Double Trouble: Addressing OCD in the Context of Co-Occurring Posttraumatic Stress

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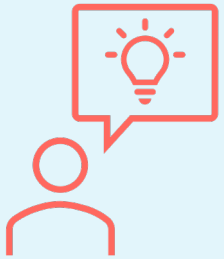
Overview

- Introduction
  - Comorbidity and conceptual overlap
  - Rationale for concurrent treatment
  - Evidence-based treatments for PTSD
    - Prolonged exposure (PE)
    - Cognitive processing therapy (CPT)
- Case presentations illustrating concurrent treatment of OCD and PTSD
  - 1. Adult outpatient treated with ERP + PE (telehealth)
  - 2. Adult in IOP treated with ERP + CPT
  - 3. Adolescent in residential program treated with ERP + PE
  - 4. Adult in residential program treated with ERP + PE
- Q & A

Key Diagnostic Features of PTSD



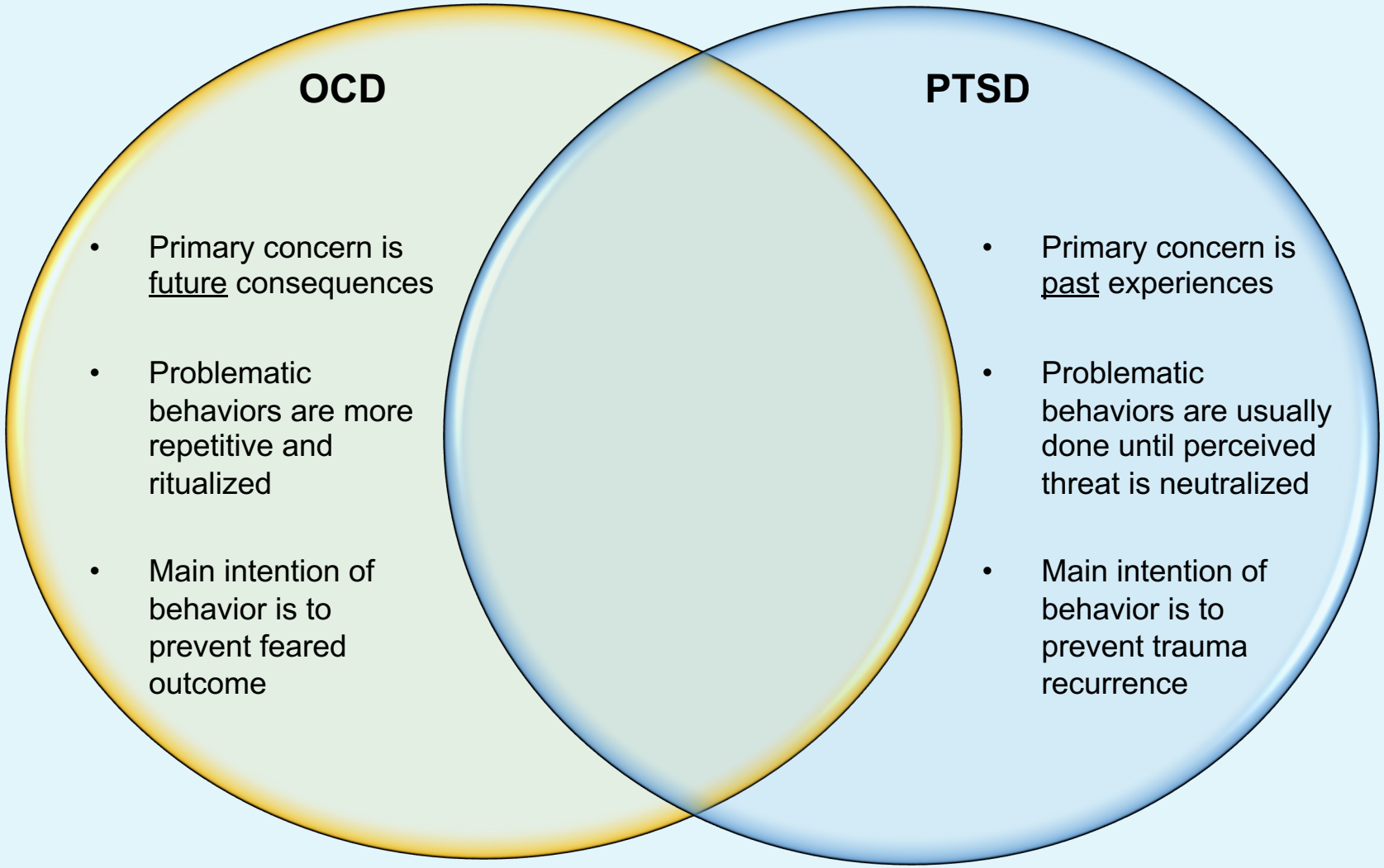
- Exposure to trauma(s)
  - e.g., death, serious injury, sexual violence
  - can be actual or threatened
  - can be direct or indirect exposure
- Intrusions/re-experiencing
  - e.g., recollections, nightmares, flashbacks
- Avoidance of:
  - memories of trauma
  - stimuli associated with trauma
- Negative impacts on:
  - thinking/beliefs
  - emotional wellbeing
  - arousal and reactivity

Comorbidity

- OCD and PTSD occur at elevated rates with one another
  - Among individuals diagnosed with OCD, approximately 1 in 4 also experience PTSD in lifetime
  - Even higher rates of co-occurring OCD among PTSD samples (~40%)
- Impact on course and treatment
  - OCD symptoms appear more severe at baseline
  - Treatment outcomes are attenuated

Brown et al., 2001; Gershuny et al., 2008; Ojserkis et al., 2017; Pinciotti et al., 2022

Conceptual Overlap



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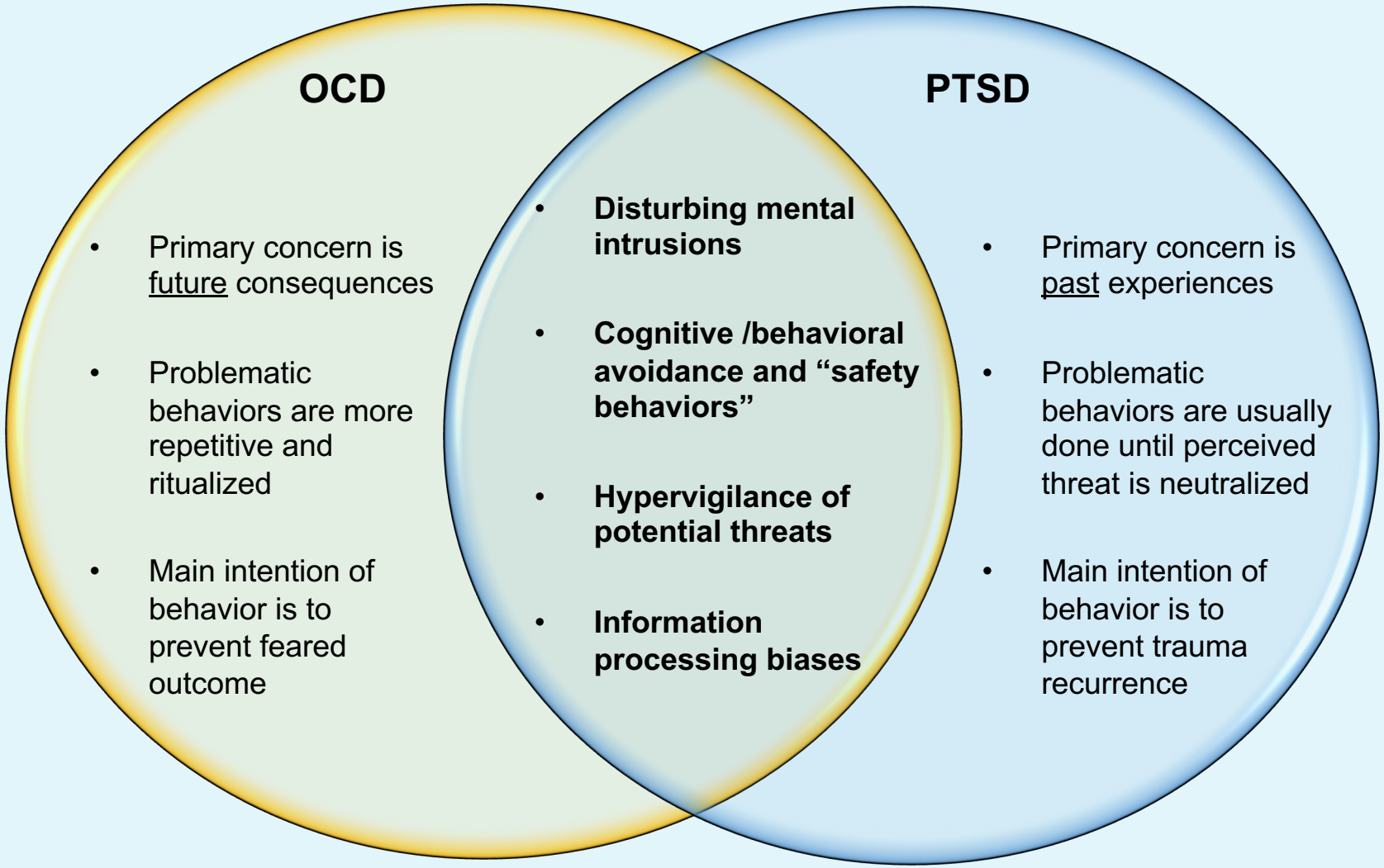

Rationale for Concurrent Treatment

- Why treat OCD & PTSD together?
  - Symptoms often:
    - interwoven with one another (e.g., exposure elicits obsessional distress and trauma reaction)
    - impede ability for other symptoms to be addressed (e.g., trauma-related dissociation occurring during ERP)
  - The co-occurrence is associated with higher rates of factors that may interfere with ERP:
    - elevated intolerance of uncertainty
    - limited insight into OCD symptoms
    - greater psychiatric comorbidities
  - Evidence-based cognitive behavioral interventions exist for both conditions
  - Preliminary results of concurrent treatment approaches are promising

Ojserkis et al., 2017; Pinciotti & Orcutt, 2020; Pinciotti et al., 2022; Van Kirk et al., 2020

Evidence-Based Treatments for PTSD

Prolonged Exposure (PE)

- Main components
  - Confronting the memory of the traumatic experience(s) in one's imagination
  - Processing the imaginal "reliving" of trauma to explore for new meanings
  - Confronting situations feared in the aftermath of trauma:
    - Cues/reminders of the traumatic experience
    - Generally safe activities assumed to be dangerous

Cognitive Processing Therapy (CPT)

- Main components
  - Identification and modification of unhelpful appraisals of the trauma(s)
  - Development of new, healthier conclusions about the traumatic experience and its impact on:
    - oneself
    - other people
    - the world in general
  - Focus on other areas of life negatively affected by trauma (e.g., sense of safety and trust)

Case Presentation

- Demographic information
  - 21 year old Latino cis male
  - Catholic faith
  - Single, straight
  - No physical or developmental disabilities

- Presenting concerns
  - PTSD (~3 years)
    - Trauma: high-profile shooting at high school
    - Intrusive recollections of friends' funerals and disturbing images of their final moments
    - Preoccupation with "why them and not me?"
    - Significant feelings of detachment and isolation
  - OCD (since childhood, worsened post-trauma)
    - Intrusive ideas of loved ones being in danger
    - "If I didn't know they were okay, I would always assume the worst"
    - Seeking reassurance from parents, older siblings
    - Responded well to CBT in adolescence, then re-emerged following the trauma

Case Presentation

- Diagnostic assessment
  - Completed DIAMOND semi-structured interview:
    - PTSD
    - OCD
    - Persistent Depressive Disorder
  - Self-report questionnaires to corroborate diagnoses and assess symptom severity
    - Dimensional Obsessive Compulsive Scale (DOCS)
    - PTSD Checklist for DSM-5 (PCL-5)
    - Depression, Anxiety, and Stress Scales (DASS-21)
- Case conceptualization
  - Trauma-related avoidance maintaining:
    - Significant anxiety in response to trauma reminders
    - Unresolved appraisals of the traumatic experience
    - Low confidence in ability to “live life”
  - OCD symptoms exacerbated by trauma
    - Enhanced awareness of unexpected tragic events
    - Renewed doubt about inability to accept uncertainty, especially with people close to him

Case Presentation

- Treatment course
  - Began with PE to address PTSD, which was comparatively more disruptive to lifestyle and responsible for more intense emotional distress
  - In-vivo exposure to physical reminders of friends
    - Looking at photos in yearbooks
    - Other stimuli that cue memories of friends
  - Imaginal exposure to events of funeral(s), including thoughts, feelings, and sensory input
  - Continued processing of this experience, with emphasis on “what it means that they’re gone and I’m not”
  - Gradually introduced ERP to present day worries about wellbeing of loved ones
  - Response prevention took into account ways to refrain from certainty-seeking via technology
    - No texting loved ones or tracking their location
    - No searching for accident reports
    - Deliberately turning off news alerts

Case Presentation

- Challenges encountered
  - Difficulty identifying index trauma (e.g., “they all blended together”)
  - Despite reduced guilt about surviving, there was persistent guilt about “moving forward in life” and what that meant
  - Hard time buying rationale for decreasing tech-related safety behaviors due to ease
- Treatment outcomes
  - Significant reductions in PTSD severity
    - PCL-5 score reduction of 55% from baseline (38) to discharge (17)
    - Funeral memories are “sad stories” vs. unbearable ghosts
  - Reduced OCD severity
    - DOCS score reduction of 32% from baseline (22) to discharge (15)
    - Increased confidence in “being okay with not knowing” about loved ones’ safety
  - Substantially reduced depressive symptoms
    - DASS-21 depression subscale reduction of 69% from baseline (16) to discharge (5)

OCD Routed in Trauma: OTTI, ERP & CPT

LAUREN WADSWORTH, PHD SHE/HER

FOUNDING DIRECTOR, GENESEE VALLEY PSYCHOLOGY

Demographics + Presenting Concern

- 40 y/o white cis woman, no developmental or physical disabilities, not religious, European American, no indigenous heritage, straight, born in US
- Presented to treatment looking for ERP for OCD related to contamination

Diagnostic Assessment

- Performed MINI Diagnostic Assessment
  - Did not endorse: MDD, Bipolar, BPD, Current Panic, Agoraphobia, Social Anxiety, Psychosis, GAD, PTSD*
    - *Did endorse traumatic experiences of father dying by suicide and mother dying 1 year ago
  - Symptoms consistent with clinically significant OCD

Symptoms

- Obsession/Fear
  - I could contaminate my kids (germs) and they could die from illness
- Compulsions/Avoidance Behaviors
  - Excessive handwashing
  - Sanitizing all living spaces multiple times daily
  - Avoiding touching anyone (shaking hands, hugging/kissing kids and husband)

Treatment

Started IOP at Genesee Valley Psychology

1. Psychoeducation on OCD
2. ERP for OCD (monitored by YBOCS, ERP tracker)
   - Hierarchy included contaminating and cross contaminating, scripts about contaminating her children and causing them to die, etc.

Challenges Encountered

- Onset of COVID-19
- Client reported either no anxiety or 10/10 anxiety during ERP
  - When anxiety triggered, pt also reported 10/10 sadness and "overwhelmed" feeling
  - Sobbing during ERP
    - Failed attempts to redirect pt to anxiety
    - Coaches struggling with presentation "not feeling like OCD"
  - Minimal progress, white-knuckling exposures, limited ritual prevention, continued to feel increasing sadness

Re-assessing

- In addition to SUDS scores, added other measures to ERP tracking
  - Level of sadness
  - Thoughts experienced
  - Images experienced

Trauma Emergence

- Pt reported experiencing the following during ERP
  - Images of father and mother dead (pt discovered both)
  - Flooding feelings of guilt and sadness, along with stuck points
    - "I should have known my father wasn't doing well and should have intervened"
    - "It's my fault my mom died- I was responsible for managing her treatment and medications and must have not dosed her right"

OCD Trauma Timeline Interview (OTTI)

- Thinking back, did your symptoms start before or after your traumatic experience?
  - Before
  - **After**
  - Simultaneous
- Do you believe your OCD and trauma are linked in any way?
  - No
  - **Yes**
    - **If Yes, how do you think they are linked?: "I guess they could be very linked- I feel responsible for my parents dying and don't want that to happen again with my kids, that would be the worst thing I can imagine"**
- Do you think that the presence of (OCD OR PTSD) made you more vulnerable to developing (OCD or PTSD)?
  - No
  - **Yes**
    - **If Yes, can you describe that to me?: "I never wanted to feel that way again, OCD gave me a sense of control"**

OTTI cont.

Obsessions/Thoughts that overlap between PTSD/OCD	**Rituals or Avoidance Behavior**	**Which more accurately describes the feeling you achieve by completing the ritual or avoidance behavior?** **a. A greater sense of safety** **b. A greater sense of certainty around future outcomes**	**If you resist doing the [Identified Ritual/Behavior] do you experience intrusive thoughts or images of:** **a. Past stressful events** **b. Potential future scenarios (e.g. "what if" scenarios)?**
If I don't wipe the car door handle down the kids will get COVID-19 and die.	-Excessively wipe surfaces -Wash own hands multiple times - Monitor kids multiple hand washing	B. I feel like my kids will be safer now and I reduced the risk of them getting COVID-19 from the car	B. What if the kids get sick and die
I am responsible for keeping everybody safe	Avoids memories/pictures/stories of/about father	A. I don't have to re-live painful memories	A. Images of father dying

Case re-conceptualization

Treatment Shift

- Paused IOP for 2 weeks while pt started Cognitive Processing Therapy (CPT) for trauma related to mom's death
  - 2x weekly sessions
  - Stuck point: My mom's death is my fault
- Once pt had started challenging beliefs, re-started ERP focusing first on contaminating self, then as CPT progressed, targeting fears of contaminating family
- Engaged in psychoeducation with family to balance trauma related support with reduction of accommodation for OCD
  - Identified behaviors that were both (hugging: comfort for trauma, triggers OCD)

Treatment Outcome

- 5 months after starting treatment
  - YBOCS down to subclinical levels of OCD
    - Pt stopped sanitizing, followed "CDC not OCD" for handwashing rules during COVID, hugging/kissing family
  - PCL-5 reduced to subclinical PTSD symptoms
  - Reported high quality of life and level of functioning
- 2 years later continuing to report subclinical OCD symptoms and no PTSD symptoms

Thank you

- OCD and PTSD teams at Genesee Valley Psychology
- Client for sharing story
- Collaborators on OCD and Trauma research: Dr. Caitlin Pinciotti, Dr. Nathaniel Van Kirk

- Contact: drwadsworth@gviproc.org

Pathological Doubt and Trauma:
What If It Didn't Really Happen?

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Patient Introduction

- Mid-20s, female, cis woman
- Transfer to OCD residential from PTSD residential
- OCD and PTSD

Presenting Concern:

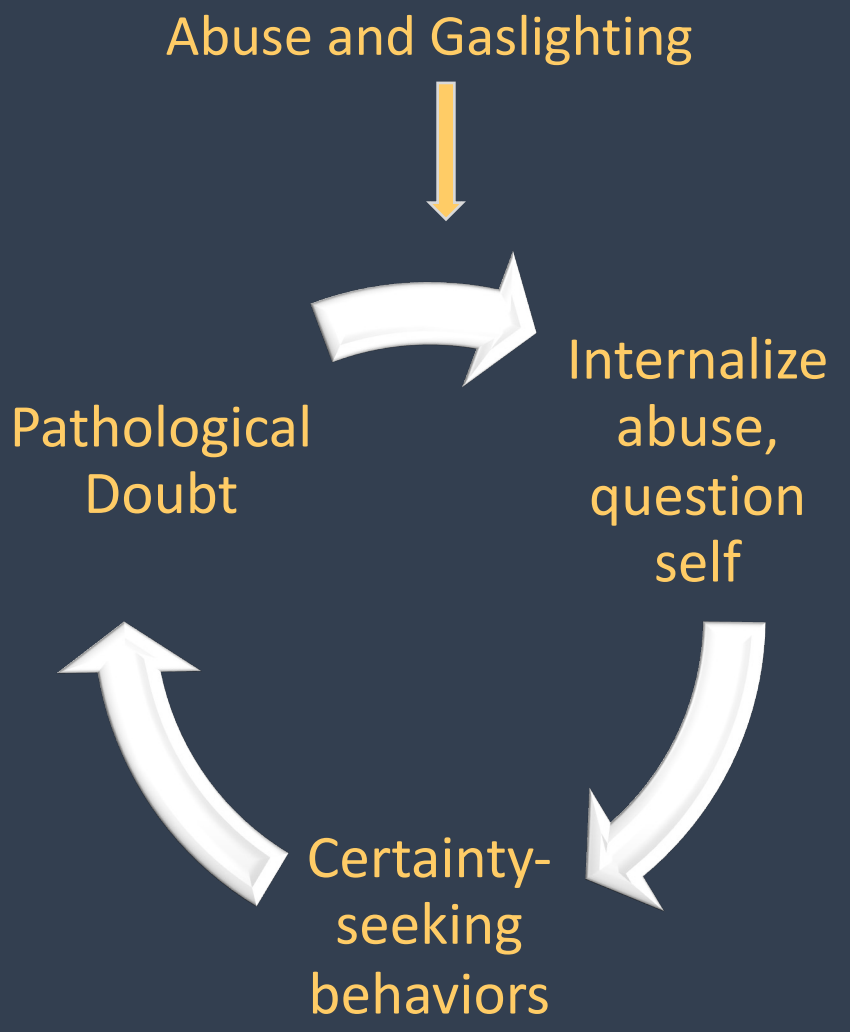
- Extensive childhood abuse (physical, psychological)
  - Experienced and witnessed
  - Responsible for abusive behavior and unpredictable mood
- Symptoms: Pathological doubt, checking, hesitating/slowness (exactness in meaning), “hoarding memories,” mental review, treatment perfecting, symmetry, people pleasing, self-blame, hyperarousal

Diagnostic Assessment

- Y-BOCS, CAPS-5, PCL-5
- Clinical interview

Dynamic comorbidity

- OCD and trauma/PTSD linked
  - OCD:
    - Doubt, responsibility for harm, checking, exactness/slowness, mental review, symmetry
  - PTSD:
    - Negative beliefs, hyperarousal, people pleasing
    - Doubting, self-blame



Case Conceptualization

Shielding: *Prevent Future Abuse*

- **Hesitating/slowness/checking/ over-explaining:** Prevent mistakes or inaccuracies
- **Confessing/reassurance:** Need for certainty about potential mistakes
- **People pleasing:** Responsible for others' moods/actions
- **Treatment perfecting:** Must be perfect

Healing: *Cope with Past Abuse*

- **Doubt:** Question own experiences and memories, validity of lived experience
- **Mental review/memory hoarding:** Make sense of trauma, get certainty, control – "I deserved it"
- **Symmetry:** Predictability and control of environment

Challenges Encountered

- OCD too severe to do Prolonged Exposure for PTSD
  - Could not remember traumas
    - Doubted recollection of events
    - Expressed as “not remembering”
  - Could not select index event
    - Fear of choosing wrong
    - Fear of fabricating experiences
  - Could not do imaginal exposure
    - Excessive ritualizing
      - Hesitating, mentally reviewing for minutes at a time, neutralizing (“might be wrong…”)
    - Elevated distress
    - Negative self-thoughts

Interventions and Course

- Concurrent ERP and Prolonged Exposure (PE)
- Adjustments to PE:
  - "Trauma log" outside of session
    - Minimal content provided used as memory prompts
      - "What do you think of when you remember the basement?"
    - Exposure, no ritualizing
    - Compare expectations (therapist disappointment/frustration) vs. reality (therapist pride)
  - Index = first salient memory that comes to mind
    - May select wrong -- Maybe index, maybe not
  - Resist compulsions during imaginal
    - May be incorrect, may be "lying" to therapist
    - Might "trick" therapist, others
    - Double exposure – trauma memory & OCD doubt

Treatment Outcomes

Outcomes: Admit to Discharge (Residential)				
	Admission	**Discharge**	**Change**	**% Change**
Y-BOCS (0-40)	34	19	-15	-44%
PCL-5 (0-80)	67	15	-52	-78%
Clinically meaningful change on Y-BOCS: 35% reduction from baseline Clinically meaningful change on PCL-5: 10 point reduction				

- Imaginal: Threatening to nostalgic
- Voice: “Not my own” to valid and louder than father’s
- Letter to sister: “I didn’t protect her” to “we survived together”

Gratitude and Contact Info

- Gratitude:
  - For this incredibly brave individual
  - For treatment team who provided support
  - Dr. Farrell, co-presenters, IOCDF
- Contact:
  - Caitlin.Pinciotti@bcm.edu

ERP, PE, and ED treatment for a Teen

Treating Trauma in a Youth with Multiple Comorbidities

nocd

Patient Introduction

- 14 year old, female, cisgender
- BIPOC youth adopted by a white family at young age
- Diagnosed with OCD, ED, and PTSD
- All conditions being addressed at residential ED program

Diagnostic Assessment

- Clinical Interview
- Children's Y-BOCS (CY-BOCS)
- Child PTSD Symptom Scale (CPSS-5)
- Eating Disorder Examination Questionnaire (EDE-Q)

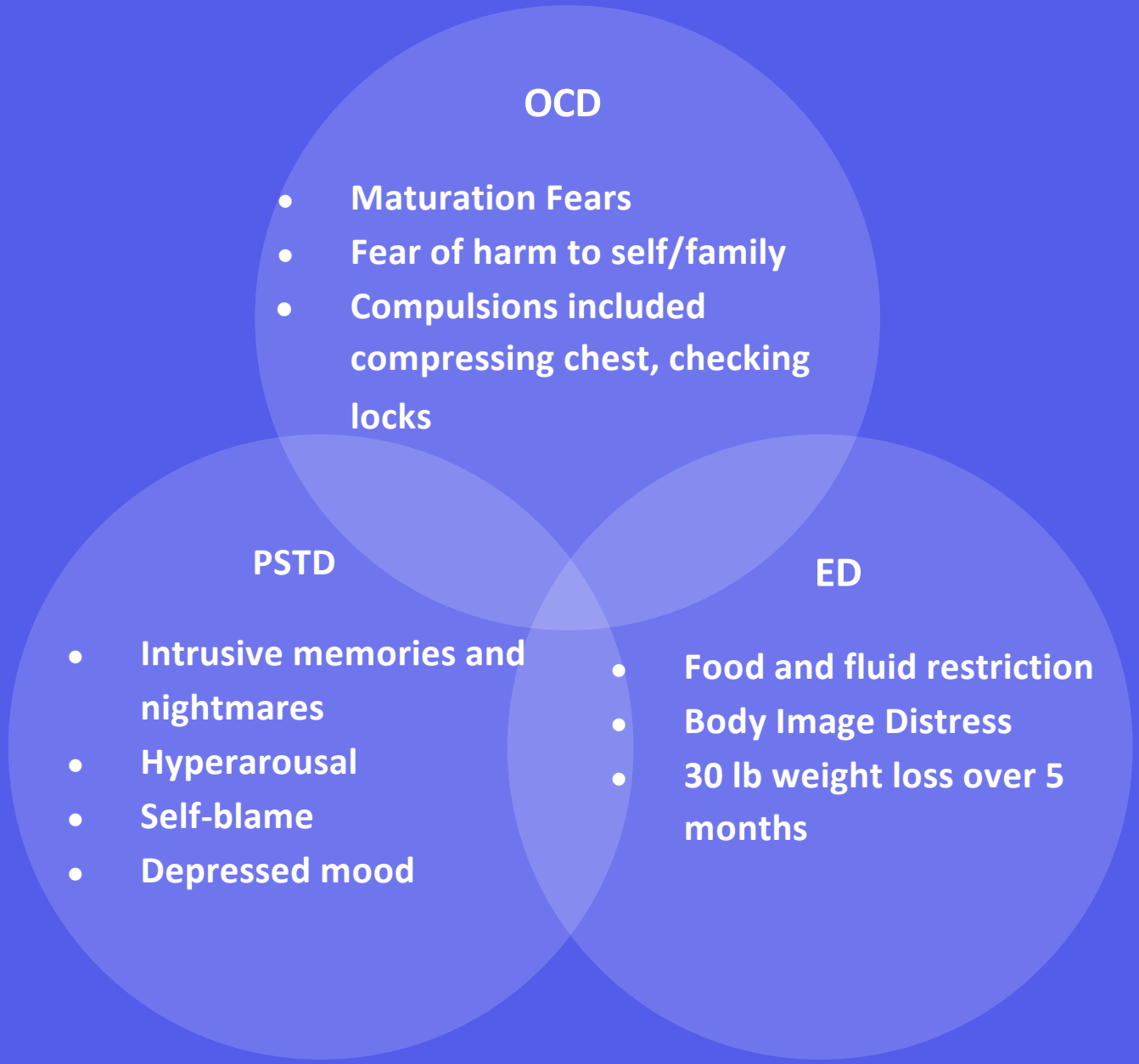
Symptoms

Index trauma: sexual assault by family friend.

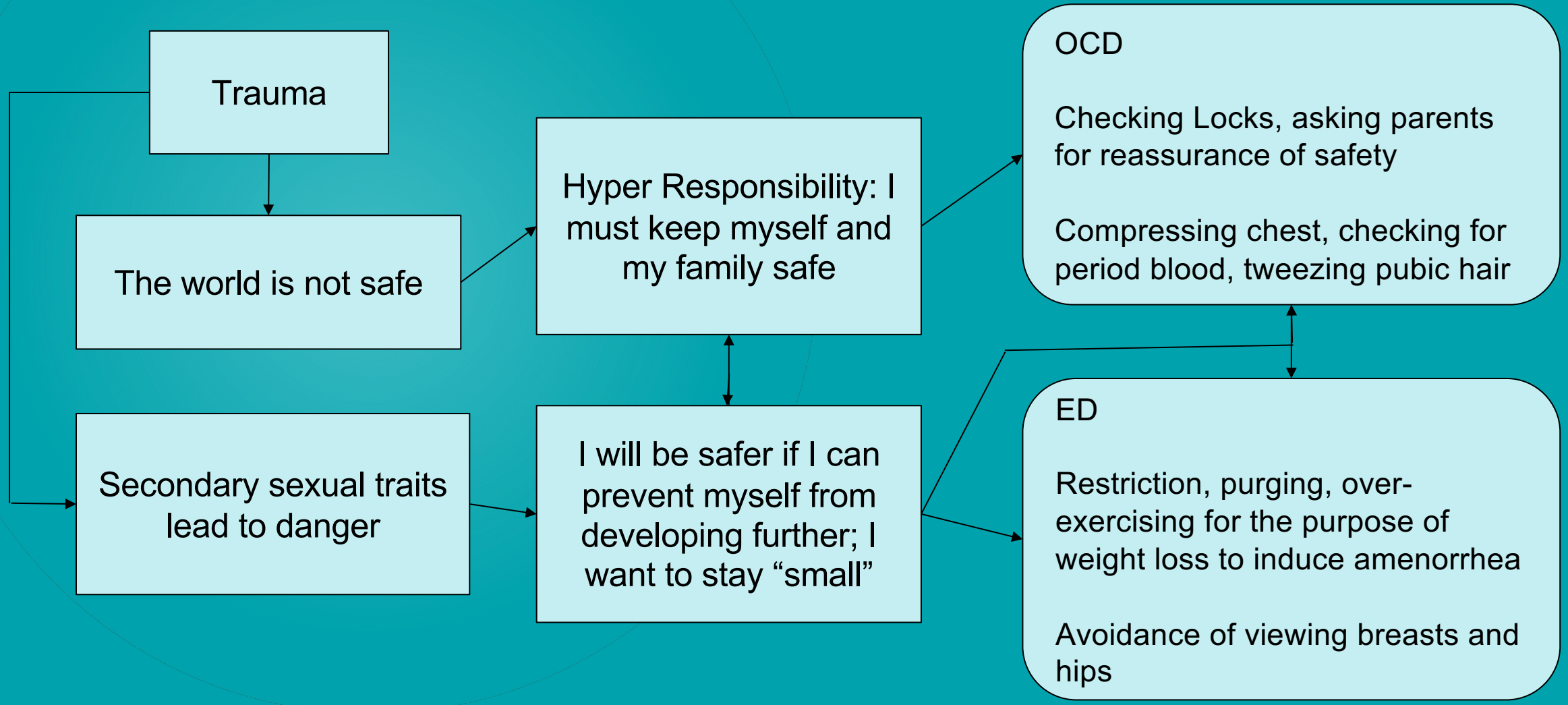
Reported PTSD symptoms developed first, then OCD, then ED.

Presented for treatment primarily for ED symptoms/weight loss.

Additional symptom: NSSI behavior



Case Conceptualization



Treatment

- Prolonged Exposure
  - In vivo exposures to be unsupervised with friends, access the internet appropriately on her own, spend time alone in room, and eventually to spend time alone in a room with trusted family members
  - Imaginal exposures to memories of trauma, including identifying and “zooming in” on hotspots
  - Addressed trauma inferences/beliefs related to her being at fault for trauma due to being more developed than peers, being unsafe if not closely supervised

Treatment

- ERP
  - Exposures: leave door open while in room, viewing of her body via showering with lights on, sex education material, etc.
  - Resist urges to check, reassurance seek, compress, etc.
- CBT for EDs (behavioral focus)
  - Exposures: Reintegrate feared foods into diet, weekly collaborative weighing, wearing tighter fitting clothing
  - Resist urges to engage in compensatory behaviors
  - Return to healthy intake and weight gain supervised by MD and RD

Unique Challenges

- PE must not result in return to restriction, over-exercising, purging
- PE must not result in compulsions that cause harm
- PE must not result in engagement in NSSI behaviors
- Self-blame related to being BIPOC in a white family: felt resulted in being “larger”, secondary sexual characteristics more pronounced.

Outcomes

	Admission	Discharge	Change	% Change
CY-BOCS	42	23	-19	45%
CPSS-5	39	24	-15	38%
EDE-Q	3.5	2.25	-1.25	36%

Future Considerations

- Trauma Focused CBT (TF-CBT)
- Family Based Treatment for ED (FBT)

Questions?