OCD SUBTYPES IN YOUTH

Understanding Lesser-Known OCD Presentations in Children & Adolescents

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OH, HI THERE.
DIDN'T SEE YOU COME IN.
I'M MICHAEL BLUMBERG.

HERE'S A LITTLE BIT ABOUT ME:

- I am the founder and director of Glenview Counseling Group, a multidisciplinary psychotherapy group in Glenview, IL
- I have been treating OCD and related disorder for 10+ years and trained with the IOCDF's Behavioral Therapy Training Institute
- I currently run a support group for family members of people with OCD as well as a consultation group for OCD-informed therapists in the Chicago suburbs. I am also a founding member of OCD Midwest, a subsidiary of IOCDF and a founding member of the Chicagoland Hoarding Task Force.
- My typical caseload is almost exclusively OCD, OC-Spectrum Disorders and Anxiety Disorders
- I like to fish, play guitar and tennis and I'm a heck of a dancer

LEARNING OBJECTIVES

At the conclusion of this presentation you will be able to:

- Learn to identify OCD in children & adolescents, especially lesser-known subtypes
- Understand evidence-based treatment options for OCD
- Know when to treat, consult or refer clients with OCD

OCD is a quest for certainty that does not, and will not, ever exist

OBSESSIONS

- An obsession is an intrusive and unwanted thought
- An obsession can come in the form a thought (e.g., a sentence or a question), an image, a memory, or even what feels like an involuntary impulse/urge
- Everyone experiences intrusive thoughts, simply because we do not have complete control over our brains all the time
- For the person with OCD, the obsession is interpreted as a threat, and therefore causes anxiety and/or disgust, distress, and discomfort

COMPULSIONS

- A compulsion is any act—physical or mental—that the person engages in in an effort to alleviate anxiety and discomfort

- Individuals with OCD come to believe that compulsions are necessary to try and "get rid of" unwanted thoughts and images, and any associated uncomfortable feelings

- Compulsions may provide temporary relief but are not a long-term solution

- The process of performing compulsions usually produces anxiety as well

THE D IS FOR DISORDER

- Causes significant emotional and/or behavioral distress
- Interferes with ability to function one or more aspect of a person's life
- The "Disorder" part is equally important in making a diagnosis of OCD

INSIGHT

- People with OCD typically, but not always, have good insight into the irrationality of their obsessions but are compelled to perform compulsions nonetheless
- It is important diagnostically to understand a child's insight, which can be done by asking questions about likelihood of feared outcomes
- It's normal to overestimate the likelihood of a feared outcome, but the client may still understand the futility of performing a compulsion
- Children who say that they fully believe that stepping on a crack will break their mother's back should carefully interviewed to determine if this is age-appropriate misunderstanding of cause and effect, general poor insight or something else entirely

DIAGNOSING

- Diagnosing OCD in children should start with the CHILDREN'S YALE-BROWN OBSESSIVE COMPULSIVE SCALE (CY-BOCS) and in adolescents over the age of 14 with the Y-BOCS.

- A combination of symptom inventory and severity scales that allow the clinician to determine if OCD is indicated and, if so, what subtypes and at what severity.

- This will help you formulate a good treatment plan and also allow you to re-administer periodically during treatment to monitor progress.

WELL-KNOWN SUBTYPES

- Contamination/Cleaning
- Ordering/Arranging/ Symmetry

WELL-KNOWN SUBTYPES

Contamination/Cleaning

Marked by obsessions regarding contamination, including, but not limited to:

- Germs & dirt (flu, bolidy fluids, etc)
- Cleaners & solvents (bleach, ammonia, etc)
- Biohazards or hazardous materials (asbestos, radiation, etc)
- Animals (house pets, insects, etc)
- Emotions (people & places)
- Anything else to which exposure may be perceived as potentially dangerous

WELL-KNOWN SUBTYPES

Contamination/Cleaning

Marked by compulsions regarding cleaning or washing, including, but not limited to:

- Excessive or ritualized hand-sanitizing, hand-washing, bathing, grooming or toilet routines
- Excessive cleaning of everyday items
- Other measures taken to prevent or remove contact with contaminants

WELL-KNOWN SUBTYPES

Ordering/Arranging/Symmetry

Marked by obsessions and compulsions regarding neatness, symmetry and exactness such as:

- Excessive or ritualized list-making
- Excessive need for neatness, orderliness or precision
- Excessive need to have even and bilateral touching, rubbing, or other tactile stimuli
- May or may not include magical thinking

LESSER-KNOWN SUBTYPES

- Pure "O" OCD
- Harm/Checking OCD
- Sensorimotor OCD
- Severe Onset (PANDAS/PANS)

PURE "O"

- Stands for Purely Obsessional, a misnomer
- Intrusive, disturbing thoughts, images or sounds without an ***overt*** set of compulsions
- Covert compulsions may include counting, praying, sensation scanning and avoidance*

HARM OCD

- Obsessions are characterized by intrusive, unwanted thoughts regarding harming others or oneself
- Compulsions are characterized by excessive checking, repeating and other measures to make sure that the child has not, or will not, cause harm.
- Can be past, present or future harm

HARM OCD

- Obsessions regarding past harm ask "what if I did.." and are followed by compulsions to make sure that the feared harm either didn't happen or that it did not cause serious damage.
- Obsession Example: What if I hit my head so hard last week that I caused my brain to bleed?
- Compulsion Example: Asking to go to doctor, asking parents if I'm OK, staring at my head to check for signs of damage, etc.

HARM OCD

- Obsessions regarding present or future harm ask "what if I will lose control and…" and are followed by compulsions to make sure that the feared harm will not happen
- Obsession Example: What if I lose control and push my baby sister down the stairs
- Compulsion Example: Avoiding being around sister, avoiding "dangerous" objects, etc

HARM OCD

- Sometimes obsessions include magical thinking and so the accompanying compulsions seem unrelated
- This is best summed up by the "step on a crack, break your mother's back" adage
- These compulsions can also appear in non-harm OCD
- The thought of harm should cause distress and not pleasure. It should be upsetting and not fantastical.

SENSORIMOTOR OCD

- Obsessions revolve around the automatic functioning of the body becoming conscious
- Includes breathing, blinking, swallowing, falling asleep* and others
- Little research regarding this subtype and most information is based on clinical observation and reporting

SENSORIMOTOR OCD

- Compulsions center around checking for bodily sensations
- Distraction is often attempted and failed as a means to stop these obsessions

PANDAS

- Pediatric Autoimmune Neuropsychiatric Disorder Associated with Strep
- Severe and sudden onset of OCD symptoms, typically in children ages 3-14, with average age of onset roughly 5-6
- Typically symptoms start at the same time a Strep

PANS

- Pediatric Acute-Onset Neuropsychiatric Syndrome
- Same symptoms as PANDAS, although likely triggered by a disease other than Strep
- Doctors should test for mycoplasma, mono, or exposure to Lyme disease

PANDAS / PANS

- Only form of OCD that does not rely SOLELY on behavioral health interventions as the FIRST line of defense
- Limited research has shown that IVIGs (intravenous immunoglobin) and antibiotics have been extremely helpful in treating this disorder
- Traditional OCD treatments, such as Exposure & Response Prevention (ERP) are also indicated

EVIDENCE-BASED TREATMENT METHODS FOR OCD

Cognitive-Behavioral Therapy (CBT)
Exposure & Response Prevention (ERP)
Acceptance & Commitment Therapy (ACT)
Mindfulness-Based Cognitive Therapy (MBCT)
Dialectical Behavioral Therapy (DBT)
Therapists Sure Love Acronyms (TSLA)

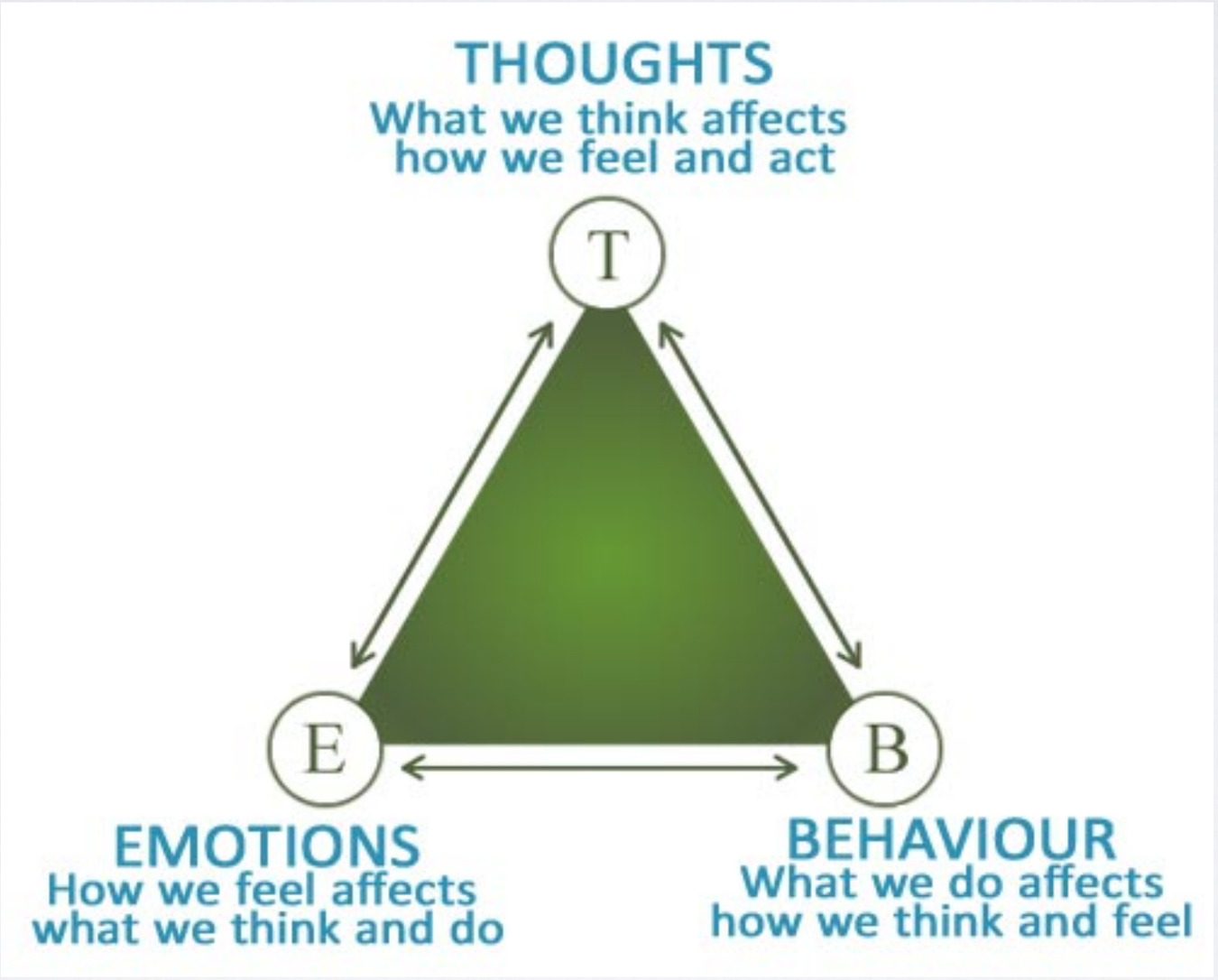
EVIDENCE-BASED TREATMENT METHODS FOR OCD

We will focus on the use of ERP (in the CBT family) to treat OCD, as this is the "gold standard" and first line of defense in it's treatment. I wanted to mention the other treatments as they are evidence-based and are often used either as adjunct therapies or independently if clinically indicated.

COGNITIVE BEHAVIORAL THERAPY

- Understanding how Thoughts, Feelings, and Behaviors ("The Cognitive Triangle") continually influence one another
- By changing the way we think and stopping unnecessary (and unhealthy) behaviors, we can lessen the intensity of unpleasant feelings

COGNITIVE BEHAVIORAL THERAPY



"I might have an intrusive image stuck in my head"

If true, then what?

"I won't ever be able to get rid of it"

If true, then what?

"It'll keep coming up and drive me crazy"

If true, then what?

"I won't be able to do school, hang out with friends, or manage my life in any way"

If true, then what?

"I will feel lonely, sad, and lost for the rest of my life"

COGNITIVE-BEHAVIORAL THERAPY

- So, what your saying to me is that the next time you have an intrusive image you'll end up lonely, sad and lost for the rest of your life. Is that right?

- It is hopeful that the child will gain some insight into ways in which his or her thoughts get out of control and may be unrealistic.

COGNITIVE-BEHAVIORAL THERAPY

- Understand the anxious child's tendency to overestimate the likelihood of feared events.

- This is because anxiety causes the mind to equate the word **possible** with the word **probable**. It may be possible for an elephant to walk in here right now, but it is highly improbable.

COGNITIVE-BEHAVIORAL THERAPY

- It's Not That Easy…

- Unfortunately, that's usually not enough to stop the fear cycle, and it certainly isn't as easy as that.

- Children with anxious thoughts often know that the thoughts are irrational, but still allow the fear drive them to compulsions and to stop them from engaging in their lives because of the remote possibility that the feared event might happen.

- That's why we have to use a combination of techniques to fight the anxiety, including helping the children face their fears.

EXPOSURE & RESPONSE PREVENTION (ERP)

- ERP falls under the umbrella of CBT, meaning it's rooted in how thoughts, feelings and behaviors influence one another.

- It focuses on the making changes from the behavioral side of the CBT triangle.

- Very basically, we make a list of feared events and turn them into a hierarchy using a self-anchored scale based on the level of distress each of them cause called the Subjective Units of Distress Scale, or SUDS.

EXPOSURE & RESPONSE PREVENTION (ERP)

- We then determine which of these feared events our client would like to start exposing him- or herself to based on his or her willingness to tolerate the distress.

- We use this experience to demonstrate to the client that it was tolerable, and that the feared outcome that he or she thought would happen did not happen.

EXPOSURE & RESPONSE PREVENTION (ERP)

- Since evidence-based treatments are based in research, we sometimes change the way we do our work.

- Recent research has caused ERP practitioners to make a slight change in how we practice. The purpose of exposure used to be something called habituation, a decrease in distress in the presence of an OCD trigger measured by SUDS. Habituation was a sign that the treatment was working.

- We no longer measure habituation in real time, as it is not necessary to the process of new learning. It still often occurs in treatment, but is no longer NEEDED for ERP to be effective.

WHY IS THAT BAD?

That feeling of relief does not last. It's a very short fix to a long-term problem.

Even if that feeling did last for more than a few seconds, it still limits your ability to interact freely with other men in the workplace, at home and in social situations.

OCD symptoms tend to be degenerative, often morphing into other similar, related symptoms.

Example: Avoidance of sister when around stairs > Avoidance of sister when around other potential harmful situations > Avoidance of sister in general > Avoidance others around stairs > etc.

Changing Your Thinking

Previous Thinking

I have to avoid any and all of the situations that cause anxiety, because if I confront them I will panic and will not be able to handle my thoughts, feelings or behavior.

New Learning

Over time, when I expose myself to the situation that causes anxiety and do not retreat my anxiety lessens.

EXPOSURE & RESPONSE PREVENTION

- Since negative experiences generalize very quickly and positive experiences generalize very slowly, it is imperative that ERP be practiced at between sessions.

- If at all possible, parents should be taught to be involved in ERP when the child is at home. ERP that is not practiced between sessions is typically ineffective and, in fact, may be harmful.*

PARENT EDUCATION

- It is common, and understandable, that parents engage in behaviors that accommodate their children in order to alleviate their anxiety.
- These accommodations can be performing rituals with/for their children, changing the household to decrease symptoms, etc.
- Parents should be educated about the adverse effects of accommodation and taught how to help their children learn adaptive skills.
- The differences between HELPING and RESCUING are sometimes difficult to understand.

HELPING VS. RESCUING

Helping

Promotes guidance into self-sufficiency.

Allows the child to learn from mistakes and missteps.

Is modeled by calm and measured behavior.

Rescuing

Promotes inadequacy and co-dependence.

Promotes the idea that mistakes are intolerable.

Comes from the rescuer's own anxiety, thereby modeling poor frustration tolerance.

WHEN TO TREAT, CONSULT OR REFER A CLIENT WITH OCD

- Every clinician who specializes in the treatment of OCD started with no experience, and experience can only be gained by practicing.

- If you have a child who is presenting with OCD symptoms and you would like to treat him or her, the first step would be to explain to the family that you are not a specialist in treatment of OCD but are willing conduct the CY-BOCS to confirm a diagnosis and better understand the severity if diagnosis is indicated.

- You should start by treating client who present with LOW to MODERATE levels of OCD and with consultation by colleagues who have treated OCD.

WHEN TO TREAT, CONSULT OR REFER A CLIENT WITH OCD

- If you refer to an outside provider, please be sure that you are referring to someone with experience in treating OCD.
- There is a need for OCD treatment providers, especially in far suburban and rural parts of the Chicagoland area.
- If you decide that you would like to regularly work with this population, you should seek more in-depth training, such as the BTTI and Mass General.
- There are also consultation groups and shorter trainings as well.

RECOMMENDED READING

General Knowledge

- The Boy Who Couldn't Stop Washing by Judith L. Rapoport
- Getting Control by Lee Baer
- The Imp of the Mind by Lee Bear
- The OCD Answer Book by Patrick B. McGrath
- Brain Lock by Jeffrey Schwartz & Beverly Beyette

Youth-Specific

- What to do When Your Brain Gets Stuck: A Kid's Guide to Overcoming OCD by Dawn Huebner
- You Do That Too? Adolescents and OCD by Jose Arturo and Rena Benson
- Touch and Go Joe: An Adolescent's Experience of OCD by Joe Wells

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