

Webinar Title: Transforming OCD Care in the Presence of Trauma and PTSD
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Moderator: Hello, and welcome to today's webinar. Transforming OCD Care in the Presence of Trauma and PTSD. This topical webinar is paid for by McLean Hospital, a top-ranked freestanding 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. Dr. Nathaniel Van Kirk, the presenter for today's webinar, has a working relationship with McLean Hospital. As such, he has both a financial and an intellectual interest in the webinar content.

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The recording will include the presentation slides. During our time together, you will be on mute. You can communicate with us using the Q&A box located on your webinar screen. The Q&A is enabled for attendee interaction with submitted questions. Attendees can view all submitted questions and upvote those they find important. This helps the presenter identify questions that many attendees want answered. A link to the presentation slides will be posted in the chat box of your webinar screen. If you miss them, don't worry. We will email them to you with the recording.

Now, let me introduce our presenter, Dr. Nathaniel Van Kirk. Dr. Van Kirk is a licensed clinical psychologist specializing in severe anxiety, OCD, and trauma and PTSD. At McLean Hospital, he is the director of psychological services at the OCD Institute. He leads clinical research on motivation and trauma, and treatment outcomes, and champions innovative recovery assessment methods. He's an advocate for mental health stigma reduction and serves on multiple McLean Hospital committees, including the patient and family advisory and Schwartz round committees. Welcome, Dr. Van Kirk.

Nathaniel Van Kirk: Thank you very much. Thank you for that wonderful introduction, and thank you all for having me. It's always a pleasure to be back and talk with APA, and it's great to see so many people that have interest in this overlap. Today, I'm going to start with just talking a little bit about some of the foundations of what we know about OCD and PTSD and trauma, but really the bulk of this will focus on what do we know clinically, and what does it mean in terms of what we should be thinking about as clinicians when we're working with individuals who do have a trauma history, whether or not they have PTSD.

We'll talk about how that may impact some of the choices that we might make in terms of treatment order, treatments that we select, and some of the other pieces that we'll be attending to help maximize outcomes and recovery for individuals who are struggling with both. On the prevalent side, we know that OCD is around 2% to

3%, depending on what study you look at when you pull the data. We also know that PTSD is around 7%. Typically, these two have existed in silos, where really if you were an OCD or OCD spectrum specialist or a trauma and PTSD specialist, there's a lot of specialty clinics for both.

A lot of times individuals were moved in between clinics if there was a question on whether or not this was OCD or whether or not this was PTSD, usually thought of as something that was one or the other, but really in probably the last 5 to 10 years, there's really been an explosion of research on looking at this overlap and realizing these aren't as separate as we thought. Sometimes, the way that they interact may actually impacts some of the clinical choices that we should be making. We do know, just a little bit of foundational data, that about 78% of individuals report stressful life events, so different from a criteria in a trauma.

Stressful life events prior to OCD onset. We also see that about a little over half of those with OCD report at least one traumatic life event, so one criterion A traumatic life event. The experience of a criterion A trauma is linked with OCD onset specifically for those that don't have familial history of OCD or don't have a first-degree relative with OCD, and we know there's a genetic component to OCD. We see that trauma can actually account for a large portion of these individuals that don't have a familial history, but maybe develop OCD later in life. That's especially true for those that have later in life onset.

We also see that in high combat, so this comes out of the Veteran Affairs Hospital, that individuals and veterans who have experienced what they consider high combat experiences actually have an elevated prevalence rate of OCD compared to the community, coming in around 5.2%. If we really think about just the rates of trauma within OCD, and we start to look a little bit closer at some of the comorbidity rates, we actually see that the comorbidity rate is around 19%. When we look at some of the individual studies, we're finding about 19% to 25% of those with OCD do meet criteria for PTSD at some point in their lifetime.

We also see that somewhere between 30% to 40% of those with PTSD will meet for OCD at some point across their lifetime. Interestingly, the risk for developing OCD is 10 times higher in those with PTSD, but this relationship doesn't actually go the opposite direction. We do see that the higher you go in OCD care in terms of level of care, so IOP, partial, residential, inpatient, we do see that a greater prevalence of trauma, of reporting trauma experiences, and PTSD comorbid diagnoses in these higher levels of care compared to community or general mental health settings. There is some challenges that we have to think about as clinicians.

We do know that there's a lot of diagnostic difficulty with OCD. Now, it has gotten a lot better, but even in 2013, we see that about 40% of the time, OCD symptoms are misidentified. I will say this has actually gotten a lot better over time, but we still do see a high rate of misdiagnosis of OCD. There are certain aspects of OCD symptomatology that tend to be misdiagnosed the most. Actually, what you can see here on the left is that it's those that tend to make us as clinicians uncomfortable or tend to trigger certain legal requirements, such as reporting or looking at stepping up someone to a higher level of care.

We also see there's a lot of overlap in common misdiagnoses like GAD, prodromal schizophrenia, delusional disorder, PTSD, autism spectrum disorder. We do see that there's some challenging differentials, PTSD being one of those. The question that is, why is this happening? Especially when we think about OCD and PTSD, both of which are fairly well known at this point, but it does raise this question, why is this happening? There will be many somewhat nerdy animations throughout here. Hopefully, everyone likes Marvel and that type of thing. Otherwise, I apologize ahead of time.

What we do know is that there are a lot of similarities in the diagnostic criteria between PTSD and OCD, specifically, unwanted intrusive thoughts or images. There are some repetitive behaviors, like safety behaviors in PTSD and rituals in OCD, and an overall preoccupation with control. We also see that both communities really talk about feeling on edge all the time, looking for danger. I think it's important to note that sometimes the danger that they're looking for is slightly different between PTSD and OCD, and what drives that is a little bit different. We'll talk about that in a second. We also know that avoidance is a huge part of both.

When we really think about these overlaps, this is one of the challenges when it comes to differential diagnosis. Now, there was a wonderful network analysis study that was done, and I'm not going to talk too much about it, but it did highlight the fact that OCD and PTSD do cluster separately as two separate diagnoses, but they can be linked. This really does get to that question of, are they really two separate things? The answer does seem to be yes. We do see that while they are separate things, it really can be difficult to tease them apart sometimes. Sometimes there might have pieces that are connected.

There are certain things that we can think about. The first is the thought content. We know in PTSD that tends to be more focused on past memories of a specific event or a set of events, where OCD does tend to be more future-focused. We talk about that what-if spiral. They tend to span more domains and jump from topic to topic and fear to fear. We also see that repetitive behaviors are a little bit different.

In PTSD, you're really doing repetitive behaviors to get a relative sense of safety, a sense of preventing a trauma from reoccurring, where OCD tends to be much more rigid and tends to be much more focused on how their behaviors are done versus the experience of relative safety. It's more focused on that need for uncertainty versus avoidance of those past memories or past experiences or those experiences reoccurring. The other thing that I think is really important is thinking about how individuals relate to thoughts. In PTSD, thoughts tend to be something that are avoided at all costs.

In OCD, there is avoidance of thoughts, but a lot of times that avoidance is really an attempt to control thoughts, this underlying belief, and we see this. For those of you that are researchers or familiar with the obsessive beliefs questionnaire, one of the main domains there is an importance and need to control thoughts, and that is a foundational OCD-based belief that tends to maintain the OCD symptoms. We do see that there are some differences, even though the overt behaviors may actually look fairly similar. There are some important differences that will inform how we integrate treatments and how we move forward with treating our clients. If we really think about the impact of trauma on PTSD on symptoms, the question is, what do we

know so far? We know that having both is linked to higher severity of OCD. Interestingly, the reverse is not true. Having higher OCD severity does not drive higher PTSD severity. It seems to be a one-directional approach. We also do know that having comorbid PTSD specifically with OCD is associated with lower insight into OCD symptoms.

Higher suicidality in general, and greater risk of substance use disorders and depression, and an overall quality of life. What's interesting is we actually see this at partial hospital and residential levels as well, where individuals that have comorbid PTSD and OCD actually tend to have a lower quality of life at admission and at discharge. They do see a significant increase in their quality of life across treatment, but they're starting at a lower point in many cases, which I think clinically makes a lot of sense.

The other thing that we do tend to see is that-- McKay did a really great study looking at what is the relationship in terms of the beliefs and the thoughts, finding that post-traumatic cognitions actually moderate the relationship between these obsessive belief domains, specifically inflated responsibility, and scores on intolerance of uncertainty and the impact that has on distress. The more impactful, there are more post-traumatic cognition someone has. The more trauma-related beliefs, the greater the distress they experience, especially when it comes to inflated feelings of inflated responsibility.

This is important because it's also thinking about how are individuals relating to the need for their rituals, or how are they relating to the why that they're engaging in treatment. Unfortunately, we do see that these effects actually appear to be cumulative. The more traumatic experiences individuals have, the more intense these relationships become, which is a very concerning trend. It also raises a lot of conceptual challenges. How do we think about these two things?

There's a lot of studies that show that treatment for OCD and for PTSD in the presence of comorbid symptoms, more generally, is still highly effective. We do see that sometimes having this comorbidity has very little impact on outcome, and sometimes it has a really big impact on outcome. There have been a number of case theories and case studies that have showed that individuals with comorbid OCD and PTSD, there seem to be a subset of individuals that are at higher risk of relapse, and when they do tend to have a really significant increase in suicidality, including plan and intent.

At the residential level of care, we actually see those that have higher scores on the PCL, so above 31, actually have significantly greater number of psychiatric hospitalizations due to psychiatric emergency than individuals who do not have that elevated trauma-related symptom score or PTSD symptom score. I think it's also important to think about how are individuals utilizing care, and what types of skills should we be helping people build foundationally to prepare them for OCD treatment or for PTSD treatment when this comorbidity exists? The really big question is, why does it have a big impact on some clients and not a big impact on others?

We can actually go back to some of the historical literature looking at comorbidity. We see Rachman in the '90s talking about this idea of static versus dynamic comorbidity, but there's more than one way that a comorbid presentation plays out,

which as clinicians, I think we all understand, we all see. One is the static comorbidity, where two comorbid symptom sets go side by side. They're walking next to each other, but not necessarily interacting. You can treat one first, whatever is the most interfering or functionally interfering, or primary, and then treat the other.

On the other side, we actually see across a lot of comorbid presentations that there's this dynamic or merged comorbidity. John Grayson talked a lot about this previously in OCD and borderline personality disorder. We also see a lot of this in presentations of PTSD and panic disorder, where there seems to be certain presentations where these symptom sets merge together and have a lot of overlap in theme or content, and there's a functional relationship between them, where one set of symptoms is functionally maintaining or protecting someone from the other set of symptoms.

When you try to just treat one, the other set of symptoms has to increase really severely. This is what we see is probably going on in a lot of these cases with comorbid OCD and PTSD, this idea of merged or dynamic OCD, PTSD comorbidity. The idea here is that there's a functional connection between the feared consequences of the PTSD and OCD symptoms. That's essentially the OCD fears may overlap in theme or content with the traumatic experiences that someone has had, and really the way we see is that OCD acts as a protective factor, almost like a maladaptive coping mechanism to help prevent or protect the individual from experiencing that influx of trauma-related intrusive thoughts, emotions, or images.

A lot of times, clients will report, "As long as I get the rituals right, I don't really struggle with my trauma symptoms, but as soon as I don't ritualize, they come flooding back and overwhelming." In some instances, we actually see that individuals have their re-experiencing symptoms from a traumatic event, so the memories of a traumatic event, the emotions go with it, as the feared consequence for OCD, that they are essentially ritualizing to prevent this not just right or this experience that has been tied to, "This is how I felt during the trauma." As long as they are doing the rituals, and I think this is important, is that they are still doing true OCD rituals.

These aren't safety behaviors because they are very disconnected from the event themselves. They also tend to be much more focused on a rigid, excessive pattern of that behavior, and the focus is more on how it's done than whether or not relative safety is being experienced. As soon as that ritual is interrupted, or someone tries to remove that ritual or block that ritual, like we would in treatment for OCD, we see a really intense resurgence of re-experiencing symptoms related to the individual's trauma or PTSD symptoms that tend to make it hard to maintain ritual prevention.

One of the projects that a few of us have been working on, Dr. Wadsworth spearheaded this project, looking at the OCD trauma timeline interview. We created essentially a clinical tool to help guide clinicians to try to ask questions about whether or not OCD and PTSD symptoms are related or not. We know that really the comorbidity is highly individualized. For some people, it's highly overlapping. For some, it isn't. As clinicians, when we're doing a good in-depth assessment, we really need to think about, what is this presentation? Is there a functional connection? Is there not? If there is, how do they interact?

How do they overlap? Because that's going to inform our treatment choices moving forward. This is freely available. I have a resource slide at the end with some great

resources for this overlap. This being one of them that is free to use. What was really interesting, and this was presented by Dr. Wadsworth recently, where when we actually looked at some of the data from this scale, or from a self-report version, we actually saw that about 85% of individuals felt like their OCD and trauma-related experiences were linked, and that about 85% also felt like they overlapped in theme or content.

Only about 67% said that they thought their OCD functioned as a coping mechanism to get distance or avoid their trauma symptoms. I think this is really important, because what it shows is that not all experiences are linked for individuals. It's not a direct connection always between trauma and OCD, or PTSD and OCD. OCD isn't always a coping mechanism. Sometimes it is completely separate. It's important as clinicians that we're thoughtful about how we evaluate these when we're working with clients who present with this comorbidity. A recent qualitative study that we've been working on, we actually found that there were some themes that we did see.

This is in preparation. Hopefully, it will be out sometime soon. We do see that there are a couple of themes that have popped up when individuals talk about and give free response feedback to how they believe their trauma and OCD symptoms are related. Some of the ones that are most common is that the OCD theme is related to trauma-based experiences. The OCD took this traumatic experience and said, "Look, here's evidence for these obsessions. Now, here are all these other obsessions that you should worry about." Because this one thing actually occurred or happened to you, all these are actually not obsessions.

They're actually very valid fears, which is understandable. Then when OCD gets involved, it becomes this, "If I can't be 100% certain, I must be afraid or must ritualize around this thing." The other thing that came up is OCD as coping, but also, OCD is trauma prevention. As long as I get my rituals right, I don't feel a danger. I don't have to be hypervigilant. I don't feel like I'm at risk of a trauma reoccurring. What's important is that in these instances, it did seem like the OCD behaviors were more traditional OCD symptoms, but it was just the feeling of fear or the feeling of anxiety that was a trigger for essentially trauma memories and hypervigilance.

They're trying to avoid that feeling of anxiety at all costs. We also see there are a couple of temporal associations that for some people, the experience of trauma triggered their OCD or triggered a change or morphing of their OCD and influenced the symptom severity increasing exponentially immediately following a traumatic experience. Now, while this is very early on, there's still a lot more research to be done on this. These are just general themes that we heard from clients who have experienced both, and we're reporting on what that experience was like for them, as we go from an up-ground-up research approach.

All this taken together, what does this mean for treatment? As clinicians, what can we do? How can we really help support individuals that have trauma or PTSD and have significant OCD symptoms, especially when we're trying to figure out how to treat those OCD symptoms? That's really what the direction I'm going to focus today. The first thing that I think is really important is just to acknowledge that the experience of traumatic events is not a rare occurrence.

We know that somewhere over 87% of individuals report experiencing what would be considered criterion A trauma, and some evidence suggests that this is actually even higher now. I love this quote, that traumatic events are extraordinary not because they occur rarely, but because they overwhelm the ordinary human adaptations to life. Trauma is all about overwhelming our ability to cope in that moment. I think it's also important to remember that because they are a part of life, as humans, we're actually pretty well hardwired to recover and move through traumatic experiences.

Sometimes things get in the way, and that's where we tend to see things like PTSD or other clinical symptoms present, when something gets in the way of that natural recovery process. Treatment's all about getting those things out of the way and helping spur forward that natural recovery process. One thing that I think is really important, given the high prevalence, is that we really need to be using trauma-informed care principles, even if we're not in a trauma clinic, but we're working with OCD, especially at higher levels of care. Now, an important thing about trauma-informed care is, trauma-informed care itself isn't a treatment.

It's a framework for how we approach all of our clinical and organizational activities in a way that realizes the impact that trauma can have on an individual, where we train everyone to recognize the signs and symptoms so it doesn't go overlooked. We incorporate awareness of how to respond effectively to someone talking about trauma or trauma-related experiences. All of this is to resist accidentally re-traumatizing them because we didn't know it was there, we didn't notice it, and to make the trauma worse. This isn't an active treatment, but it's an important framework for how we engage in care and how we implement empirically-based treatment protocols.

It's also something that happens both clinically in your one-on-one interactions with clients, but also organizationally, as a clinic, as a hospital. This is something that is larger than just one single interaction, but a way that we should be approaching all interactions, especially in OCD or specialty care units, where we know there's a higher risk of trauma experiences for our clients. A couple things to think about, if you're not a trauma or a PTSD treatment provider, or that's not your specialty, there are a couple things that are important to think about because it can be challenging and somewhat nerve-racking to talk about trauma with someone.

A lot of times, there's this feeling that trauma is in a box, and if I don't talk about it, it'll stay there. Now, we really know that's a myth. Individuals who experience trauma or have PTSD, whether or not they're talking about it, they are struggling with those experiences. It is always there. You can avoid it only for so long, but I think early on, it's very common to feel like, if I ask questions or talk about it, what if I make it worse? We actually know that it's actually better to talk about it as long as you talk about it in an appropriate way.

One of the things that I always tell people to look out for is don't assume that which trauma is the most impactful for an individual, because there is a subjective component to it. I've done many trauma assessments where the traumatic experience that seemed like it was the most out of the norm of human experience, the most overwhelming, was the one that they actually had a context for. This happens a lot with veterans in a war, where they have a context for it, but sometimes

it's the things that happen outside of that context that are the hardest to reconcile with your beliefs about the world.

You also want to make sure that you're not just asking yes and no questions, but asking open-ended questions to allow the person the space and the time to respond and talk about their experience in a way that they feel comfortable. Then, because trauma is something that the majority of humanity has gone through or will go through, we also want to make sure that we're not over-identifying with their experiences so that we're not putting our own subjective interpretation of their experiences onto them.

Allow them to share what that impact was for them, and so you have a good understanding of what it was like to go through it and how it's impacted the way they view the world moving forward. It is a delicate balance of listening and asking questions, but you also want to make sure to use neutral terms, remain calm during the assessment. You don't want to necessarily talk about being shocked by it or overreacting to it in an attempt to validate. Be neutral and calm, and supportive, and as you do that, individuals typically will find it hopeful to be able to talk through it with you and will feel safe in doing so.

As I mentioned, we are physiologically hardwired to recover from trauma, and we do see that actually about 50% of those who experience trauma show full recovery within three months. I think it's around 80% once you get up to 6 to 12 months. There are some pieces that do influence whether or not this happens, but I just want to put this up there to know that just because someone has experienced trauma doesn't mean that they're going to struggle with it or that it drives their other symptoms, their OCD, or whatever else they're struggling with, and so it's important that we ask with that framework in mind. What do we do? What do we know?

Now, the research on this in terms of this comorbidity is actually fairly new comparatively speaking to both OCD and PTSD fields, but coming out of some of the more residential and intensive treatment facilities, we see about 82% of those seeking intensive treatment for OCD or who have been identified as treatment refractory report trauma, with the average number of traumatic experiences reported being 5.9, which is actually quite high. We also see that about 40% of those who carry a refractory label, if you will, meaning they've tried multiple gold standard treatment approaches without significant effect, actually meet for a comorbid diagnosis of PTSD.

We also see that patients with OCD and PTSD show greater difficulty with intolerance of uncertainty and less improvement on intolerance of uncertainty measures across treatment, and this came from Dr. Caitlin Pinciotti and her group looking at intensive treatment as well. We also see that individuals with OCD in a lifetime history of PTSD have consistently more severe OCD symptoms, and this persists over a seven-year longitudinal study, and this is following treatment. It is important that we think about how do we make treatment more effective for this group because while it's working a little bit, it's not working as well as we hope.

We see this also in case series all the time, where there's limited treatment response or quick relapse, that sudden increase in suicidal ideation, and that rebound effect that we tend to say. A lot of clients that I've talked to who have this comorbidity have

gone through specialized treatments for both say, "It feels like I'm being ping-ponged place to place. I'm doing treatment, it's working, but it doesn't seem to be working the same as some of my peers. When I listen to my peers in groups or on the unit, it feels like I get what they're saying, but there's something different for me."

I've heard this both in the VA working in intensive PTSD treatment settings and at the OCDI and intensive OCD treatment settings. A lot of times, they say, I've been bounced back and forth because every time one set of symptoms increases, even if I'm making progress, the notion is, well, now your OCD is in the way, so go get OCD treatment. We'll work on OCD treatment. Now your trauma symptoms are in the way, so go get PTSD treatment.

I do think there are a subset of individuals where we really must have to think about can we do more of an integrative approach for them to actually make sure they're not feeling like they're being ping-ponged around the system, because that can really have a huge impact on how someone feels about how hopeful they are about recovery. I will say that's a very common thing we hear is that with this comorbidity, people lose hope pretty fast because they see their peers, they see others going through treatment and showing these great gains, and then they seem to get close but not quite there, or they see it slip away really quickly when the other symptoms increase and it causes a relapse of both.

What does this mean for treatment planning? How can we take what we know so far, acknowledging that this is a fairly new literature, and use it to inform our clinical practice? I think the first thing that we should do is make sure that whether you are in an OCD or a PTSD specialty setting, we need to make sure that we are screening for trauma and PTSD, and OCD. Screening for both in both of these settings using empirically-based and validated assessment measures. The PCL-5, the YBOX, I do want to acknowledge there's a high correlation between the PCL-5 and the YBOX severity scale because they're of a lot of the hypervigilance and physical experiences with PTSD and OCD, they do overlap.

We definitely want to make sure that if we think there is-- if someone screens positive for OCD and PTSD, then we do a diagnostic assessment to confirm, is there a diagnosis there or not? If so, I think it's really helpful to think about what is the order of onset. We do know from the literature that there is some impact on order of onset on how someone's symptoms present. Those that have developed PTSD and OCD within the same year or developed OCD after a traumatic experience tend to have slightly higher symptom severity. They also tend to have a greater suicidality, greater risk, and different risks around substance use disorders as well.

It is important for us to think about the order of onset. Now, this is not like an all-or-nothing thing, that if trauma is first and OCD is second, it's worse. We do see, there is some back and forth, but there does seem to be a trend there that we should be looking for as clinicians. The next thing to look for is, can we do a functional analysis, or a really good functional analysis or a really good deep dive on evaluating whether or not there's an overlap in themes between the OCD fears or the obsessional fears and the trauma-related experiences.

There's a lot of ways this can play out. Many of you may have heard things like real event OCD, where someone has had an event and the OCD has latched onto it, but

they don't have any meaningful PTSD symptoms, just OCD symptoms. There's others where you might've heard post-traumatic OCD. This has been used to coin a lot of different presentations, but really, the general piece here is that there's a functional or dynamic relationship between the two symptom sets. The OCD is working as a coping mechanism to avoid trauma-related memories. There's a lot of different ways that this overlap may happen, or there may be no overlap whatsoever.

All of that will inform your case conceptualization. Are we looking at a comorbid presentation or a trauma-informed presentation? What does that mean for selecting treatment, and what other skills we should bring in? I will say the thing that I hear the most from clients that they find the most helpful is a really in-depth psycho-ed around both OCD and PTSD and trauma, and how they may overlap, look similar, and then how they're different.

A lot of times, if you can give someone the language to delineate between the two, they experience it as somewhat separate, and they can tell where it's overlapped and where it feels different, but they may not have the language to actually describe that to treatment providers. The more education you can give to help them actually map out their symptoms. A lot of times, I'll have them map it out. One side is, here are your OCD symptoms, here are your PTSD symptoms. In the middle, here are the ones that seem to be functionally connected or do overlap. Then they have that with them so they can share it with new providers.

They can also use it to think about when to implement certain treatment strategies that are maybe more appropriate for PTSD versus OCD. This psycho-ed is really important, and spending the time to really make sure the individual has a great understanding of why their experience is a little different and how they can think about it, talk about it, and understand it. The great news is that we have wonderful treatments, wonderful empirically-based treatments for OCD and PTSD. They share a lot of similar foundational aspects, but there are some important differences to acknowledge.

For example, the target of exposure in prolonged exposure and exposure and response prevention is slightly different. In OCD treatment, we are really targeting uncertainty. We're targeting the ability to tolerate the unknown and lean into the unknown. We're not necessarily going to take that same approach where someone says, "I'm afraid that I'm going to die in a car accident and be like, I don't know, let's see, let's drive around. Let's wing it." If they've been in a really bad car accident and almost died. To them, it isn't an unknown, it's an experience.

Also, with PTSD exposure, you're also trying to help them process and work through the other emotional experiences that go with a traumatic life event. In OCD, we're like, if it feels bad, keep going. Not quite so sarcastically, but generally speaking, we're trying to teach people to lean in versus in PTSD treatment, we'll focus a little bit more on processing the emotions to help make sense of them and organize them. There are important differences. The other piece is that in trauma treatment, we may tend to taper out some of the safety behaviors because they don't have as big of an impact on the outcome of exposure treatment.

Where in OCD, we know that if we leave ritualistic behaviors in there, treatment is not going to work. Exposure isn't really going to work. As long as rituals are going on,

it's going to maintain that OCD cycle. The focus that we give to rituals versus trauma-related safety behaviors are a little bit different. The good news is they all work. Now we just have to think about how do we put them together for individuals? Once you've gone through that intake, that functional analysis, then it comes down to, all right, what treatment approach are we going to take? In the comorbidity literature, there's a couple of ways that people think about this.

The first is what we call the sequential approach. It's what most often. First, you'll treat the primary diagnosis of the most functionally impairing. Next, once they make progress on that, you'll treat the secondary diagnosis. In some instances, if individuals are able to have two providers, you may treat them in parallel where someone is doing PTSD treatment and OCD treatment simultaneously. Now, honestly, this isn't always accessible to everybody. This can be hard to do, but if this is occurring, it's really important that the two providers are actually talking to one another and are noticing how the OCD versus PTSD symptoms are showing up in both sessions.

That is a coordinated approach. Then there's also a lot of evidence for what we call integrated approaches. We see this with PTSD and panic disorder with multiple-channel exposure therapy. We see this with PTSD and substance use with dual diagnosis treatment approaches. We're starting to get a little bit of evidence of that this can also work in OCD and PTSD. Dr. Pinciotti did a really wonderful pilot study of ERP plus prolonged exposure and found great outcomes on an eight-person pilot.

I have some case studies and there's been a number of other case studies coming out around ERP and cognitive processing therapy that they can actually be integrated pretty well using the CPT strategies to address the trauma symptoms and allowing someone to have the skills or strategies necessary to stay engaged in the OCD exposures, even when trauma-related symptoms come up. There is some great burgeoning research here that gives us hope for what we can do moving forward.

These are very early stage and we need a lot more empirical evaluation of this for sure. One thing I do want to highlight that no matter which approach you take, one of the things that we've seen at higher levels of care, so at the OCI, we're working a little bit and we have a study ongoing looking at the impact of trauma on motivation for treatment, especially OCD treatment. What we found is those with high trauma-related symptoms or high PCL scores came into treatment with much greater what we call controlled motivation. Now, this is the way I think about controlled motivation is contingencies. They're essentially in treatment because they were given a contingency.

Much like if you have a kid, your child probably takes out the trash because you pay them or give them an allowance or tell them they have to. They're trying to either get a positive reward or avoid a negative consequence, so they take out the trash. Now, as adults, we may wish that we get paid to take out the trash, but I'd venture a guess that most of us are not getting paid to take the trash out of our homes or apartments or otherwise, but we still do it. A lot of times the reason that we do that is because we actually have started to see an importance of it, a value, right? It overlaps with some internal value.

I want to have a nice home. I want to have a place that doesn't smell like trash that I can come home and relax after. We take out trash as part of that value. That's what we call autonomous or internalized motivation, which we know is the best motivation, if you will, for increasing persistence on a task, engagement with treatment and enhancing outcomes. What's interesting is when you look at what we call more intrinsic style of motivation or more internalized motivation across time, we see that those with comorbid PTSD have much lower internal motivation at admission, significantly lower than those without comorbid PTSD.

Now, this OCD group does also have other comorbidities, but there's something specific about this PTSD comorbidity that really drives a decrease in autonomous motivation, and they tend to be in treatment because of a contingency, which makes a lot of sense, right? If we're asking you to face your worst fears, but some of your worst fears just happened, you're really not going to be super motivated to say like, "All right, let's lean in and see what happens, because in your mind, what happens, and you're still haunted by it. I think this makes a lot of sense, but what's really great to see is that as treatment progresses around week four, we actually see that gap starts to close.

By week six, it is no longer significantly different between the two, and at the end of treatment, there's no significant difference between motivation and those that respond to treatment for those with OC and OC and PTSD. We know that treatment can work, that people can get motivated for it, but it might take a little bit longer, and you may need to focus more on motivation early on in treatment. To wrap it up, and I just want to make sure that we have enough time for questions, I'm going to wrap it up with a few clinical takeaways here, and then we can open up for discussion and questions. As I say, there are a number of questions in the Q&A box.

The first thing is that hopefully what you take away from this is that the impact of trauma and PTSD on OCD is actually quite individualized. If you see this overlap or this comorbidity, an in-depth functional analysis, and really understanding that relationship for the individual, is incredibly important. The other is that we should always be looking for interactions between the symptom sets. Do they maintain one another or not? Do they overlap in theme or not? They may or they may not, but it's important that we know because that also will factor into how we think about the sequence or ordering of treatment and how we think about relapse prevention planning.

All these are going to be very important. The other is that you should really focus on motivation early in treatment. Spend a little extra time on the psychoeducation, on enhancing motivation for treatment if this comorbidity is present because whether you're doing trauma treatment or OCD treatment, the impact of this comorbidity on motivation can be quite profound. The other is that if there is comorbid PTSD, it's really important to reinforce crisis intervention, distress tolerance strategies early on because of the greater risk of suicidality, especially if someone has a lapse or a setback during the course of treatment, that suicidality can increase very rapidly.

It is important to make sure that these are reinforced. Even if they haven't experienced significant suicidality yet, I always think it's a good idea just to lay the foundation with these first just in case, and then help teach them when to and when not to use them in the case of the OCD symptoms. The final one is we should always

be integrating trauma-informed care practices no matter what type of specialty clinic that we're in. We do this naturally in trauma clinics and PTSD clinics, but when we're working with OCD, we should also be integrating these trauma-informed care practices at every level of our practice.

With that, I just want to say thank you all so much for joining. Hopefully this was helpful in just thinking through how you can adapt OCD treatment regardless of the level of care that you're at to the presence of trauma and OCD. I also wanted to share, these are a number of resources that some of us have put together. Please feel free to check them out. If you have questions, please let us know. With that, I just want to say thank you so much and look forward to the Q&A.

Moderator: We're now moving into the live Q&A. Thank you to everyone who submitted questions during registration and to those adding them in the Q&A box today. Dr. Van Kirk will do his best to answer as many as possible, though he may not get to all of them. Your questions are appreciated. Let's dive in. We have one question that asks, "I am interested in the integration of trauma informed approaches in OCD treatment. I work from a CBT framework."

Nathaniel: I think that's a really great question. I think this is one [unintelligible 00:41:31] I was trained in CBT and did inpatient CBT work in the VA hospital. I actually, it lends itself really nicely to integrating that into OCD treatment when there's comorbid PTSD. You can really do a lot of great work on some of the cognitive work around the core beliefs, the stuck points, in CBT. I think an important thing is that you really need to make sure that you're delineating what is trauma and PTSD and what is OCD because you don't necessarily want to use the challenging beliefs worksheet or some of the cognitive strategies on the obsessions because they don't play by the same rules.

Now, there are parts of that can be helpful. there is a wonderful cognitive therapy for OCD guide, Dr. [unintelligible 00:42:13] put or guess I could put out. I really think that's a great one to take a look at. We do know cognitive therapy does work for OCD. It's effect size is around 0.8, but we do know there are some specific changes to cognitive therapy that you're doing when it comes to OCD versus PTSD or other anxiety disorders.

If you're integrating the two, it's important to have a good understanding of both and making sure you're not using the CBT strategies to try to disprove obsessional fears, but are more focusing on addressing the core beliefs that came from the traumatic experience and the stuff points that are related to the traumatic experiences specifically. The other thing I would always say is when you're doing this, sometimes you'll be doing like a, an exposure for OCD and trauma symptoms will pop up.

What I have been able to do when someone has a good command of both ERP and CPT is actually have them use the CBT strategies on those trauma-related beliefs when they pop up just to help them cope with them a little bit and turn the volume down. Most importantly, it allows them to re-engage in the OCD exposure so that exposure isn't lost. We know if they, if we just switched to the trauma treatment strategies and don't go back to the ERP, the thing that the individual takes is I have to stop my OCD exposures anytime I have trauma intrusions or memories, or experiences, because I can't do both.

We actually know that you can do both. Exposure is an empirically based treatment for both and actually go well together, both for PE and ERP and CPT and ERP. You always want to make sure you're returning to the exposure and finishing it out when you're integrating the two.

Moderator: Brilliant. Thank you. We have another question that asks, "If added stabilization skills work is indicated for this comorbid presentation, doesn't that undermine the efficacy of ERP?"

Nathaniel: Great question. It can, and we do talk about ERP a lot. We don't like to use necessarily the distress tolerance skills during exposures because it does undermine some of the exposure learning. I think that one thing that's important is when you do these foundational skills and these kinds of crisis intervention or augmentation skills, part of teaching them the skill is also teaching them when to use it and when not to use it.

While we may not use it during a targeted ERP exposure, if someone is out to dinner with their family and they're caught off guard and they start panicking, it's okay to use some of these skills to help them stay engaged in what they're doing and not fall into the avoidance pattern of leaving or running away or ritualizing, as long as they're using it to resist those pieces because that's the whole goal, right? To stay engaged in your life.

We don't want to use them during structured purposeful ERPs. I think when you teach these skills for this comorbidity, it's important to tell people when to use it, when not to use it, and then what signs to look out for if OCD starts messing with the skills. The thing I'll tell people is if you start feeling like I have to use this skill and only this skill, or once you use it, you become more focused on did I do it right versus the impact that it had and the effect of coping, that's usually when OCD is getting involved and turning the skill into a ritual. One of the things that I'll ask people to do is say, "All right, we've practiced a lot of these skills.

I want you to write them down like one to six. Get a dice or gaming dice on your phone. There's a lot of apps that you can do it. Whenever you need to cope, pick a number or roll a dice. Whichever number comes up is the one that you use so that it always keeps the OCD guessing," if their OCD is the type that likes to latch onto skills and turn them into rituals. Anytime you start feeling like I have to do it, and I have to do it a very specific way or a certain number of times or until it feels just right, that's when OCD is getting involved and you will want them to mix it up.

Moderator: Wonderful. Thank you. We have another question that asks, "How do you negotiate basic discrepancy between OCD and PTSD of using reassurance about safety and PTSD but not reassuring OCD?"

Nathaniel: Sometimes that is a very tough line. I would say my main approach is making sure as a clinician, I have a really good understanding of what is trauma-related for the individual and what is OCD-related. I will tell people before we dive into it, if you ask me OCD reassurance seeking questions, I'm not going to answer. I'll say I'll answer each question once and not again so I don't reinforce your OCD.

If it is trauma-related and specifically, for example, if they're maybe struggling with really intense hypervigilance symptoms, or if they're having like in the midst of flashbacks, for example, or dissociating because they're so, overwhelmed with the trauma component or they're being pulled into the past, that's when I will focus on helping them ground and reestablish relative safety in the moment and maybe talking about, that you're safe in this moment.

If it's going future-oriented and it's going to spiral of what-ifs that don't seem to be related to that content or aren't necessarily flashbacks or re-experiencing symptoms, then I'm going to essentially lean more into the OCD style of not giving safety, but reminding them that we're enhancing their self-efficacy with their ability to cope during the unknown. I'll talk a lot about, all right, let's cope through this together. Remember, you can tolerate not knowing.

You do it all day every day. This is no different. Let's practice this here. Now, sometimes they are closely related, and you do have to make a judgment call in those moments, depending on where they are in treatment, of, "Okay, if there are both re-experiencing symptoms or flashbacks and some, rituals and obsessions going on, which one is getting in the way of them functionally moving forward the most?" Target that enough to bring them back to the moment so that they can make a choice on how they want to move forward, on how they want to engage in their life.

Then you're , then leaning into the OCD piece once they've re-established , connection with the current moment. That gets a little tricky, and a lot, that's really part of that individualized component. I do think the biggest part is making sure you have a clear conceptualization of which is which so that when to lean on, reaffirming safety and assuring safety versus not giving into OCD-related reassurance.

Moderator: Wonderful. Thank you. Our next question asks, what to treat first, OCD or PTSD symptoms?

Nathaniel: I would say this goes back and forth, again, to the individual experience. I think if there's a dynamic comorbidity and they're functionally connected, I would lean more towards the integrative approach or a parallel approach and try to do them together, or at least give core skills for both, and then pick which one is most functionally impairing and the individual is most ready and willing to work on, and then move forward with that.

Now, if they're static and distinct and there isn't really overlap or functional connection, then I think you go with the one that is most functionally impairing for them and that they say, "I really want to deal with this." I think the challenge can be, if you're working on trauma or PTSD, but their OCD, and even if it's separate from their OCD, but the OCD is so severe that they can't, get out into, if you're doing prolonged exposure, and they can't get out of the house in order to go do some of these exposures, or be in these triggering environments, because the process of ritualizing to get there is so hard, you may have to treat the OCD first to be able to make trauma treatment accessible.

If someone has really experienced a lot of flashbacks or a lot of re-experiencing symptoms and it's happening all day, every day. It's going to be really hard to do OCD treatment when you're always being pulled into that. You might start with the

trauma treatment first to also help them cope with those pieces more effectively and then we'll get at OCD treatment, but it's definitely individualized.

Moderator: Brilliant, thank you. Our next question asks, "How do you piece out the difference in intrusive thoughts between OCD and PTSD? When are they combined?"

Nathaniel: A lot of times the way that I tease it apart is it related to a specific event or set of events that someone has experienced? I always describe this to patients as, are you going back into the past or are you spiraling forward trying to predict the future or into possibilities of the future? That's one way. I will also say that in OCD intrusive thoughts, there's a lot of what if, right? There's a lot of uncertainty, a lot of fear of that uncertainty. What if this happens? What if this happens? When someone is having a flashback or is struggling with re-experiencing images or thoughts from a past event, there really isn't a lot of what if. In that moment to them, they are sure that it happened.

They're not questioning whether or not it happened. That to me is one of the big differentiators. What is the role of uncertainty in it? What are they focused on in the moment? What direction is it going? Whether or not has that thing ever happened to them? What I will say is that there are instances where if they overlap in theme, they may start as one and then turn into the other or may bounce back and forth. That's where it gets really tricky. Some of that is going to be teaching the individual to notice the differences between them, to raise awareness and insight so that they can better catch them before they start ping-ponging back and forth.

There are instances where they are the same. In those instances, I think it can be helpful to try to integrate the skills a little bit. You can do exposures to the overlapping ones, but you're going to pick a very specific target of that exposure that typically won't be like, maybe this will, maybe this won't happen, but it's going to be, can I-- I would say focus more on the inhibitory learning piece of like, can I tolerate this distress effectively and do something that-- and respond in like a non-fear way. Essentially be able to focus more on the functional activities in the moment when it's not clear which is which.

Moderator: Wonderful, thank you. Our next question asks, "Could rumination of past events be OCD subtypes?"

Nathaniel: Yes. I would say that the difference between rumination of past events and flashbacks is really an important differentiation. If someone is ruminating or thinking of that negative self-referential thought about past events that they're making judgments about themselves, that can be PTSD, it can be depression, it can be OCD. What we do see with a ritualistic rumination, what we might call it in OCD, and this is more of a clinical anecdote, is that it does tend to be a little bit more purpose-driven in the sense of individuals have an idea of what they're trying to achieve to be able to stop ruminating.

Whether it's they are trying to get a certain feeling, ruminate until they can do something functional, or if they're trying to convince themselves with 100% certainty what the meaning of those past events are, that's where it can be more OCD-related. Either way, what I would say is that if someone is ruminating, it is essentially a

cognitive avoidance strategy in many cases, and rumination never really helped anybody for anything.

If they're ruminating, focus on having them shift back to the present moment, practice disengaging from rumination as a skill in and of itself, because that will work whether it's trauma-related rumination, depression, or OCD, at least gives them some choice and volition over whether or not they're stuck ruminating and how to pull themselves out. That's an area we still need a lot more research on. I feel like the last few questions have been a lot of non-answer answers, but we do need more research on how to most effectively do that.

Moderator: Thank you. Our next question asks, "Is there a possibility that the checking behavior of OCD could be conflated with the hypervigilance of PTSD and vice versa? If so, how would a clinician distinguish between the two?"

Nathaniel: That definitely happens. Sometimes what we see is individuals who have a trauma trigger, and maybe you're doing some safety-related behaviors, once they get started, it gets really hard to stop because the OCD takes over. In that case, I think the first thing I would focus on is how do we get rid of the safety behaviors, the thing that triggers the OCD behaviors? How, for the individual, can they distinguish what is trauma-related and what is OCD-related? Then if it's the trauma experience and the safety behaviors, like the safety checking, that starts out as fully a response to a trauma-related intrusion or re-experiencing symptom.

Then once they start, they can't stop because then it's typically what I'll hear people say is like, once I've started, it doesn't feel right. Then I start checking in patterns or checking a certain way until I get this just right feeling. That's where the OCD and the not-just-right OCD tends to take over. A lot of times, at least clinically, when I've talked to individuals, they're actually able to describe when that turning point happens, and they notice that it feels different, like the purpose of that behavior feels different when the OCD takes over. In those cases, I would say you're trying to raise awareness of when that shift happens.

Then trying to say like, "All right, when it shifts away from safety into just right feeling, you want to stop doing anything, sit with that just right feeling as best you can." That's virtual prevention. You still want to try to target what is driving the need for safety behaviors. That might be where you're going to do a little bit more like a trauma narrative will, or exposures to that, like a script exposure, where you're also processing the trauma-related experiences to try to reduce the need for safety behaviors, so that then you can just target and separate it from the OCD just right checking.

Sometimes they do blend together. That gets really tough. That's usually just collaborating with the individual to notice when that shift happens and what's driving each version of that behavior.

Moderator: All right, it looks like we have time for one more question.

Nathaniel: That's great.

Moderator: Someone asks, "How do you negotiate the discrepant treatment strategies for OCD versus PTSD?"

Nathaniel: I would say that I tend to rely on what has the largest empirical base. For both of them, what has the largest empirical evidence and the greatest understanding of the mechanisms of how it works and why it works, so that we can use that mechanistic understanding to tailor the treatment strategies to the person, to make them fit the individual and their symptom presentation. I think once you get down to the mechanistic level, there's actually a lot of similarities between them. They share a lot of pieces, they share a lot of goals and the type of learning that you're trying to facilitate is similar. The targets are slightly different, but the actual approach is fairly similar.

If you can understand, really learn and have a mastery of the mechanisms of the empirically-based treatments, it'll help you have an understanding of how to reconcile those differences and tailor them to the individual and explain it to them, so that they're using similar strategies, just tweaked in their target or in their implementation versus feeling like they're having to use two completely disparate and at-odds treatments.

Clinically, I would say that I don't feel they're at odds as much as we tend to experience them during when we're learning about them. Once you really have a command of them, there are so many similarities in the foundational research that led to both, that you can actually really use them in a complimentary way pretty effectively. If you're collaborating with the individual and helping them navigate and understand their different experiences and when to use one versus the other, they can actually become quite complementary.

Moderator: All right. Thank you so much for joining us, Dr. Van Kirk.

Nathaniel: [crosstalk] My pleasure, thanks for having me.

Moderator: Thank you to all our listeners for your participation. We'd also like to thank McLean Hospital for making this webinar possible. A recording of this presentation will be emailed to everyone in two weeks' time. The recording will include the presentation slides. As soon as the webinar has ended, a short survey will appear on your screen. Please take the survey and give us your feedback. We thank you for your attention and hope you have a great day.

[00:59:16] [END OF AUDIO]