are Some Accommodations for OCD?

- The Job Accommodation Network (JAN) outlines numerous accommodations for people with OCD, including:

- Source: *Job Accommodations for People with Obsessive Compulsive Disorder (OCD)*, available at <http://askjan.org/media/eaps/employmentOCDEAP.doc>.

Attendance/Punctuality Issues

- Allow flexible leave
- Provide flexible start-times

- Source: *Job Accommodations for People with Obsessive Compulsive Disorder (OCD)*, available at <http://askjan.org/media/eaps/employmentOCDEAP.doc>.

Meeting Deadlines/Staying Organized

- Have employee make daily to-do lists and check items off
- Provide ongoing feedback/direction about pending assignments

- Source: *Job Accommodations for People with Obsessive Compulsive Disorder (OCD)*, available at <http://askjan.org/media/eaps/employmentOCDEAP.doc>.

Maintaining Concentration / Managing Distractions

- Provide space enclosures or a private office
- Allow for use of white noise or environmental sound machines

- Source: *Job Accommodations for People with Obsessive Compulsive Disorder (OCD)*, available at <http://askjan.org/media/eaps/employmentOCDEAP.doc>.

III. *Humphrey* Case

Humphrey v. Memorial Hospitals Association, 239 F.3d 1128 (9th Cir. 2001).

The Players

- Carolyn Humphrey was a medical transcriptionist with OCD
- Worked for Memorial Hospitals Association (MHA) in California

Carolyn's Work Performance

- Excellent
- Exceeded company's standards for speed, accuracy, and productivity

How Carolyn's OCD Affected Her Job

- Problems getting to work on time (or at all) due to obsessive rituals
  - Wash/brush hair for 3 hours/day
  - Dress very slowly
  - Repeatedly check/recheck for papers
  - Pull out strands of hair/examine them closely

Company's Response

- Gave Carolyn several disciplinary warnings

Carolyn's Psychiatrist

- Sent letter to company explaining OCD
- Said they could treat the problem
- Said Carolyn may need some time off

Carolyn / Company Engaged in Interactive Process

- Leave of absence may have been discussed (disputed by parties)
- Carolyn accepted a flexible start time arrangement (could begin work any time within a 24-hour period on days scheduled to work)

Results

- Carolyn continued to miss work
- Asked for new accommodation: work from home (as other transcriptionists were doing)

Company's Response

- Denied work-from-home accommodation request due to disciplinary warnings
- Did not suggest an alternative accommodation

Termination and Lawsuit

- Carolyn was absent additional times and was fired
- Carolyn sued Company for violation of ADA and its California counterpart, the Fair Employment and Housing Act (FEHA)

Refresher

- To be protected under the ADA, you must:
  - Have a disability, or an impairment that substantially limits a major life activity
  - Be qualified: can perform the essential job duties with or without accommodation

Company's "Disability" Argument

- Carolyn was not disabled because she was not substantially limited in a major life activity

Court's Response: ARGUMENT REJECTED

- "Caring for oneself" is a major life activity
- Carolyn was substantially limited when caring for herself: took her hours (sometimes entire day) to wash/dress for work

Company's "Qualified" Argument

- Carolyn was not qualified for the job
- Regular and predictable attendance was an essential function of the position

Court's Response: ARGUMENT REJECTED

- Either of two potential accommodations might have worked: leave of absence or working from home
- Company failed to attempt both

Court: Duty to Accommodate is Continuing Duty

- An employer must consider each request for accommodation
- If an accommodation is ineffective, employer must consider alternative accommodations

REMEMBER

- YOUR EMPLOYER CANNOT SAY "ONE AND DONE" TO YOU!!!

IV. *Earl* Case

Earl v. Mervyns, Inc., 207 F.3d 1361 (11th Circuit 2000).

The Players

- Debra Earl was a Store Area Coordinator with OCD
- Worked for Mervyns, Inc.

Debra's Job Duties

- Prepare her department for store's opening in morning:
  - Obtain cash for registers, stock merchandise, arrange displays

How Debra's OCD Affected Her Job

- Debra was late to work several times and received warnings

Interactive Process

- Company offered to permit Debra to clock in early and receive overtime pay
  - Debra requested that she be allowed to clock in at whatever time she arrived
    - Company said this was unreasonable; offered to schedule Debra on afternoon/evening shift at her request

Termination and Lawsuit

- Debra was late additional times and was fired
- Debra sued Company under ADA

Refresher

- To be protected under the ADA, you must:
  - Have a disability, or an impairment that substantially limits a major life activity
  - Be qualified: can perform the essential job duties with or without accommodation

Having a "Disability"

- Parties did not dispute Debra had a disability
- Issue was whether she was "qualified"

Was Debra "Qualified" for the Job?

- Could she perform the essential job duties with or without reasonable accommodation?

Debra's Essential Duties

- Punctuality was an essential duty of Debra's job; her tasks had to be performed at a specific time
  - If she was late, her area would not be ready for customers; Area Coordinator from previous shift would have to work longer shift

Was There Any Reasonable Accommodation Available?

- Debra's psychiatrist said there was nothing Company could have done to help her arrive at work on time
- Debra admitted she was unable to arrive at work on time even when scheduled for afternoon or evening shift

One Accommodation

- Only accommodation Debra identified was to allow her to clock in at whatever time she arrived; Company said this was unreasonable
  - Court agreed: an employer is not required to accommodate an employee in any manner in which the employee desires

Debra Was Not "Qualified"

- Debra couldn't identify a reasonable accommodation
- She could not perform her essential job duties; she was not "qualified"

V. Conclusion

2 Main Takeaways

- You have the right not to be discriminated against because of your OCD
- You have the right to a reasonable accommodation for your OCD (if one exists)

My Email: Please Get in Touch!!!

- mvgigante@gmail.com
- I published an article on these issues last year in the New York State Bar Association *Labor and Employment Law Journal*
  - Please contact me or them about how to obtain a copy of this article

THANK YOU AND HAVE A WONDERFUL DAY!!!

Apply Your Oxygen Mask First: Parental Self-Care

Noah Weintraub, Psy.D.
Sherrie Vavrichek, LCSW-C
Behavior Therapy Center of Greater Washington
Sun, July 29th, 9:45 AM - 11:15 AM

1

OCD: A Heavy Burden for Young People

- Tormented by thoughts about danger to themselves or others
- Engage in odd, time consuming compulsions in hopes of gaining perfect safety/comfort, demand caregiver's help
- Impacts on self-esteem, friendships, school, their future

2

Checking In: How Are You Feeling Right Now?

3

On a scale of 0-10, How Are You Feeling Now?

0 1 2 3 4 5 6 7 8 9 10

Terrible OK Great

4

Caregivers Suffer, Too!

5

Likely Reasons for Increased Burden & Decreased Quality of Life

Financial strain

Emotional and Interpersonal Stress

-conflicts and anger/criticism

-feeling responsible and helpless

-stigma/shame

Family accommodation makes things worse

6

So What is Family Accommodation (FA)?

Changes in family members' behaviors with the ***intent of*** reducing OCD sufferer's distress/rituals and facilitating sufferer's functioning

7

Exercise #1: Stress Management

Five Minute Meditation on the Breath

8

What You Can Do

- Learn, Share Information
- Set Limits
- Provide Support, Motivation
- **Take care of yourself**

9

*Isn't taking care of myself **selfish** when my loved one is suffering so much?*

10

No, it isn't selfish, because…

11

You Will Be Better Able to Help Your Loved One

12

2. Accommodating for the OCD sufferer is doing the *opposite* of helping anyway.

13

3. Taking care of yourself is good **modeling** for your child

14

4. Parents who take care of themselves are more likely to feel hopeful and less likely to be depressed

Geffkin, G, E. Storch, et.al. Hope and coping in family members of patients with obsessive-compulsive disorder. Anxiety Disorders 20 (2006) 614-629

15

Exercise 2:
Self-Compassion

16

What does self-care involve?

17

Behavioral Antidepressants

- **Pleasurable** (e.g., taking bath, solving crossword, sitting in sun)
- **Mastery** (fixing something in house, learning an instrument, completing a task)
- **Novelty** (listening to new music, trying new restaurant, new activity)
- **Exercise**/Open Air/Sunlight
- **Social** (talking with friend, going to party, support group)
- **Mindfulness** (paying attention to the present moment with a curious, open, and non-judgmental mind)

18

Exercise # 3:
Mindfulness Exercise

19

Self-Assessment
Are you taking care of yourself?
OCD Caregiver Self-Care Scale

20

0 1 2 3 4 5 6 7 8 9 10

Almost Never……Almost Always

Physical Health

1. Engage in exercise.
2. Take care of my physical health (fulfill medical, dental needs).
3. Eat healthy foods.
4. Engage in pleasurable activities.
5. Get adequate sleep.

21

0 1 2 3 4 5 6 7 8 9 10

Almost Never……Almost Always

Interpersonal Support

6. Find someone to talk to when sad.
7. Get comfort from someone else when upset.
8. Spend time with friends.

22

0 1 2 3 4 5 6 7 8 9 10

Almost Never……Almost Always

Psychological Health

9. Comfort myself when upset.
10. Find time to relax each day.
11. Meditate.
12. Engage in a personal hobby or interest.
13. Manage my time well so as not to fall behind on work and other responsibilities.
14. Get help to increase your knowledge and skills re. OCD.
15. Laugh.

23

More Powerful With Others

- Dancing to music that involves memorizing steps
- Singing/playing instrument with others
- Yoga class
- Meditation/Mindfulness groups
- Laughter [laughter yoga exercise]

24

Checking In:
How Are You Feeling
Right Now?

25

I'm More Scared of You Than You Are of Me

What Teens Should Know to Form OCD-Fighting Alliances

Alex Rosenberg & Jon Hershfield, MFT

Part One: Combating OCD: Working Together to Take Your Life Back

Alex Rosenberg

My Story

My Symptoms

- First symptoms were around age 10 in 5th grade
- Got worse and worse so quickly
- Couldn't eat, couldn't sleep, late for classes, scratched myself until I bled, etc.

My Initial Therapy

- Had no idea what was wrong with me or how to get treatment
- Eventually decided to go to psychodynamic psychologist-didn't work, but I did get snacks
- Went to a psychiatrist who prescribed medication

Cognitive Behavioral Therapy

- Went to a cognitive behavioral therapist
  - Was very afraid
    - What if I look stupid/inferior, getting treatment for OCD?
    - What if he's mean?
    - What if the treatment doesn't work/I can't do it/it's not helpful?
    - What if my parents interfere?
    - What if the treatment is really difficult?
    - What if he doesn't know what he's doing?

Cognitive Behavioral Therapy- Recovery

- The treatment was difficult-it caused a lot of anxiety
- I felt very uncomfortable talking about my OCD-I still feel a little uncomfortable
- My therapist was incredibly kind and understanding
- He saw me as if I was completely normal, and not inferior to anyone
- He didn't punish me for my OCD; he encouraged and supported me in doing my recovery exercises

Cognitive Behavioral Therapy- Recovery

- We developed a system of doing the exercises at home
- Me, my therapist, and my parents always communicated about how/what my compulsions were, which exercises were working and would work, and how the treatment was going
- My family and therapist supported me in everything I did, and pushed me to do the best I could with the recovery exercises
- Little by little, we reduced the compulsions-we worked together to take my life back

Essential Tips For Ensuring Therapy Goes As Well As Possible

Tips for Other Children With OCD

- It will be hard, but try your best to do your therapy exercises
  - If you keep at it, you *can* treat your OCD.
  - Know that millions of other people are going through what you're going through, and your therapist and family have your back
- Don't be ashamed/embarrassed about your OCD or therapy--you are completely normal and you are not alone.
- Create strategies and systems to do your exercises and have your family and friends help you. You can also get creative and find fun ways to do your exercises.
- Communication is key

Tips for Working With Children With OCD

- Use POSITIVE reinforcement to help with therapy, NOT negativity or punishment
- Understand that OCD is not something to be ashamed of, and don't make the child feel ashamed
- Push the child to do the best they can with their exercises, but don't be too harsh or put too much pressure on them

Tips for Working With Children With OCD

- Therapists: Always share your thoughts and ideas with the child and their parents/family, but also listen to their feedback and ideas about the therapy
- Parents:
  - Share your thoughts about the therapy and help your child in doing their therapy exercises, but open up to what they think or feel about their exercises and to the advice of the therapist
  - Understand that the therapy is hard for the child and it takes time

Part Two: Who Is This Guy and How Can He Help?

Jon Hershfield, MFT

My Story

- Struggled with OCD throughout my teens
- Invested heavily in CBT in my late 20s
- Became a therapist treating OCD in my 30s
- Now, 41, run my own clinic, have gray nose hairs

How we begin

- It all starts with a phone call from a concerned parent
  - Hear the story
  - assess the potential of being able to help
  - Comfort the parent with plausible assertions of my competence
  - If the child is under 18, I rarely get to speak with them
  - Then we schedule the assessment

What am I thinking first?

- As I collect the family from the waiting room:
  - Does the client (the kid) look
    - happy to be here ?
    - afraid to be here?
    - angry to be here?
    - indifferent to being here?
  - Am I going to get along with the parents? Will they:
    - Like me?
    - Trust me?
    - Frustrate me?
    - Expect miracles from me?

What I know about the teen

- OCD has new material to work with as new areas of the brain come online. This means thoughts about sexual identity, body image, violence, religious identity, the meaning of life, and your role in society all get supercharged.
- You are not particularly jazzed about identifying as having a mental health issue. You worry enough about what people think on the surface to add that kind of depth to how you are perceived by your peers.
- You want your parents, other adults you respect, and me to understand the depth of your pain, but you hate feeling pitied or defective.
- You're sometimes only 99% sure you want to get better because you don't know what better looks like and what will be expected of you.

What the teen may not know about me

- I feel tremendous pressure from parents to give them what THEY want for you
  - I am a people pleaser and want to see them happy, but I don't care what they want as much as you think I do
  - I really care about what YOU want
  - My goal is not to "get you to" do anything
  - My goal is to teach what I know about how OCD keeps you from doing what *you* want and how to outsmart the OCD and overcome your obsessive fears
  - I'm not disappointed in you when you feel ERP is too hard. I'm already looking to collaborate on the next approach against OCD.
  - I know how dumb mindfulness sounds (but I wish I knew about it long ago)

Yikes!

- Not gonna lie. I'm afraid:
  - Of your parents (just, generally)
  - You won't like me
  - You won't talk to me
  - You'll tell your parents I don't know what I'm doing
  - You won't trust me, won't get better, and your parents will blame me
  - Your parents will sue me (seriously)
  - Word will get out that I am a fraud

What I like about us

- I still love music, movies and pop culture. Even though my encyclopedic knowledge of 80s horror movies and 90s electronic music means nothing to you, I feel good connecting on your level
- Humor is an essential part of our interaction and I already know you have a great sense of humor because that's just being aware of the wrong things to think at the exact wrong times (and you have OCD)
- Your brain is literally growing and you get to influence how it grows when we collaborate on changing your behavior
- We get to explore what I wish I knew when I was your age about OCD and you get to teach me how to be a better therapist

I need watch out for

- Superhero complex
- Making it *my* job to cure *your* OCD
- Thinking I know you better than I do
- Letting your parents' anxiety get in my head

When everything clicks

- You invite me into the family system and, as a result, my input changes the way you and your family relate to your OCD and to each other. EVERYONE is involved in treatment, even if your assigned role is to do less
- You don't view me as the guy your parents make you see, but as the coach of Team YOU against Team OCD
- You view ERP not as something you have to do, but as your creation, your invention that you use to master OCD. You come up with better exposures than I do.
- You understand that your unwanted thoughts are not who you are as a person, but are merely a reflection of a creative and detail-driven mind for which CBT is an instruction manual for maximized use.

SpongeBob Teaches Us Something Important About Fear!

Mary Kathleen Norris, LPC
DFW Center for OCD and Anxiety

Mary Norris, M.Ed.
Regent University

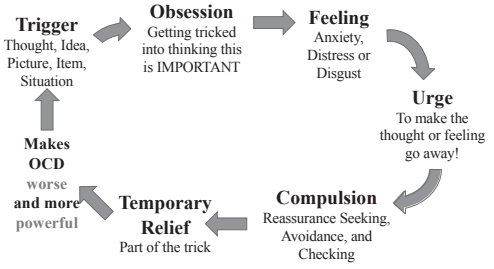
* There are no financial affiliations, manufacturer relationships, or off-label / investigational usage of pharmaceuticals used in this presentation.

Common Fears in Childhood OCD

- Contamination by germs
- Contamination of mood
- Death
- Pathological doubt- "not sure" checking
- "Just so" internal symmetry, perfectionism
- External symmetry, counting
- Scrupulosity, morality, God
- Fear of vomit

2

What Happens in OCD?



3

What Happens in ERP?

4

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5

A Parenting Plan That Works for OCD- Kids, Teens and Young Adults

Mary Kathleen Norris, LPC

Katherine Moss, LISW

* There are no financial affiliations, manufacturer relationships, or off-label / investigational usage of pharmaceuticals used in this presentation.

Basic Assumptions for This Presentation

- Thoughts and behaviors in OCD can be disruptive to the emotional balance of the sufferer as well as others
- Organization, predictability, and structure influence emotional balance
- Positive parenting helps OCD sufferers find that balance and have optimal outcomes

2

Difficulty with Emotional Regulation

OCD sufferers often struggle with emotional balance.

May be due to thoughts which are:

- Rigid
- Inflexible
- Polarized (Black and White)
- Judgemental

3

Difficulty With Emotional Regulation (cont.)

May be due to behaviors which are:

- Manipulative
- Argumentative
- Avoidant
- Disruptive
- Defiant
- Explosive

4

Common Problems As A Result of Disruptive Behaviors

Family Consequences:

- Conflicts between parent and child
- Aggressive behavior by child leading to reciprocal patterns of coercion
- Unwillingness to discipline

5

Common Problems As A Result of Disruptive Behaviors (cont.)

Family Consequences:

- Conflicts between parents
- Parents participating in "rescues"
- Non-OCD siblings acting out for attention
- Conflicts between siblings

6

What About Discipline?

OCD kids have optimal outcomes when they are on a well defined parenting plan which must include:

- Finite, clear, concise rules and consequences
- Daily feedback (receive daily rewards or consequences)
- Components that teach autonomy
- Applied consistently, unemotionally

7

Pitfalls of Discipline by Emotion

Instance #1

"Crime" Committed by child = Parent in positive mood ⇩ ⇩ Warning or lecture = Zero punishment or consequence

8

Pitfalls of Discipline by Emotion

Instance #2

Parent in a Negative Mood

⇩ ⇩ ⇩

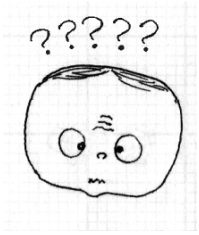
Crime Repeated = Taking Advantage of my Grace / Hurt, Disrespected my Warning / Angry for Reoffending / Angry for Original Crime = 4x Punishment or Consequence

9

The Result of Discipline by Emotion

Child is confused by the chaos

Inconsistency Breeds Persistence



10

Need a Parenting Plan

- Not variable by emotion
- Consistent
- Not difficult to implement

11

Positive Parenting With a Plan (Grades K-12): Family Rules

By Matthew A. Johnson, Psy.D.

12

The Philosophy of a Good Parenting Plan

1. The "real world" is ordered & structured and has a hierarchy of authority to make it work
2. A healthy respect for authority is vital to function effectively
3. Families need organization, structure, predictability, and have a hierarchy of authority
4. A parent's primary responsibility is to prepare their child for the "real world" which requires respect for authority

Concept from: *Positive Parenting With a Plan* by Matthew A. Johnson, Psy.D.

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Here's What We Will Do:

- Make a list of Family Rules
- We will have a Chore System
- We will have a Reward system
- We will have a Penalty System
- We will cover Troubleshooting

Let's Get Started

Supplies Needed:

1. 3x5 cards (at least 55 per family) for Good Habit Cards
2. 3x5 card box (Good Habit Cards)
3. 3x5 cards for Chores (one set per child)
4. 3x5 daily dividers (one per child)
5. 3x5 card box- Chores (one per child)
6. Poker chips
7. Small envelopes for "the Bank"

15

Step One: Make a Rules List

Include:

- Schedule
- Daily chores
- Misc. rules

16

Suggested Rules List

1. Do what is asked at once. No "wait just a minute"
2. Take "No!" for an answer- no arguing
3. No tattling on others
4. No interrupting others until they have finished
5. No verbally abusing others

See Appendix 1: Suggested Rules List

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Chore Box and Cards

- Better than charts
- Designed for ADD adults
- Each child has own box with daily dividers
- Put one card for each chore/ or one card with day's chores
- Put cards in for chores done weekly
- Can use colored cards

18

Reward System

Poker Chip

- Given Daily when no rule is broken
- Bonus Weekly when no rule is broken for a week (Bonus=3 chips)
- Maturity Chips- given at parent's discretion for mature, kind, thoughtful acts, use judiciously

19

How to Figure Chip Value

- Daily $
  - Take one month's worth of spending money and divide by 30
- Can be Exchanged
  - Ex: more time to play video games, more time to stay up
- Weekly Banking Night
  - Exchange token for $
  - Pay bonuses if earned

20

Penalty System

"Good Habit" Cards

1. Suggested Tasks
2. Must spend at least 30 minutes on task
3. "Grace" cards
4. "Wild" cards

Concept from: *Positive Parenting With a Plan* by Matthew A. Johnson, Psy.D.

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Suggested "Good Habit" Cards

1. Clean the front door and handle
2. Sweep the front/back porch
3. Windex the front door sidelights
4. Clean the baseboards in entry
5. Clean the tile grout in entry
6. Vacuum the downstairs

See Appendix 2: Suggested "Good Habit" Cards

22

Freeze

1. Card must be completed to end a freeze
2. Conditions of freeze
   - No perks (i.e. phone, computer, car, play outside, have friends over, go to a movie)
3. Getting out of power struggles

23

Reasonable Request Card

- Written to request a change in plan, problem, or request
- Helps be flexible
- Teaches how to approach problems

24

Getting Started

- Explain program at a family meeting
- Week 1 - felonies not misdemeanors
- Week 2- plan enforced
- Watch warnings

25

Watch for Shaping

- Changes come slowly as we learn
- Be patient
- Children don't have to receive "punishment that hurts" to change behaviors

26

Special Concerns

- Parents who don't follow the rules themselves and are hypocritical
- The child who has to have the "last word"
- Parents who taunt when giving a card
- The child who won't draw a card

27

Can We Use This Plan to Help OCD Behaviors?

The answer is YES!!

28

Enabling vs. Accommodating

Enabling involves:

- Placating, going along with, or facilitating OCD behaviors
- Overlooking, ignoring or pretending
- Not challenging OCD
- Allowing it to thrive and grow
- Not challenging WILL problems

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Enabling vs. Accommodating (cont.)

Accommodating means:

- Teaching how to handle negative emotion (skill)
- Fostering autonomy over dependence (skill)
- Supporting ERP by hierarchy (skill)
- Providing positive reinforcement for victories

30

Separating Skill Problems From Will Problems

Skill Problems:

- We don't know how to solve
- We don't have enough practice
- Confidence comes from practice

31

Separating Skill Problems From Will Problems (cont.)

Will Problems:

- We know how to solve
- We don't do things we don't want to do
- We choose not to practice so that…
- We can claim we don't have the skill

32

A Parenting Plan Means

- Improved behavioral responses
- Better emotional regulation
- A happier, healthier and more self-confident child

33

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35

The Interplay Between PTSD and OCD: Treatment Considerations and Tactics

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Outline

- Background
- PTSD
- OCD
- Interplay between PTSD and OCD
- Treatment Plan
- Case Study

Background: The Role of Trauma and PTSD in Treatment of Refractory OCD

- Treatment-resistant OCD has been found to develop after experience of trauma.
  - **Existence of both OCD and PTSD** in an individual may be difficult to treat i.e., **"treatment-resistant"**
- Recent studies have demonstrated that **individuals with PTSD seeking treatment for OCD resulted in poor treatment outcome** than those seeking treatment for OCD without PTSD.

Gershuny et al., 2003
Pitman, 1993
De Silva and Marks, 1999
Gershuny at al., 2002

Background: The Role of Trauma and PTSD in Treatment of Refractory OCD

- In a study by Gershuny et al. (2008), 82% of 104 treatment-resistant OCD participants were found to have experienced at least one traumatic event.
- The **majority of treatment-resistant OCD** participants **reported traumatic experiences** such as:
  - Adulthood interpersonal violence
    - E.g. Robberies/mugging, physical assault, rape/sexual assault, and combat
  - Childhood interpersonal violence
    - E.g. Physical abuse, sexual abuse

Background: The Role of Trauma and PTSD in Treatment of Refractory OCD

- A research study conducted by Gershuny et al., (2008)
  - Study of 104 individuals diagnosed with treatment resistant OCD and PTSD
  - Almost 40% of this sample met criteria for PTSD
  - 50% of individuals seeking treatment for resistant OCD reported a history of traumatic experiences

Gershuny et al., 2008

Background: The Role of Trauma and PTSD in Treatment of Refractory OCD

- PTSD diagnoses were higher in those participants who also met criteria for co-morbid disorders, such as major depressive disorder or borderline personality disorder.
- Predictors of PTSD included incestuous childhood sexual abuse and witnessing violence, in addition to greater overall frequency of trauma.

Gershuny et al., 2008

Post-Traumatic Stress Disorder

- Epidemiology: Prevalence
  - 12-month prevalence among U.S. adults is about 3.5%
  - Lower estimates seen in European, Asian, African, and Latin American countries, clustering around 0.5 – 1.0%

APA, 2013

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Obsessive-Compulsive Disorder

- Epidemiology: Prevalence
  - 12-month prevalence is 1.2%
  - Similar prevalence rates internationally (1.1 – 1.8%)

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Comorbidity OCD and PTSD

- 12-month prevalence of OCD is 30% among people with PTSD
- Prevalence of OCD after a traumatic incident (not necessarily resulting in PTSD) ranges from 30% to 82%

Badour et al., 2012
Cromer et al., 2006
Fontenelle et al., 2012
Gershuny et al., 2008

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Comorbidity Between OCD and PTSD

- Exposure to an extreme stressor (and not simply PTSD) increases the risk for OCD, including high combat exposure.
  - In Vietnam veterans with high combat exposures but no PTSD, the NVVRS revealed elevated rates (5.2%) of OCD.
  - Rate of OCD in veterans with low combat exposure and no PTSD was low, 0.3%.

Helzer et al., 1987
Davidson et al., 1991
Kulka et al., 1988

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Traumatic Stressor

- According to the DSM-5, a stressor is traumatic when exposed to actual or threatened death, serious injury, or sexual violence (or more) of the following ways:
  - Directly experiencing the traumatic event(s)
  - Witnessing, in person, the event(s) as it occurred to others
  - Learning that the traumatic event(s) occurred to a close family member or close friend.
  - Experiencing repeated or extreme exposure to aversive details of traumatic event(s).

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Predisorder Negative Life Events

- PTSD, unlike OCD, is always preceded by an adverse instigating external event, usually major stressors, e.g.,
  - Combat, rape, severe accidents, natural disasters, captivity, criminal assault
  - Loss of or major threat to a loved one

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Predisorder Negative Life Events

- OCD persons are not sheltered from negative life events
  - Such events sometimes but not always coincide with the onset of OCD, such as childbirth
  - However, OCD may also involve neurobehavioral vulnerability factors

OCD and Trauma Relationship

- Trauma may lead to the chronic presence of anxiety and affective syndromes, such as depression, generalized anxiety, and panic disorder
- OCD symptoms are not generally described in the discussion of PTSD, but PTSD is viewed as an important differential diagnosis for OCD.

OCD and Trauma Relationship

OCD may develop after a trauma. Theories include:

1. Biological predisposition to OCD prior to trauma
2. The severity of the trauma may disrupt biological mechanisms underlying normal thought processes
3. OCD may act as a psychological defense

OCD and Trauma Relationship

4. OCD symptoms may emerge early, resulting in a difficult child who evokes violence in an emotionally-disturbed parent.
5. Alternately, there may be a group of OCD patients who exhibit PTSD symptomatology with other symptoms temporarily obscured by OCD

- All of these hypotheses deserve further evaluation

Other Comorbidities

- Many have other clinical problems
  - Substance abuse
  - Depression
  - Panic attacks
  - Eating disorders
  - Somatoform disorders
- Common consequences include: social withdrawal, unemployment, disability, divorce, and/or homelessness

Kilpatrick et al., 1993
Barad, 2011

Further Research

- The relationship between trauma and the onset of OCD raises many provocative questions:
  - How does trauma, for example, contribute to the onset of OCD?
  - Is the relationship direct, or is it mediated by other factors?
  - Is OCD in some cases a maladaptive coping strategy that, once removed, leads to fragmentation and re-emergence of underlying pathology?

Predisorder Negative Life Events: Differences between OCD and PTSD

- Subjective impact of the stressor is crucial to the development of PTSD.
- Subjective reactions to obsessions determine resistance to OCD

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OCD Characteristics

- **Obsessions** are
  - Recurrent thoughts, images, or impulses experienced as intrusive and inappropriate, causing marked anxiety or distress
  - Not simply excessive worries about real life problems
  - Accompanied by efforts to ignore, suppress, or neutralize thoughts
  - Recognized as the product of one's own mind
- Examples: contamination, mistakes, impulses, order

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OCD Characteristics

- **Compulsions** are
  - Repetitive behaviors and mental acts that the person feels driven to perform in response to an obsession or according to rigid rules
  - Aimed at preventing or reducing distress or preventing some dreaded event or situation clearly excessive or not realistically connected to the obsessive fear
- Examples: checking, washing, cleaning, repetition of normal activities, ordering, collecting, mental compulsions

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PTSD Characteristics

- **Re-experiencing**
  - Intrusive distressing recollections of the trauma
  - Recurrent distressing dreams of the event
  - Sense of reliving the experience (flashbacks)
  - Psychological distress at exposure to trauma reminder (internal or external)
  - Physiological reactivity upon exposure to trauma reminders

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PTSD Characteristics

- **Avoidance**
  - Efforts to avoid trauma-related thoughts or feelings
  - Efforts to avoid trauma-related activities or situations
  - Psychological amnesia
  - Diminished interest in activities
  - Detachment from others
  - Restricted range of affect
  - Foreshortened future

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PTSD Characteristics

- **Increased Arousal**
  - Sleep disturbances
  - Irritability or outburst of anger
  - Difficulty concentrating
  - Hypervigilance
  - Exaggerated startle response

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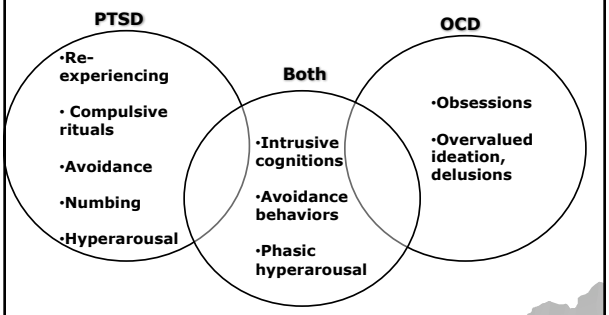
Symptom Patterns in PTSD
(Comparisons with OCD)

- Clusters give clear areas of overlap between PTSD and OCD as well as characteristics that differentiate them
- Relationship is due to symptom overlap between two disorders, not to the comorbidity of the diagnosis

Clusters between PTSD and OCD



- **Content of obsessions and relationship between obsessions and compulsions differentiates OCD from PTSD**

Cognitive Biases: Differences between OCD and PTSD

- Persons with OCD and PTSD may share a common set of anxiety-related cognitive biases for judging the world as:
  - Unpredictable (i.e., "It might happen again")
  - Uncontrollable (i.e., "I can't stop or master it")
- **Content** and **severity** of the cognitive biases expressed in relationship to an antecedent stressor may distinguish PTSD from OCD

Summary

- PTSD has a broader and more pervasive symptom cluster that includes some OCD-like symptoms, but also unrelated cognitive biases and distortions
  - **Cognitive intrusions** in PTSD are both similar to and substantially different from **obsessions** in OCD.
- **OCD and PTSD sometimes coexist**. Exposure to high-magnitude **stressors** increases the risk for both disorders. However, OCD is generally unrelated to antecedent trauma.

Are PTSD and OCD linked epidemiologically?

- Probably yes, but surprisingly, OCD is more common than panic disorder among persons with PTSD, but there have been relatively few studies.
- There seem to be **similarities among all anxiety disorders**, rather than a special relationship between PTSD and OCD.

Specialized Treatments

- The early detection and treatment of later potential behavioral disturbances is important.
- These patients may require a **broader form of intervention** rather than ERP.
  - Cognitive behavior strategies in conjunction with elements of an insight-oriented approach
- Treatment of OCD symptomatology alone in these cases is insufficient as patients may require more complex case management.

Tynes, 1990

Differentiating OCD and PTSD

- There are substantial differences between PTSD and OCD even though symptoms **appear to be similar.**
- **PTSD** involves a reaction to some situation that was initially traumatic realistically.
- **OCD** involves cognitive and emotional reactions to stimuli that the patient is well aware that they may be illogical, but which the patient is unable to prevent him or herself from engaging in.

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Treatment: Concurrent PTSD and OCD

- Sometimes it is clear how an individual's OCD is related to their PTSD, and therefore, it is easier to combine treatments
- Because OCD impedes on functioning, it is recommended to treat the OCD first
- However, it is **important to determine which disorder is primary** i.e., which set of symptoms are causing the most distress

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Treatment: Concurrent PTSD and OCD

- It is recommended to routinely inquire about traumatic events when assessing patients with OCD
- Both conditions must be dealt with or else the patient is likely to relapse
- Symptoms often overlap, so it is important to differentiate between the two disorders

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OCD Treatment

- A combination of behavior therapy and pharmacotherapy have been found to be the most effective
- Individual psychotherapy
  - Prolonged Exposure and Response Prevention
  - Cognitive strategies designed to address patient's thoughts
- Medication used as "water-wings"
  - Anti-depressants
  - Anti-psychotics

Foa & Kozak, 1996

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PTSD Treatment

- Medication
  - Antidepressants, anticonvulsants, mood stabilizers
    - According to research studies, SSRIs have best evidence
  - Beta blockers medication to block reconsolidation
    - Reminders reactivate members and render them labile
    - Blocks reconsolidation of the memory and thus weakens it

Barad, 2011
Pitman et al., 2008

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PTSD Treatment

- Sleep is always almost disturbed
  - Sedating antidepressants (e.g. mirtazepine)
  - Alpha blockers, such as Prazosin, is effective in promoting sleep and reducing nightmares.
  - Avoid benzodiazepines and other GABA agents.

Barad, 2011
Pitman et al., 2008

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Sleep Wake Cycle Guidelines

- Bed for sleep and sex only
- Complete darkness
- Don't check the clock
- Ritualize bedtime routine
- Relaxation exercises before bed
- Exercise, but not within three hours of bedtime
- Herbal tea
- Avoid caffeine
- No alcohol at night
- No naps after 2pm

PTSD Treatment

- **Cognitive Behavioral Therapy**
  - Psychotherapy is the only approach with sufficient evidence for efficacy (according to 2008 IOM study).
  - Best evidence is for ***exposure*-based psychotherapy** (trauma focused).
    - Education (about disease and therapy), relaxation/mindfulness, monitoring mood and "events", narrative exposure, real life exposures, and **homework.**

Barad, 2011
Foa, Davidson and Rothbaum, 1995

PTSD Treatment

- **Prolonged Exposure (PE) Therapy** (used at WIAD) utilizes imaginal and in vivo exposures to target avoidances
  - Must be carefully designed due to the extreme distress that the patient may experience from revisiting their trauma

Barad, 2011
Foa, Davidson and Rothbaum, 1995

Stages of Treatment for OCD-PTSD Comorbidity

- In general, issues involved in OCD are dealt with first, and those of PTSD are dealt with next.

Stages of Treatment for OCD-PTSD Comorbidity

1. **Establishment of trust / rapport**
   - Educate the client in the dynamics of OCD and how the treatment is designed to bring these dynamics under control.

Stages of Treatment for OCD-PTSD Comorbidity

2. **Assessment and evaluation of fear structures**
   - Involves the analysis of the tests given for this purpose.
   - Address hierarchy of fears
   - Correct fear structures

Stages of Treatment for OCD-PTSD Comorbidity

3. **Exposure Response Prevention**
   - Imaginal and In vivo exposures
   - Writing/taped narratives
   - It is important that the OCD is brought under complete control for successful treatment of the comorbid PTSD.

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Stages of Treatment for OCD-PTSD Comorbidity

4. **Address the PTSD issues**
   - Educate the client in terms of what is a normal/abnormal reaction
   - Address subjective units of distress (SUD) for cues and triggers for anxiety. The client must be able to monitor the environmental triggers that lead to symptoms
   - Discussion of difficulties dealing with the anxiety. Thus, educating the client of the impact of these dynamics
     - –Craft to the individual

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Stages of Treatment for OCD-PTSD Comorbidity

5. **Treat the PTSD symptoms using both in vivo and imaginal techniques that approximate the original trauma**
   - Psychoeducation
   - A hierarchy of triggers
   - Involves development of scripts for either of the techniques
   - Exposure to fears
   - Response prevention
   - Mindful breathing
   - Progressive muscle relaxation
   - Anticipation of reactions

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Stages of Treatment for OCD-PTSD Comorbidity

6. **Relapse prevention**
   - Must address **both** OCD and PTSD.

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Stages of Treatment for OCD-PTSD Comorbidity

7. Prior to discharge, the patient will be provided with a list of coping strategies and exercises that can be used to maintain gains

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Case Study

- A 41-year-old patient at the OCD Day Treatment program
- At admission, patient was experiencing severe anxiety and disabling excessive fears revolving around contamination
- Had previously been treated for 17 years without positive result
  - Had an obsessive fear of writing
- Mother was physically and emotionally abusive to patient when she was a child

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Case Study: Diagnosis

- Met diagnosis for OCD, PTSD, and Bipolar Disorder
  - On the Anxiety Disorders Structured Interview Schedule (ADSIS), patient met criteria for a dual diagnosis of OCD and Bipolar Disorder as well as Generalized Anxiety Disorder.
- Pretesting diagnostic tests included Y-BOCS, HAM DEP, HAM ANX, GAS
  - Within three months of treatment, patient's Y-BOCS score dropped 33%, Hamilton Depression Inventory 75%, Hamilton Anxiety 50%, and GAS increased by 30%

Case Study: Pre-Treatment Assessment History of Trauma

- Mother was both physically and emotionally abusive.
  - Frequent outbursts and criticism that would come "out of the blue."
  - Patient excelled in school but was always paralyzed by fear of her mother's outbursts.
- Mother's temper and criticism caused patient to avoid writing, procrastinate, and obsess about her performance, which resulted in a pathological fear of making mistakes.
- In high school, patient completely refused to write and instead, patient's mother wrote the patient's dictation.

Case Study: Pre-Treatment Assessment Obsessions and Compulsions

- **Obsessive fears**
  - Contamination/hypochondriacal concerns, making mistakes, rereading, hoarding, preservation of experiences, and conservation of hierarchical order.
- **Compulsive behaviors**
  - Excessive hand washing, hoarding, list making, checking, and tracking different aspects to be sure nothing has been missed.

Case Study: Pre-Treatment Assessment Obsessions and Compulsions

- Obsessions lead to **avoidances** of behaviors
  - Haircuts and shaving, reading, writing, laundry, crowds, public spaces, eating raw vegetables, petting pet, and not sharing a bed with her husband unless he had showered.

Case Study: Treatment Plan

- **Address fear of contamination that resulted in hypochondriacal concerns**
  - Refrain from washing for 3 days and confront, in hierarchical order, the triggers that would result in washing.
  - Rate body hierarchically and refrain from checking parts of body.

Case Study: Treatment Plan

- **Address avoidance of writing**
  - Start with desensitization.
  - Fear of writing associated with fear of making mistakes, therefore, habituated to short periods of writing surrounded by periods of relaxation.
- **Address avoidance of reading**
  1. Read paragraph aloud to therapist.
  2. Underline key words in front of therapist.
  3. Without going back, had to restate the paragraph in her own words as succinctly as possible.

Case Study: Treatment Plan

- **Address food avoidances**
  - Hierarchy of threat arranged
  - On a daily basis, patient was to begin with vegetables of least threat and work up to those of highest threat.
- **Address making mistakes**
  - Hierarchy of type of mistakes arranged
  - Patient was to engage in unimportant work activity in which mistakes would be made, gradually working up to more important work activity.

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Case Study: Treatment

- Five week treatment program
- OCD symptoms addressed first
  - Scores on the Y-BOCS, Hamilton Anxiety and Hamilton Depression Scale declined in first three weeks of treatment while GAS scores increased.

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Case Study: Treatment

- OCD symptoms alone were addressed.
  - In the following weeks, trauma symptoms, specifically exploring the abuse suffered, were addressed via imaginal exposure.
- Bipolar disorder symptoms were controlled by medication.

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Case Study: Results of Treatment

- Follow-Up Testing
  - Scores on the Fear Survey Schedule declined by 75%
    - Items previously rated as 4 dropped to 2 or 1. No items were rated as 4.
  - On the OCM for Obsessive-Compulsiveness, the patient's scores declined by 91%

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Case Study: Results of Treatment

- Symptoms on the Willoughby Cluster declined by 87.5%
  - Clusters identified on the Willoughby were reduced from highs of 3 and 4 to lesser numbers.
    - I.e., Stage fright/being left alone/making decisions were rated as 1.
    - I.e., Meeting important people/self-consciousness before superiors/self-consciousness about appearance were rated as 0.

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Case Study: Results of Treatment

Table 2: Tests Administered

Date	9/19	9/26	10/2	10/24	11/12	12/11	4/18/96
YBOC	33	24	11	15	15	11	4
HAM DEP	24	23	9	14	16	6	2
HAM ANX	36	22	18	19	19	18	15
GAS	50	55	60	60	65	65	90

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Case Study: Results of Treatment

- Six month-follow up
  - Patient had taken the Bar Examination and reported:

> "The fear of writing had vanished as if it had never existed… My fear of making mistakes and being evaluated did not even cross my mind. In fact, I do not even care at this point whether or not I passed the Bar. I know that whatever the results will be, I will eventually obtain my license. OCD no longer controls me. I have mastered it."

Conclusions

- Traumatized OCD patients may exhibit new, previously obscured pathology once OCD symptoms are under control.
- Exposure to trauma in OCD patients is an important factor that should be evaluated more thoroughly.
- Psychological vulnerability stemming from childhood abuse or trauma may predispose certain patients to OCD.

Roth, 1988
Levenkron, 1991

Thank you for participating!

Question and answers session.

For more information, please visit
hope4ocd.com

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