

Title: Assessing and Treating OCD and Anxiety Disorders A Look Across the Lifespan

Date & Time: THU, APR 28, 2022 01:00 PM - 02:00 PM ET

Speaker 1: Hello, and welcome to today's webinar assessing and treating OCD and anxiety disorders: A look across the lifespan. This webinar is paid for by McLean hospital, a top-ranked free-standing psychiatric hospital. A leader in psychiatric care research and education, and the largest psychiatric teaching hospital of Harvard medical school. Some important points before we get started, APA does not endorse any products or services.

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During our time together, you will be on mute. You can communicate with us using the Q&A box located on your webinar screen and if you have a question for our presenters, please type them in using the Q&A box located on your webinar screen. A link to the presentation slides will be posted in the chatbox. If you miss them, don't worry. We will email them to you with the recording.

Now I'd like to introduce our presenters. First. We have Dr. Nathaniel Van Kirk. Dr. Van Kirk is a licensed clinical psychologist specializing in severe anxiety disorders, excessive compulsive disorder, and trauma, PTSD at McLean hospital. Dr. Van Kirk is the director of the inpatient group therapy and the coordinator of clinical assessment at the OCD Institute.

Next, we have Dr. Elizabeth McIngvale. Dr. McIngvale is the director of the McLean OCDI Houston, where she maintains an active clinical research and leadership role. Her clinical interests focus on obsessive-compulsive disorder, anxiety disorders, mental health stigma, and access to mental healthcare. Welcome to both Dr. MacIngvale and Dr. Van Kirk.

Dr. Nathaniel: Thank you for having us.

Dr. Elizabeth: Yes. Thank you so much. We are so excited and looking forward to today's presentation. We're going to do our best to get through everything that we can. There was lots of pre-submitted questions and we know there will be lots of questions live so both Nathaniel and I's goal for today is that we can do our best to give a pretty good, hopefully, detailed understanding of both OCD, what OCD looks like and then, of course, be able to talk quite a bit about treatment and treatment and practice.

Hopefully, we'll get some opportunities to conceptualize together. We are going to be sure to end about 15 to 20 minutes early for Q&A so our goal will be that we will definitely get to Q&A. I see a couple of people have asked about the slides. We are

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happy to share our slides, if possible, after this webinar. We'll hop in, so what is OCD? Many of you may already know what OCD is, but OCD is made up of really two things, both obsessions, and compulsions.

What's really important for us to recognize is how the obsessions present and what is defined as an OCD obsession compared to a general obsession or intrusive thought and same with compulsion so when we're talking about OCD, the obsessions are unwanted intrusive thoughts. The unwanted is the most important piece. These are not thoughts that bring the individual pleasure or joy.

These could not be better defined as something else, but instead, they're intrusive and unwanted in nature. They cause a lot of distress, a lot of discomfort. The individual then engages in repetitive behavior, also known as a compulsion or a ritual to get rid of that distress and anxiety that's brought on by the intrusive thought. The compulsions, also very important to note as well are not desirable.

They do not bring any pleasure so the individuals with OCD will say things like I don't want to be doing these compulsions. I wish I didn't have to, but I do them because I feel like I have to, or because it's the only way to get rid of the anxiety or distress that the obsessions bring on. Important to note that compulsions can be both external or internal, so an OCD compulsion might be something like a hand wash.

It might be something like going in and out of a threshold repeatedly, but it also could be things like a mental ritual. Ruminating, trying to solve a fall, a past memory, engaging in prayer, thinking of a neutralizing color, et cetera. Those would all be compulsions. Important to note, obsessions alone are not definitive of OCD, same with compulsions, right?

When we think about, for example, an ASD diagnosis, we might see lots of compulsive behavior and rigidity and things that can look like maybe OCD, but really there may not be that same fear or that unwanted intrusive thought. We also, if you think about other diagnoses, you might see violent or intrusive thoughts, but they're not defined as OCD, because they may not be unwanted in nature.

Again, repetitive behaviors. The big thing I want us to think about when we think about diagnosing OCD is to think about the impact it has on one's life and so that's often defined as it takes more than an hour a day and really impacts functioning across the board. One thing to note is that DSM-4, so previous DSM, OCD fell under anxiety disorders and anxiety disorder, chapter, and DSM-5 OCD now has its own chapters so OCD and related disorders.

What happens is this chapter is made up of OCD, but it's also made up of some of the related disorders, which fall under the OCD category. This could be BDD hoarding excoriation disorder. While we're not going to get to go into those in detail today, those are treated similarly to OCD, but at the same time differently and so it's important to know they are related disorders.

OCD impacts about 3% of the population worldwide so this is a stat that is, it's really important to note that this is when we're talking about the global population, OCD impacts all genders, all groups equally and what we know is that 3% actually makes

it one of the most prevalent and chronic mental health conditions. It's one of the top 10 reasons people file for disability worldwide and it's recognized as one of the most disabling mental health disorders.

This is important because I think this is very different than what general society thinks of when they think of OCD. We often hear people thinking of OCD as someone who just likes to keep their kitchen clean or has their desk really organized. That's not what OCD is, right? OCD is a disabling chronic mental health condition. That's defined again, as unwanted, intrusive thoughts and repetitive behaviors or compulsions that the individual doesn't want to do, but they do because they feel like they have to.

Dr. Nathaniel: Let's just add on something you and I had conversations about is that that misconception too also has a big impact for those going through it and whether or not they're willing to seek treatment. I think the more we can get the word out there of how we clarify that terminology is a really important part that what we can do as a field as well, moving forward.

Dr. Elizabeth: It's critical when we talk a lot about this from the advocacy perspective and one of our big slogans we've coined over the years is OCD is not an adjective. It's really important. We're not talking about it of, oh, you should see my coworker. They're so OCD or, oh, you should see my mother-in-law's house. She's so OCD-like. That's often actually not what OCD is, that might be OCPD.

We could talk about that later if we have time, but OCD in and of itself, it's a chronic disabling disorder and we want to recognize it that way because the individuals living with it know too well, that that's the case, but they often experience a lot of shame and stigma around talking about it. Because is it going to be diminished? Are people going to understand the severity of it?

When we talk about 17 years, it sure, certainly shouldn't take 17 years to treat OCD but what we mean in this stat is that on average, it takes about 12 to 17 years from the time somebody displays symptoms to when they're appropriately both diagnosed and treated for OCD. What we know, however, is that with appropriate treatment, often 12 to 16 sessions, there should be incredible outcomes and so this number should be really disturbing to all of us.

There's many reasons for it, right? Whether it's misdiagnosis, providers who are not appropriately trained and able to treat OCD, lots of different reasons. It's important for us to work, to close that gap. Webinars like this are ways that we get to do that, so we are certainly grateful for APA and McLean in allowing us to do this today. The most effective treatment for OCD, which Nathaniel will go into in much more detail is both a combination of a specific form of cognitive-behavioral therapy called ERP and medication.

When you think about OCD and you want to start to conceptualize and understand it both as a clinician and/or with your patients. I want us to think about the OCD cycle and what it looks like. What happens is individuals experience obsession. Again, that unwanted, intrusive thought which could be a trigger, or this could be something in therapy we actually evoke. It's an exposure that we do together, but let's pretend

somebody has a fear of HIV and they have an obsession. They have to leave their office. Let's pretend this, if I leave my office, I have to touch my doorknob, and I go and I have to touch my doorknob. That's the trigger, right?

Touching the doorknob and the obsession is, oh my gosh, what if I get a disease? What if there was somebody else touch the doorknob who has a bloodborne illness? What if I get a disease from this? My anxiety immediately starts to increase. It's not this like prolonged time. Our anxiety onsets actually it's simultaneously with a trigger or that intrusive thought. What happens is immediately I start to think, "Okay, I need to feel better. I need to get rid of this fear. I need to know that I'm safe. Something's not going to happen." I engage in a repetitive behavior to try to feel better in this case maybe it's a hand wash, so I go to our bathroom down the hall and I wash my hands. That hand wash actually allows me to feel immediate relief. Physiologically, if we look at distress scales and numbers, we would see someone's anxiety decreasing once they engage in a ritual.

The problem is twofold, is that yes your anxiety has been reduced, but it is temporary relief. We've now reinforced the OCD cycle because what we've taught ourself is that we need to be afraid of that doorknob, and the only way to feel better around this trigger or fear is to engage in a behavior like a hand wash and that that's the only way we're going to stay safe. Not only do we find that the relief that we get is short-term. We also have reinforced OCD. We've done what we call feeding the cat or the bird.

I want to give the analogy that if you're at a restaurant and you're sitting outside eating lunch and there's a bunch of birds, and they're begging, they want food, they're annoying, they're chirping, you have some choices. Oftentimes, especially if you're with a young kid and they want the birds to go away, they just think, "Oh, just throw the crumb. The crumb is going to get rid of the bird."

It does temporarily because the bird runs off to get the crumb or whatever food you threw to them, but what happens? The bird comes back and it comes back actually more aggressive, tells its friends, and now all of a sudden you've got 5, 10, 15 birds surrounding your table wanting food, because they know that you are a food source. You have taught them that I will feed you if you're annoying enough or if you're there.

How do we get rid of the birds? Feeding them doesn't get rid of them, it makes them come back. The way we get rid of them is actually, we can't just pretend they're not there, because they're there they're annoying, but we acknowledge their presence, but we don't respond. We don't feed them. While it will take longer for them to go away than if we just throw them a crumb, when they go away, they don't come back, because they learn that you are not my food source.

OCD is very similar. We have choices in which we either feed our fear to get immediate relief, but it actually gives it so much power in the long run, or we can feel that discomfort in a short-term manner, but be able to have freedom in the long run, and that's really what we're teaching our patients. When we talk about freedom, we talk about uncertainty and how they go hand in hand. No better time in the world than to talk about uncertainty than right now. We've all lived through or living through a global pandemic where we have had to learn to accept uncertainty.

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We've all heard a million times like, "Well I just need COVID to go away, or I need to know what's going to happen next. I need to know that this trip is going to happen." Guess what we've had to learn to live and be okay with the fact that we can't guarantee that. We have no idea if it's actually going to happen, if it's not going to happen. We've had to learn to embrace uncertainty in our life. That's what we're teaching patients with OCD. We're teaching them to learn to live with uncertainty, because there's really no other choice.

There's three reasons. The main goal of OCD treatment is that I need you to be willing to learn to live with uncertainty. A lot of my patients think when they first come in, "Okay, well, the goal is that I have to live with uncertainty." Well, if you could do that, you want to be coming in, you wouldn't need treatment. It's instead can you acknowledge that you want to learn to be able to live with it? If a patient comes in which happens more often than not, and their first goal is I want you to get rid of my thoughts.

I want you to get rid of my anxiety so that I don't have to live with uncertainty. I can't do that. That's not feasible. I need to spend a lot more time in Psychoed because really the goal is I want you to learn to live with uncertainty, because there's no other choice we have. There's three reasons to learn to live with uncertainty. Number one, we have no other choice. In life we can feel certain, we can feel sure, but that's a false feeling.

There is no real certainty. You might be certain that when you get married on your wedding day this person is the person you're going to be in love with them forever, but you don't know that for sure. You might feel like you do, and that's a feeling, but you can't guarantee that. Lots of things happen, in America probably 50% of people end up divorced, and that's the reality.

Number two, what's the cost. Trying to achieve certainty costs you everything. It costs our patients their life, their functioning, their relationships, their friendships, their career, you name it. Number three, which OCD patients never really love to hear is, how do you know your rituals are the right ones? You feel like you're doing that ritual to achieve certainty, but how do you know that's the one you're supposed to do versus something else? You don't.

The point is that you actually are living with uncertainty anyways. You're just trying to convince yourself that you're not having to. We don't have a choice in life. Uncertainty exists in everything. Both Nathaniel and I committed to this webinar at one o'clock today and felt comfortable that we were going to be here, but we couldn't guarantee that, things could happen.

We had it planned and we were hoping, and we had no reason to believe we wouldn't attend or we wouldn't be able to be here for the webinar, but again we accept there are a lot of uncertainty just by committing to saying, "Oh yes we'll do that. We're happy to be there." That is the core of treatment. At the core, we want to teach you how to live with uncertainty.

Dr. Nathaniel: I think also highlighting the idea that for individuals with OCD that there are select parts of their life where uncertainty isn't acceptable, but we forget the

how much uncertainty we do except every time we get into an Uber, for that matter, lots of uncertainty there, especially in busy cities. I think what's important to remind individuals about is that they're already doing this day in and day out, just OCs said, but in this area uncertainty is not okay.

Dr. Elizabeth: Right. Yes. You accept uncertainty everywhere. You accept uncertainty in your life until you can't. Most of us don't think about the fact that every time we get in a car we could end up paralyzed. That's not something we really want to think about when we're getting into a car, but guess what? If we ended up paralyzed, we'd have to think about it because we'd have to address it at that point.

Unfortunately, for people with OCD OCD just jumps to that latter part, where the things that OCD latches onto it goes automatically to worst-case scenarios and all the what-ifs, and wants to have confirmation that we can be sure nothing's going to happen, but again that's not life. We can't guarantee any of that. What are some common obsessions and compulsions?

When we think about OCD, we often will categorize OCD into different subtypes or themes. These themes might include sexual intrusive thoughts, harm intrusive thoughts, scrupulosity which is the religious form of OCD, contamination which could be a fear of germs, it could even be airborne contamination, can be chemicals, can be bloodborne illnesses, and lots of different subtypes in which OCD can come up. Then what we find is there's various compulsions that you guys have heard of and some you have or haven't heard of that contribute or that can fall into certain subtypes or categories.

Compulsions might be checking the lock, it could be checking the stove, it could be touching or tapping, it could be going in and out of thresholds, it could be mental rituals you name it. These can present all different ways. What's important to note is two things. Number one, it doesn't matter what your theme is, treatment doesn't change. ERP is the same. It might look a little bit different, because the way we apply it, sure, will look a little bit different in practice for contamination compared to scrupulosity, but at the end of the day the treatment, the way we engage in treatment, the goals of treatment stay the same.

We want to teach you to face your fears, to not reinforce your fears and to learn to live with uncertainty. To learn to accept the unknown. Which again have to accept anyways in life. The reason themes can be really useful is that we do want to get to people's core fears. If somebody is for example walking in and out of a doorway and that's their ritual, there is no way if someone told both Nathaniel and I who treat OCD that that's their ritual. We're going to know why that's their ritual without asking them.

Is it because of scrupulosity fears? If they have a bad thought they go in and out saying a prayer until it feels just right. Is it because there's good and bad numbers for them? Is it because they think if they don't go in and out of this doorway a certain way something bad is going to happen to their mom? We don't know. For each individual there are rituals in the way they present. Can be around all sorts of different fears, different subtypes, different themes.

It is important to get to the core and understand that, because treatment doesn't go for just the symptoms. We're not just going to address the doorway or going in and out of a threshold, we want to also address the core fear, because if your core fear is God's going to be upset with you that's very different than something bad is going to happen to my mom, but we need to be able to address both of those core fears if that's what's going on.

You want to really explore and understand how does your OCD present as far as your triggers and obsessions, what do your compulsions or rituals look like, and what's the core fear. If you don't go through that doorway, what might happen? What causes you anxiety, What causes you distress? Nathaniel?

Dr. Nathaniel: Well, I just say briefly one thing I always like to highlight, McIngvale, go to the next slide. With this one I always think this is just a fascinating study and just real quickly. One of the things that they found early on is that all people have intrusive unwanted thoughts. I think that's incredibly important to tell people who are going through this, because a lot of times they may feel like there's something wrong with me. Like there's something and why would I have this thought, especially if it comes like harm someone they care about.

We know that over 80% to 90%% of individuals can actually endorse the intrusive thoughts that they've had, they know that they're having them, they can describe that experience. What's really interesting is some of the early studies actually, and as this replicated showed that even as OC specialists, we're not really great at being able to differentiate between an intrusive thought that someone without OCD has versus someone with OCD.

The difference is the meaning that they kind of subjecting, meaning they put on that thought, the thoughts of like, "What if I throw the baby? What if I stabbed somebody while I'm cooking dinner, or stabbed my significant other while I'm chopping peppers?" These are thoughts that are just part of human life and there is no difference in the content of the thoughts. I think that's really important to highlight for clients as you're going through it and for our providers when you're starting to work in this area.

Dr. Elizabeth: It's the way we respond. That's the differentiator. When I always give this example, I'll talk about we've all been driving down the road and had a thought that we can veer our car off the road and kill that person. When we see a pedestrian, people had that thought, many of us. Most people, when you have that thought, you keep driving, and you start thinking about your to-do list, and what you have to do after work or the stuff you have to get done. By the time you get to the office, you forget you had the thought.

In fact, until I just said that, you might've forgot that you even have ever had that thought or that you've had it recently. For someone with OCD, when they have the thought, they start automatically engaging in behaviors to be sure the thought doesn't have any validity, so they start looking in the rearview mirror, they start scanning around them. Did any car stop? Did all the cars move?

Does that mean that something bad didn't happen? They might check their car when they get to work to see if there's any blood. They look on the news to see if there were any reports of a hit and run. All of these things, by the time they get to the office, they can't think about anything except that intrusive thought. The thought itself isn't what was OCD, it's the way we respond and the distress that the thoughts cause us. Nathaniel, were you able to take over?

Dr. Nathaniel: Yes.

Dr. Elizabeth: Perfect.

Dr. Nathaniel: Here we go. All right. I think what Liz was saying, and Liz, thanks for such a great foundation because I think this is really going to set the stage for-- When you start working with OCD, it's so incredibly important that you actually focus on things like diagnosis and really understanding the connection between the obsessions, and compulsions, and making sure that the diagnosis is correct.

One of the biggest challenges that we see with OCD, and this was even as recent as 2013, that almost 40% of OCD symptoms are misidentified on a general basis, which is somewhat unfortunate piece of this. A lot of times, misdiagnoses can come in the form of GAD, other anxiety disorders, psychosis, or prodromal schizophrenia, autism spectrum disorder.

Especially in children and adolescents, if they haven't had a full diagnostic evaluation or PTSD, essentially, a lot of these ones that share some features with OCD but maybe don't have all the features together that make OCD. This also can be more complicated is that we know that those with OCD tend to have a lot of comorbidities also. About 76% of adults will have a comorbid anxiety disorder such as GAD or social anxiety disorder. For kids, specific phobia is very common as a comorbid diagnosis.

41% will have comorbid major depressive disorder. What's interesting, I think this is always good to highlight for clinicians, is that the ones that symptoms that tend to get misdiagnosed the most are actually the ones that generally tend to make us a little bit more uncomfortable. Things like the taboo thoughts like obsessions about sexuality or obsessional fears around pedophilia, aggressive obsessions of harm.

I think it's really important whenever you're working with OCD to think about the assessment and the differential diagnosis process. We have the foundational approach where we're using structured clinical interviews such as the ADAs or the SCID. For adults and for children, the child and parent version of the ADAs or the child version of the SCID as well.

I also think it's important to add in we're really conceptualizing OCD symptoms using the OCD-specific measures to get a good sense of how these symptoms connect and what is a good conceptualization of the OCD symptoms as a whole. The ones that we tend to use the most are the Yale-Brown Obsessive Compulsive Scale. This is both a clinician interview and they have a self-report version both with great psychometric properties.

The original Y-BOCS or Y-BOCS I comes with a two parts, a symptom checklist that gives an overview of a lot of different OCD obsessions and compulsions that can be really helpful in case conceptualization and making sure you've caught all the different symptoms associated with OCD, and then a symptom severity measure. That is great both for initial assessment but also for monitoring treatment gains across time.

More recently, the Y-BOCS II has come out, which takes a little bit more dimensional approach but against good psychometric properties and have both has that symptom checklist that's really helpful in case conceptualization, and initial assessment, and these symptoms severity measure for ongoing monitoring. Another one that we really like to use is the Dimensional Obsessive Compulsive Scale or the DOCS. This is a self-report 20-item measure that looks at the four main dimensions of COD symptoms.

What it does is it gives a dimension score for each of those, so contamination and washing rituals, fear of harm and checking style rituals, intrusive taboo unwanted thoughts. Then the other one, the fourth one is the not just right experiences, perfectionism, symmetry, and order. This can be a great way to do as a screener because it gives you a sense of like, "All right, so there's some elevations in one of these dimensions, here's where I can dig in a little bit more."

We also have child versions of the Y-BOCS. This is what we do, they call it the CY-BOCS that are set up in a similar way. I think the one thing to highlight is when you're doing diagnostic assessment for children and adolescents with OCD, it's incredibly important to get a parent report and other report because while an individual with or especially an adolescent with OCD, will have the same type of thoughts that adults have.

This includes sexual taboo, violent thoughts. The message that we send to them when we were doing the assessment is incredibly important. We don't want to say, "Oh, I'm hesitant to ask you about these thoughts" because that's just going to reinforce that these thoughts are dangerous for them. I always encourage people to talk about it in a very objective way.

I'll steal the line from my wife who's a child psychologist in OCD, who said "I've heard it all, see if you can shock me" as a way to make it a little bit more open with kid, child, children, adolescents because these thoughts can be incredibly scary to them, and usually, they really haven't told anyone about them before. One of the questions comes up a lot is how do I differentiate from all these anxiety disorders because OCD does have somewhat of a unique aspect to it, especially when it comes to this intolerance of uncertainty?

While this is not a hard and fast guy, this is just a general way in which I tend to think about differential diagnosis. One of the things I usually ask if I'm thinking about is this PTSD or GAD or OCD is when I look into the thought content. I might be looking at "all right, where's the focus of the obsession of the thought or image? Is it focused on a past memory of a specific event? Is it more of that snowball catastrophic reaction to daily life concerns?"

Or is it really focused on what I think as OCD clinicians, we call it the what-if factor. The idea that no matter what comes into mind, there's always that, "What if, blank?" That really gets at what Liz was talking about with that intolerance of uncertainty. One of the things that's important about this is a lot of times, it might change how we do treatment, which I'll talk about in just a second because we're not just looking to do as much probability or estimation because if you're telling someone that, "All right, so there's 99.9% chance that this fear won't come through?"

For PTSD or GAD, they may have increased feelings of safety or lower that catastrophic interpretation, with OCD, essentially, he'll be "Oh, so you're telling me there's a chance and I've got to do something about that chance because I can't risk it." Then with the repetitive behaviors, one of the things that we're looking at is what is the purpose? What is the function of them?

Is it to prevent having to think about a past event such as in PTSD? Is it more as a way that's almost problem-solve these daily life worries? Or in OCD, the repetitive behaviors or the rituals tend to be more rigid in their implementation that focuses on how these are implemented, and they tend to grow in complexity because they're, again, trying to eliminate uncertainty, which as Liz mentioned is pretty much impossible in our world.

I think these are things just to think about when you're doing diagnostic assessment is what is the functional relationship between the behavior and the feared thought or the thought image, or in some cases also, it can be a sensory experience and not just right experiences. Once we have that diagnostic assessment and we have a sense of like, "All right, this is OCD. I have a case conceptualization of the symptoms," then when it moves into the treatment phase.

Just real quickly, we do know that there are good pharmacological interventions. I say this not as a psychiatrist, so I'm just saying what the research shows us is that the frontline treatment really is SSRI's. There's also some evidence for certain tricyclic antidepressants like Clomipramine, also for Effexor, which is a serotonin-norepinephrine reuptake inhibitor. Primarily, we're going after an SSRI intervention.

We see around for those that it works about 40% to 60% decrease in symptoms, but an important part of this is that once if, without the behavioral interventions to deal with it, there are very high relapse rates if you stop medication and you haven't learned the skills to cope with that uncertainty effect of those behavioral skills. That really brings us to what we're going to talk about today, which is really the frontline treatment, which is exposure and response prevention.

Exposure and response prevention is highly effective. It has a meta-analytic effect size of 1.41, which is astronomical, but is also a very challenging treatment to engage in as a client. We're essentially asking someone to face their worst spheres that their mind can come up with over and over again, and then saying, but you know those things that make you feel better, don't do any of them, because we're going to teach you a different way to cope with that fear and that uncertainty.

We also know that more general cognitive behavioral therapy still based on the foundations of ERP because that is really the crux of effective treatment, also has a

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similar meta-analytic effect size. There's also been some emerging evidence on acceptance commitment therapy for OCD, and it has found support in literature and there's a wonderful RCT done in 2018, where it looked at Exposure Response Prevention compared to Exposure Response Prevention with an act augmentation, an act of framework for engaging in the ERP. What they found is that they were both equally effective. There's no significant difference between treatment outcome. I think it really highlights an important part about treatment, is we're essentially taking these effective empirically based treatments and finding how do we connect this with the individual? Which one do they resonate with? What framework do we use to help them access the ERP skills?

I think that's really an important way to know is that, it is highly effective. If we step back to this OC cycle that was presented to us, when we think about where does ERP intervene? The most important part of any treatment, and this is I think, where most treatment goes awry is ritual prevention. Exposure without ritual prevention for OCD is just practicing doing OCD better.

Really the big part of successful ERP is ritual prevention, because it essentially breaks the association between and the belief from the necessity of the rituals to regulate my distress, that I need these rituals to feel better, without them there's no other option. Once you stop the rituals and you do these target exposures, then it leads to the extinction process where you're essentially trying to reduce the conditioned response or distress response to the obsessional fears over time with repeated exposure and not engaging in those rituals that someone's think feels are necessary to prevent the figured outcome and feel safe.

Some important things though, to think about, and I'm going through this quick, because I know that I've seen a lot of questions pop up in the chat and the Q&A, so I want to make sure we have plenty of time for that. When you translate this theory into practice, couple of things to keep in mind. The goal of exposure is to teach clients that anxiety and distress is fleeting, were hardwired to go through this process, ride that weight, if you will, also to help them build confidence in their ability to face fears effectively without these rituals that have taken over their life.

I always tell people that exposure is they need to be planned and purposeful. They should be repeated and prolonged. If someone goes and you dive into exposure and to use this as example, like if I go and if I touch the door knob real fast, I'm like, all right, cool, I did my exposure, I'm going to go wash my hands now because I'm done, that's not really getting in contact with that uncertainty.

It's not just about facing the fear, but sticking with it in a way. We can do this either in real life or in vivo, or through imaginal scripts for those that maybe we can't replicate in day-to-day life. There is this purposeful systematic process to it, so that we can move through it together with the client. The other pieces with the ritual prevention, you're essentially teaching them how to handle distress more effectively without these maladaptive rituals.

A very important practical note is forced blocking of rituals has been shown to reduce long-term effectiveness of ERP. Essentially what ends up happening is the responsibility for that feared outcome, gets delegated to you as the person blocking

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the rituals. OCD is very sneaky that way, where I'll say, they are keeping me from doing the ritual, so if someone dies, it's their fault, I absolve myself a responsibility, and I think that's a really important piece as well.

Also to be on the lookout for mental rituals and subtle avoidance rituals, such as maybe touching that doorknob as Liz was talking about, but then you like isolate your hand, and one hand just stays out here for a little while, where it's subtle avoidance, and so we want make sure to cross-contaminate to have them come into full contact with that fear and that fear trigger.

This really brings us to the big piece, which is through treatment for OCD, you are not trying to prove that something is safe. You're trying to help individuals tolerate uncertainty more effectively. While we don't create objectively dangerous situations, we want to be very careful as clinicians about how we present it to the clients, saying things like, I will never have you do anything dangerous.

That from the outset can undermine all subsequent ERPs because you have essentially given them certainty that you're taking a responsibility for their wellbeing or the dangerousness of that situation, so they don't have to tolerate that uncertainty. Be careful and be on the lookout for things like, are you sure when people say, are you sure this is safe? You would tell me if this wasn't safe. I bet you would stop me if this ERP became unsafe, so I'll keep going.

A lot of times I'll respond back with, maybe, but I also don't know everything and I've been in a lot of accidents on the farm growing up, so maybe I'm not the best person to tell if this is safe or not, let's see if we can find out together. The other thing that I want to highlight is while we've talked about this habituation and fear extinction model, inhibitory learning has also provided an additional avenue for how we can enhance outcomes in addition to this, because some people will say like, I just don't get that relief, especially at the very severe end.

Their habituation may not happen within a 90-minute session, but inhibitory learning has actually showed us some really great ways around focusing on distress tolerance and tolerating those feelings versus the goal of getting rid of them but also ways that we can use cognitive strategies after exposures to violate initial expectancies, and essentially develop what we would call inhibitory or competing responses.

The way that I frame this very quickly, and this is the whole literature I recommend jumping into, is really it's teaching people that they have a choice. I can choose to ritualize when I'm triggered or I can choose to do something different. I can still stay in contact with that fear and that uncertainty, but ritualizing, isn't the only choice, I can practice and build up these other options in my ability to choose, if you will.

That's a very quick distillation of a very large literature. I definitely encourage you diving into it more. The final piece that I really want to just highlight so we make sure we have time for questions, and Liz, I'd like to hear your piece on this as well too because I think this is something we talk a lot about, when working with children, adolescents, and adults is incredibly important to involve the family.

When you're working with children in adolescence, ERP includes a lot of work with the family because OCD infiltrates its way into the family system, and a lot of times loved ones will try their best to try to ease someone's discomfort by doing a lot of different pieces that make their OCD easier to maintain, and we call it accommodation. When you're doing work, there's a great scale called the family accommodation scale.

I'd highly recommend using because it identifies different ways in which individuals might be accommodating OCP behaviors because for treatment to be effective, we have to remove that family accommodation. Otherwise that system will still stay in place, even after ERP. Any other pieces, Liz, on that you want to add?

Dr. Elizabeth: I think the biggest piece is to think about the age range, just because as you know, it's interesting because I think oftentimes we think, oh, certainly if someone's under 18, we're going to incorporate family into treatment, but oftentimes when you think about the disabling nature of OCD, a lot of us are treating adults who live at home, adults who've been struggling for a long time.

If you are living at home with your family and family members play an active role in enabling your OCD through reassurance or any cleaning behaviors, whatever it might be, we need to be involving them in treatment as well. Family plays such a big role in the entire treatment process for individuals with OCD, and as Nathaniel said, it's not just about making sure they're on board and they understand the work to be done, but it's also about educating and providing psych ed to them and working with them so they understand the ways they have been enabling.

Many times as a parent, they don't even recognize that what they're doing is actually just a part of this entire OCD cycle, and it's further ingraining this cycle compared to helping break it.

Dr. Nathaniel: I always tell parents and family members, we're essentially teaching you a new way to care. It makes sense why you were responding the way you were, because it's hard to see someone you love in pain, but at the same time, we're teaching you a new way to care by holding that line so that their future looks brighter. I think the other piece that's important with children in adolescence is that there's a lot of parent training that goes into it.

Also supporting the parents to be able to hold their child's distress and anxiety, because that's a really tall order. I think that's a really crucial be part of treatment. Then just one thing to highlight before we roll it into questions, is that there are also multiple levels of care. We've been talking about the standard outpatient approach, which is we know as highly effective, but we also know that there's a lot of self-help options available as well.

There's support groups of really large OCD community that are really wonderful about supporting each other. There's also in residential services where partial hospital services day programs, intensive outpatient programs, multiple levels of care based on Exposure Response Prevention, that provide a lot of options based on severity. One of the questions that was submitted earlier in the talk was, when do I look for a higher level of care? I think this is one of the important pieces is that there

are times where OC is so integrated in a daily life where someone may not be able to physically take care of themselves eat drink do ADLs because the OCD is so ingrained. It may take so long. They may just completely avoid it or they get so stuck doing it. Those are type or cases where there's so much else going on maybe around comorbidities or just a difficult home environment where a higher level of care may help someone focus more specifically on their OCD treatment and remove distractions or they might need coaching.

In residential care we routinely do ADL coaching. There's someone there 24/7 because OC might pop up at any time of day. That includes 2:30 in the morning. Sometimes OCD is like well, you're awake. Am I here's a trigger. Here's an urge to ritualize at in a residential here we can help people work through that in real time. There's also times where there aren't OCD providers that have training in this in a reasonable area where they could go get treatment.

This can be another time to look at a higher level of care to get a maximize dosage if treatment isn't available in your area. I'll wrap up with this idea that even in the most with those that have the highest severity who usually will come to intensive residential treatment, we see that treatment works. Exposure and response prevention shows significant reductions in Y-box scores and across all four docs.

We also see in a significant effective time or number of weeks in the program on reduction. We can say that at least what we're doing works and even for those that maybe aren't responding to traditional outpatient therapy there are options available if we just have to increase the dosage of treatment at times but true hope is still out there. I think that's an important message to pass along as well.

With that, I know that was a lot of information really quick but I hope I know we have a number of really great questions coming in. I hope we spend some time on those but thank you all for joining us and letting us talk a little bit about OCD with you.

Speaker 1: Yes. Thank you so much. Thank you both. We have gotten so many questions, really, really good thoughtful questions. I'm going to try and group similar ones into one question so we can get through a couple of different topics. I'll start with are there any cultural or racial variations in how OCD may present? We also got along those same lines cultural or racial variations causing misdiagnose. How can you make sure that any implicit bias you may have does not present itself diagnosis?

Dr. Elizabeth: It's a great question. Monica Williams has led a lot of our research in the diversity arena in the OCD work specifically. What we know is that certainly populations may find that OCD presents a little bit differently in the sense that what we know about OCD is that it tends to target what's most important to us, what our values are, the way we live our life.

We may see that certain cultural differences or maybe even like family rituals. OCD may latch onto those differently. For example, we know that if you live with scrupulosity the rituals aren't the same across the board. They're different depending on your faith background? If you're an Orthodox Jewish, it might attack some of your Kosher practices, if you are of the Islam faith, it may attach to some of the abolition or cleaning rituals.

For Christianity, it may attach to some of the prayer rituals. It really just depends. As far as treatment, we do know there are some studies that have shown that individuals of color prefer clinicians of color and have better outcomes of clinicians of color when doing OCD work. What I will say at the same time is we have so much work to do in this arena. There is just not been enough done.

What we also know is there's been a recent article an incredible article about social justice based ERP and us really starting to transition and better think about the way we do ERP and is it socially appropriate? Is it justice based? Is it building up marginalized communities versus potentially breaking them down or using them as props as a part of ERP treatment which would be totally inappropriate and so lots of growth and lots of ways that we can continue to improve and learn IOCDF.

You can go to iocdf.org. They do have a diversity committee and we do do a diversity round table once a month where we're talking more specifically about these different issues.

Speaker 1: Awesome. Thank you. Next we're getting a lot of questions about co-occurring disorders specifically ASD, ADHD, and PTSD as they relate to OCD. If you could just talk a little bit to that. Does that cause misdiagnosis? How can we separate them?

Dr. Nathaniel: Definitely, that could be a webinar in and of itself. I think we do know that there are higher rates of ADHD in individuals with OCD. There are some underlying neurological mechanisms that are similar. We do see actually a high comorbidity rate between OCD and ADHD. The OCD and ASD, there's been a wonderful book called *Stuck* that it's great to read. Just get a little sense of how this can overlap but we definitely do see comorbidity in it but we also see misdiagnosis. It can go both ways.

I think if there's a question of either or if whether it's both or either or getting a full diagnostic workup for ASD and for OCD is really important because there are areas that the repetitive behaviors or self soothing behaviors can look very similar. There are subtle differences between them but someone might have ASD and OCD and an important part of that is identifying what are actual rituals within the OCD context.

What are repetitive interests or repetitive behaviors that are more in the ASD aspect but also changing the way we talk about it to adjust also for the way the symptoms may interact? Yes we definitely do see a pretty high comorbidity rate there as well. The OCD and PTSD one is I think is a great one. It's something that Liz and I have worked together a lot. We were at the VA as well where we both worked on this OCD and trauma and PTSD piece. We see that the comorbidity rate there is about 19.6%.

Those with PTSD are 10 times more likely to develop OCD. There is definitely a relationship between them but I think the key that you want to focus on is what is the intrusive thought or image in reference to and those repetitive behaviors what is the functional purpose of them? Are they to gain relative feelings of safety in order to prevent that outcome from or that event from occurring again or a similar event or having to be in contact with those memories?

Or is it about this what-if factor of the future of what if X, Y, and Z something that has happened in the past but what if all these other things could happen that may not be related to the content of the traumatic event? You're really looking at for that functional connection. What is it that they're trying to gain? Is it certainty or relative safety? I think that's one way to approach it.

Speaker 1: Also a lot of questions about ERP again try to group them together. Are there any major differences in approaches for adolescence versus adults could also provide some examples and is it as effective via telehealth?

Dr. Elizabeth: All great questions. What we know so far is that we have no reason to believe it can't be as effective in telehealth versions. Most of the early literature has shown or literature to date has shown that ERP can be extremely effective through telehealth. We're seeing that across the board. What I will say is the major differences. Mechanically conceptually it's no different for adolescents or adult. It really comes down to language in the way we do it.

I might be explaining OCD to a kid as OCD is tricking you. It's playing a trick. It's a fire drill where you think it's real you get really scared but there was nothing to be afraid of. The description the way we describe it but the engagement and treatment is very similar. We're slowly and surely going to teach them to lean into, embrace, however you want to call it, their fear and the uncertainty and to not try to fix it. To not let feelings dictate our actions or how we respond or what we do in life.

That's the same with adults. Some examples. When you think about this doorknob example I gave earlier, as Nathaniel mentioned, it's not just about the exposure. Touching the doorknob is great but if I touch the doorknob and walked down my hall and washed my hands, I've reinforced OCD. I've made OCD bigger. The exposure therapy is not the treatment for OCD. It has to be exposure with response prevention.

We engage preventing that response that our OCD wants us to do. We prevent engaging in a hand wash. If that's the trigger. The third piece is I call it the ERP plus. ERP is like I touch the door knob. That's the exposure response prevention. I don't wash my hands. I will eventually extinguish the fear of the doorknob but I want to go further. I want to lean into the uncertainty.

After I touch the door knob and I don't wash my hands, I also want to lean into the fact that like I don't know for sure if my hands are dirty or clean. I don't know for sure if I may or may not get a disease and I'm still going to choose to go do blank, blank, blank. That's really important. It's really important to be able to lean into both.

Dr. Nathaniel: I think one of the things is also, I think, the idea of framing that was mentioned is really important. Especially, with your very younger kids, you're going to focus on being brave and things like that and probably, not quite as much as with adults who might lean into like, "Let me list out all the uncertain ways in which this can go terribly, terribly wrong."

If they're doing mental rituals and we might be trying to challenge those mental rituals. With young kids, it's also about being brave, learning how to ride out those

emotions, those type of pieces, and a lot of parent coaching as part of the exposures too. Where with adults, we do remove the family accommodation. As an adult, it's up to them to practice, do these self-directed ERPs.

With young kids in our lessons, especially young kids, the role of the family members as a coach during these ERPs in daily life and helping the practice as well, and teaching the parent how to coach ERPs is incredibly important as well.

Speaker 1: Great. See here. Are there any instances where during treatment, clients might end up replacing their previous ritual with another ritual? How do you prevent your therapy techniques from becoming-- **[inaudible 00:51:18]**

Dr. Nathaniel: [laughs]. That is a great question.

Dr. Elizabeth: All the time.

Dr. Nathaniel: Oh, yes. That's actually something we always think about with some relaxation strategies, skills that they might teach for general anxiety, OCD loves. They turning those into a ritual like, "I'd have to do it perfectly. I have to do it right." There are times where someone's anxiety is so high that things like DBT, distress tolerance skills, are necessary for them to even access the exposure. Yet, those are the instances to be very careful about, is it turning into a ritual in of itself?

One of the ways I've with adults been able to keep that from happening is by being flexible and unpredictable with the skills. Don't use the same skill all the time. Also, teach them what is the line. When do you notice when any functional behavior is becoming a ritual? What is that line to help them better identify it, so they can notice that change and shift it up? I think I've done once where they have to roll, essentially, a die. That's the coping skill they use if they really have to use a coping skill at that moment. That way, it's always somewhat random so it keeps OCD guessing.

Dr. Elizabeth: I think the big piece, here again, is are we getting at the core fear? If we're just like, "I'm going to do this exposure. I'm not going to do this one ritual," but they're replacing it with another ritual, that's not ERP. We've just shifted one for the other. That's why that core fear is so important, that plus part, the leaning into the uncertainty doing that sacred piece is because even if there's an urge for another ritual next or the urge to engage in some other behavior if you've leaned into the core fear, you won't feel that same pull to do the ritual.

This is the same with mental rituals. A patient cannot do an external ritual, but they can be ritualizing internally. For me, the indication is usually, are we seeing anxiety reduce? If anxiety is not reducing, not that we always need to follow a traditional habituation model, but at the same time, if patients are saying, "I'm doing ERP and it's not getting better. I'm still really scared." They're probably not doing it correctly.

They're probably holding on to something, or they're still trying to solve it in their mind, or they haven't fully committed. It's really important, you have to commit all the way. When you do, patients will actually say, "Wow. I feel more freedom." You'll see their insight increase, and their freedom will start to really be present.

Dr. Nathaniel: The one thing I always, I think, it's really important to think about when you're going through as a provider, there is also this phenomenon with OCD as we see it a lot on the residential level where the obsessions will also shift towards the ends. When someone's coming close to discharge, they might be coming up with this idea of like, "Oh, no. How do I know if this thought is an obsession or a normal thought?" That's usually a clue OCD is pivoting on them.

They're trying to gain certainty around the thought now itself and what isn't? Isn't OCD? Are they ready for discharge? Anytime that they're trying to get after that 100% certainty, that's a good clue to help them say, "Maybe that's an obsession, maybe it's not. It doesn't really matter."

Dr. Elizabeth: Exactly.

Dr. Nathaniel: "What you're going to do? Maybe you're ready, maybe you're not. Let's give it a shot. You get to choose what you do and your behavior anyway." You're leaning into that uncertainty with them as it's pivoting to try to hit it off the most.

Interviewer: I'm going to try to get through to more questions. We're almost at the hour. How can you best help clients who struggle with either articulating their obsession or their trigger?

Dr. Elizabeth: How do we help them articulate either? It's really just about having them describe it. This is where those measurements can be really useful and come in handy, is the obsessive-compulsive measure that we talked about the Y-box obsessive-compulsive scale, also comes with a symptom checklist. I love that as an early assessment tool just because it allows you to talk about all different ways OCD presents because sometimes a lot of our patients don't even realize that this is OCD and they've been having it for a long time.

I often will start with like, "Here's some common examples. Here's some fears that people might have. Here's a trigger that they might deal with. Let's talk about yours." I think that if a patient is coming to you for OCD treatment, they tend to be able to at least start. Maybe they're not going to jump into the taboo ones off the bat. They often are going to start by being willing to say, "Here's things that scare me, and here's some of the behaviors that I do to try to feel better."

Dr. Nathaniel: I think that's also where you can use more cognitive therapy augments and cognitive therapy. There's a great study on a 24-week cognitive therapy for OCD that had showed a significant reduction in OCD symptoms. We can also take those strategies that are tailored to OCD and cognitive therapy and use them in addition to the ERP to help in those instances where you might do the downward arrow piece where you say, "What if that happens are you afraid of something else?"

You get to help walk them through. What is the underlying fear? What is the thing that you might even be afraid to say out loud because sometimes that is also the trigger itself? Like "I can't say this thought." Or, "I can't acknowledge this thought or it's going to happen." Part of it is rapport building, and also psychoeducation. The

other is supporting them as we walk through it. Also framing that as an exposure like, "We're going to walk through this worst possible fear." Have you say it out loud. That's the starting point.

Speaker 1: Last one. If you have a couple of books or resources you would like to recommend for everyone on the call? Also, Dr. Van Kirk, people missed the name of the book you recommended earlier. They think it was *Stuck*.

Dr. Nathaniel: Yes.

Interviewer: [laughs]. That, any other resources you would like to recommend?

Dr. Nathaniel: [unintelligible 00:57:10] *Stuck* is a book for ASD and OCD comorbidity.

Dr. Elizabeth: I'm sharing a couple. *Freedom from OCD* by John Grayson is my favorite book for both professionals and individuals. John Abramowitz has an incredible OCD workbook that I highly recommend. Then, of course, please go to iocdf.org. That's the international OCD Foundation. We have our upcoming annual conference in July in Denver. We have an online conference, and you can find tons of resources and education support materials for family members, individuals, or professionals around OCD.

Dr. Nathaniel: For individuals who went through it, there's a lot of great stigma reduction resources. There's a number of webinars, Clean MGH has a couple of them, Deconstructing Stigma Campaign has some stories about OCD and education about it that sometimes can be helpful for individuals if they never talked with somebody who's gone through it before. The International OCD Foundation and the webinars, Liz is part of doing weekly webinars. I think I'd highly recommend people checking those out as well because it gives a perspective of going through it, what it's like if they have people from all over the country talking about different perspectives on it? It's really a great way just to build that education and connection with the community.

Speaker 1 Great. Thank you both so much for joining us. We're getting tons of comments flooding in saying how valuable everyone found this presentation. Thank you. Thank you to everyone on the line for your participation, your great questions. Thank you to McLean Hospital for making this webinar possible.

Dr. Nathaniel: Thank you so much for having us.

Dr. Elizabeth: Thank you for having us. It's our pleasure. For anyone interested or who wants more info on OCD, feel free to reach out to both Nathaniel or myself through McLean, or of course through iocdf.org. We would be happy to provide any resources that we can.

Dr. Nathaniel: Definitely.

Speaker 1: We've mentioned this a couple of times in the chat, that the recording of the presentation and the slides, someone did note that they look a little different than the link we dropped in earlier. They made a couple of changes. We will be emailing File name: Assessing and Treating OCD and Anxiety Disorders A Look Across the Lifespan.mp4

out the most recent version of the slides, the one you saw on the screen today. Both of those will be coming out in email in about two weeks' time.

Also when the webinar ends, you will see a short survey on your screen. We'd ask that you take that survey and give us your feedback. Thank you everyone for your attention and we hope you have a wonderful rest of your day.

Dr. Nathaniel: Thank all.

Dr. Elizabeth: Thanks, you guys.

[00:59:43] [END OF AUDIO]