BEHAVIORAL TREATMENT FOR CO-MORBID OCD AND TICS

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TIC RELATED OCD PRESENTATION IS COMPLICATED

- Higher rates of physical sensations accompanying the cognitive components of OCD
- Mental sensations like "just right"
- Complex tics involving patterns of movements that look like purposeful actions
- Tapping, rubbing, touching, symmetry
- Co-morbidity leads to complex treatment planning for clinician
- Accompanying symptoms to address – anger, irritability, ADHD. All of which can impact treatment adherence and participation in ERP & CBIT

THERAPEUTIC APPROACH

Symptom by symptom assessment is key

	TICS	OCD COMPULSIONS
PRECEEDING EXPERIENCE	Tension, sensory, pressure, somatic discomfort	Cognitions, worries
VOLUNTARY	Involuntary, purposeless	Voluntary purposeful
MOTOR BEHAVIORS	Sudden, jerky, non-rhythmic, repetitive	Ritualistic, repetitive
EMOTIONS	Not usually; distress at the premonitory urge	Anxiety, disgust about the content of thoughts & consequences of refraining from compulsions
FLUCTUATION/CHANGE	Can fluctuate from one part of body to another	Symptom change can be connected to obsessional content
CHRONICITY	Tics can decrease & fluctuate spontaneously with age	Waxing & waning possible
AGGRESSION/ANGER	Rage attacks, aggression, anger, perhaps higher in the co-morbid ADHD children	Rage, anger, interruption or disruption of compulsions

ASSESSMENT

- **Trigger/Antecedent internal experience**
  - Premonitory urge vs. worry vs. right feeling
- **Function of behavior**
  - To reduce physiological discomfort vs. control/reduce harm/risk
- **Cognitions**
  - Presence or absence of thoughts
  - Types of thoughts
    - "My body just has to move" vs. "I have to do this or else my parents will get in accident"
- Presence of emotions
- **Consequence**
  - "I felt better"

ASSESSEMENT

- When cognitions occur in both instances
  - **TICS ALONE:** "I have to do behavior to relieve the physical discomfort/tension"
  - **OCD ALONE:** "I have to do the compulsion so x doesn't happen, to make the anxiety go away, to make the thought go away"
  - **TICS PLUS OCD** "I have to do the tic a certain number of times or else…"
- Are there other tics? Or a history of tics?
- Is there a family history of tics?
- Does one disorder exacerbate the other?
- If an OCD individual presents with symmetry, just right, touching, tapping, rubbing; assess carefully for tic disorders

TREATMENT PLANNING

- Treat the primary condition causing most functional impairment
- **OCD**: target the least anxiety provoking item on hierarchy
- **Tics:** choose the most distressing
- Adding Exposure techniques to CBIT – do the tic in the "wrong way" or do response prevention so it does not satisfy the urge

TREATMENT PLANNING

- Address co-morbid symptoms: ADHD, aggression, academic difficulties
- Weave in adjunct techniques as necessary: Acceptance Commitment Therapy, Motivational Interviewing
- Address psychosocial impairment
- Social skill building – strengthen communication & advocacy
- Support to child, family & siblings
- Be flexible to "trial and error" with client
- Behavioral exercises as assessment can be more tolerable to client than "talking" assessemnt

COMPREHENSIVE BEHAVIORAL INTERVENTION FOR TICS (CBIT)

- Psychoeducation
- Motivation building
- Habit reversal training (awareness, competing responses, social support)
- Relaxation training
- Parental training
- Contingencies: Praise, behavioral

Woods, D., et al. (2008). Managing Tourette Syndrome: A Behavioral Intervention for Children and Adults. Oxford University Press: Oxford.

TREATMENT GOALS

- Decrease frequency of tics
  - By increasing patient's ability to tolerate the urge/sensation without engaging in tic
  - May leads to decreases in urges or increase control/reaction to urges

ASSESSMENT

- **Antecedents**
  - Events that happen before the tic to make them more or less likely to happen
  - Internal & external
- **Consequences**
  - Events that happen after tics that make them more or less likely to happen in the future
  - Internal & external
- Environmental & individual factors impact tic variability (intensity & frequency)

INTERVENTIONS

1. Avoid places/situations which make tics worse
2. In situations where tics most likely to happen, reactions by others should be minimized & eliminated (comfort, attention, scolding)
3. Be prepared with competing responses in tic inducing situations
4. When entering situations that are not easily modified, child should learn strategies to minimize reactions that contribute to tics

COMPETING RESPONSES

- Practice in session
- Ask patient to monitor urge out loud with you
- Demonstrate tic and competing response for patient
- Continue talking to patient so you demonstrate that life goes on while doing CR
- Create tic exacerbating situations in session & practice CR (child brings in Math HW, reads etc.)

COMPETING RESPONSES FOR COMPLEX TIC

- Find CR for first movement of tic
- If doesn't work, find for later parts of sequence
- Stop tic as early in sequence as possible

CASE EXAMPLE

- Zach – abdominal clenching
  - Impacts speech fluency
  - Happens mainly outside of family conversations
  - Triggered by social anxiety/negative self-evaluation/fear of judgment by others
  - Functions to "control" his conversations when fearful he will offend others and say the wrong thing
  - Interrupts his train of thought which increases his anxiety
  - At other times, can be tic like minus cognitions/anxiety

TREATMENT OUTCOME RESEARCH FOR TS

- CBIT results in positive outcomes in randomized observer blind controlled trial in children (Piacentini, et al., 2010).
- CBIT results in positive outcome in randomized trial for adults with TS (Wilhelm, et al., 2012).

IN SUMMARY

- Thorough assessment of each behavioral symptom determines intervention
- Be flexible in combining treatment techniques
- Combination of ERP & CBIT can be effective