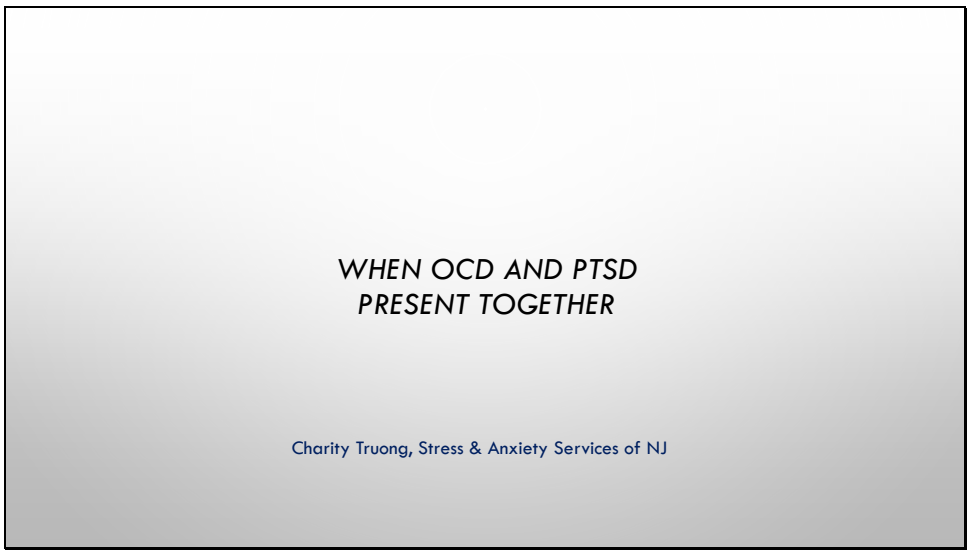
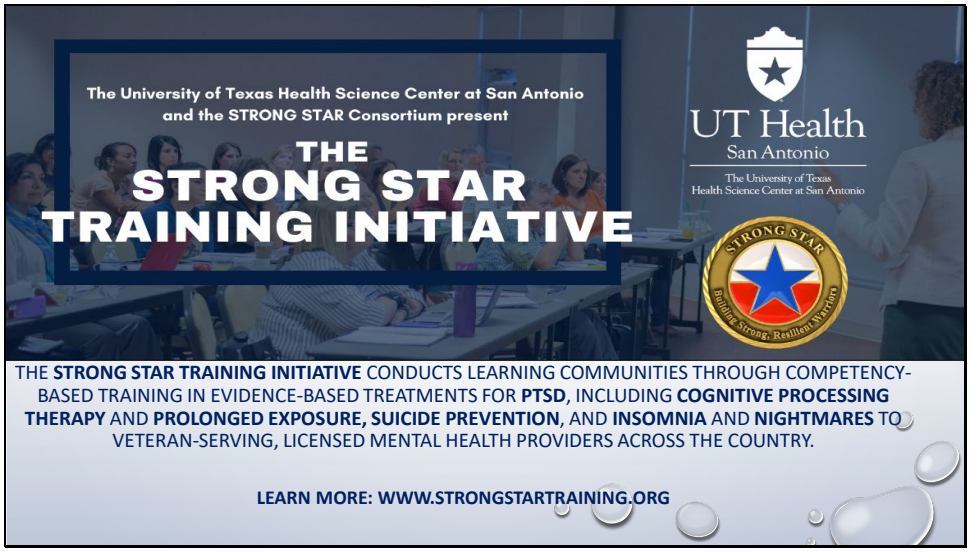
Slide 1


WHEN OCD AND PTSD
PRESENT TOGETHER
Charity Truong, Stress & Anxiety Services of NJ

Slide 2


The University of Texas Health Science Center at San Antonio
and the STRONG STAR Consortium present
THE
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TRAINING INITIATIVE
UT Health
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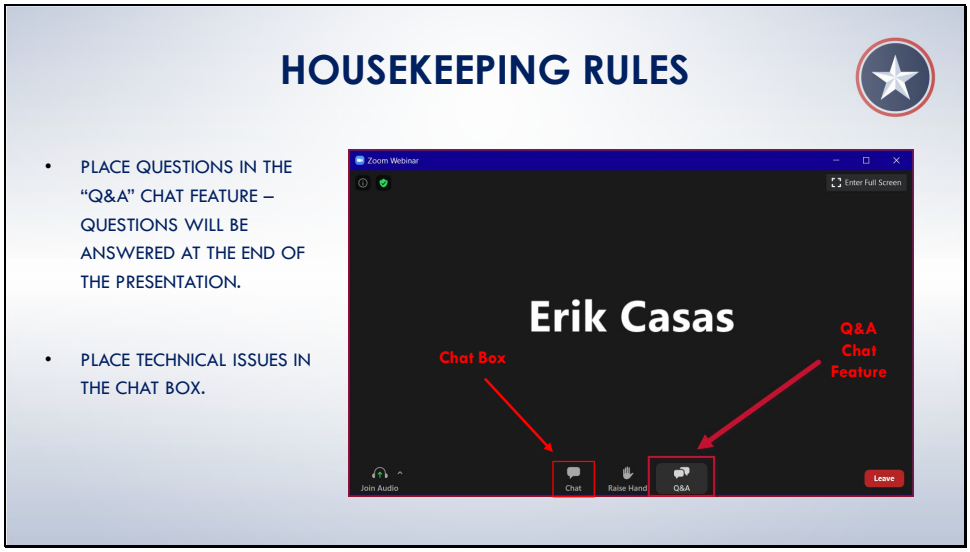
The University of Texas
Health Science Center at San Antonio
STRONG STAR
Building Strong, Resilient Warriors
THE STRONG STAR TRAINING INITIATIVE CONDUCTS LEARNING COMMUNITIES THROUGH COMPETENCY-BASED TRAINING IN EVIDENCE-BASED TREATMENTS FOR PTSD, INCLUDING COGNITIVE PROCESSING THERAPY AND PROLONGED EXPOSURE, SUICIDE PREVENTION, AND INSOMNIA AND NIGHTMARES TO VETERAN-SERVING, LICENSED MENTAL HEALTH PROVIDERS ACROSS THE COUNTRY.
LEARN MORE: WWW.STRONGSTARTRAINING.ORG

Slide 3


HOUSEKEEPING RULES
PLACE QUESTIONS IN THE "Q&A" CHAT FEATURE – QUESTIONS WILL BE ANSWERED AT THE END OF THE PRESENTATION.
PLACE TECHNICAL ISSUES IN THE CHAT BOX.
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Join Audio
Chat
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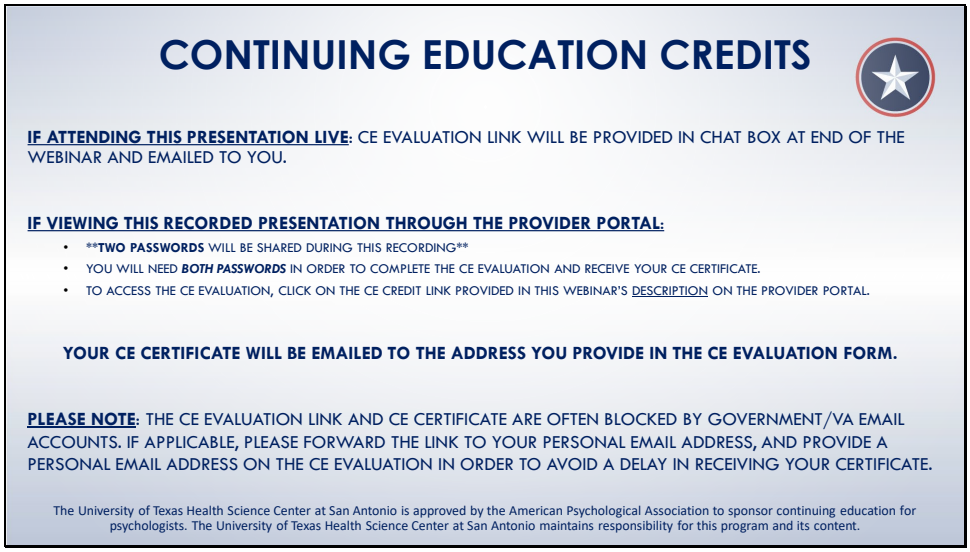
Q&A
Leave

Slide 4


CONTINUING EDUCATION CREDITS
IF ATTENDING THIS PRESENTATION LIVE: CE EVALUATION LINK WILL BE PROVIDED IN CHAT BOX AT END OF THE WEBINAR AND EMAILED TO YOU.
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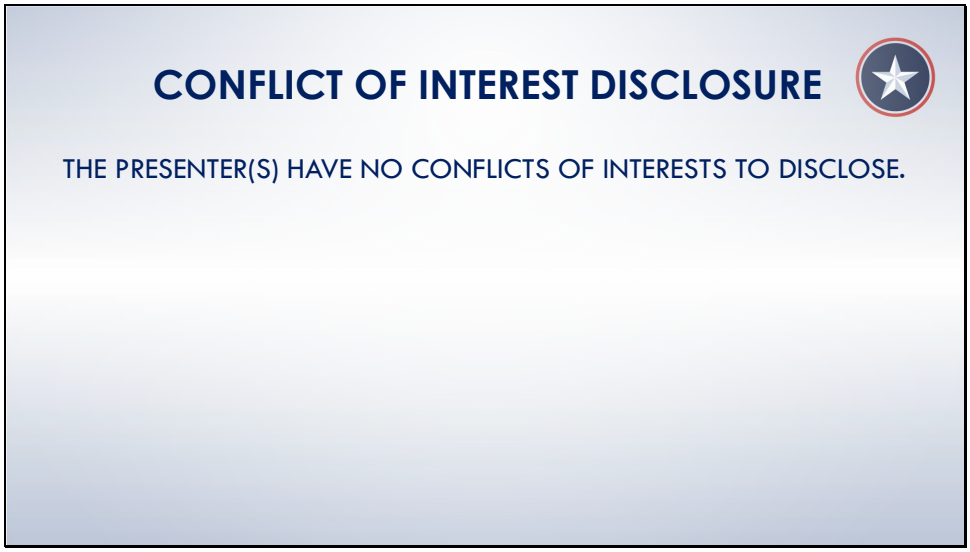
PLEASE NOTE: THE CE EVALUATION LINK AND CE CERTIFICATE ARE OFTEN BLOCKED BY GOVERNMENT/VA EMAIL ACCOUNTS. IF APPLICABLE, PLEASE FORWARD THE LINK TO YOUR PERSONAL EMAIL ADDRESS, AND PROVIDE A PERSONAL EMAIL ADDRESS ON THE CE EVALUATION IN ORDER TO AVOID A DELAY IN RECEIVING YOUR CERTIFICATE.
The University of Texas Health Science Center at San Antonio is approved by the American Psychological Association to sponsor continuing education for psychologists. The University of Texas Health Science Center at San Antonio maintains responsibility for this program and its content.

Slide 5


CONFLICT OF INTEREST DISCLOSURE
THE PRESENTER(S) HAVE NO CONFLICTS OF INTERESTS TO DISCLOSE.

Slide 6


STRESS & ANXIETY SERVICES of New Jersey
STRONG STAR TRAINING INITIATIVE
WHEN OCD AND PTSD PRESENT TOGETHER
CHARITY TRUONG,
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Slide 7


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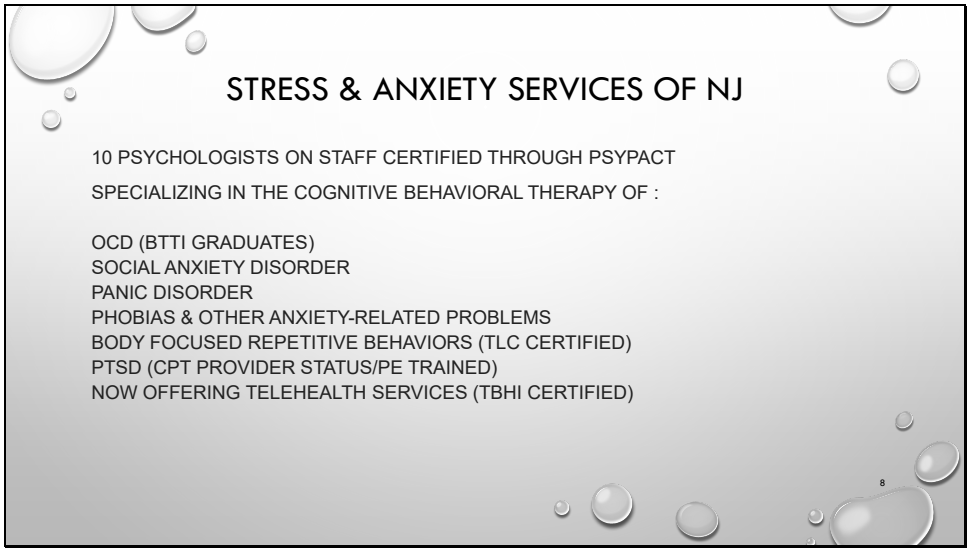
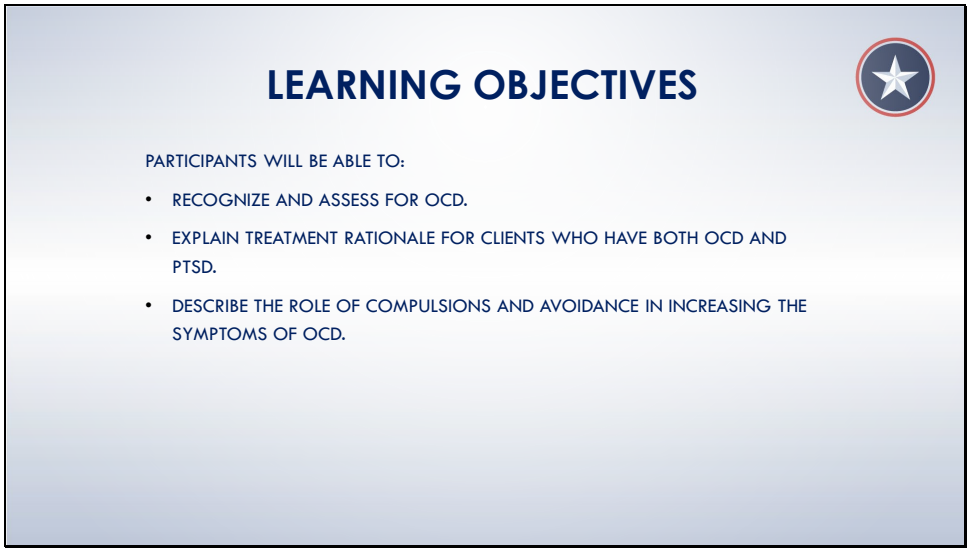
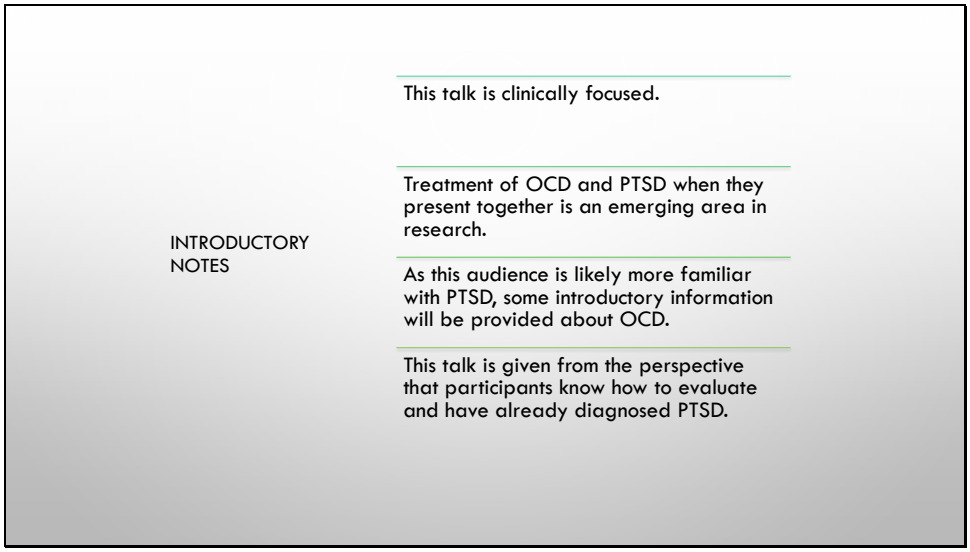
Slide 8


STRESS & ANXIETY SERVICES OF NJ
10 PSYCHOLOGISTS ON STAFF CERTIFIED THROUGH PSYPACT
SPECIALIZING IN THE COGNITIVE BEHAVIORAL THERAPY OF :
OCD (BTTI GRADUATES)
SOCIAL ANXIETY DISORDER
PANIC DISORDER
PHOBIAS & OTHER ANXIETY-RELATED PROBLEMS
BODY FOCUSED REPETITIVE BEHAVIORS (TLC CERTIFIED)
PTSD (CPT PROVIDER STATUS/PE TRAINED)
NOW OFFERING TELEHEALTH SERVICES (TBHI CERTIFIED)
8

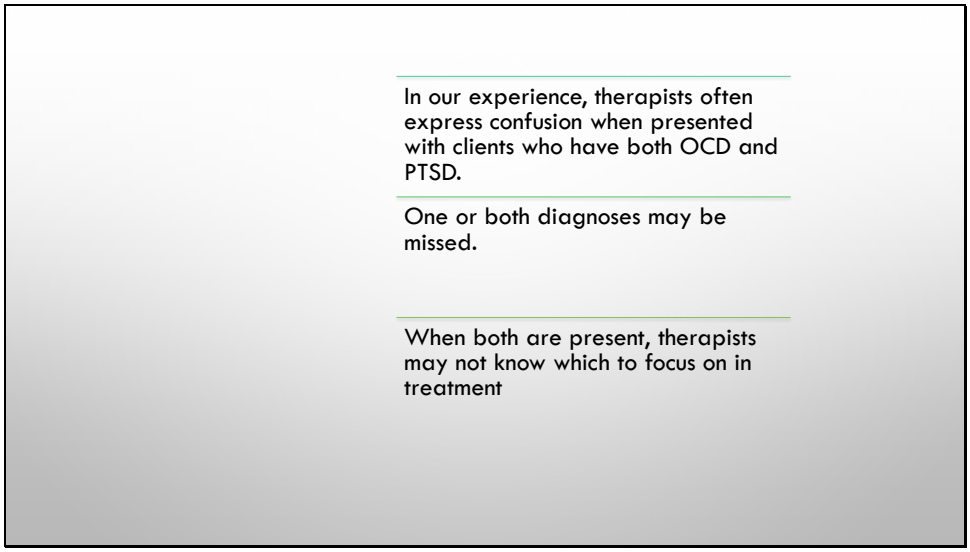
Slide 9


LEARNING OBJECTIVES
PARTICIPANTS WILL BE ABLE TO:
• RECOGNIZE AND ASSESS FOR OCD.
• EXPLAIN TREATMENT RATIONALE FOR CLIENTS WHO HAVE BOTH OCD AND PTSD.
• DESCRIBE THE ROLE OF COMPULSIONS AND AVOIDANCE IN INCREASING THE SYMPTOMS OF OCD.

Slide 10


INTRODUCTORY NOTES
This talk is clinically focused.
Treatment of OCD and PTSD when they present together is an emerging area in research.
As this audience is likely more familiar with PTSD, some introductory information will be provided about OCD.
This talk is given from the perspective that participants know how to evaluate and have already diagnosed PTSD.

Slide 11


In our experience, therapists often express confusion when presented with clients who have both OCD and PTSD.
One or both diagnoses may be missed.
When both are present, therapists may not know which to focus on in treatment

Slide 12

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Slide 13

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NACASCH, N., FOSTICK, L., & ZOHAR, J. (2011). HIGH PREVALENCE OF OBSESSIVE-COMPULSIVE DISORDER AMONG POSTTRAUMATIC STRESS DISORDER PATIENTS. *EUROPEAN NEUROPSYCHOPHARMACOLOGY, 21*, 876–879. HTTPS://DOI.ORG/10.1016/J.EURONEURO.2011.03.007.

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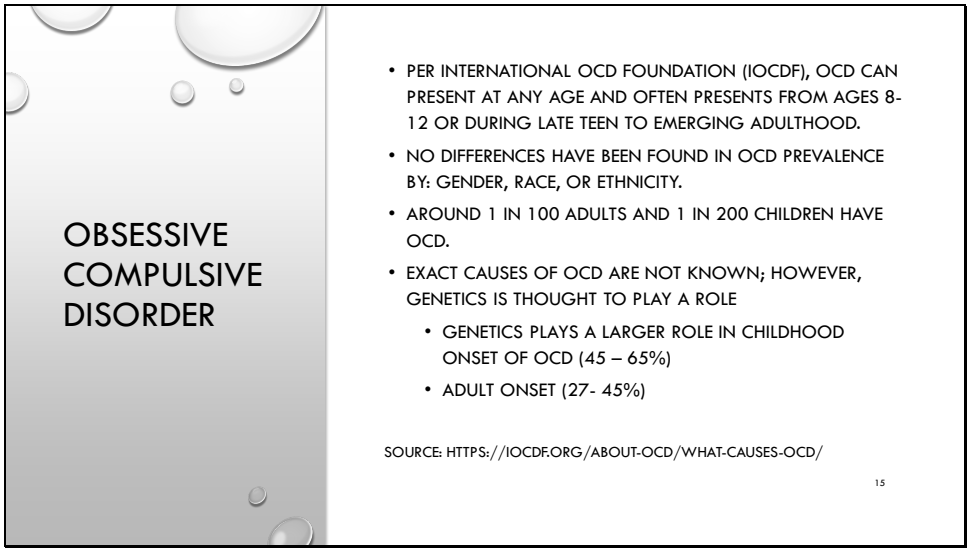
Slide 15


OBSESSIVE COMPULSIVE DISORDER
• PER INTERNATIONAL OCD FOUNDATION (IOCDF), OCD CAN PRESENT AT ANY AGE AND OFTEN PRESENTS FROM AGES 8-12 OR DURING LATE TEEN TO EMERGING ADULTHOOD.
• NO DIFFERENCES HAVE BEEN FOUND IN OCD PREVALENCE BY: GENDER, RACE, OR ETHNICITY.
• AROUND 1 IN 100 ADULTS AND 1 IN 200 CHILDREN HAVE OCD.
• EXACT CAUSES OF OCD ARE NOT KNOWN; HOWEVER, GENETICS IS THOUGHT TO PLAY A ROLE
• GENETICS PLAYS A LARGER ROLE IN CHILDHOOD ONSET OF OCD (45 – 65%)
• ADULT ONSET (27- 45%)
SOURCE: HTTPS://IOCDF.ORG/ABOUT-OCD/WHAT-CAUSES-OCD/
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OCD DIAGNOSTIC CRITERIA:

The presences of Obsessions, Compulsions or Both

Obsessions: "Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress."

People who have OCD try to get rid of or neutralize obsessions via thoughts or behaviors

Compulsions are Behaviors that are repeated and that an individual feels they must perform to eliminate obsessive thoughts and/or accompanying feelings or physical sessions or to prevent a feared future outcome

Notably – there is no real connection in reality between compulsions and preventing the outcome or eliminating the thought. Or the compulsion is in excessive

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USUAL DISCLAIMERS:

- NOT BETTER ACCOUNTED FOR BY ANOTHER DISORDER
- NOT DUE TO SUBSTANCES
- NOT DUE TO A MEDICAL CONDITION
- OBSESSIONS OR COMPULSIONS TAKE UP 1 OR MORE HOURS A DAY AND CAUSE DISTRESS AND IMPAIRMENT (NOTABLY, CLIENTS MAY NOT AGREE THAT THEIR COMPULSIONS ARE GETTING IN THE WAY AND MAY ARGUE FOR KEEPING THEM).

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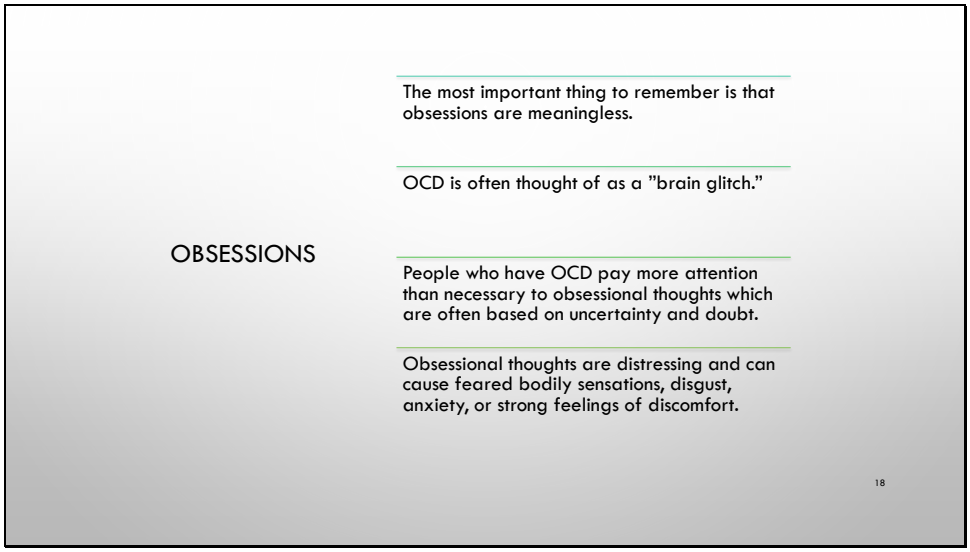
Slide 18


OBSESSIONS
The most important thing to remember is that obsessions are meaningless.
OCD is often thought of as a "brain glitch."
People who have OCD pay more attention than necessary to obsessional thoughts which are often based on uncertainty and doubt.
Obsessional thoughts are distressing and can cause feared bodily sensations, disgust, anxiety, or strong feelings of discomfort.
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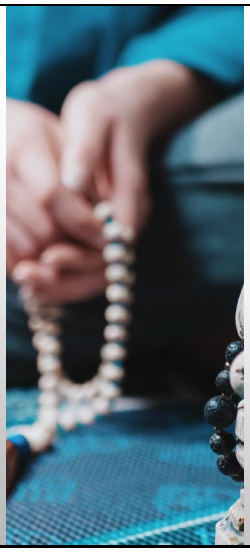
Slide 19



COMPULSIONS

- COMPULSIONS ARE PERFORMED TO GET RID OF OBSESSIONAL THOUGHTS OR THE FEELINGS THAT ACCOMPANY THEM.
- COMPULSIONS CAN BE PHYSICAL, SUCH AS HAND WASHING, REREADING OR REWRITING, TAPPING OR ARRANGING OBJECTS
- COMPULSIONS CAN BE VERBAL ACTIVITIES SUCH AS PLANNING, SEEKING REASSURANCE FROM OTHERS, REPEATING PHRASES OR WORDS, OR ASKING QUESTIONS.
- COMPULSIONS CAN BE MENTAL ACTIVITIES LIKE SELF-REASSURANCE, CHECKING, PRAYING, OR "SOLVING."

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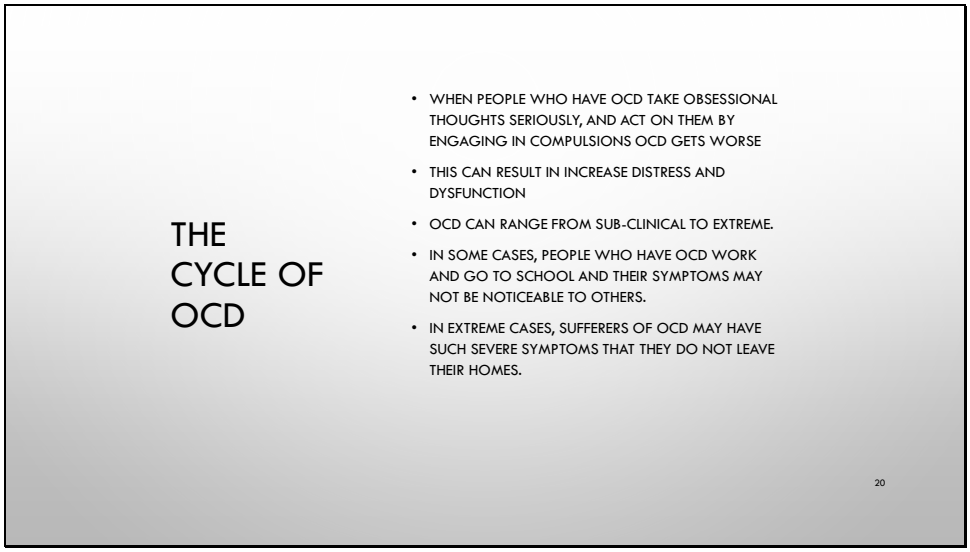
Slide 20


THE CYCLE OF OCD
• WHEN PEOPLE WHO HAVE OCD TAKE OBSESSIONAL THOUGHTS SERIOUSLY, AND ACT ON THEM BY ENGAGING IN COMPULSIONS OCD GETS WORSE
• THIS CAN RESULT IN INCREASE DISTRESS AND DYSFUNCTION
• OCD CAN RANGE FROM SUB-CLINICAL TO EXTREME.
• IN SOME CASES, PEOPLE WHO HAVE OCD WORK AND GO TO SCHOOL AND THEIR SYMPTOMS MAY NOT BE NOTICEABLE TO OTHERS.
• IN EXTREME CASES, SUFFERERS OF OCD MAY HAVE SUCH SEVERE SYMPTOMS THAT THEY DO NOT LEAVE THEIR HOMES.
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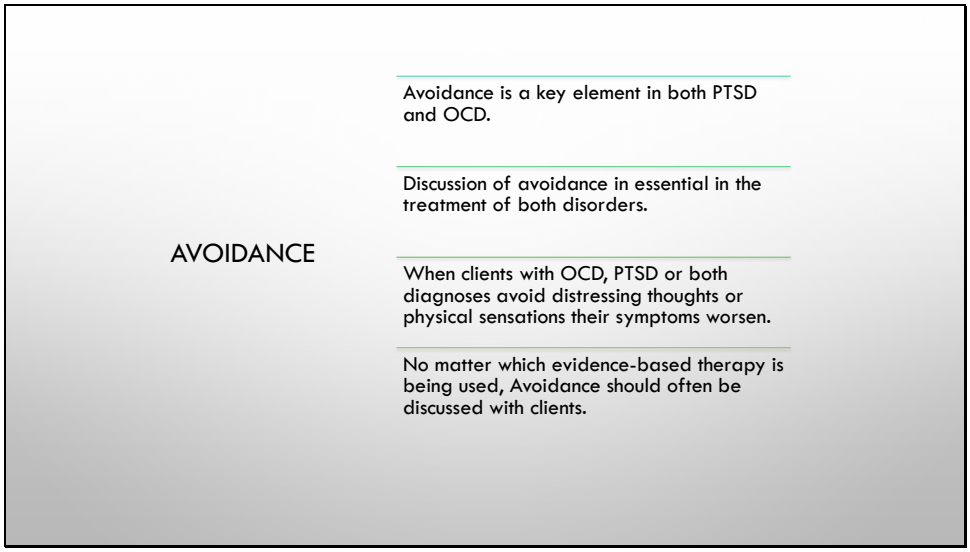
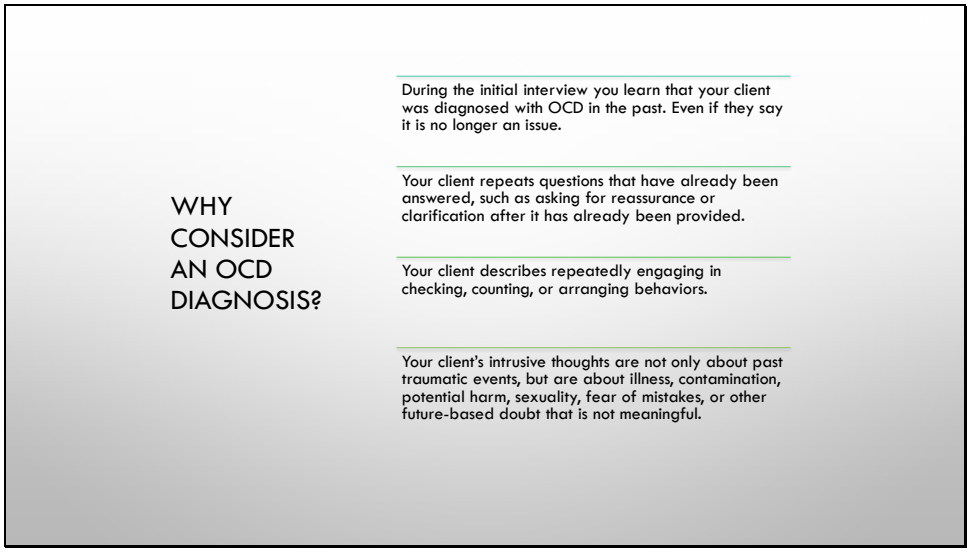
Slide 21


AVOIDANCE
Avoidance is a key element in both PTSD and OCD.
Discussion of avoidance in essential in the treatment of both disorders.
When clients with OCD, PTSD or both diagnoses avoid distressing thoughts or physical sensations their symptoms worsen.
No matter which evidence-based therapy is being used, Avoidance should often be discussed with clients.

Slide 22

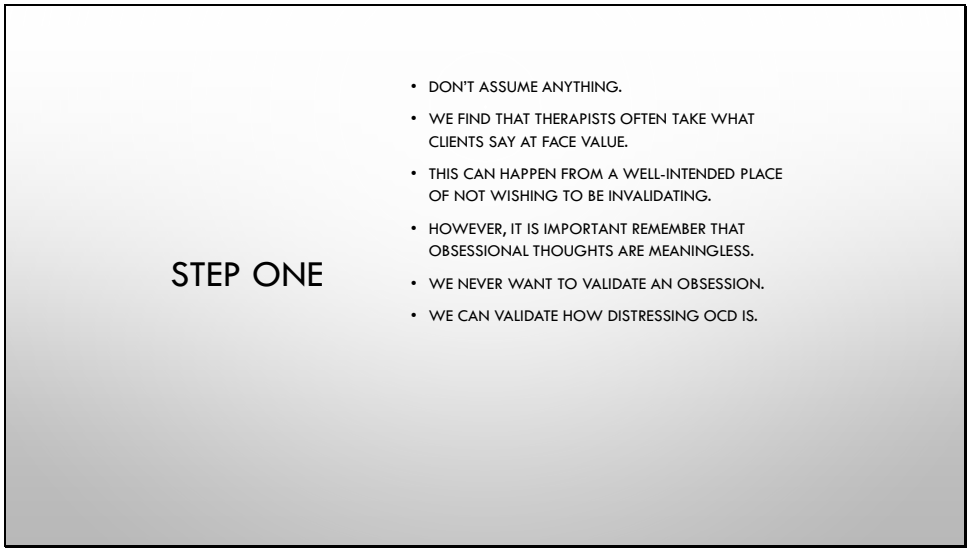

WHY CONSIDER AN OCD DIAGNOSIS?
During the initial interview you learn that your client was diagnosed with OCD in the past. Even if they say it is no longer an issue.
Your client repeats questions that have already been answered, such as asking for reassurance or clarification after it has already been provided.
Your client describes repeatedly engaging in checking, counting, or arranging behaviors.
Your client's intrusive thoughts are not only about past traumatic events, but are about illness, contamination, potential harm, sexuality, fear of mistakes, or other future-based doubt that is not meaningful.

Slide 23

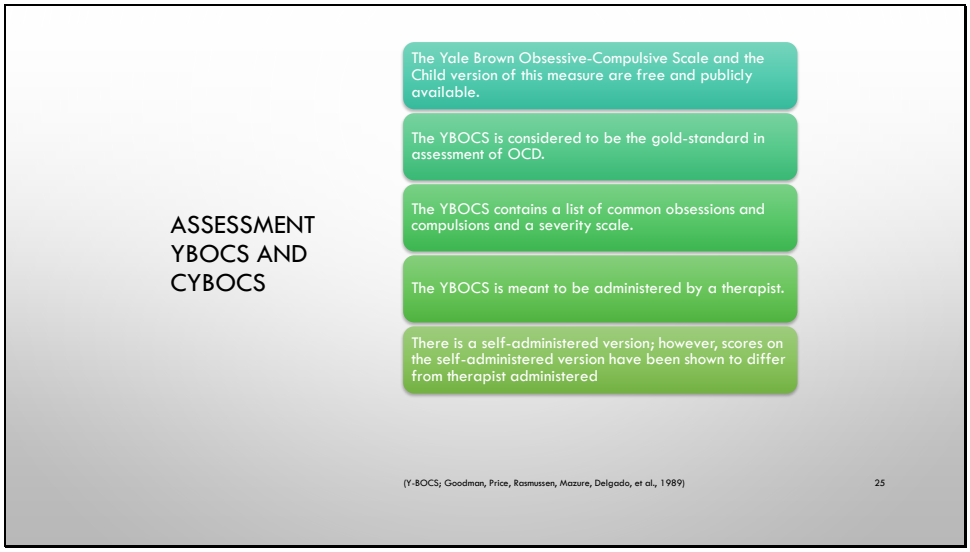
THEORIES?

- PER TO GERSHUNY ET AL., 2008, DATA SUGGESTS PEOPLE WITH TREATMENT RESISTANT OCD HAVE HIGH RATES OF TRAUMA AND PTSD
- NOTE THAT THERE IS A CULTURAL MYTH THAT EVERYONE WHO HAS OCD OR OTHER DISORDERS HAS THEM AS THE RESULT OF TRAUMA, THIS IS OF COURSE UNTRUE. MANY CLIENTS WITH OCD HAVE NO TRAUMATIC EVENT IN THEIR HISTORY.

Slide 24


STEP ONE
• DON'T ASSUME ANYTHING.
• WE FIND THAT THERAPISTS OFTEN TAKE WHAT CLIENTS SAY AT FACE VALUE.
• THIS CAN HAPPEN FROM A WELL-INTENDED PLACE OF NOT WISHING TO BE INVALIDATING.
• HOWEVER, IT IS IMPORTANT REMEMBER THAT OBSESSIONAL THOUGHTS ARE MEANINGLESS.
• WE NEVER WANT TO VALIDATE AN OBSESSION.
• WE CAN VALIDATE HOW DISTRESSING OCD IS.

Slide 25


ASSESSMENT
YBOCS AND
CYBOCS
The Yale Brown Obsessive-Compulsive Scale and the Child version of this measure are free and publicly available.
The YBOCS is considered to be the gold-standard in assessment of OCD.
The YBOCS contains a list of common obsessions and compulsions and a severity scale.
The YBOCS is meant to be administered by a therapist.
There is a self-administered version; however, scores on the self-administered version have been shown to differ from therapist administered
(Y-BOCS; Goodman, Price, Rasmussen, Mazure, Delgado, et al., 1989)
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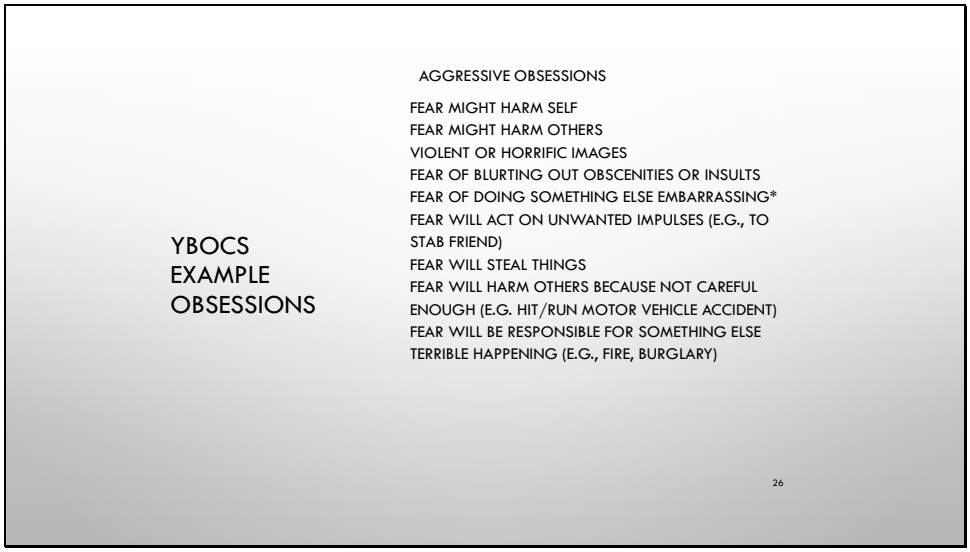
Slide 26


YBOCS
EXAMPLE
OBSESSIONS
AGGRESSIVE OBSESSIONS
FEAR MIGHT HARM SELF
FEAR MIGHT HARM OTHERS
VIOLENT OR HORRIFIC IMAGES
FEAR OF BLURTING OUT OBSCENITIES OR INSULTS
FEAR OF DOING SOMETHING ELSE EMBARRASSING*
FEAR WILL ACT ON UNWANTED IMPULSES (E.G., TO STAB FRIEND)
FEAR WILL STEAL THINGS
FEAR WILL HARM OTHERS BECAUSE NOT CAREFUL ENOUGH (E.G. HIT/RUN MOTOR VEHICLE ACCIDENT)
FEAR WILL BE RESPONSIBLE FOR SOMETHING ELSE TERRIBLE HAPPENING (E.G., FIRE, BURGLARY)
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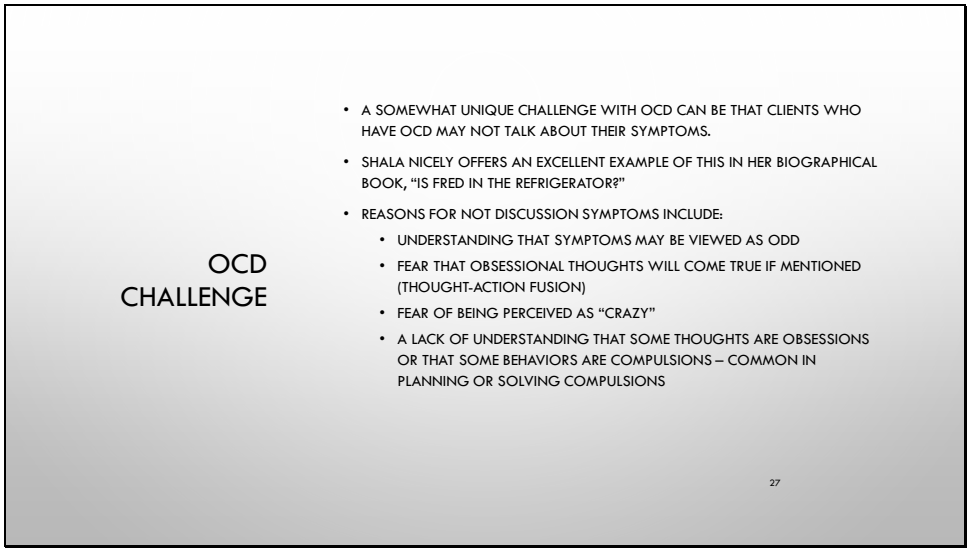
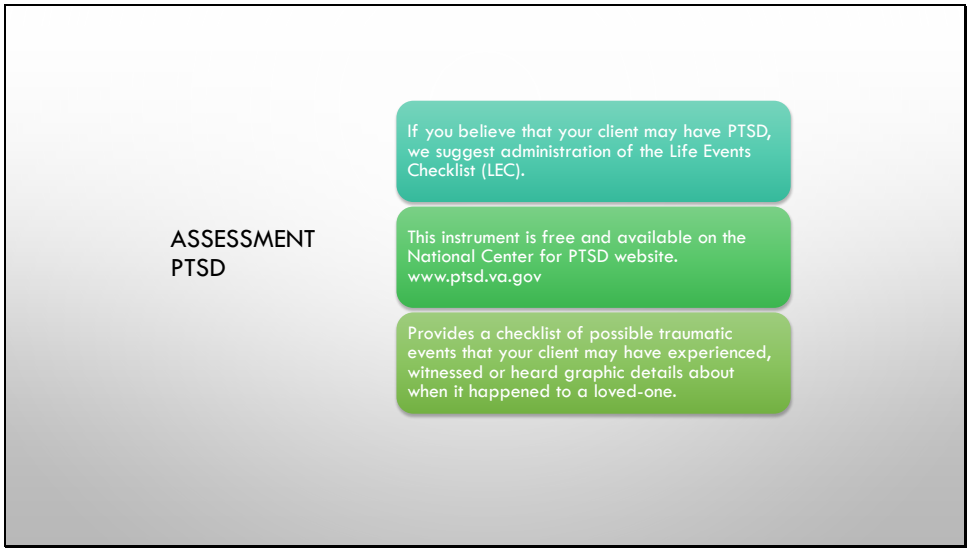
Slide 27


OCD CHALLENGE
• A SOMEWHAT UNIQUE CHALLENGE WITH OCD CAN BE THAT CLIENTS WHO HAVE OCD MAY NOT TALK ABOUT THEIR SYMPTOMS.
• SHALA NICELY OFFERS AN EXCELLENT EXAMPLE OF THIS IN HER BIOGRAPHICAL BOOK, "IS FRED IN THE REFRIGERATOR?"
• REASONS FOR NOT DISCUSSION SYMPTOMS INCLUDE:
• UNDERSTANDING THAT SYMPTOMS MAY BE VIEWED AS ODD
• FEAR THAT OBSESSIONAL THOUGHTS WILL COME TRUE IF MENTIONED (THOUGHT-ACTION FUSION)
• FEAR OF BEING PERCEIVED AS "CRAZY"
• A LACK OF UNDERSTANDING THAT SOME THOUGHTS ARE OBSESSIONS OR THAT SOME BEHAVIORS ARE COMPULSIONS – COMMON IN PLANNING OR SOLVING COMPULSIONS
27

Slide 28


ASSESSMENT
PTSD
If you believe that your client may have PTSD, we suggest administration of the Life Events Checklist (LEC).
This instrument is free and available on the National Center for PTSD website. www.ptsd.va.gov
Provides a checklist of possible traumatic events that your client may have experienced, witnessed or heard graphic details about when it happened to a loved-one.

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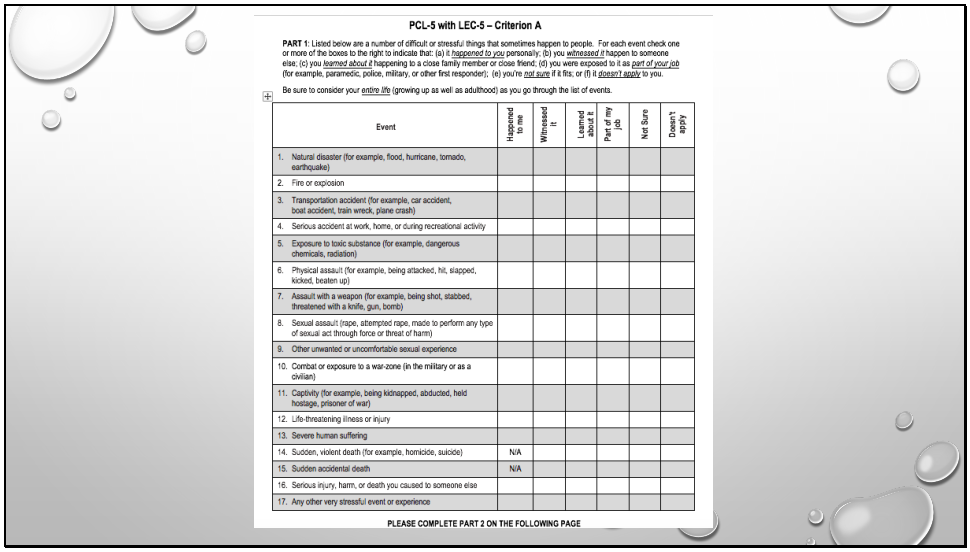
LEC-5

- **INSTRUCTIONS:** LISTED BELOW ARE A NUMBER OF DIFFICULT OR STRESSFUL THINGS THAT SOMETIMES HAPPEN TO PEOPLE. FOR EACH EVENT CHECK ONE OR MORE OF THE BOXES TO THE RIGHT TO INDICATE THAT: (A) IT HAPPENED TO YOU PERSONALLY; (B) YOU WITNESSED IT HAPPEN TO SOMEONE ELSE; (C) YOU LEARNED ABOUT IT HAPPENING TO A CLOSE FAMILY MEMBER OR CLOSE FRIEND; (D) YOU WERE EXPOSED TO IT AS PART OF YOUR JOB (FOR EXAMPLE, PARAMEDIC, POLICE, MILITARY, OR OTHER FIRST RESPONDER); (E) YOU'RE NOT SURE IF IT FITS; OR (F) IT DOESN'T APPLY TO YOU.
- BE SURE TO CONSIDER YOUR *ENTIRE LIFE* (GROWING UP AS WELL AS ADULTHOOD) AS YOU GO THROUGH THE LIST OF EVENTS.

Slide 30



PCL-5 with LEC-5 – Criterion A

PART 1: Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it *happened to you* personally; (b) you *witnessed it* happen to someone else; (c) you *learned about it* happening to a close family member or close friend; (d) you were exposed to it as *part of your job* (for example, paramedic, police, military, or other first responder); (e) you're *not sure* if it fits; or (f) it *doesn't apply* to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not Sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)						
2. Fire or explosion						
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)						
4. Serious accident at work, home, or during recreational activity						
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)						
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)						
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)						
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)						
9. Other unwanted or uncomfortable sexual experience						
10. Combat or exposure to a war-zone (in the military or as a civilian)						
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)						
12. Life-threatening illness or injury						
13. Severe human suffering						
14. Sudden, violent death (for example, homicide, suicide)	N/A					
15. Sudden accidental death	N/A					
16. Serious injury, harm, or death you caused to someone else						
17. Any other very stressful event or experience						

PLEASE COMPLETE PART 2 ON THE FOLLOWING PAGE

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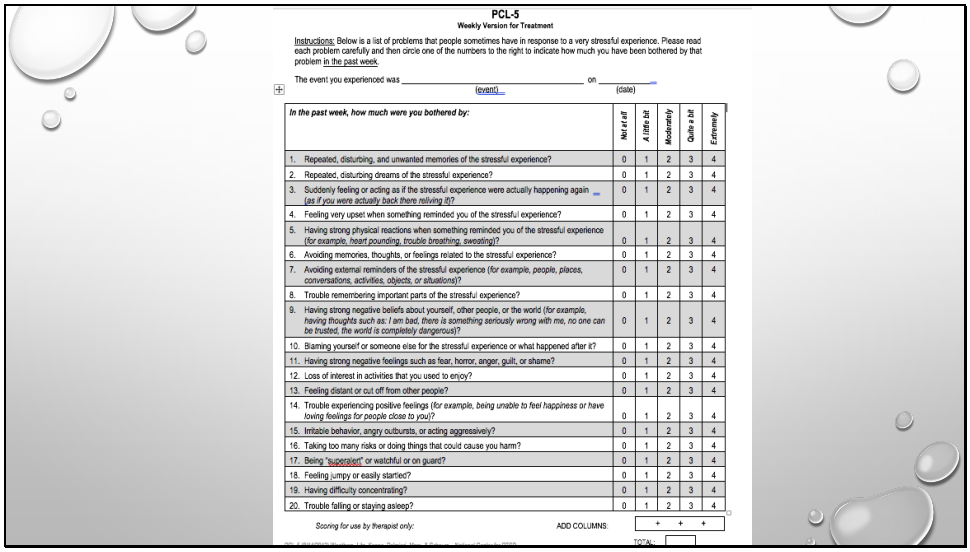


PCL-5

Weekly Version for Treatment

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past week.

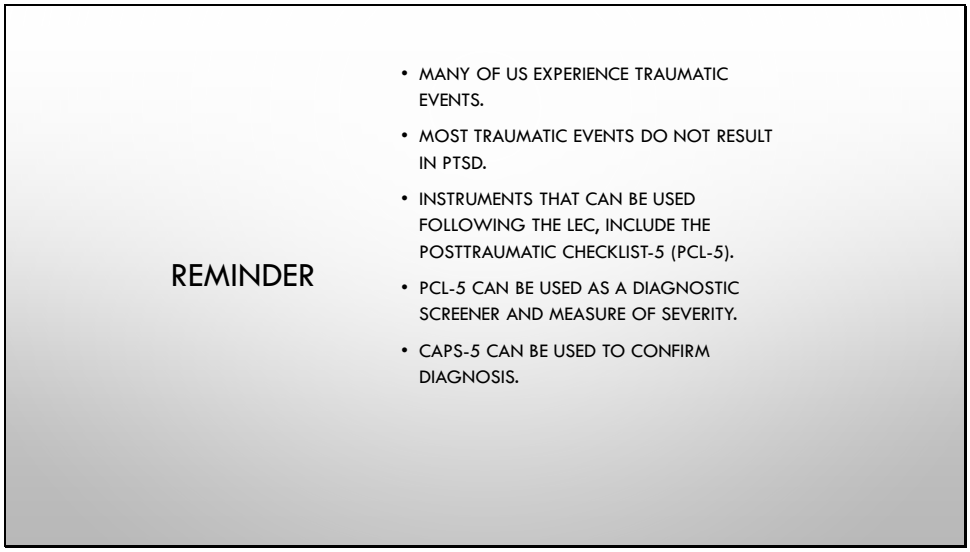
The event you experienced was _____ on _____
(event) (date)

In the past week, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (*as if you were actually back there reliving it*)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (*for example, heart pounding, trouble breathing, sweating*)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (*for example, people, places, conversations, activities, objects, or situations*)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (*for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous*)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (*for example, being unable to feel happiness or have loving feelings for people close to you*)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Scoring for use by therapist only: ADD COLUMNS: + + +

TOTAL:

Slide 32


REMINDER
• MANY OF US EXPERIENCE TRAUMATIC EVENTS.
• MOST TRAUMATIC EVENTS DO NOT RESULT IN PTSD.
• INSTRUMENTS THAT CAN BE USED FOLLOWING THE LEC, INCLUDE THE POSTTRAUMATIC CHECKLIST-5 (PCL-5).
• PCL-5 CAN BE USED AS A DIAGNOSTIC SCREENER AND MEASURE OF SEVERITY.
• CAPS-5 CAN BE USED TO CONFIRM DIAGNOSIS.

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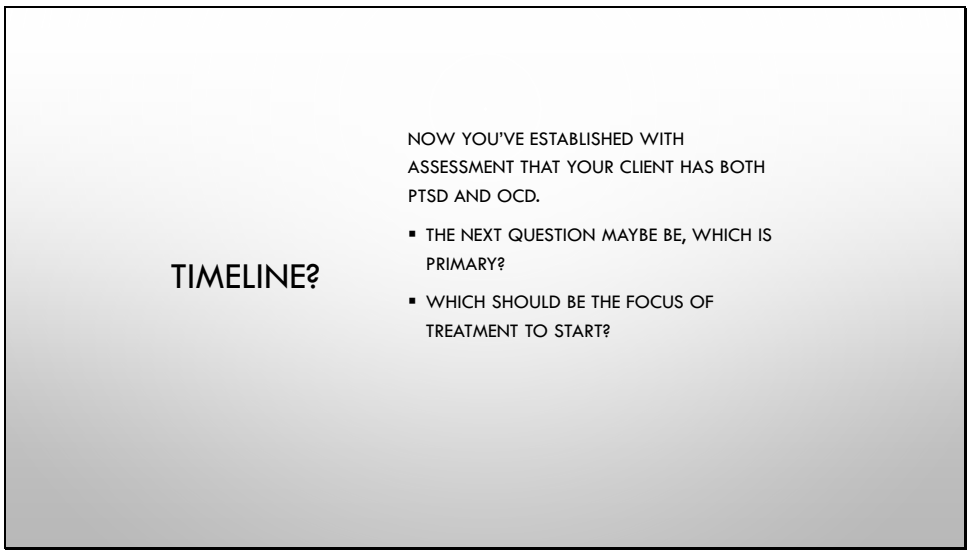
TIMELINE?
NOW YOU'VE ESTABLISHED WITH ASSESSMENT THAT YOUR CLIENT HAS BOTH PTSD AND OCD.
THE NEXT QUESTION MAYBE BE, WHICH IS PRIMARY?
WHICH SHOULD BE THE FOCUS OF TREATMENT TO START?

Slide 34


DECISION MAKING MODEL
• DEAN MCKAY PROPOSES TREATMENT DECISION MAKING TREE:
• HTTPS://MYOCDCARE.COM/TRAUMA/
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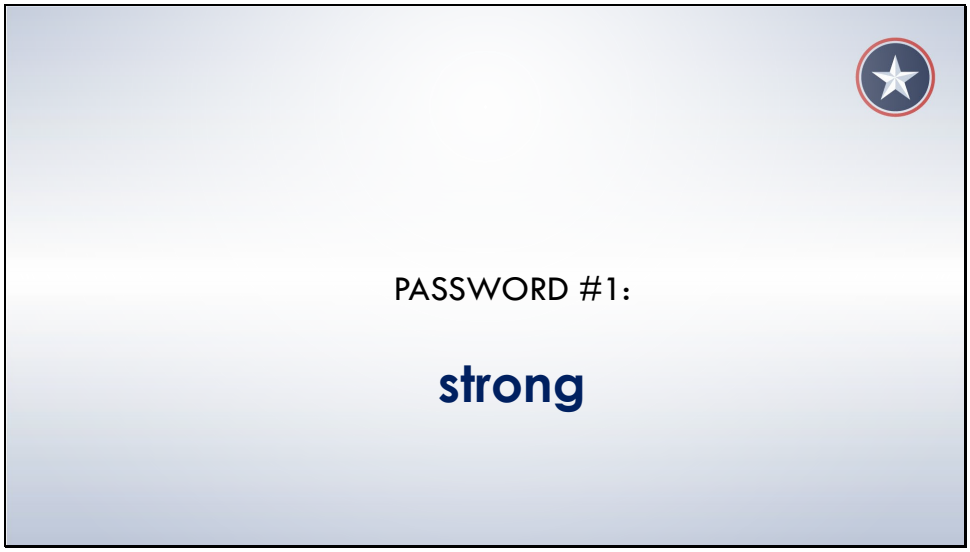
EXAMPLE ONE: THE TRAUMA COMES FIRST – SYMPTOMS ARE RELATED

- JANE, EXPERIENCED A SERIOUS AUTOMOBILE ACCIDENT AT AGE 23.
- PRIOR TO THIS, SHE HAD NO KNOWN DIAGNOSIS OR SYMPTOMS.
- FOLLOWING THE ACCIDENT, SHE BEGAN TO ENGAGE IN: AVOIDANCE OF DRIVING, COMPULSIVELY CHECKING HER CAR MIRRORS, TIRES, AND OVERALL FUNCTIONING OF HER VEHICLE, SHE ALSO CHECKS ROAD SIGNS, SPEED LIMITS AND HERSELF, TO ENSURE THAT SHE IS ALERT ENOUGH TO DRIVE.

Slide 36



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EXAMPLE 1 CONTINUED

- IN THERAPY, JANE SAYS, "THE ACCIDENT WAS MY FAULT BECAUSE I WASN'T PAYING ATTENTION." EVEN THOUGH SHE WAS NOT GIVEN A TICKET AND THE POLICE REPORT INDICATES THAT THE OTHER DRIVER WAS MORE AT FAULT.
- JANE SPENDS 2 HOURS A DAY CHECKING THE SAFETY OF HER CAR INCLUDING: TIRE PRESSURE, MIRRORS, HOOKING AND ADJUSTING HER SEAT BELT.
- SHE OFTEN MISSES WORK BECAUSE SHE DOESN'T FEEL SHE CAN DRIVE.
- SHE CONTINUOUSLY HAS THOUGHTS THAT SHE WILL KILL OR HARM SOMEONE BY HAVING ANOTHER ACCIDENT.

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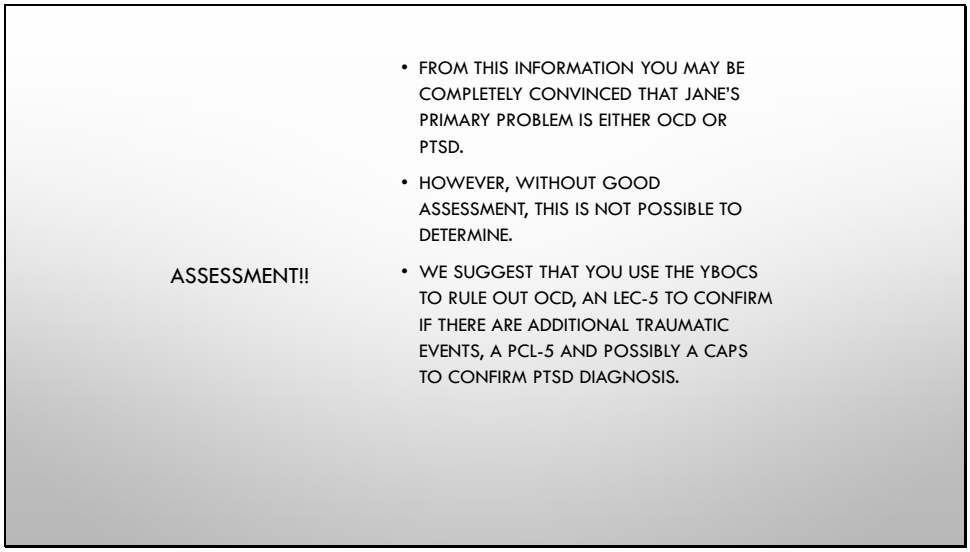
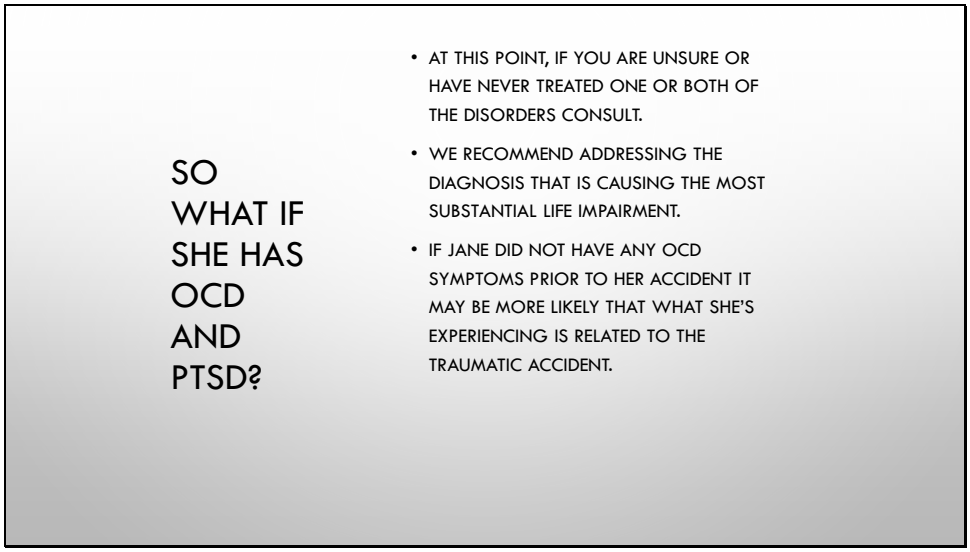
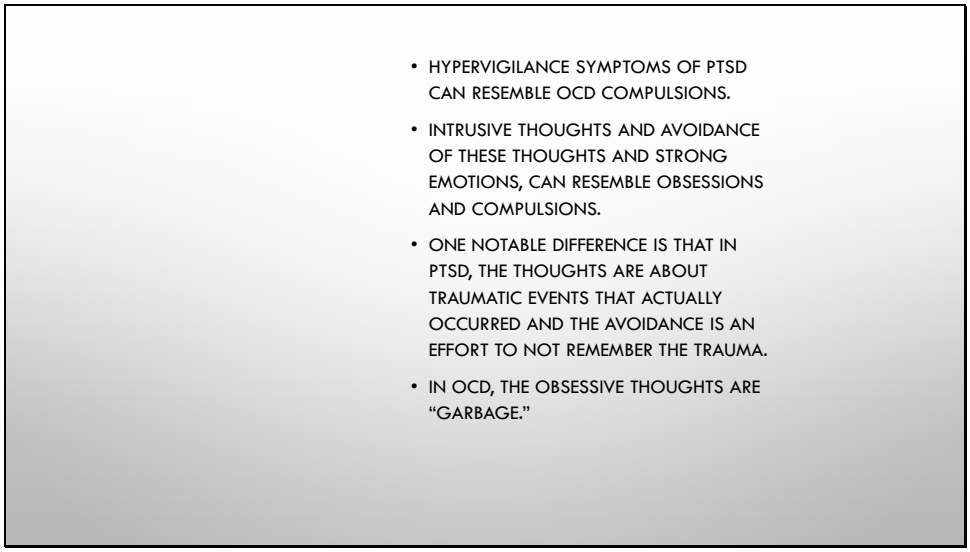
Slide 39


ASSESSMENT!!
• FROM THIS INFORMATION YOU MAY BE COMPLETELY CONVINCED THAT JANE'S PRIMARY PROBLEM IS EITHER OCD OR PTSD.
• HOWEVER, WITHOUT GOOD ASSESSMENT, THIS IS NOT POSSIBLE TO DETERMINE.
• WE SUGGEST THAT YOU USE THE YBOCS TO RULE OUT OCD, AN LEC-5 TO CONFIRM IF THERE ARE ADDITIONAL TRAUMATIC EVENTS, A PCL-5 AND POSSIBLY A CAPS TO CONFIRM PTSD DIAGNOSIS.

Slide 40


SO WHAT IF SHE HAS OCD AND PTSD?
• AT THIS POINT, IF YOU ARE UNSURE OR HAVE NEVER TREATED ONE OR BOTH OF THE DISORDERS CONSULT.
• WE RECOMMEND ADDRESSING THE DIAGNOSIS THAT IS CAUSING THE MOST SUBSTANTIAL LIFE IMPAIRMENT.
• IF JANE DID NOT HAVE ANY OCD SYMPTOMS PRIOR TO HER ACCIDENT IT MAY BE MORE LIKELY THAT WHAT SHE'S EXPERIENCING IS RELATED TO THE TRAUMATIC ACCIDENT.

Slide 41


• HYPERVIGILANCE SYMPTOMS OF PTSD CAN RESEMBLE OCD COMPULSIONS.
• INTRUSIVE THOUGHTS AND AVOIDANCE OF THESE THOUGHTS AND STRONG EMOTIONS, CAN RESEMBLE OBSESSIONS AND COMPULSIONS.
• ONE NOTABLE DIFFERENCE IS THAT IN PTSD, THE THOUGHTS ARE ABOUT TRAUMATIC EVENTS THAT ACTUALLY OCCURRED AND THE AVOIDANCE IS AN EFFORT TO NOT REMEMBER THE TRAUMA.
• IN OCD, THE OBSESSIVE THOUGHTS ARE "GARBAGE."

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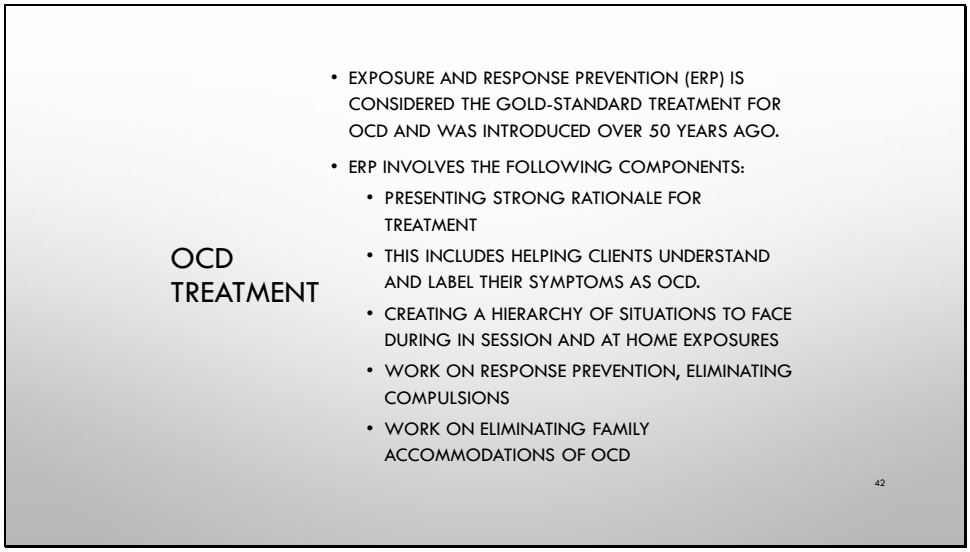
OCD TREATMENT
• EXPOSURE AND RESPONSE PREVENTION (ERP) IS CONSIDERED THE GOLD-STANDARD TREATMENT FOR OCD AND WAS INTRODUCED OVER 50 YEARS AGO.
• ERP INVOLVES THE FOLLOWING COMPONENTS:
• PRESENTING STRONG RATIONALE FOR TREATMENT
• THIS INCLUDES HELPING CLIENTS UNDERSTAND AND LABEL THEIR SYMPTOMS AS OCD.
• CREATING A HIERARCHY OF SITUATIONS TO FACE DURING IN SESSION AND AT HOME EXPOSURES
• WORK ON RESPONSE PREVENTION, ELIMINATING COMPULSIONS
• WORK ON ELIMINATING FAMILY ACCOMMODATIONS OF OCD
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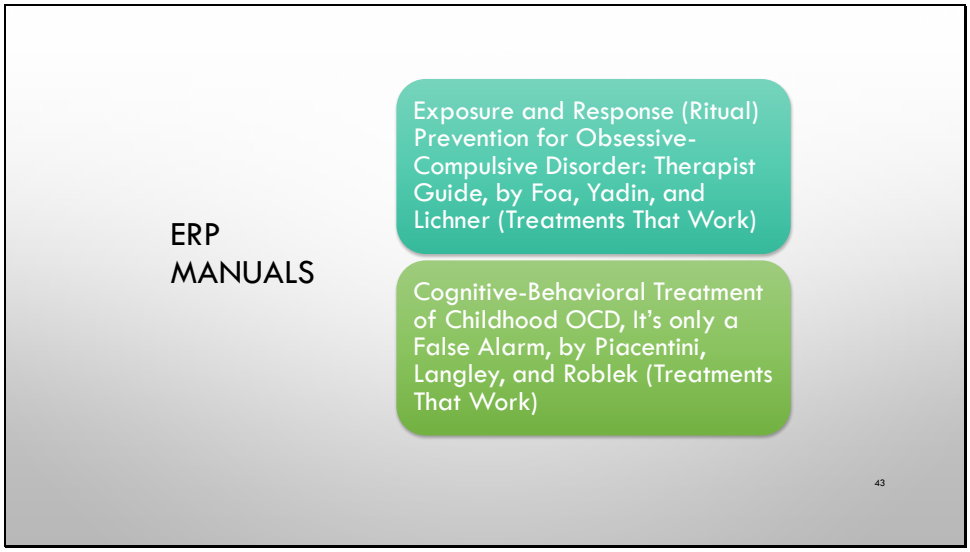
ERP MANUALS
Exposure and Response (Ritual) Prevention for Obsessive-Compulsive Disorder: Therapist Guide, by Foa, Yadin, and Lichner (Treatments That Work)
Cognitive-Behavioral Treatment of Childhood OCD, It's only a False Alarm, by Piacentini, Langley, and Roblek (Treatments That Work)
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TRAINING IN ERP
• IT IS HIGHLY RECOMMENDED THAT BEFORE PROVIDING ERP, THERAPISTS COMPLETE ERP TRAINING.
• EXCELLENT TRAINING IS AVAILABLE THROUGH INTERNATIONAL OCD FOUNDATION'S, BEHAVIOR THERAPY TRAINING INSTITUTE (BTTI): HTTPS://IOCDF.ORG/PROFESSIONALS/TRAINING-INSTITUTE/BTTI/
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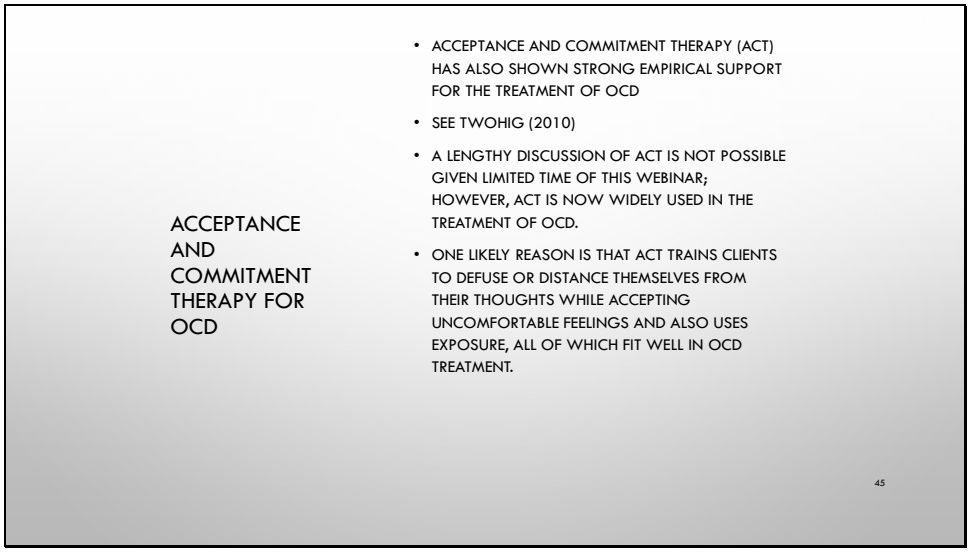
ACCEPTANCE AND COMMITMENT THERAPY FOR OCD
• ACCEPTANCE AND COMMITMENT THERAPY (ACT) HAS ALSO SHOWN STRONG EMPIRICAL SUPPORT FOR THE TREATMENT OF OCD
• SEE TWOHIG (2010)
• A LENGTHY DISCUSSION OF ACT IS NOT POSSIBLE GIVEN LIMITED TIME OF THIS WEBINAR; HOWEVER, ACT IS NOW WIDELY USED IN THE TREATMENT OF OCD.
• ONE LIKELY REASON IS THAT ACT TRAINS CLIENTS TO DEFUSE OR DISTANCE THEMSELVES FROM THEIR THOUGHTS WHILE ACCEPTING UNCOMFORTABLE FEELINGS AND ALSO USES EXPOSURE, ALL OF WHICH FIT WELL IN OCD TREATMENT.
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OTHER OCD TREATMENTS

- COGNITIVE THERAPY THAT IS SPECIFIC TO OCD ALSO HAS EVIDENCE TO SUPPORT ITS USE BUT IS DIFFERENT THAN OTHER COGNITIVE THERAPIES.
- INFERENCE-BASED THERAPY ALSO HAS SOME EVIDENCE TO SUPPORT ITS USE.

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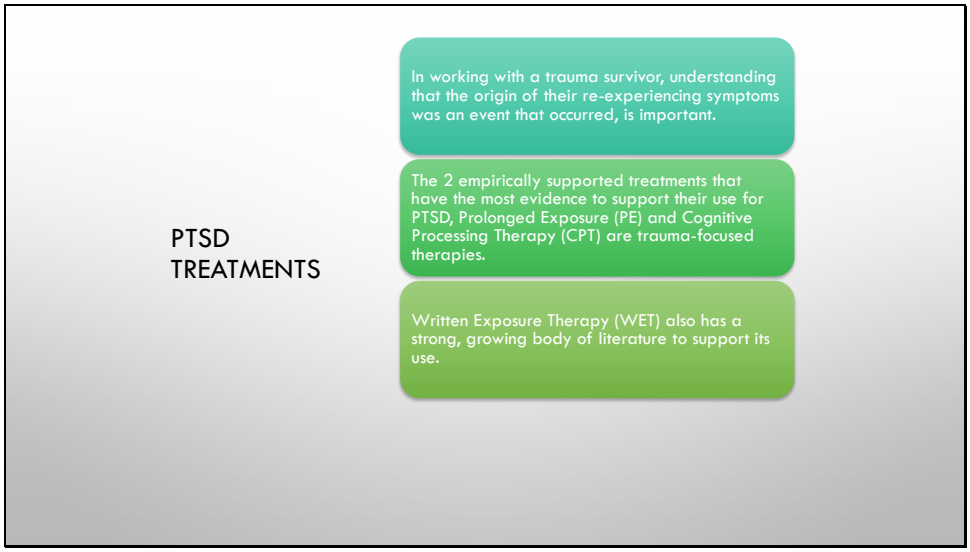
PTSD
TREATMENTS
In working with a trauma survivor, understanding that the origin of their re-experiencing symptoms was an event that occurred, is important.
The 2 empirically supported treatments that have the most evidence to support their use for PTSD, Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT) are trauma-focused therapies.
Written Exposure Therapy (WET) also has a strong, growing body of literature to support its use.

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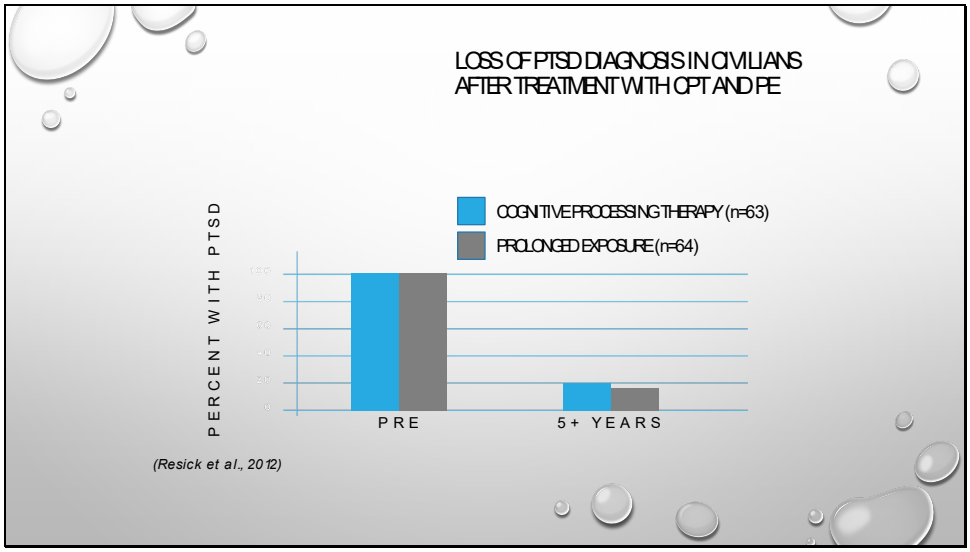
LOSS OF PTSD DIAGNOSIS IN CIVILIANS AFTER TREATMENT WITH CPT AND PE
COGNITIVE PROCESSING THERAPY (n=63)
PROLONGED EXPOSURE (n=64)
PERCENT WITH PTSD
PRE
5+ YEARS
(Resick et al., 2012)

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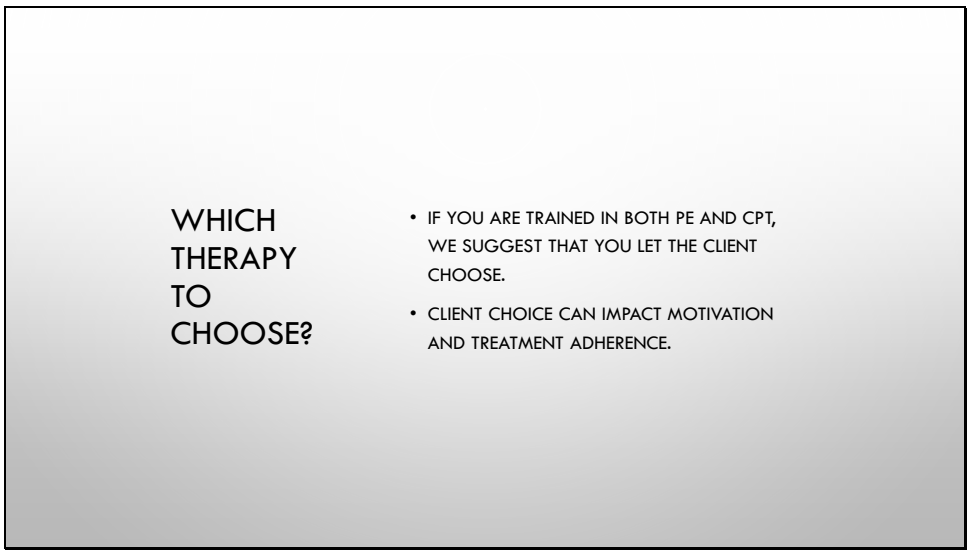
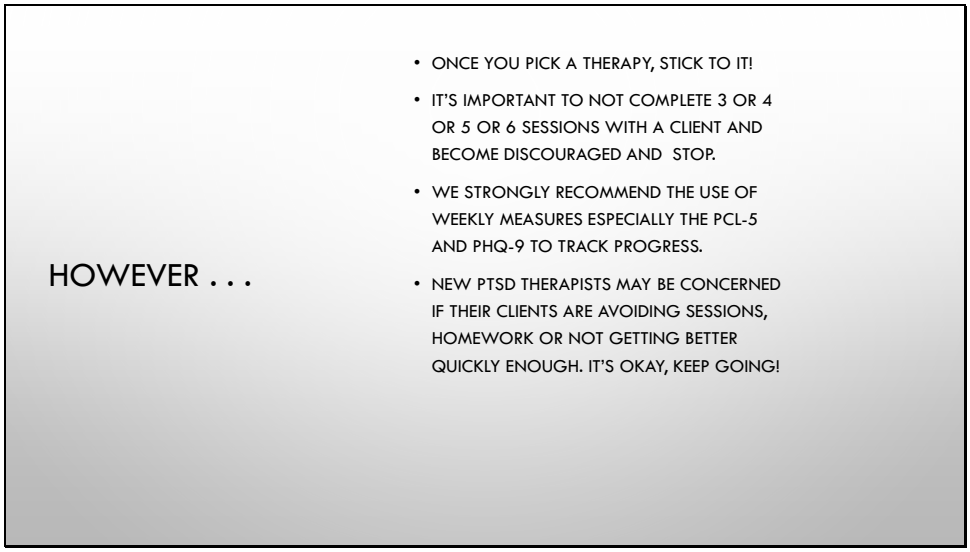

WHICH THERAPY TO CHOOSE?
• IF YOU ARE TRAINED IN BOTH PE AND CPT, WE SUGGEST THAT YOU LET THE CLIENT CHOOSE.
• CLIENT CHOICE CAN IMPACT MOTIVATION AND TREATMENT ADHERENCE.

Slide 50


HOWEVER . . .
• ONCE YOU PICK A THERAPY, STICK TO IT!
• IT'S IMPORTANT TO NOT COMPLETE 3 OR 4 OR 5 OR 6 SESSIONS WITH A CLIENT AND BECOME DISCOURAGED AND STOP.
• WE STRONGLY RECOMMEND THE USE OF WEEKLY MEASURES ESPECIALLY THE PCL-5 AND PHQ-9 TO TRACK PROGRESS.
• NEW PTSD THERAPISTS MAY BE CONCERNED IF THEIR CLIENTS ARE AVOIDING SESSIONS, HOMEWORK OR NOT GETTING BETTER QUICKLY ENOUGH. IT'S OKAY, KEEP GOING!

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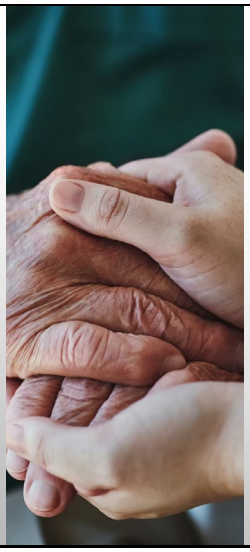

- THERAPISTS MAY START TO BELIEVE THAT THEY SHOULD DO ONE OF THE FOLLOWING:
  - INTEGRATE OTHER THERAPIES OR TECHNIQUES LIKE RELAXATION SKILLS, STOP FOLLOWING THE PROTOCOL, QUICKLY DECIDED TO OFFER EMOTION REGULATION SKILLS OR DBT IF CLIENTS ARE UPSET, OR GO BACK TO WHAT THEY ARE USED TO USING WITH CLIENT.
- WE DISCOURAGE EACH OF THESE AS THEY MAY INCREASE AVOIDANCE IN YOUR CLIENTS.
- INSTEAD KEEP FOLLOWING THE PROTOCOL. WORK ON AVOIDANCE.

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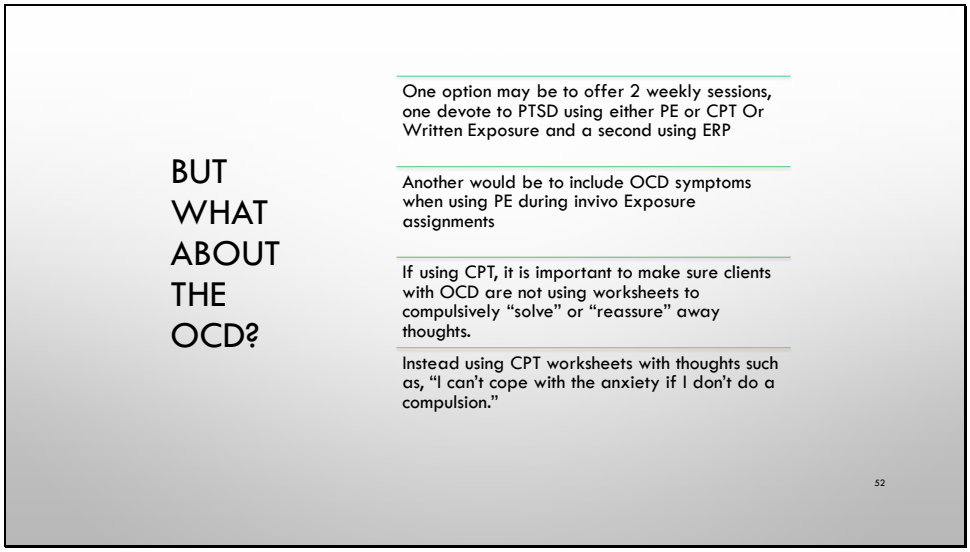
BUT WHAT ABOUT THE OCD?
One option may be to offer 2 weekly sessions, one devote to PTSD using either PE or CPT Or Written Exposure and a second using ERP
Another would be to include OCD symptoms when using PE during invivo Exposure assignments
If using CPT, it is important to make sure clients with OCD are not using worksheets to compulsively "solve" or "reassure" away thoughts.
Instead using CPT worksheets with thoughts such as, "I can't cope with the anxiety if I don't do a compulsion."
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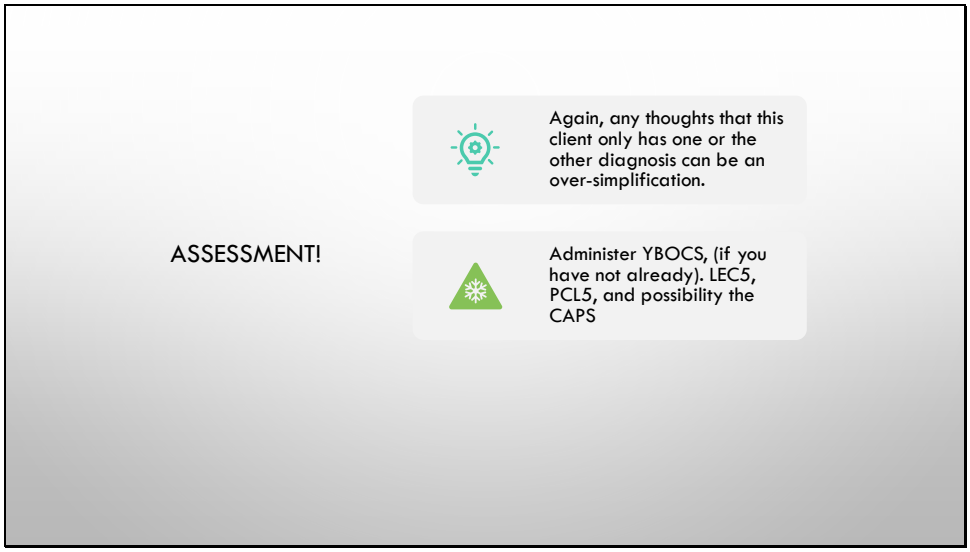
EXAMPLE 2

- AN ADULT CLIENT PRESENTS WITH A HISTORY OF CHILDHOOD ONSET OCD INCLUDING OBSESSIVE THOUGHTS ABOUT MORALITY AND FEARS OF GOING TO HELL. COMPULSIONS INCLUDE HOURS OF PRAYER AND CONFESSION EACH DAY, INCLUDING CALLING AND EMAILING HIS PRIEST.
- AFTER 5 SESSIONS, DURING WHICH YOU HAVE STARTED ERP, THE CLIENT DIVULGES TO YOU THAT HE WAS SEXUALLY ASSAULTED BY A NEIGHBOR WHEN HE WAS 12, YEARS AFTER THE ONSET OF OCD SYMPTOMS.
- IN ADDITION TO CONTINUING OCD SYMPTOMS, HE IS FEARFUL OF BEING ALONE WITH MEN AND HAS FREQUENT RE-EXPERIENCING SYMPTOMS RELATED TO THE SEXUAL ASSAULT.

Slide 54

Slide 55


ASSESSMENT!
Again, any thoughts that this client only has one or the other diagnosis can be an over-simplification.
Administer YBOCS, (if you have not already). LEC5, PCL5, and possibility the CAPS

Slide 56


START ERP
• YOU PROVIDE A TREATMENT RATIONALE AND START EXPOSURE AND RESPONSE PREVENTION TREATMENT FOR OCD
• CREATE A HIERARCHY WITH YOUR CLIENT (SEE NEXT SLIDE)
• ASK YOUR CLIENT TO TRACK HIS OBSESSIONAL THOUGHTS AND COMPULSIONS THROUGH OUT THE WEEK.
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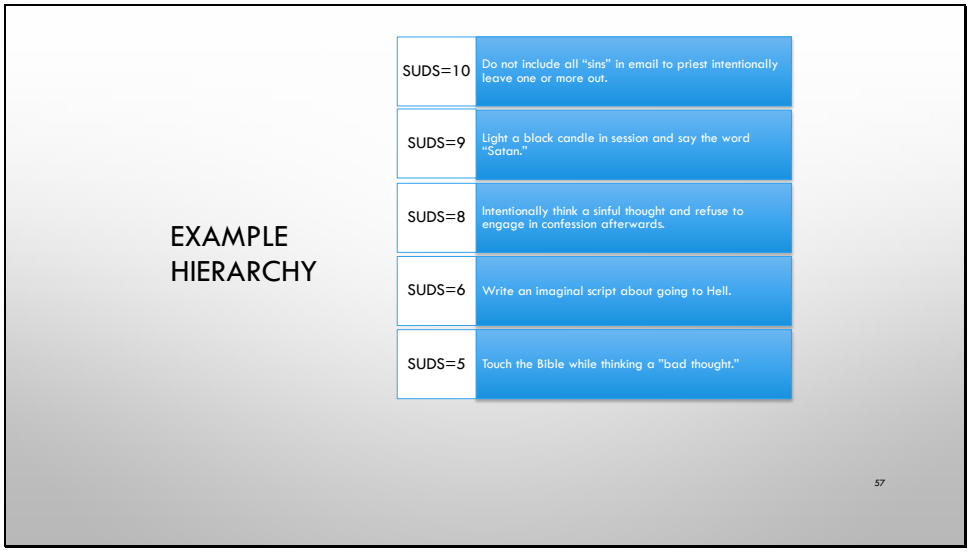
EXAMPLE HIERARCHY
SUDS=10
Do not include all "sins" in email to priest intentionally leave one or more out.
SUDS=9
Light a black candle in session and say the word "Satan."
SUDS=8
Intentionally think a sinful thought and refuse to engage in confession afterwards.
SUDS=6
Write an imaginal script about going to Hell.
SUDS=5
Touch the Bible while thinking a "bad thought."
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BUT WHAT IF. . .
• WHAT IF YOUR CLIENT'S SYMPTOMS ARE SO OVERWHELMING THAT HE OR SHE IS NOT FUNCTIONING?
• GOOD QUESTION -

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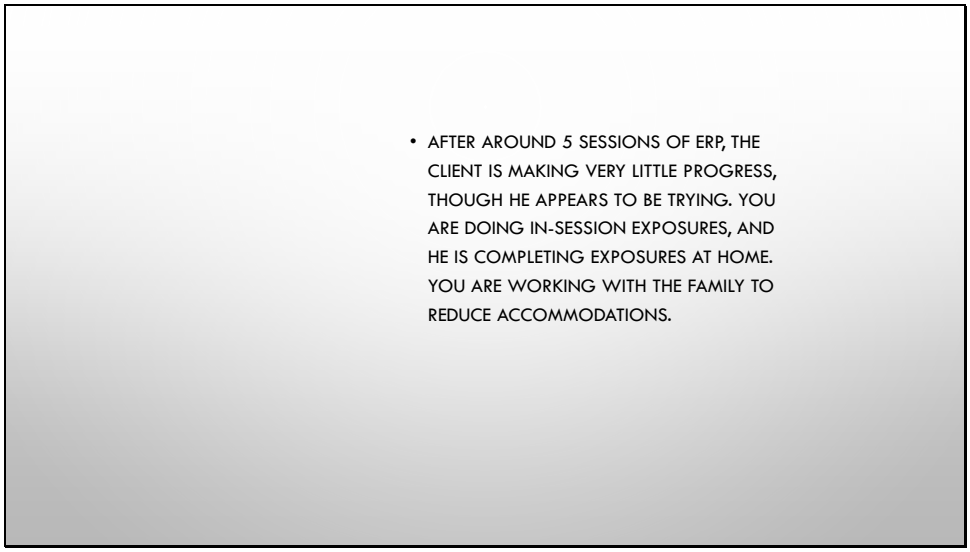
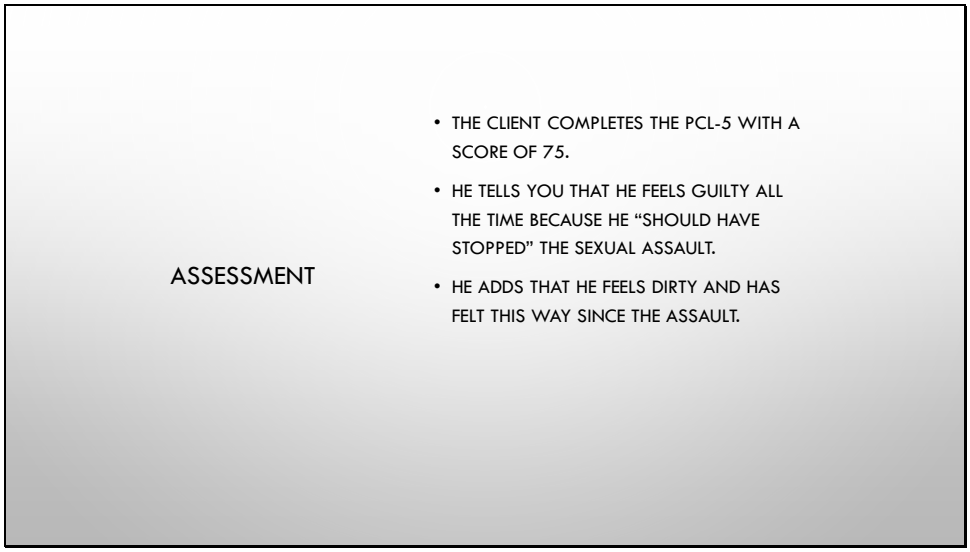

• AFTER AROUND 5 SESSIONS OF ERP, THE CLIENT IS MAKING VERY LITTLE PROGRESS, THOUGH HE APPEARS TO BE TRYING. YOU ARE DOING IN-SESSION EXPOSURES, AND HE IS COMPLETING EXPOSURES AT HOME. YOU ARE WORKING WITH THE FAMILY TO REDUCE ACCOMMODATIONS.

Slide 60


ASSESSMENT
• THE CLIENT COMPLETES THE PCL-5 WITH A SCORE OF 75.
• HE TELLS YOU THAT HE FEELS GUILTY ALL THE TIME BECAUSE HE "SHOULD HAVE STOPPED" THE SEXUAL ASSAULT.
• HE ADDS THAT HE FEELS DIRTY AND HAS FELT THIS WAY SINCE THE ASSAULT.

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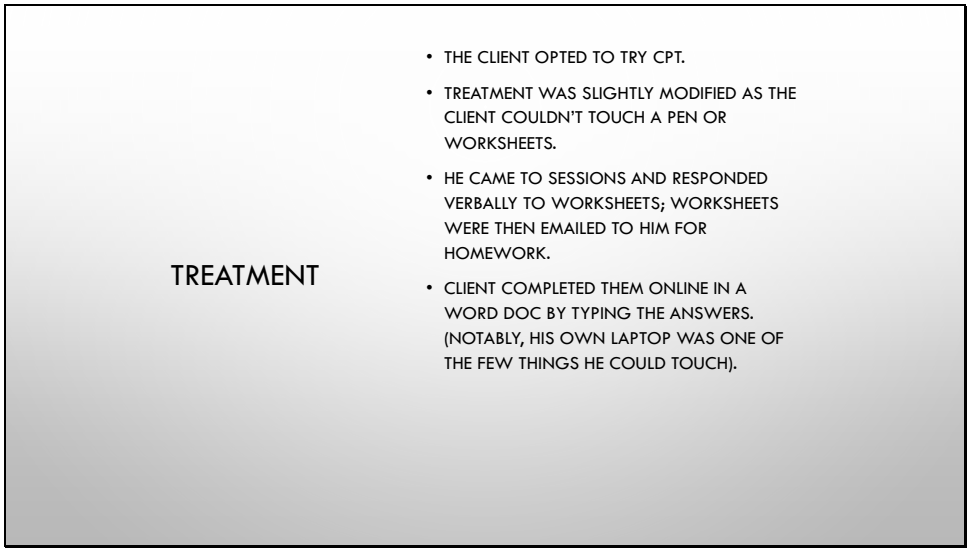
CONSULT!

- IN A VERY SIMILAR CASE CONSULTATION WAS MADE WITH EXPERTS IN ERP FOR OCD, TF-CPT, PE AND CPT.
- THIS MAY BE A HISTORIC FIRST BUT . . . THEY ALL AGREED –
- TREAT THE PTSD!

Slide 62


TREATMENT
• THE CLIENT OPTED TO TRY CPT.
• TREATMENT WAS SLIGHTLY MODIFIED AS THE CLIENT COULDN'T TOUCH A PEN OR WORKSHEETS.
• HE CAME TO SESSIONS AND RESPONDED VERBALLY TO WORKSHEETS; WORKSHEETS WERE THEN EMAILED TO HIM FOR HOMEWORK.
• CLIENT COMPLETED THEM ONLINE IN A WORD DOC BY TYPING THE ANSWERS. (NOTABLY, HIS OWN LAPTOP WAS ONE OF THE FEW THINGS HE COULD TOUCH).

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AND. .

- HE COMPLETED ALL 12 SESSIONS.
- HE DID ALL OF THE HOMEWORK ASSIGNMENTS.
- TREATMENT INITIALLY FOCUSED ON REDUCING HER SELF-BLAME ABOUT THE TRAUMA.
- HE WAS ABLE TO STOP BLAMING HIMSELF AND APPROPRIATELY BLAME THE PERPETRATOR.

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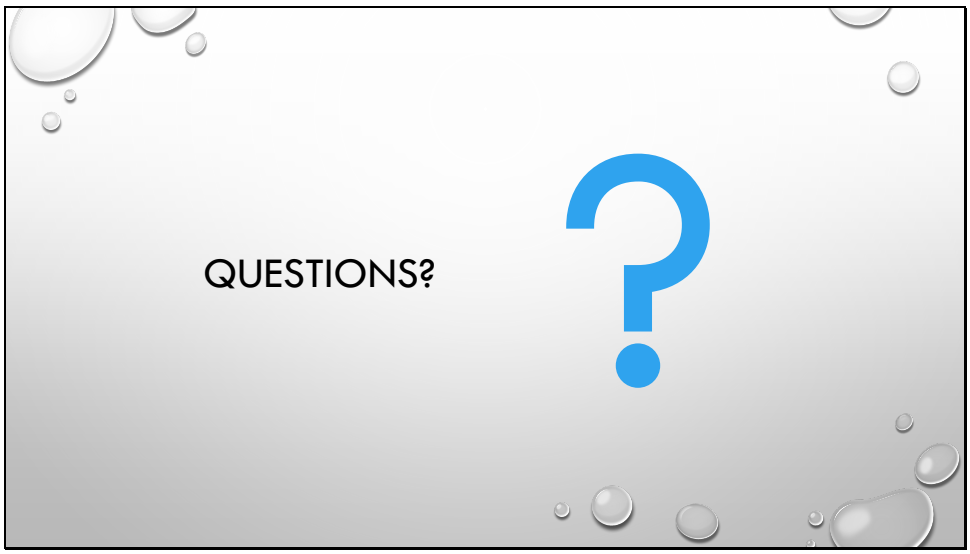

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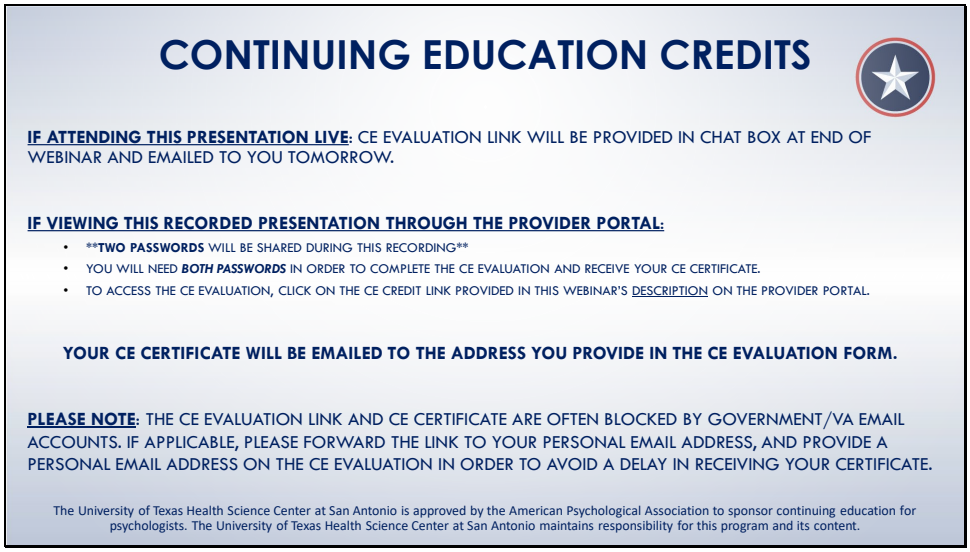
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IF ATTENDING THIS PRESENTATION LIVE: CE EVALUATION LINK WILL BE PROVIDED IN CHAT BOX AT END OF WEBINAR AND EMAILED TO YOU TOMORROW.
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TWO PASSWORDS WILL BE SHARED DURING THIS RECORDING
YOU WILL NEED BOTH PASSWORDS IN ORDER TO COMPLETE THE CE EVALUATION AND RECEIVE YOUR CE CERTIFICATE.
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Q&A
• PLEASE TYPE YOUR QUESTIONS IN THE Q&A FEATURE AT THE BOTTOM OF THE SCREEN.

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NEXT MONTH'S WEBINAR

Socratic Dialogue: A 4-Stage Model of Discovery

Presented by Christine Padesky, Ph.D., the Co-founder of the Center for Cognitive Therapy in Huntington Beach, California and Co-Creator of Strengths-Based CBT

When: Thursday, November 3 at 1pm CDT/ 2pm EDT