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The Little Program that Could: Obsessive Compulsive Disorder Treatment and Building a Specialized Mental Health Program for Outpatient OCD Treatment

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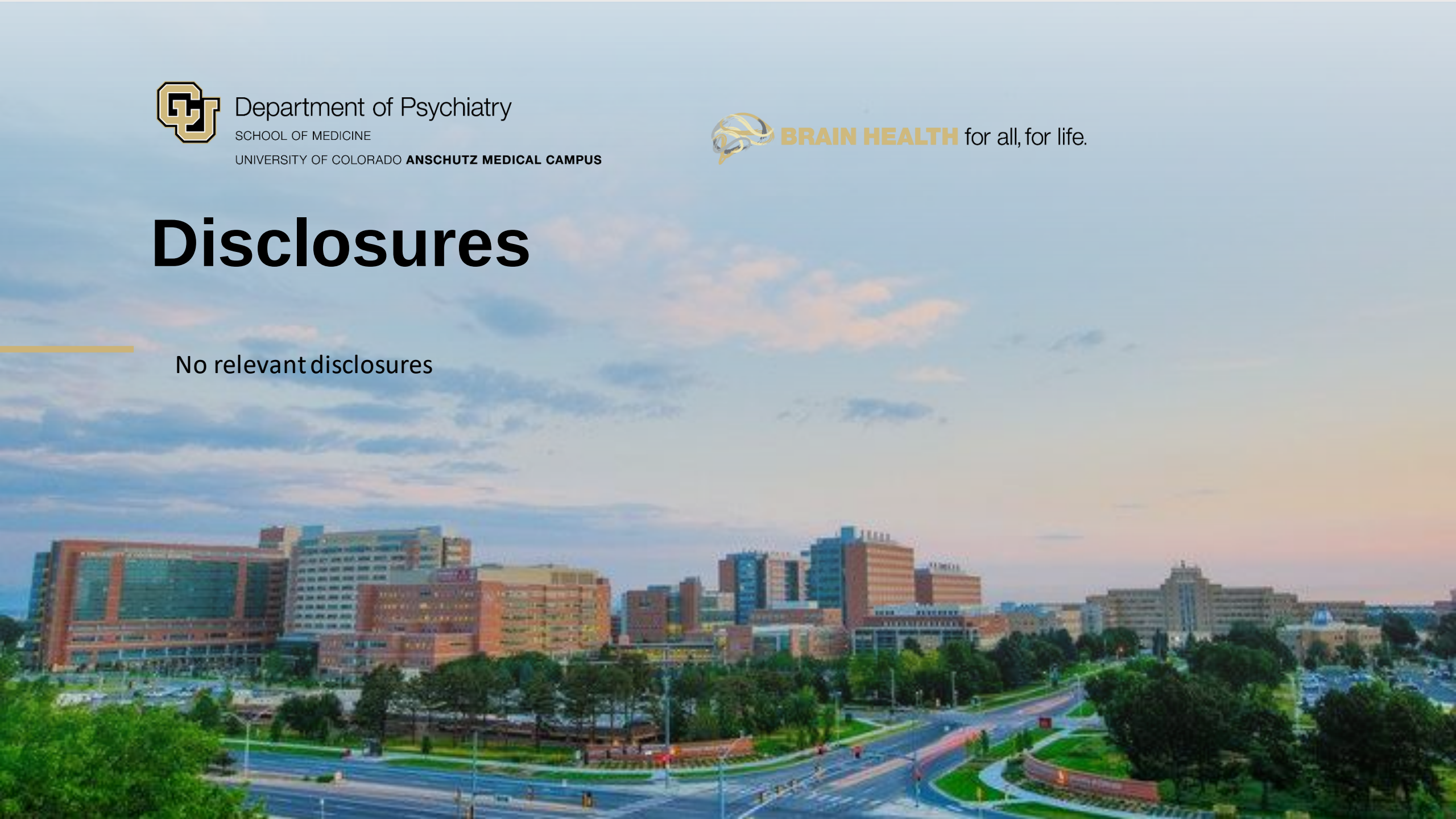
BRAIN HEALTH for all, for life.

Disclosures

No relevant disclosures



University of Colorado Anschutz OCD Program

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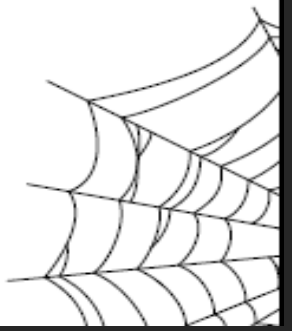
CU Anschutz OCD Program Presents

EXPOSURE PALOOZA

10-29-23

Join us to experience fun and spooky OCD exposure activities, lots of prizes, and hear our guest speakers, Rev. Katie O'Dunne, Dr. Moksha Patel, and our OCD Program Medical Director, Dr. Rachel Davis, share their own experiences living with OCD.

REGISTER HERE!

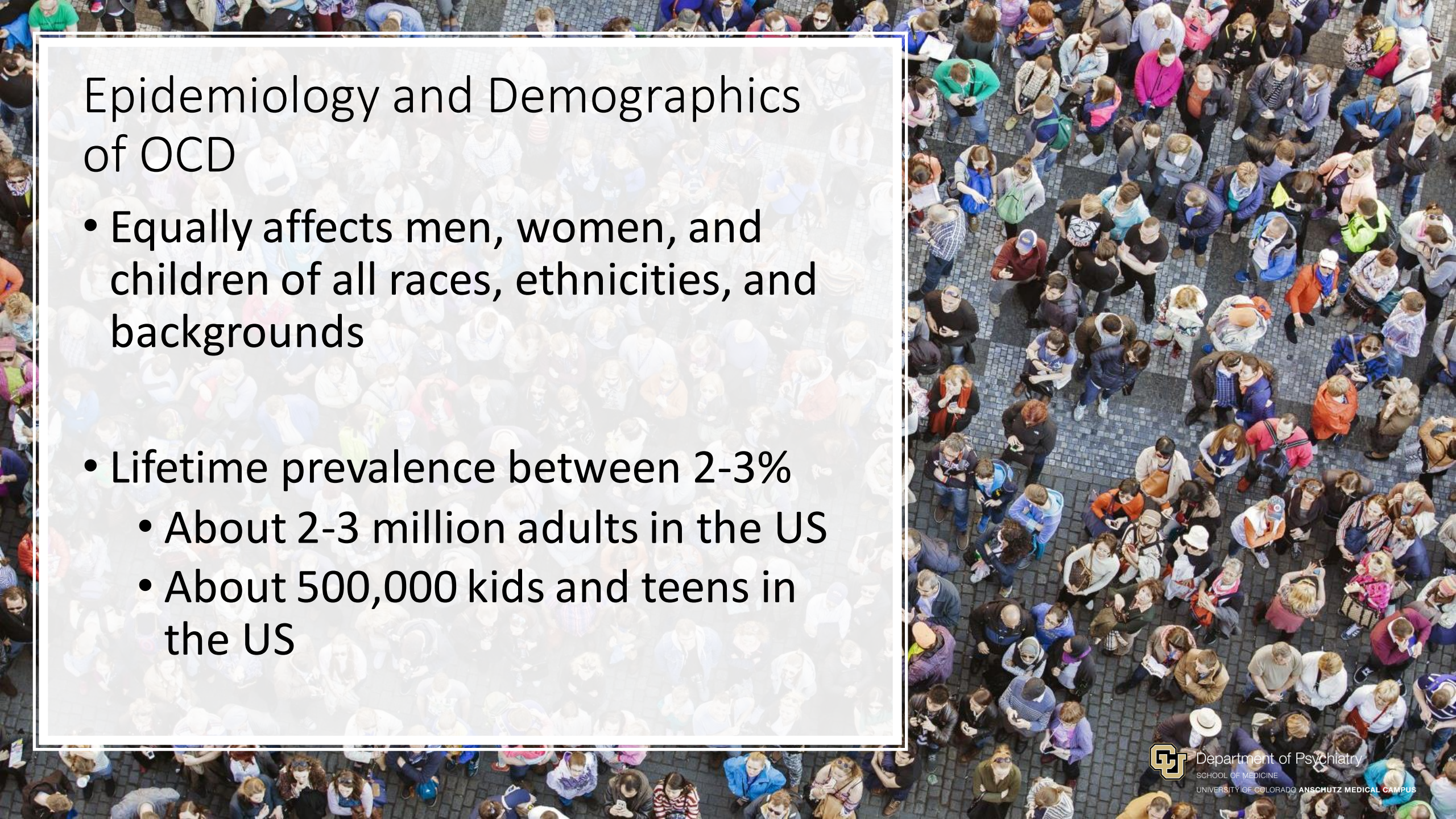


OCD Assessment and Treatment

Epidemiology and Demographics of OCD

- Equally affects men, women, and children of all races, ethnicities, and backgrounds

- Lifetime prevalence between 2-3%
  - About 2-3 million adults in the US
  - About 500,000 kids and teens in the US



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OCD, Co-Morbidities, Differential Diagnosis

- Co-morbidities are extremely common

- HOWEVER, sometimes it's not OCD and it might be a different diagnosis:
  - OCPD
  - Autism
  - Borderline Personality Disorder
  - Depressive rumination
  - Bipolar disorder
  - ADHD

- Differential diagnosis could be an entire presentation on its own, SO **Seek consult from an expert in a particular comorbidity**

OCD - DSM-5

A. Presence of obsessions, compulsions, or both

B. Greater than 1 hr per day or cause distress/impairment

C. Not attributable to substance or medical condition

D. Not explained by another mental disorder

Specify:

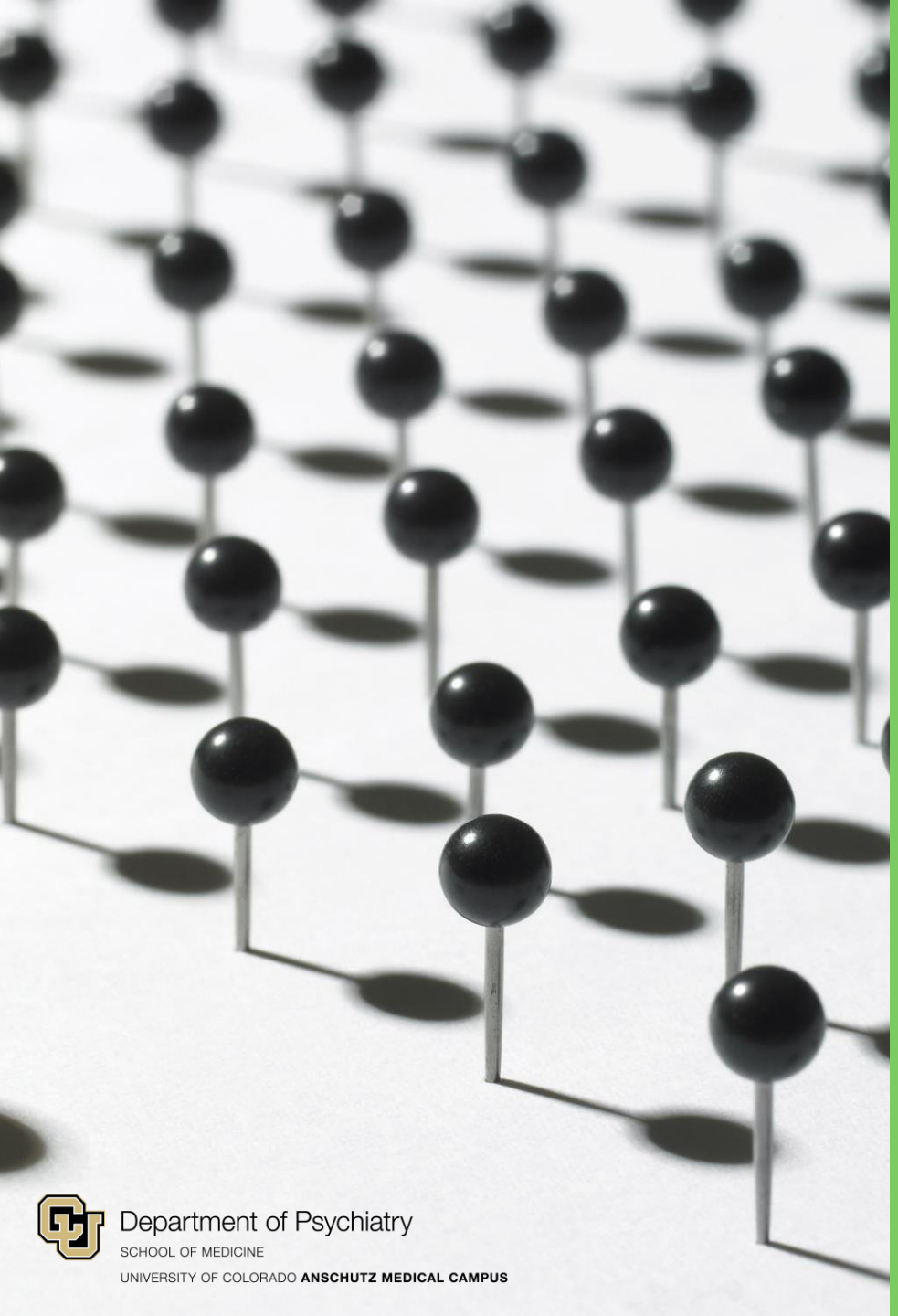
- Good or fair insight
- Poor insight
- Absent insight
- Tic-related

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: **DSM-5**. Washington, D.C: American Psychiatric Association.

Obsessions

1. Recurrent and persistent thoughts, urges, or images
   - Intrusive and **unwanted**
   - Cause anxiety or distress
2. Individual attempts to ignore, suppress, or neutralize

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: **DSM-5**. Washington, D.C: American Psychiatric Association.



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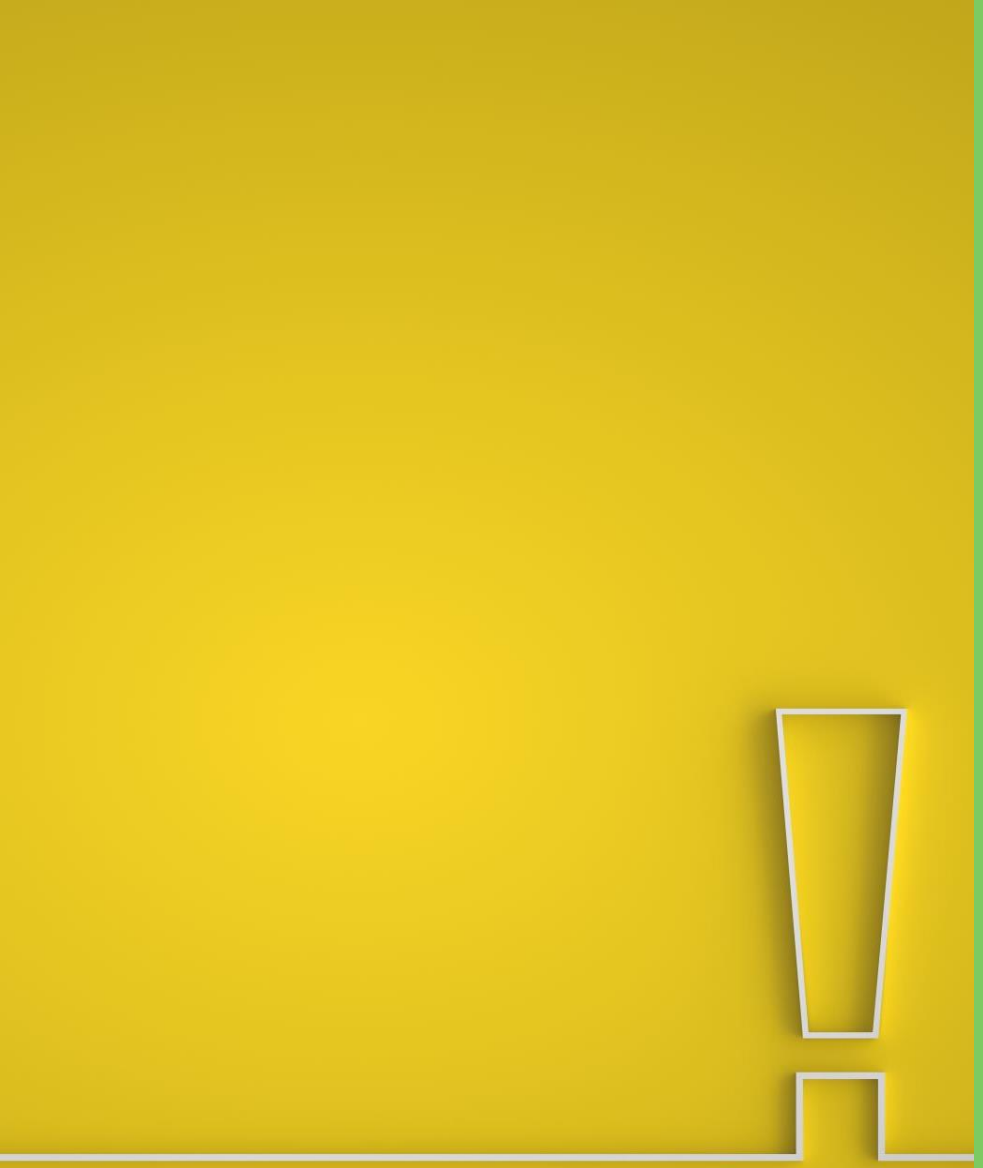
Compulsions

1. Repetitive behavior or mental act
   - Feels driven to perform in response to an obsession
2. Aimed at preventing or reducing anxiety or distress
   - Excessive or unrealistically connected

Rituals are done to avoid *anxiety* just as much or more than to avoid the *feared consequence*.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: **DSM-5**. Washington, D.C: American Psychiatric Association.



Triggers, Obsessions, and Feared Consequences

- Trigger: environmental or mental
- Obsession: what the sufferer fears
- Feared Consequence: if I don't ritualize, this will happen

Three Components of Obsessions

Triggers

- External: "contaminated" objects, tasks involving responsibility, asymmetry, e.g. bump in the road, article about ethics
- Internal: disturbing thoughts or images about sex, violence, or immorality

Intrusive thoughts/feelings

- "I might have just hit someone." "I might have committed insurance fraud." "I might have missed a finding on an MRI." "I am a bad person." "I feel disgusting." "I feel uncomfortable."

Core fears (feared consequences)

- "I will end up isolated and alone in prison." "I will get fired." "Someone will die, and I will have to feel guilty forever." "I cannot tolerate feeling this way."

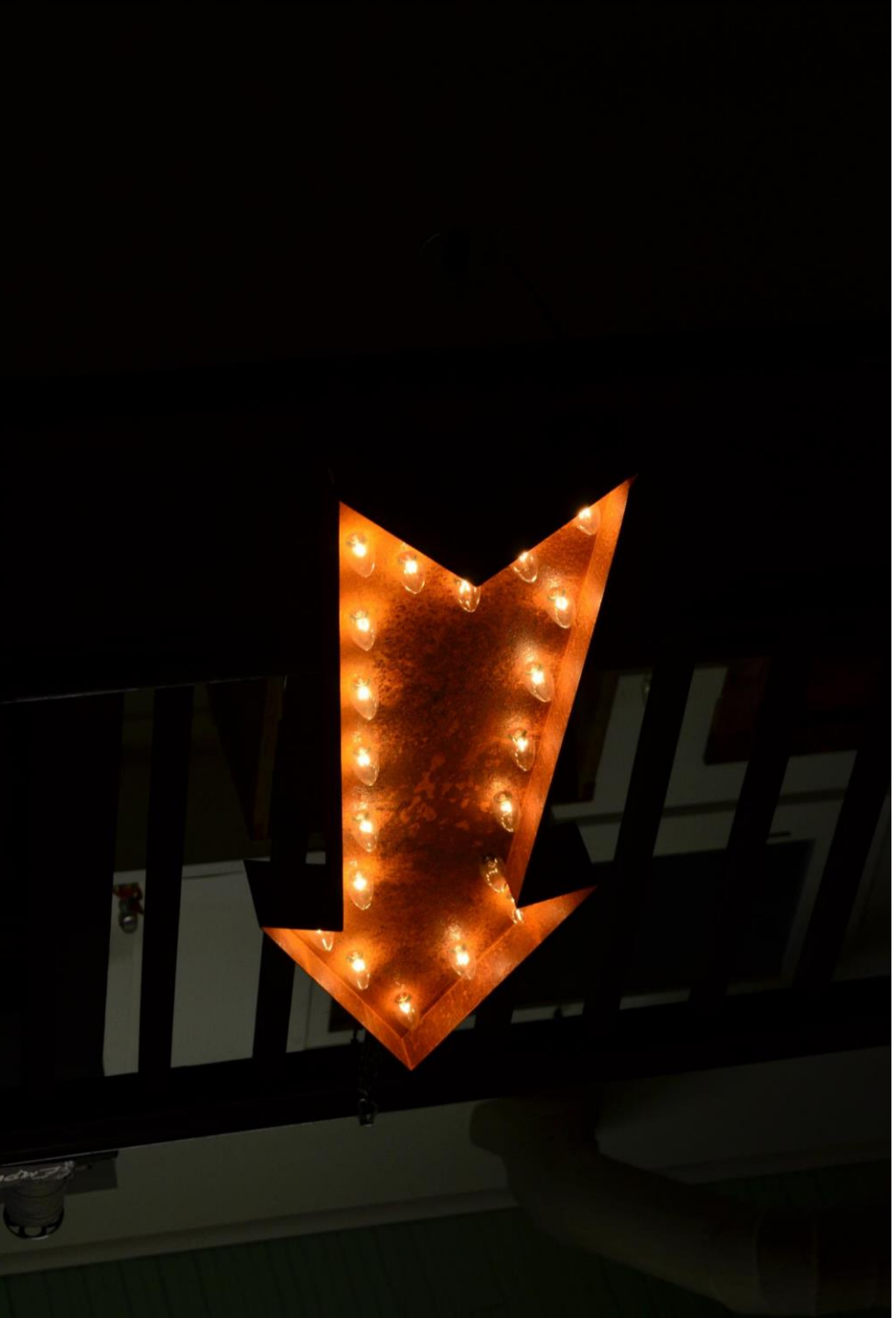
*Jonathan Grayson's Obsessive Concerns Checklist

Feared Consequence: If I don't ritualize, this will happen

(Obsessional core fears usually boil down to one or more of the three below)

- Proximal, specifiable catastrophic events
- Interminable, intolerable distress: not just right/disgust
- Interminable, intolerable distress: uncertainty

(A. Pollard IOCDF 2017)



Downward Arrow to Identify Core Fear

- Trigger: bowel movement
- Intrusive thought: “I might smell like poop.”
- Why is that bad? People will smell me →they’ll talk about me behind my back → I won’t know they’re talking about me → they’ll think I’m gross → they’ll start to avoid me → I will be isolated and lonely

Biopsychosocial Model

- Genetic component
- Psychological vulnerabilities from early life experiences
  - Trauma
  - Dysfunctional beliefs
- Modeled through family, media, society
  - Stereotypes
  - Stigma
- Cultural norms and standards
- Maladaptive form of coping

Behavioral Compulsions

- Washing
- Checking
- Reassurance-seeking
- Repeating
- Straightening
- Organizing
- Confessing
- Researching
- Maintaining routines

*Jonathan Grayson's Compulsive Activities Checklist

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Mental Compulsions

- Counting
- Mental Reviewing
- Reasoning
- Scenario bending
- Figuring it out
- Thought or image replacement
- Thought neutralization or suppression
- Mental rehearsal
- Memory hoarding
- Praying
- Mental self-punishment

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Avoidance

- Primary: staying away from the trigger
- Secondary: rituals/compulsions ➔ seeking safety when stimulus cannot be avoided

Subtypes

- Harm
- Hyper-responsibility
- Contamination
- Health
- Pedophile
- Hyper-awareness
- Scrupulosity (moral/religious)
- Sexual orientation
- Symmetry/Just right

Subtypes

- Relationship
- Existential
- Stuck thought
- False memory
- Perfectionism
- Perinatal and Postpartum

Goals of Treatment

- **ACCEPTING UNCERTAINTY**
  - What do you feel certain about?
  - Why?
  - How do you know?
- Logic doesn't change it
- Goal: Accepting possibility of feared consequence (living with uncertainty)
- Goal: Responding to uncertainty like you do in the non-OCD aspects of your life

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Habituation

- Also known as anxiety reduction
- Goal to reduce anxiety through exposures, usually with a gradual approach to exposures
- Potentially shames anxiety and reinforces idea that anxiety/distress is intolerable or “bad”
- Suggests that exposure therapy is only successful if anxiety is “gone”

Habituation

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Inhibitory Learning

- Explains differences between exposure SUDs and SUDs after exposure
- Fear-based thoughts are not gone, but remain and new learning occurs (Example: Fear that all dogs will bite is changed to most dogs are safe)
- The fear may decrease, but the thought/meaning may return
- Goals of exposures are to 1: Develop new thoughts, 2: Increase use of new thoughts across different settings

Inhibitory Learning Continued

- Therefore, there is fear tolerance not fear extinction or “no anxiety”
- May also introduce “desirable difficulties”
  - Randomly pick exposures vs moving through a fear hierarchy
  - Not using coping skills during exposures
  - May increase learning that anxiety is tolerable vs something to avoid

Exposure with Response Prevention

Assessment & Education	**Identify feared outcome/core fear**
Create a hierarchy for exposures to feared outcome	**Intentionally face the** fears
Do not do safety behaviors/follow the **response prevention plan**	Inhibitory learning --> reduced fear, increased tolerance of distress & uncertainty

Developing a Hierarchy

- List of feared and avoided things, places, situations, feelings, etc. ranked from least distressing to most distressing
- Make sure to include the trigger and core fear when creating a hierarchy item
- Hierarchy items are rated by how they would feel in the absence of rituals or avoidance
- Make the exposure and distress unavoidable
  - No “safe” areas

Example Hierarchy

Core fear: If I interact with marijuana in any form, I'll be contaminated and be irresponsible; I might contaminate others; I'm a bad person

Go into marijuana dispensary: 9/10
Walk around parking lot of marijuana dispensary: 8/10
Sit outside marijuana dispensary with car windows down: 8/10
Use CBD lotion sample at CBD kiosk: 8/10
Go to CBD kiosk at mall and peruse items: 7/10
Hold CBD dog treats in hand: 6/10
Hold bag of CBD dog treats (closed): 5/10
Imaginal scripting around being contaminated by marijuana: 5/10
Watch videos/TV shows/movies about marijuana: 4/10
Write the word marijuana (and nicknames for it): 2/10

Example Hierarchy

Core fear: I'm a bad person

- Throw out old shoes instead of donating them and buy new pair that costs more than $30: 9/10
- Put plastic in trash instead of recycling bin: 8/10
- Start shower and wait 10 mins before going in: 8/10
- Frown at someone on the train: 7/10
- Send email with spelling errors/grammar errors: 7/10
- Therapist buys candy bar for patient with own money and patient throws it away: 6/10
- Express an opinion in group of friends: 6/10
- Leave shopping cart in parking spot: 5/10
- Interrupt someone mid conversation: 5/10

Types of Exposures: In-vivo/Situational

- Intentionally facing fears
- Agreed upon that are intended to be as similar to the fear as possible
- Include situations that are avoided or there are safety behaviors with
- May involve completing sessions out of the office

Types of Exposures: Imaginal

- Scripting exercises
  - Prompts for types of OCD are in “The Mindfulness Workbook for OCD”
- Exposures to intrusive thoughts/images
- Method to explore mental cues/triggers
- The aim is to have exposure to mental events and tolerate these events/that these events are not dangerous

Imaginal Continued

- **Primary Imaginal Exposure**: exposure to intrusive thoughts
- **Secondary Imaginal Exposure:** used with in-vivo exposures to face outcomes that are not able to occur (example: drive around the block and imagine someone being hit by the car)
- **Preliminary Imaginal Exposure:** Used to prep for a in-vivo exposure

Types of Exposures: Interoceptive

- Used when there is a fear of body sensations to decrease misinterpretation of meaning
- Examples:
  - **Emetophobia**: Spinning on a chair, laying with books on the stomach, quickly drinking soda
  - **Somatic/hyper-awareness** OCD: Intentionally focus on a body sensation that is feared, such as swallowing, blinking, breathing
  - **Fear of signs of a panic attack**: Physical exercise to increase heart rate, breathing through a straw to simulate hyperventilating

Response prevention guidelines

- More than telling them to “just stop it”
- New rules for behavior
- 2 kinds of ritual behavior
  - Abnormal/unnecessary (e.g., tapping, counting)
  - Excess of normal behavior (e.g., washing)
- Need to specify what to do and when to do it, not just what not to do
  - Form: *Response Prevention Plan
  - May need to specify “normal” behavior (e.g., washing)

*Anxiety Disorders Center, Saint Louis Behavioral Medicine Institute

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Symptom Management

- OCD tends to focus on the negative/minimize the success; help client recognize success and practice **self-compassion**
- Teach relapse prevention*
  - Identify triggers and vulnerabilities; plan for red flags of a setback**
  - Distinguish setbacks from relapse
  - Agree on plan to address setbacks
- With progress, you can titrate sessions down and eventually just have “booster” and “tune-up” sessions

*Jon and Shala’s Top 10 Tips For Coping with OCD and Relapse Prevention

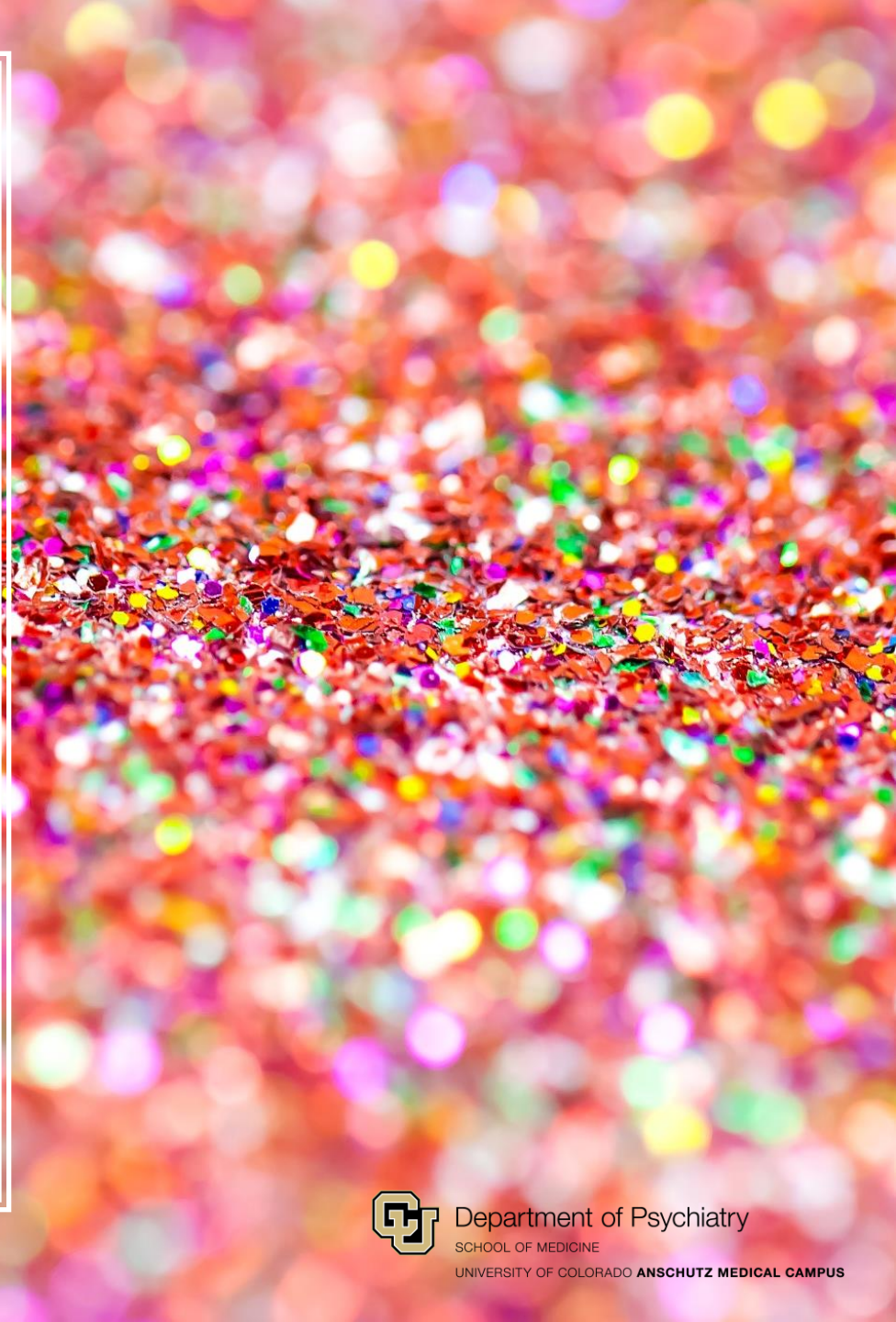
**Grayson, Jonathan. *Freedom from Obsessive Compulsive Disorder: A Personalized Recovery Program for Living with Uncertainty.* Penguin-Putnam. NYC, NY. 2014.

Accommodation

- Actively and directly participating and/or facilitating compulsions or avoidance
- Reinforces the OCD and makes it stronger
- Impairs individual and family functioning
- Only provides temporary relief

Common Accommodations

- Buying supplies for compulsions
- Avoiding using triggering words, watching triggering media, listening to triggering songs, etc.
- Waiting for a loved one to complete a ritual
- Overly assisting in daily activities
- Providing reassurance
- Making decisions for loved ones
- Making changes in routines



ERP SESSION STRUCTURE –CHILDREN

Session 1 – Assessment of OCD and impact on functioning in family, social, individual, school, etc. roles

Session 2 – Feedback and Psychoeducation about OCD and rationale for treatment

Session 3 – Education on accommodation; assessment of current family/caregiver accommodation; plan to reduce accommodation

Session 4 – Review implementation of accommodation strategies; develop behavioral intervention if needed; Review rationale for treatment and create hierarchy (if time)

Session 5 – Review rationale and complete first exposure with response prevention plan (or create hierarchy if needed); prep parents to cope with their own distress

Session 6 & beyond – Complete in-session exposures, modify behavior plans and family accommodation plans as needed

ERP SESSION STRUCTURE –ADULTS

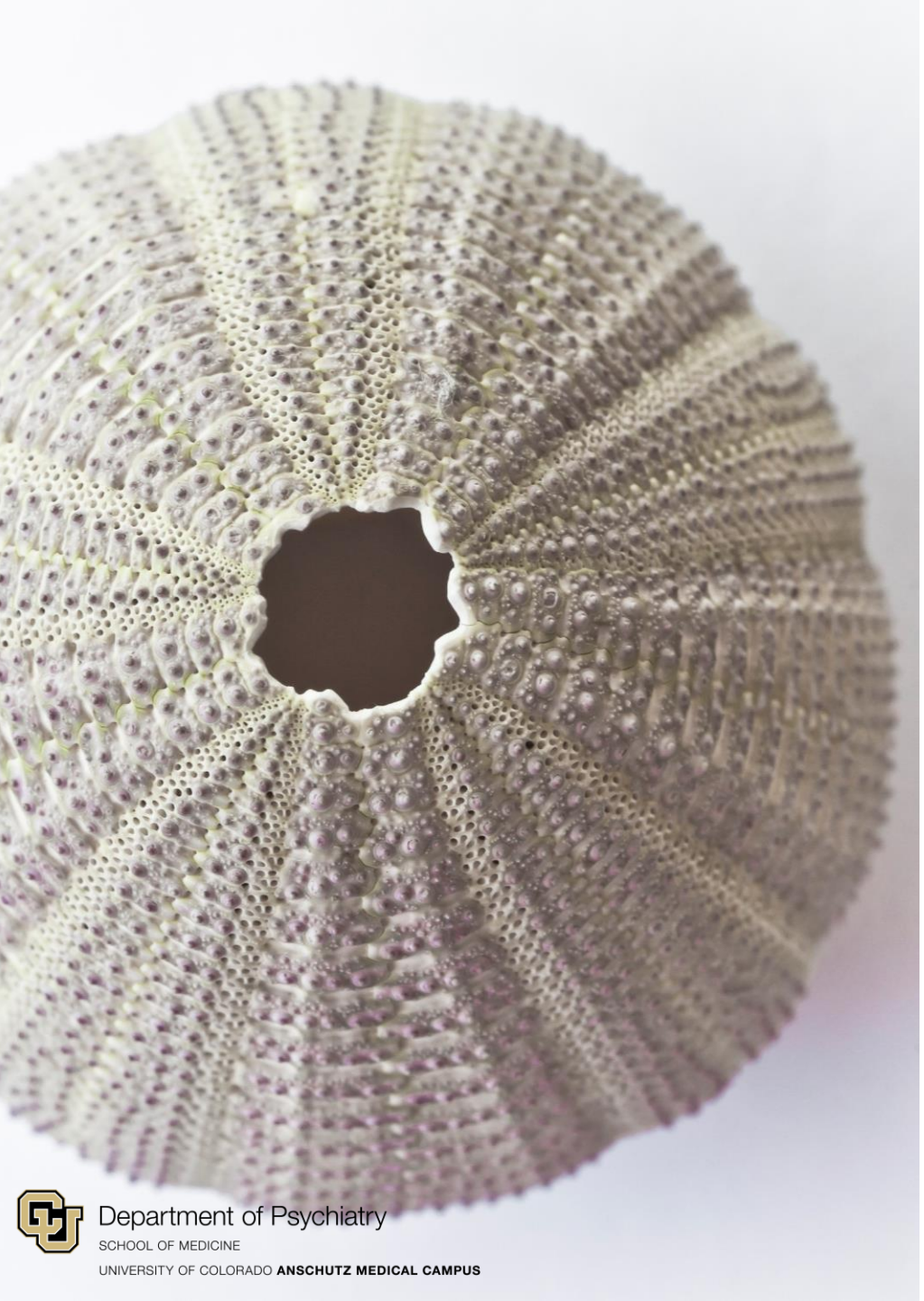
Session 1 – Assessment of OCD and impact on functioning in family, social, individual, work, etc. roles

Session 2 – Feedback and Psychoeducation about OCD and rationale for treatment • **(types of exposures, types of avoidance, compulsions, etc.)**

Session 3 – Education on accommodation; Continued **education on OCD/ERP;** Introduce **"Subjective Units of Distress," Create hierarchy; Discuss** "Response Prevention"

Session 4 – If completed all prior steps, review rationale and complete first **exposure**. Make sure to have a **response prevention plan** to prevent compulsions and "undoing the exposure".

Session 5 & beyond – Complete in-session exposures, review homework and check-in regarding any avoidance or "un-doing" of exposures – if so, help client identify ways to re-engage with distress if they undo an exposure through a mental ritual, self-reassurance, subtle compulsion, etc.



Need for specialized treatment

- ERP vs CBT
- Homework
- Half the patients with OCD who have first line treatment fail to respond
- Further research is needed for suggested treatments

Stein, Costa, Lochner, et al. (2019)

Need for specialized treatment

- ERP is efficacious and specific

- There is hesitancy for clinicians in the community to use exposures

Ponniah, Magiati, & Hollon (2013)


Ethics of ERP

Ethical considerations of ERP

- Some fears with doing exposures
  - Do the ends justify the means
  - Will it generalize
  - Doing something to someone vs with
  - It's rigid/does not consider individual needs
  - It's basically torture

(Olatunji, Deacon, & Abramowitz, 2009)

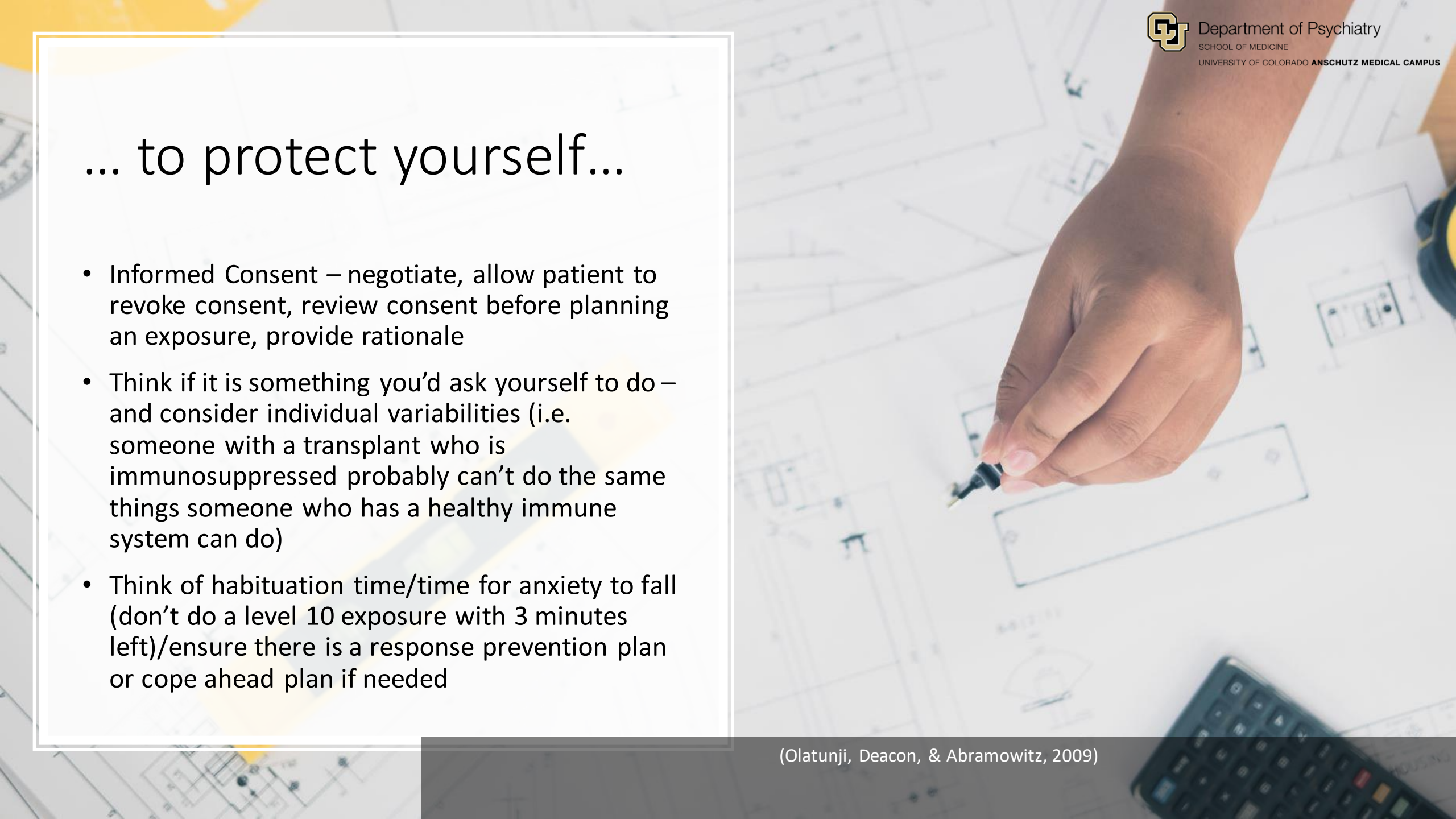
What to do…

- Inform patients that they are likely to have temporary distress, but that it will (hopefully) eventually be beneficial with repeated practice
- Exposure therapy was thought to be effective and relationship-oriented (maybe due to patients not being intimidated by the increase of anxiety being temporary as it is something that is already experienced)
- Review of literature indicates that there are not many (if any) reports or legal action due to exposures
- Of course, to practice, you should be competent in exposure therapy
- It is important to consider your own distress and tolerance for distress – it's not easy watching someone go through the exposure process!

(Olatunji, Deacon, & Abramowitz, 2009)

… to protect yourself…

- Informed Consent – negotiate, allow patient to revoke consent, review consent before planning an exposure, provide rationale
- Think if it is something you'd ask yourself to do – and consider individual variabilities (i.e. someone with a transplant who is immunosuppressed probably can't do the same things someone who has a healthy immune system can do)
- Think of habituation time/time for anxiety to fall (don't do a level 10 exposure with 3 minutes left)/ensure there is a response prevention plan or cope ahead plan if needed



(Olatunji, Deacon, & Abramowitz, 2009)

… and your client

- Sometimes exposures do not go as planned, remind patients it is a test of the feared outcome – is the feared outcome harmless or harmful? Consider risk vs reward
- Potentially crossing boundaries with off site exposures– patients already experience anxiety and F/F/F responses are not inherently dangerous
- Boundary violation with out of office sessions can be mitigated with informed consent

(Olatunji, Deacon, & Abramowitz, 2009)

Risk Management

- ERP can be done in the office AND outside of the office
- Some things to consider:
  - Is the client appropriate for in vivo and outside the office exposures?
  - Is it clinically necessary for this type of exposure to be done?
  - Does my program have any protocols around these types of exposures?
    - Consent form
    - Risk/Waiver
    - Home/environment safety checklist

Criteria for in-vivo/out of office exposures

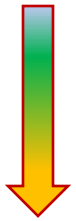
Candidates NOT appropriate for in-vivo (out of office) exposure

- **Actively suicidal/homicidal/self-harming**
- **Active ego-syntonic violent ideations**
- **History of assaultive behaviors**
- **History of repeated anti-social behaviors**
- **Active substance use (intoxicated at time of appointment)**
- **History of risk-taking and impulsive behaviors**
- **Low distress tolerance/emotion regulation**
- **Have never attended in-person sessions at the CU Anschutz OCD Program**
- **Have never participated in any type of exposure therapy**
- **Have issues more pressing than OCD (e.g. eating disorder, substance misuse or abuse, self-harm behaviors, lack of housing, etc.)**
- **Substantial cognitive impairment**

Candidates appropriate for in-vivo (out of office) exposure

- ✓ Attending sessions regularly in-person at the CU Anschutz OCD Program
- ✓ Reasonable distress tolerance/emotion regulation (reasonable enough to remain safe and not engage in maladaptive or dangerous coping strategies)
- ✓ Have demonstrated ability to tolerate exposures in the office setting
- ✓ Sober and refraining from other self-medicating/numbing behaviors
- ✓ Motivated and engaged in treatment
- ✓ Ability to plan for safety if distress/increased anxiety persists at the end of session

ERP Risk Hierarchy

Lower risk	In-office exposures → consider using virtual reality to increase the number of exposures that can be done in-office
	In-building exposures (e.g. bathroom, kitchen)
	On-campus exposures (e.g. campus shuttle, gym)
	Off-site in the community (e.g. bus, nail salon, store)
Higher risk	Off-site in a patient's home/driving or riding with a patient

Our Program

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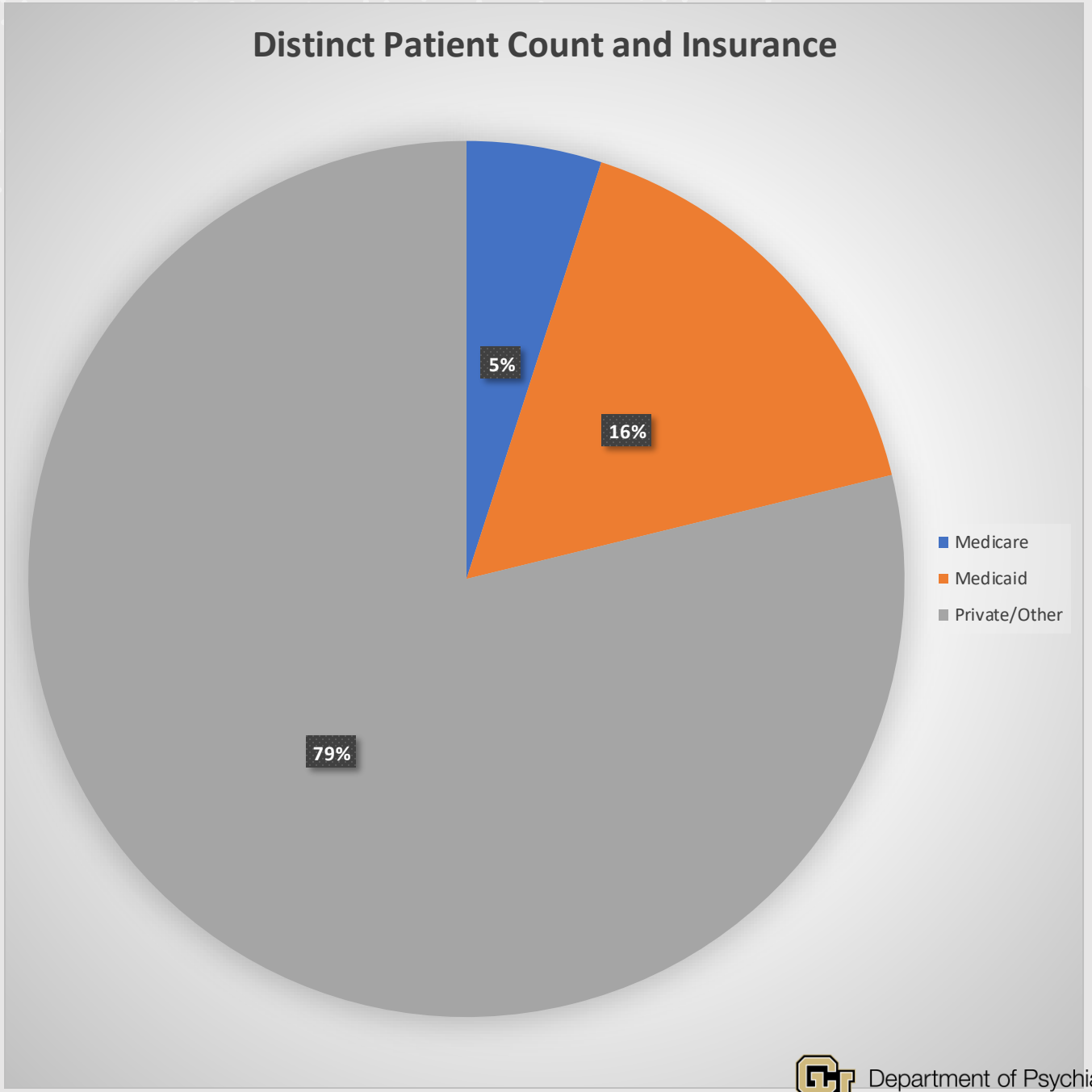
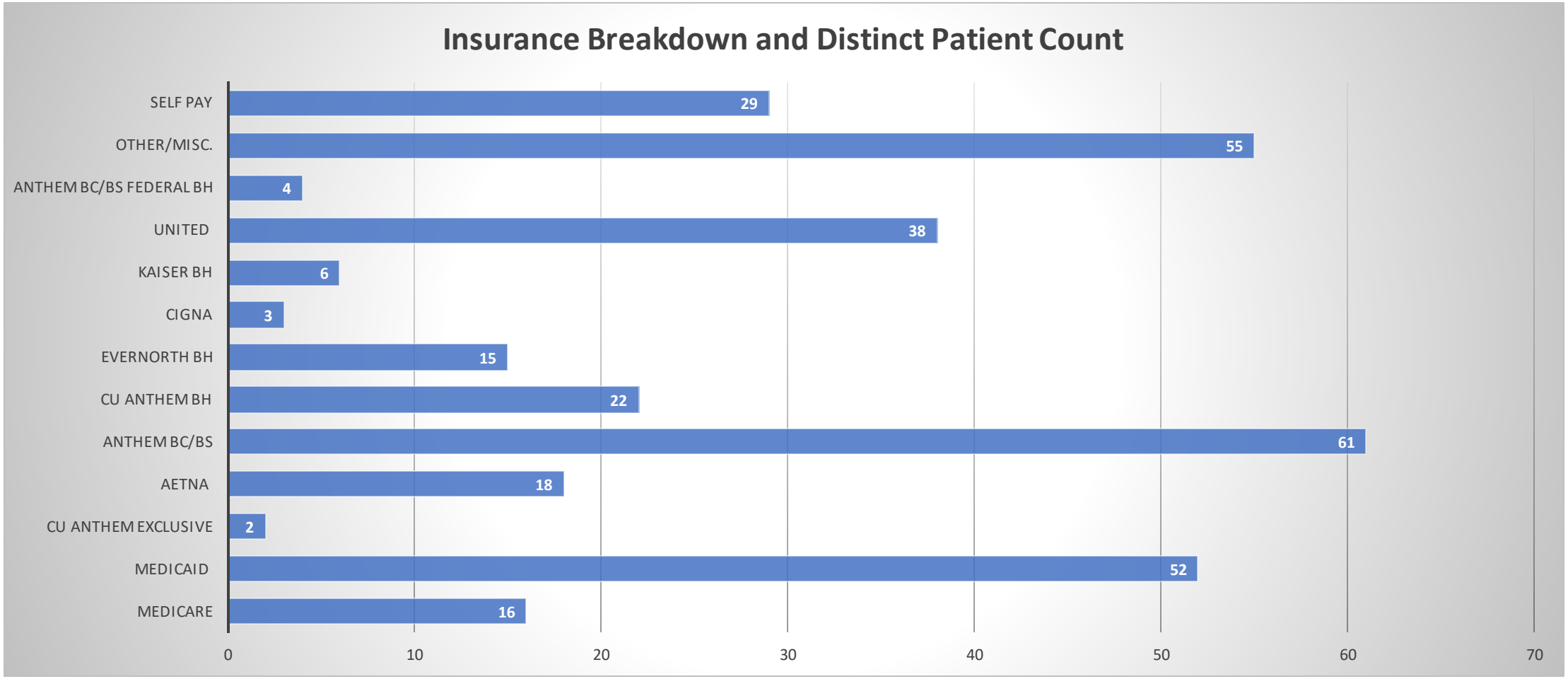
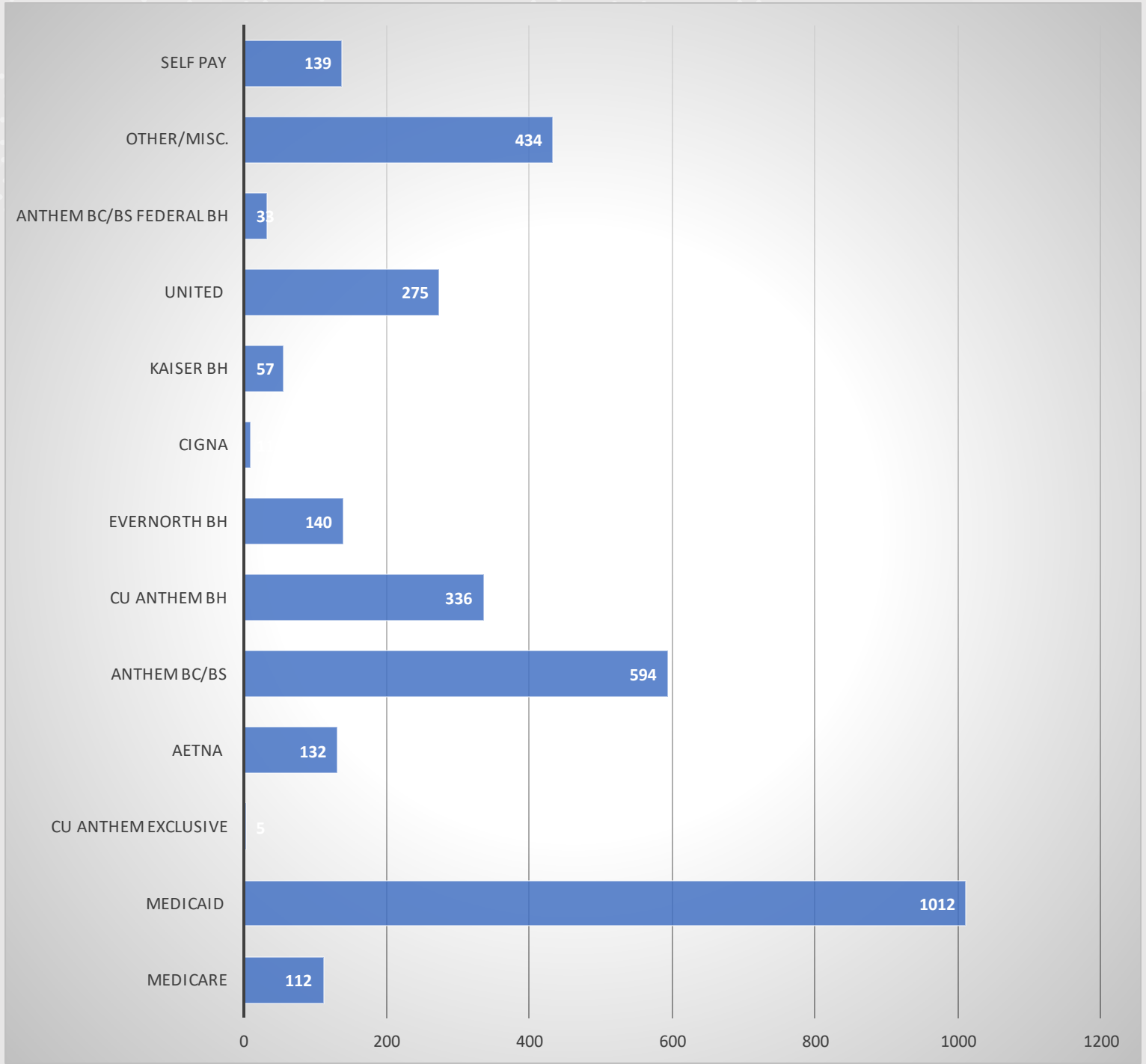
Distinct Patient Count and Insurance



Distinct Patient Count Insurance Breakdown



Number of Visits by Insurance



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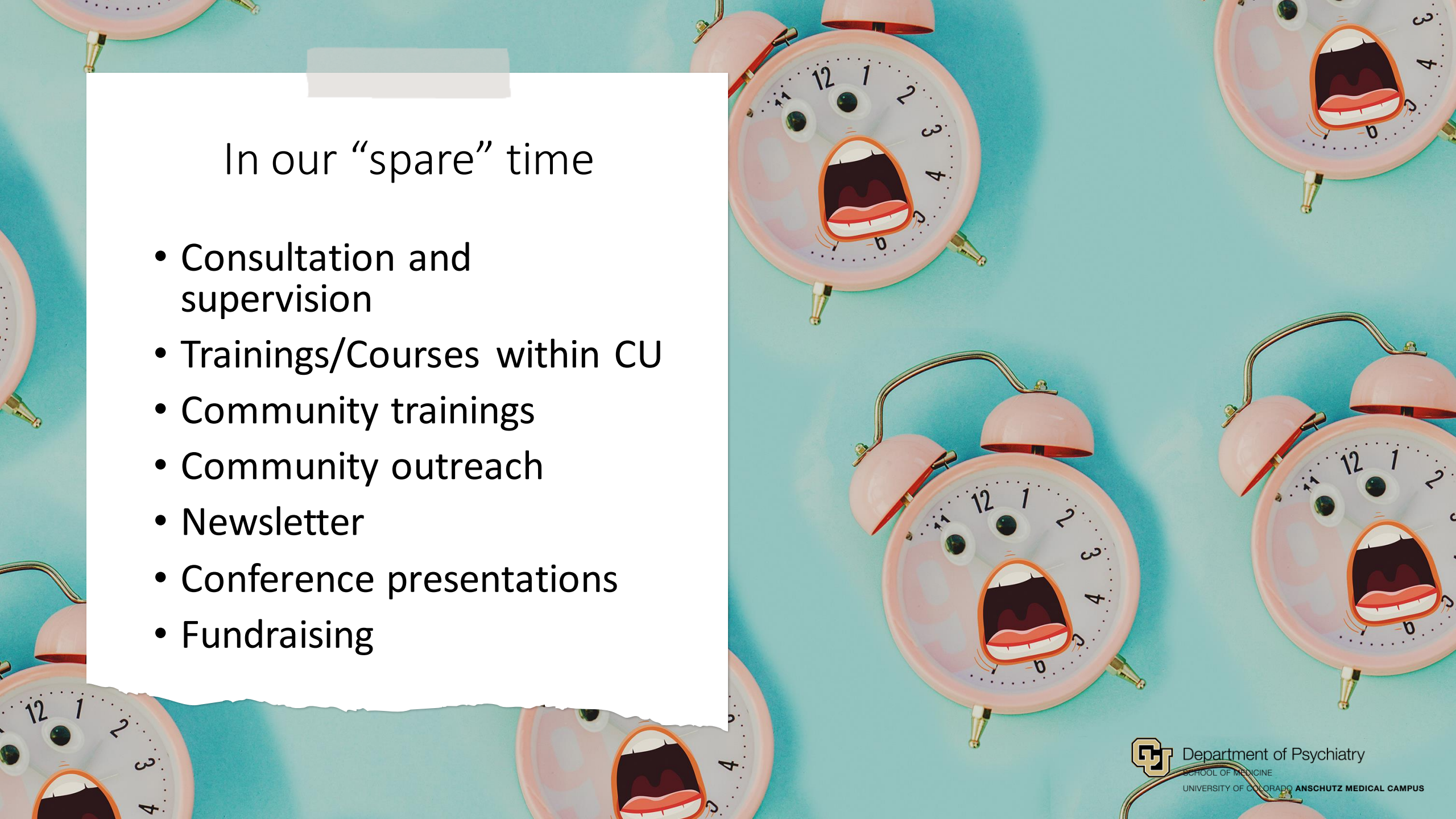
In our “spare” time

- Consultation and supervision
- Trainings/Courses within CU
- Community trainings
- Community outreach
- Newsletter
- Conference presentations
- Fundraising

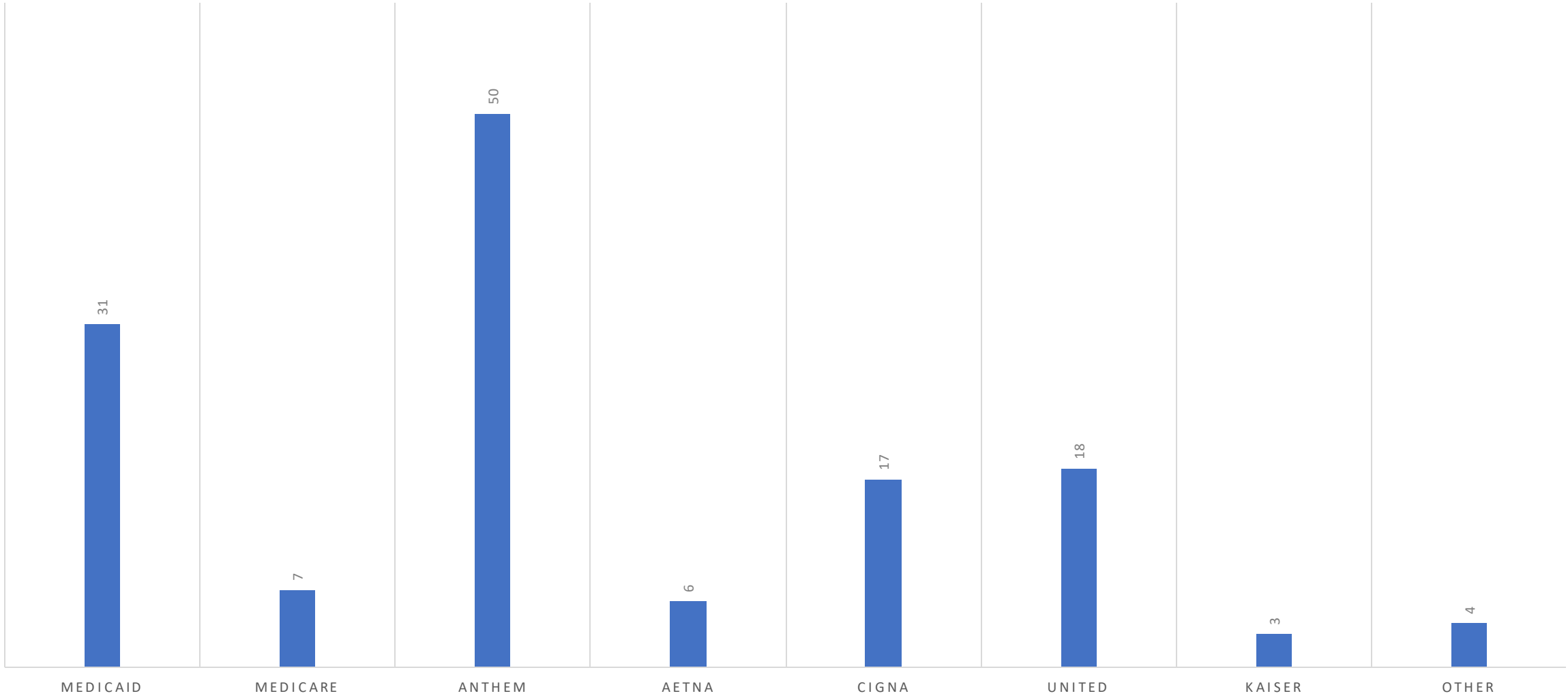


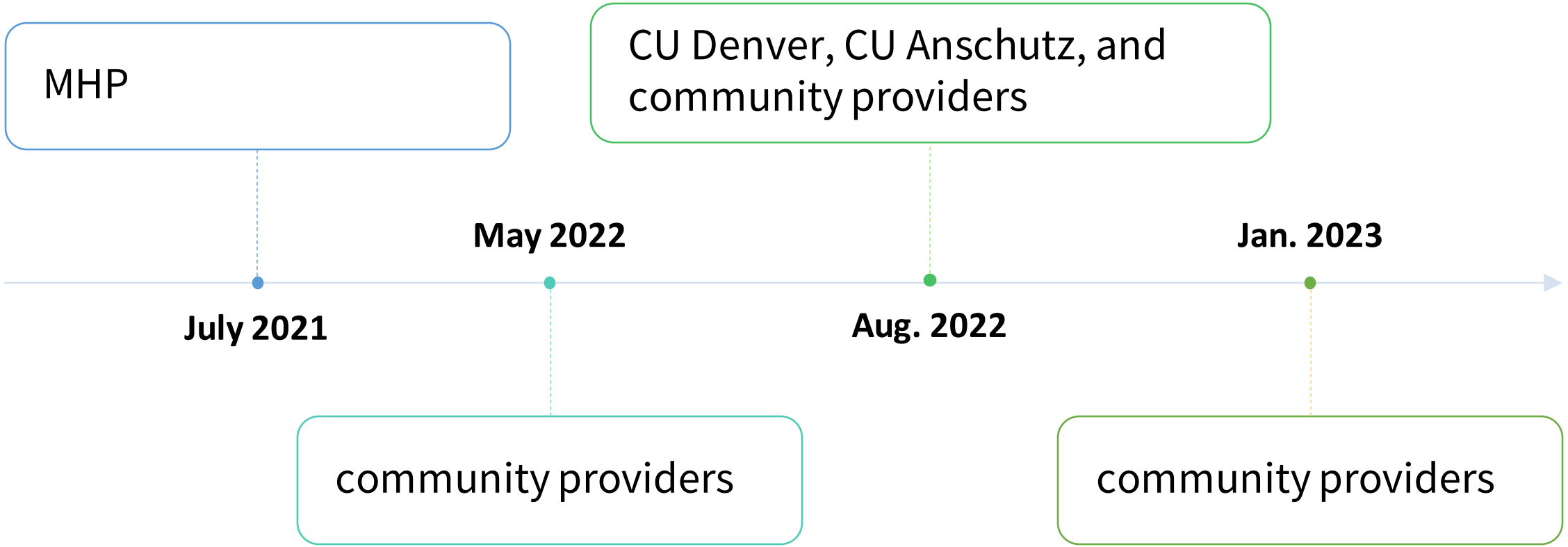
Month/Year	Number of referrals
Jan-21	7
Feb-21	5
Mar-21	5
Apr-21	8
May-21	8
Jun-21	18
Jul-21	15
Aug-21	12
Sep-21	8
Oct-21	13
Nov-21	8
Dec-21	7
Total for 2021	114

Month/Year	Number of referrals
Jan-22	8
Feb-22	5
Mar-22	16
Apr-22	12
May-22	8
Jun-22	10
Jul-22	6
Aug-22	12
Sep-22	8
Oct-22	4
Nov-22	8
Dec-22	11
Total for 2022	108

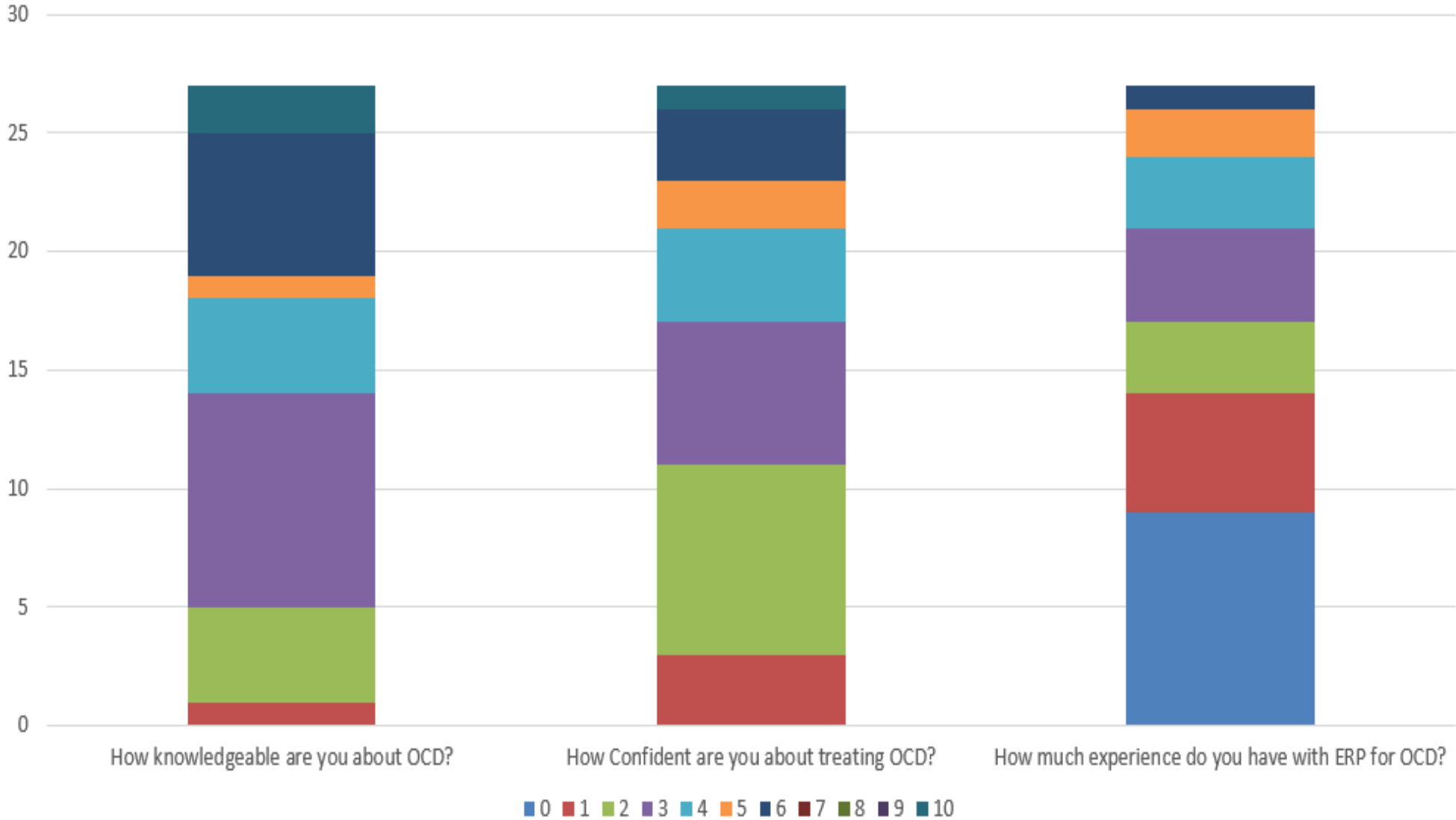
Month/Year	Number of referrals
Jan-23	10
Feb-23	17
Mar-23	17
Apr-23	14
May-23	20
Jun-23	20
Jul-23	11
Aug-23	6
Sep-23	
Oct-23	
Nov-23	
Dec-23	

WAITLIST INSURANCE NUMBERS
TOTAL = 136




MHP
CU Denver, CU Anschutz, and community providers
May 2022
Jan. 2023
July 2021
Aug. 2022
community providers
community providers

Mental Health Partners 2021 Pre-test



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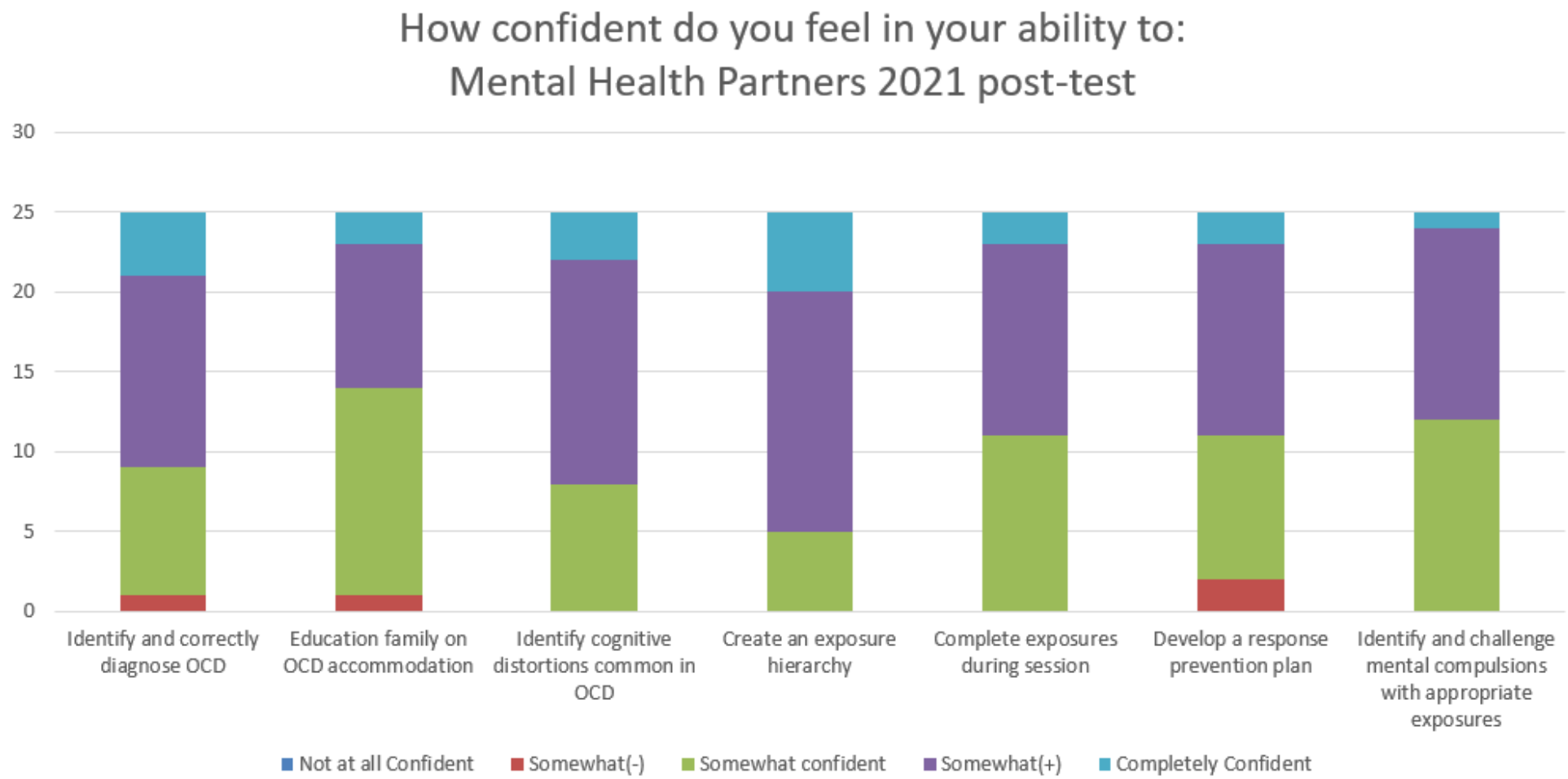
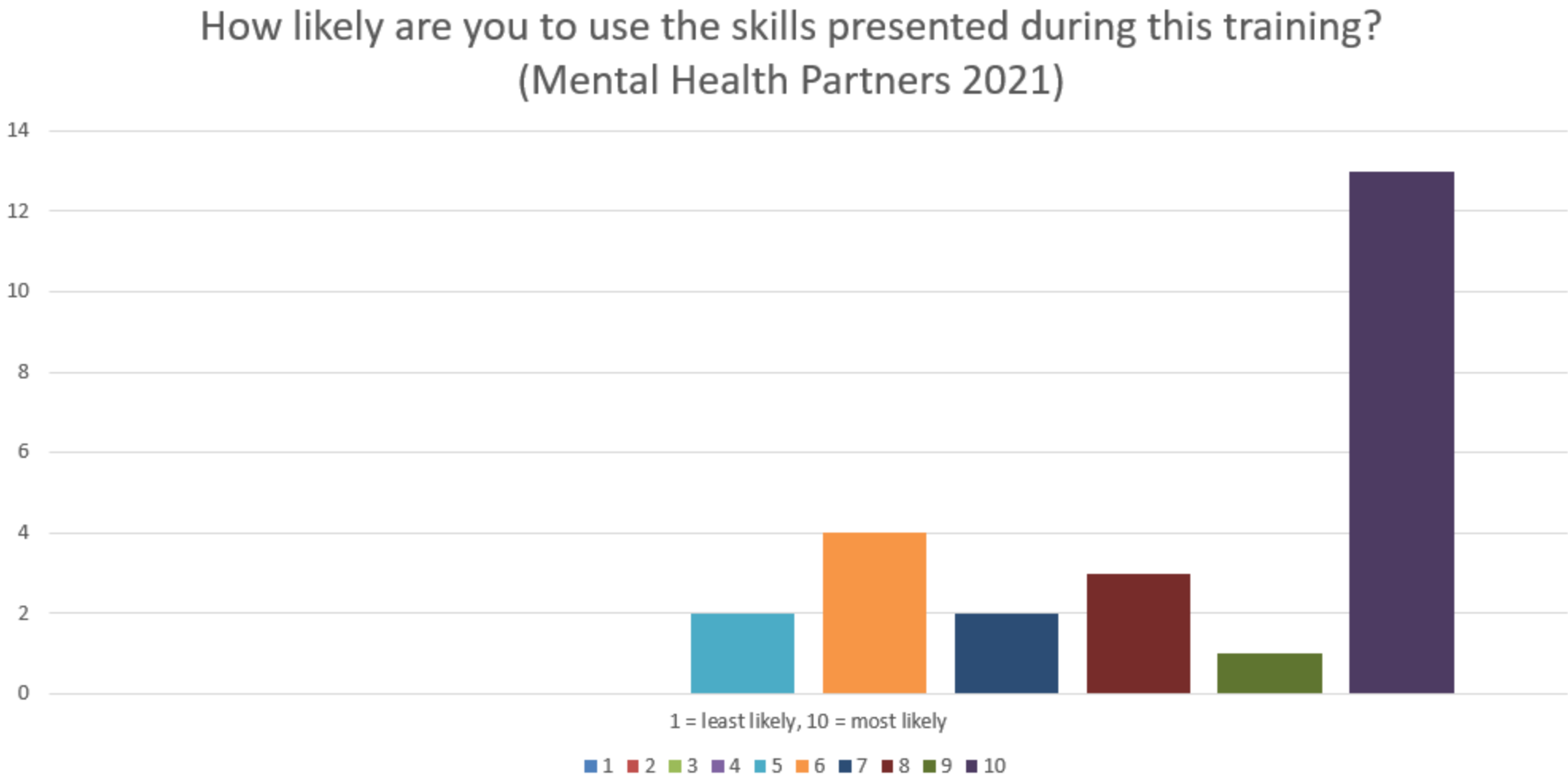
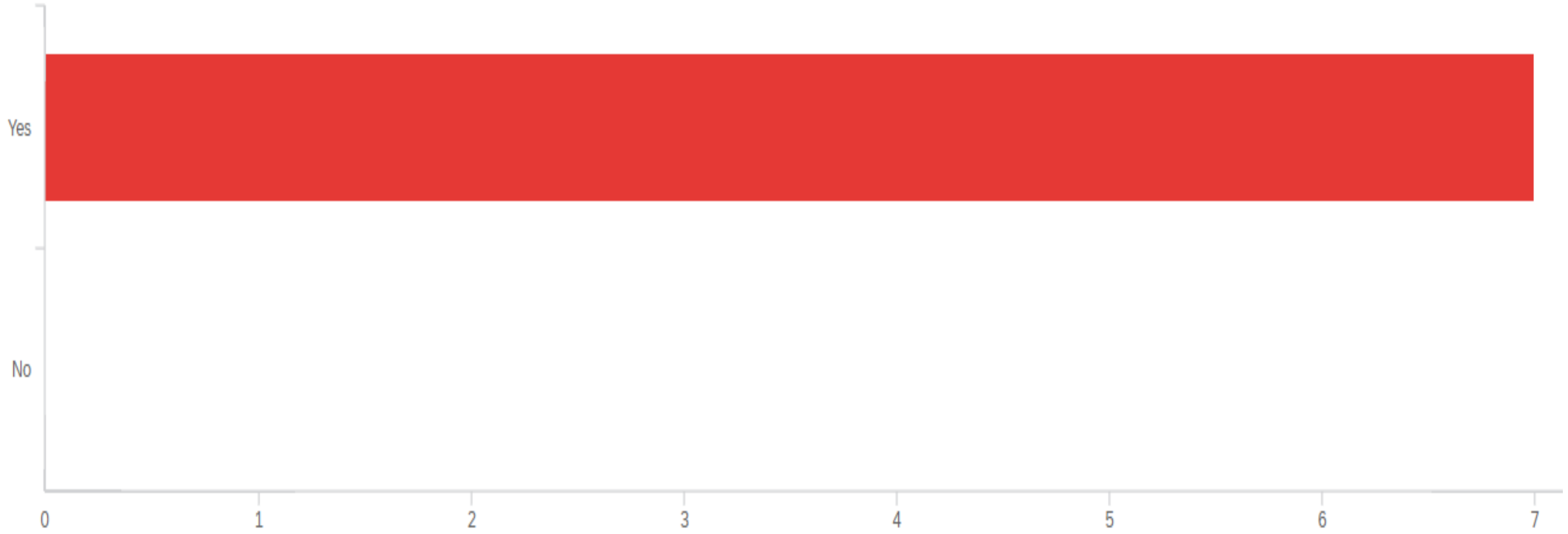

How confident do you feel in your ability to:
Mental Health Partners 2021 post-test
30
25
20
15
10
5
0
Identify and correctly diagnose OCD
Education family on OCD accommodation
Identify cognitive distortions common in OCD
Create an exposure hierarchy
Complete exposures during session
Develop a response prevention plan
Identify and challenge mental compulsions with appropriate exposures
Not at all Confident
Somewhat(-)
Somewhat confident
Somewhat(+)
Completely Confident


How likely are you to use the skills presented during this training?
(Mental Health Partners 2021)
14
12
10
8
6
4
2
0
1 = least likely, 10 = most likely
1 2 3 4 5 6 7 8 9 10

Have you used the skills learned in the Anxiety and OCD training?



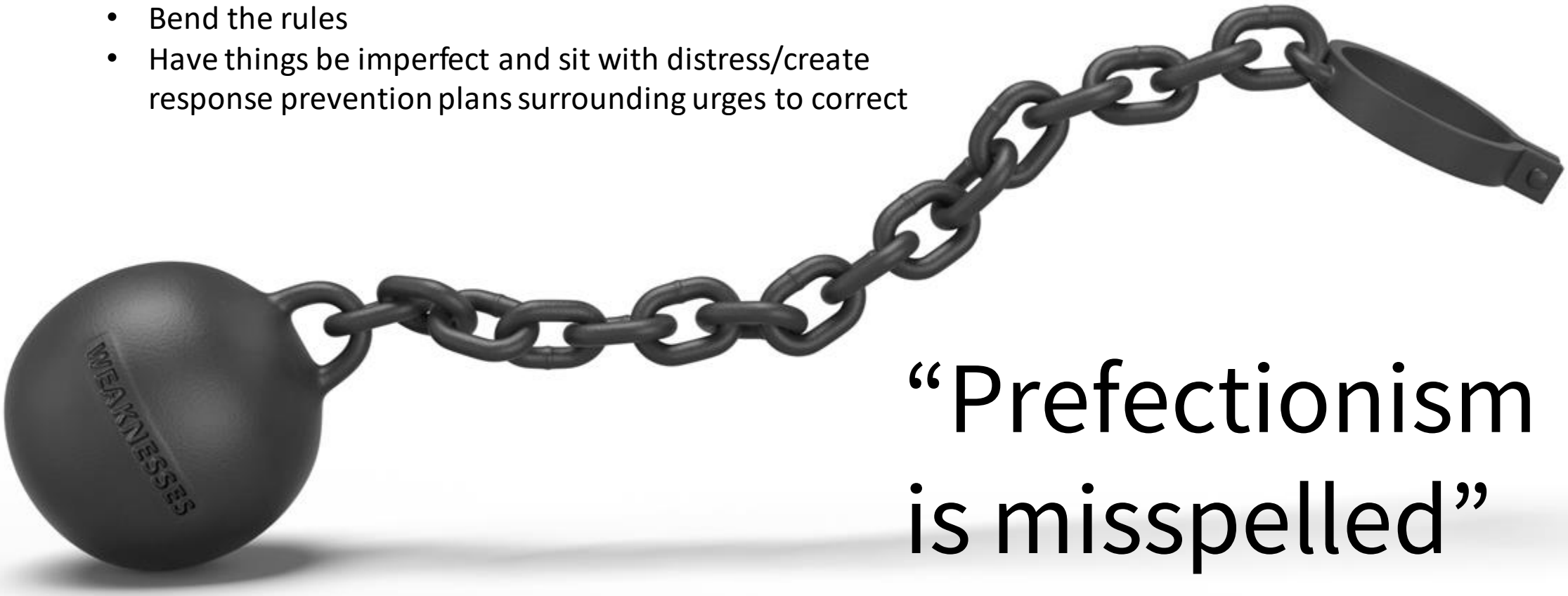
What barriers have you encountered in using ERP?

- Translating in Spanish
- Whether the client is seen in person or virtually
- Understanding and literacy of mental health in the family system
- Certain intrusions and being sure if they are OCD, or related to something else, puberty, ASD, etc.
- Keeping to the hierarchy
- The type of therapy my agency provides is short term

What challenges do you face when treating patients with OCD?

- Motivation to do the final exposures
- Translating in Spanish
- The type of therapy provided at my agency is short term
- If they do not have a support person in their life then it makes it harder to successfully treat

- Applying a rigid set of rules that cannot be bent or modified
- Treatment
  - practice flexibility
  - Bend the rules
  - Have things be imperfect and sit with distress/create response prevention plans surrounding urges to correct



"Prefectionism is misspelled"

Prefectionism

Future of Our Program

Coming Soon!

OCD and Anxiety Intensive Outpatient

Mondays, Tuesdays, and Thursdays

8:30am-12pm

Accepting Aetna, Anthem, Cigna, and Colorado ACCESS Medicaid

For inclusion/exclusion criteria or questions, reach out to Emily Emily.Hemendinger@CUAnschutz.edu

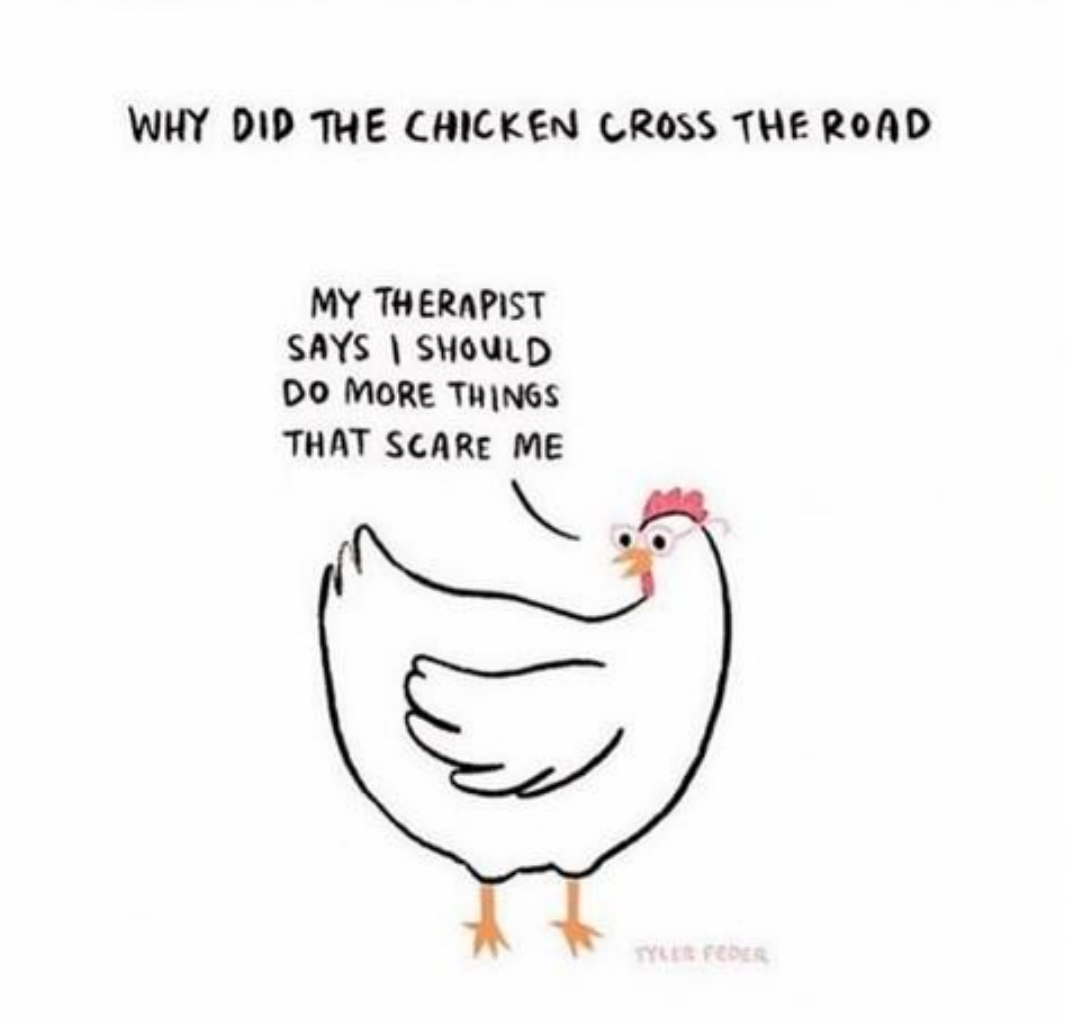
CU Anschutz OCD Program Presents

EXPOSURE PALOOZA

10-29-23

Join us to experience fun and spooky OCD exposure activities, lots of prizes, and hear our guest speakers, Rev. Katie O'Dunne, Dr. Moksha Patel, and our OCD Program Medical Director, Dr. Rachel Davis, share their own experiences living with OCD.

REGISTER HERE!


WHY DID THE CHICKEN CROSS THE ROAD
MY THERAPIST SAYS I SHOULD DO MORE THINGS THAT SCARE ME
TYLER FEDER

BRAIN HEALTH for all, for life.

Department of Psychiatry
SCHOOL OF MEDICINE
UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

Thank you!

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