Treatment Centers

EVOLVE™

Mental Health & Substance Abuse Treatment for Teens

Financial Disclosures

Dr. Shikha Verma does not, nor does her family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation.

SOURCE	EMPLOYEE	HONORARIUM	TRAVEL EXPENSES
Evolve Treatment Center	x		

Who We Treat

Adolescents 12 to 17 years old struggling with mental health, substance abuse and/or behavioral issues.

- Anxiety
- Depression
- Suicidality
- Psychosis
- Non-Suicidal Self-Injury (NSSI)
- Borderline Personality Disorder
- Substance Abuse / Dual Diagnosis
- Behavioral Disorders

Continuum of Care

Our admissions team is skilled in helping families and providers determine what level of care is appropriate for each teen.

- Residential Treatment Center **(RTC)**
- Partial Hospitalization Program **(PHP)**
- Intensive Outpatient Program **(IOP)**

Our Therapeutic Approach

- **Dialectical Behavioral Therapy (DBT)**
- **Cognitive Behavioral Therapy (CBT)**
- **Group Therapy**

  (Behavioral Activation, Seeking Safety, Relapse Prevention, 12-step...etc)
- **Structural Family Therapy**
- **Experiential Therapy**

Evolve's Residential Model

- 24-hour support and supervision
- Length of stay 30-60 days
- 6 clients per home
- Co-ed
- Individual Therapy 3x weekly
- Family Therapy 2x weekly
- Psychiatric Consultation 1x weekly
- Group Therapy and Psychoeducation 4x daily
- School Time 2 hours daily (Monday – Friday)
- 3:1 client to therapist caseload
- Ability to offer 1:1 patient monitoring if needed
- Onsite nursing 8+ hours daily

Evolve's Outpatient Model

Partial Hospitalization Program (PHP)

- Full day of programming, five days a week
  - Individual therapy sessions 2x weekly,
  - Family therapy session 1x weekly
  - Psychiatry session 1x weekly
  - Group Therapy and Psychoeducation daily
  - Academic support

Intensive Outpatient Program (IOP)

- Minimum of three hours of programming three to four days a week, depending on the needs of the teen and family
  - Individual therapy sessions 1x weekly,
  - Family therapy session 1x weekly
  - Psychiatry session 1x weekly
  - Group Therapy and Psychoeducation daily

Exposure-Based Treatment for Anxiety Disorders and Obsessive-Compulsive Disorder

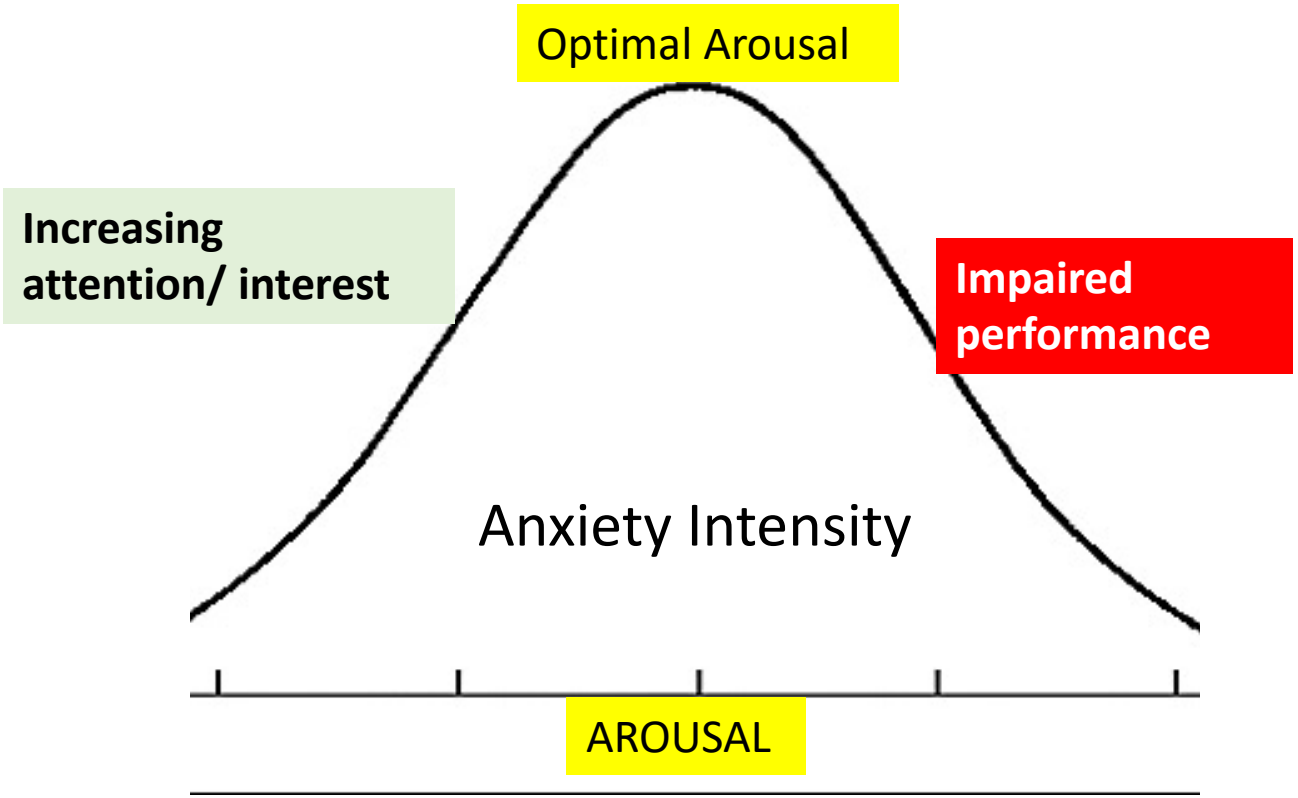
Shikha Verma, MD
Medical Director
Evolve Treatment Centers

Objectives

- Describe common presentations of Obsessive-Compulsive Disorders (OCD) and anxiety disorders.
- Compare assessment tools used for identifying severity/ functional impairment due to OCD/ anxiety disorders.
- Discuss evidence-based treatments for OCD/ anxiety disorders and primarily focusing on ERP.
- Analyze available measures for follow-up assessments.

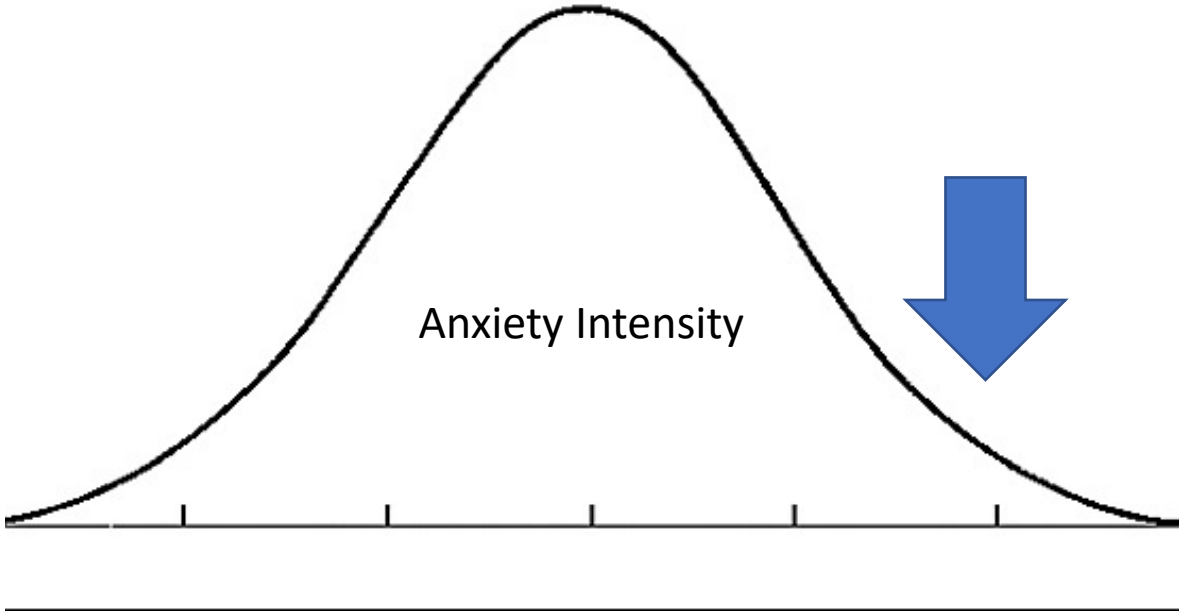
What is anxiety?

- Common human emotion
  - Serves a purpose/adaptive
    - Threat detection
    - Fight-or-flight
      - Physiological: arousal
      - Cognitive: shift towards threat
      - Behavioral: escape/avoid



What are Anxiety Disorders?

- Broken threat detection
  - Exaggerated perceptions of danger
    - Absence of danger
    - Response out of proportion to the actual threat



Worry

Apprehension and thoughts

Focused on possibilities of negative future events

Content and complexity increases with age and ability

Fear

Response to threat or danger

Perceived as actual or impending.

Declines with age and change from immediate and tangible concerns to anticipatory and less tangible.

Common Worries/ Fears

- Toddlers: Fears about imaginary creatures, monsters, or darkness
- Ages 5-6: Worries about physical well being and later fears of natural events
- Ages 8-13: Young ones express fear about darkness, spiders, thunderstorms.

  Older children have worries about school performance, behavioral competence, social evaluation, psychological well being.

Deconstructing Anxiety phenotype

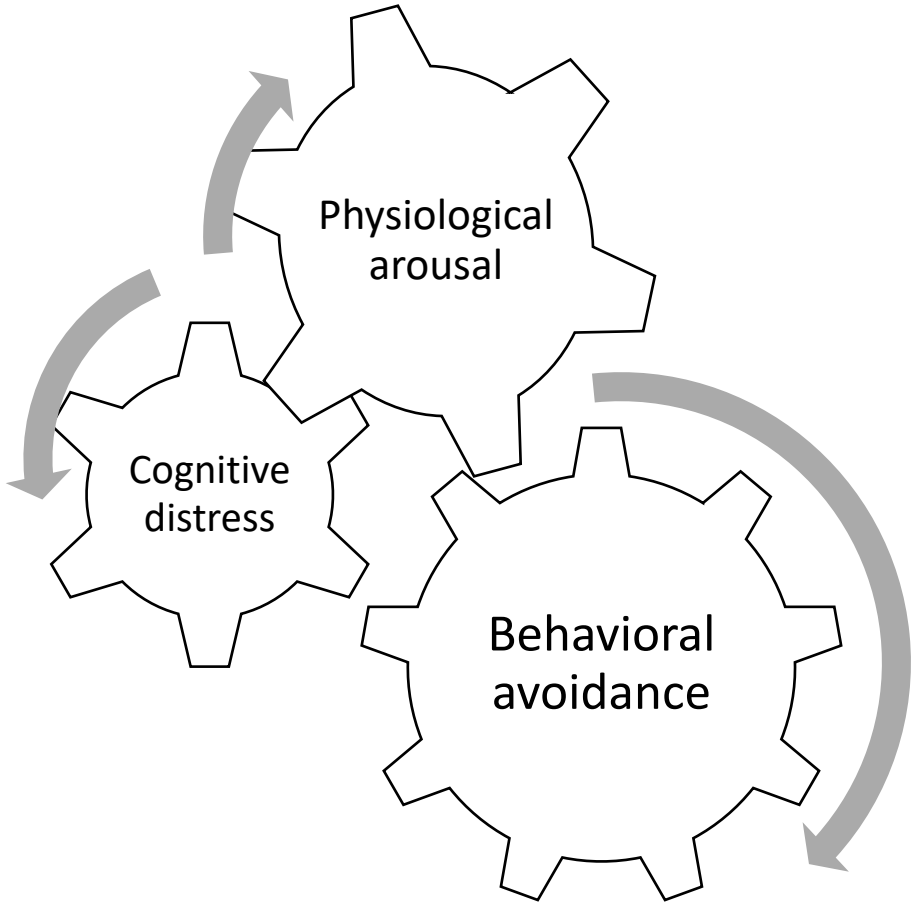
Amygdala centered circuit

- **Fear**
- Panic
- Phobia

Cortico-striatal-thalamic circuit

- **Worry**
- Anxious misery
- Apprehensive
- Expectation
- Obsessions

Tripartite Model of Anxiety



Separation Anxiety Disorder

A. Developing inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached, as evidenced by at least three of the following:

- Recurrent excessive distress when anticipating or experiencing separation from home or from major attachment figures.
- Persistent and excessive worry about losing major attachment figures, about experiencing an untoward event Persistent reluctance or refusal to go out, be away from home, go to school, go to work, about being alone or without major attachment, to sleep away from home or to go to sleep without being near a major attachment figure.
- Repeated nightmares involving the theme of separation, physical symptoms (eg. headaches, stomach aches, nausea, vomiting) anticipating separation

B. The fear, anxiety, or avoidance is persistent, lasting at least 4 wks in children and adolescents.

C. The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning.

Decreases from childhood to adulthood (Kearney et al).

Associated Features

- social withdrawal, apathy, sadness, difficulty in concentrating
- Individual may get homesick, leads to school refusal
- May show anger, tantrums
- Unusual perceptual experiences
- May come across as demanding, intrusive, needing constant attention
- Separation anxiety- Normal from 6 months to 30 months

Generalized Anxiety Disorder

- Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance;
- The individual finds it difficult to control the worry.
- associated with 3 (or more) of the following 6 symptoms (with at least some symptoms having been present for more days than not for the past 6 mths): ***Note:*** **Only 1 item required in children.** Restlessness, feeling keyed up or on edge, Being easily fatigued, Difficulty concentrating or mind going blank, Irritability, Muscle tension, Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).
- clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Panic Disorder

- Unexpected panic attacks with abrupt feelings of intense fear or discomfort reaching peak within minutes, with at least four of the following symptoms occur:

  Palpitations or increased HR, Dizziness or faintness, Numbness or tingling sensations, Chills or hot flashes, Fear of losing control or “going crazy”, Fear of death, Abnormal sweating , Trembling or shaking, Instances of shortness of breath or feeling smothered, Feelings of choking, Chest pain or discomfort, Nausea or abdominal pain, Derealization (feelings of unreality) or depersonalization (feeling detached from his or herself)

- The attacks were followed by a month (or longer) of one or both of the following:
  - Persistent worry about having more panic attacks and/or their consequences (e.g., having a heart attack)
  - A significant abnormal change in behavior in response to the attacks, such as ones intended to avoid unfamiliar situations.

Agoraphobia

A. Marked fear or anxiety with at least two different situations, such as open spaces, being in enclosed spaces, public transport or crowded areas or being outside of home alone

B. Individual fears or avoids these situations worrying that escape might be difficult or help may not be available.

C. Agoraphobic situation almost always provoke fear or anxiety.

D. Actively avoidance of agoraphobic situations, requiring presence of companion.

E. Fear is out of proportion to the actual danger posed by situation.

F. Symptoms are persistent, typically lasting for more than 6 months.

G. Avoidance behaviors, distress or anticipatory anxiety that significantly disrupts normal routine, relationships, occupational or social activities

❖1.7% adolescents and adults every year are diagnosed with agoraphobia

Social Phobia (social anxiety disorder)

- ❖ Fear or anxiety specific to social settings, in which a person feels noticed, observed, or scrutinized. In children, the phobic/avoidant behaviors must occur in settings with peers and will be expressed in terms of age-appropriate distress.
- ❖ fear of displaying their anxiety and experience social rejection; grossly disproportionate to the actual situation; lasts more than 6 months.
- ❖Social interaction will consistently provoke distress, are avoided, or painfully and reluctantly endured
- ❖ Cause personal distress and impairment of functioning in one or more domains
- ❖Specify if anxiety is related to Performance only

- Similar temperamental, environmental and genetic risk factors like other anxiety disorders

Specific Phobia

A. Marked fear or anxiety about specific object or situation. {in children, fear or anxiety may be expressed by crying, tantrums, freezing or clinging}

B. The phobic object or situation almost always provokes immediate fear or anxiety

C. The phobic object is actively avoided or endured with intense fear or anxiety.

D. the fear or anxiety is out of proportion to actual danger posed by specific object or situation or sociocultural context

E. the fear or anxiety or avoidance is persistent, lasting more than 6 months

F. the fear or anxiety or avoidance causes clinically significant distress or impairment in social/ occupational or other areas of functioning.

Specify if: animal, natural environment, blood injection injury, situational, other

Selective Mutism

- A. Consistent failure to speak in specific social situations (in which there is an expectation for speaking, e.g., at school) despite speaking in other situations.
- B. The disturbance interferes with educational or occupational achievement or with social communication.
- C. The duration of the disturbance is at least 1 month (not limited to the first month of school).
- D. The failure to speak is not due to a lack of knowledge of, or comfort with, the spoken language required in the social situation.
- E. The disturbance is not better accounted for by a Communication Disorder (e.g., Stuttering) and does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder.

Selective Mutism Questionnaire has parent and teacher report forms to assist with baseline and clinical monitoring

Onset and Prevalence

	12 months prevalence	Mean age of onset	F : M
Separation anxiety disorder	Adol- 1.6%, Child- 4%	7-9 years	2: 1
Specific phobia	7-9%,(children- 5%; adol-16%)	7- 11 years	2: 1
GAD	0.9% in adol	Adulthood	2:1
Panic disorder	2-3% in adol	Adulthood	2:1
Social Anxiety disorder	7%	8-15, ~ 13 years	2:1
Selective mutism	< 1% point prevalence	< 5 years	

Triggers, Predisposing and Risk factors

Biological risk factors

- (a)Genetics – twin studies.
  - Parental anxiety disorder has been associated with increased risk of anxiety disorder in offspring (Biederman et al., 2001; Merikangas et al., 1999)
  - High levels of functional impairment in children with childhood anxiety disorders (Manassis and Hood, 1998).

- (b)Child temperament: behavioral inhibition in early childhood increases the likelihood of anxiety disorders in middle childhood (Biederman et al., 1993) and social phobia in adolescence (Kagan and Snidman, 1999).

Triggers, Predisposing and Risk factors

- **2) Environmental risk factors-** parent-child interactions and parental anxiety can contribute to anxiety.

❖A) Anxious parents can model fear and anxiety, reinforce anxious coping behavior, and unwittingly maintain avoidance, despite their desire to be of help to their child

❖B) Overprotective, overcontrolling, and overly critical parenting styles that limit the development of autonomy

❖C) Insecure attachment relationships with caregivers, specifically, anxious/resistant attachment (Warren et al., 1997)

Rating Scales

Children 8 year and older

- Multidimensional Anxiety Scale for Children (MASC)
- Screen for Child Anxiety Related Emotional Disorders - screening and monitoring response to treatment(SCARED, Child and Parent form)- 41 questions scale
- Spence Children's Anxiety Scale (SCAS Child and Parent Report) - 45 questions

OCD: DSM V Obsessions

- Either obsessions or 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 cause marked anxiety or distress.
    - Egodystonic
  - The individual attempts to ignore or suppress such thoughts, urges, and images or to neutralize them with some other thought or action (i.e., performing a compulsion)

OCD: DSM V Compulsions

- Compulsions are:
  - Repetitive behaviors or mental acts that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly (i.e., “ritual”)
  - Behaviors or mental acts are aimed at preventing or reducing anxiety or distress or preventing some dreaded event or situation
    - Not connected in a realistic way or are clearly excessive

OCD: DSM V

- Time consuming/ cause significant distress or impairment
- Not attributable to physiological effects of substance or OMC
- Not explained by another mental disorder
- Specify:

❑ With good or fair insight/ with poor insight / with absent insight or delusional beliefs

❑ Tic related

OCD (continued)

- Symptom presentation.
  - Mixed obsessions and compulsions = 98%
  - “Pure obsessional” “Pure O” = < 2%
- Consider changing diagnostic criteria from “or” to “and”?

Obsessions

CONTAMINATION (45%) **I might touch that dirty table.** **Laundered clothes are not clean enough**	**PATHOLOGIC DOUBT (42%)** **She might hear me flush the toilet.** **Made a mistake** **Will lose something** **I can never do it right.**
SOMATIC (36%) Oh, she sneezed. Does she have Corona? Stomachache, do I have cancer?	NEED FOR SYMMETRY (31%) Even-odd
AGGRESSIVE (28%) I can just kick him now. I should just die.	SEXUAL (26%) I feel like rubbing myself to my nephew.
OTHERS	MULTIPLE OBSESSIONS (60%)

Compulsions

CHECKING (63%) **Did someone text me?** **Are doors locked?**	**WASHING (50%)** **I need to wash my hands.** **I need to scrub my bathroom with Lysol many times a day** **Need gloves all the time**
COUNTING (36%) Counting tiles on the ground while walking. Number of words written in a paragraph.	REASSURANCE or CONFESS (31%) Did I do it correctly. Asking you to repeat. Apologizing profusely.
SYMMETRY AND PRECISION (28%) If I take two steps forward from left leg, I need to take two from right. Touching or tapping	HOARDING (26%) 320 pokemon cards
MULTIPLE (48%)	

OCD

- No two cases are alike
- *Functional Assessment*
  - *Antecedent (OCD triggers)*
  - *Behavior (rituals)*
  - *Consequence (negative reinforcement)*

Prevalence and characteristics

- **How common is OCD?**
  - 2.5% of population- life-time prevalence
  - 4th most common psychiatric condition in U.S.
  - The World Health Organization ranked OCD 10th in terms of disability causing conditions (medical and psychiatric) in the developed world. Leading cause of disability.
- **Sex differences?**
  - No (males do seem to develop earlier, however)
- **Onset?**
  - Average age is 20.2 years
  - Rarely *develop* after 50 years of age

Associated features

- Depressed mood (65- 85%)
- Social phobia (~25%)
- Academic and occupational impairment
- Low self-esteem
- Social withdrawal
- Family discord
    - Family Accommodation
- Fear of embarrassment (hide symptoms)
- Avoidance

What is not OCD?

- Pathological gambling, kleptomania, substance use disorders, certain sexual behaviors
  - Thoughts are not unwanted (i.e., ego-syntonic) and often anticipate and experience pleasure from “compulsive” behavior
    - OCD obsessions = unwanted (i.e., ego-dystonic)
    - OCD compulsions = relief (reduce anxiety)
  - Typically, only want to stop because of negative consequences of acts

What is <u>not</u> OCD?

<u>Obsessive Compulsive Personality Disorder</u>

- ***Inflexible, maladaptive*** pattern of concern with orderliness, perfectionism, excessive attention to detail, miserliness, and control
- <u>No intrusive, unwanted thoughts</u>
  - Wanted thoughts
  - Rigid thinking
- <u>No compulsions</u>
  - Do not perform behavior to alleviate anxiety
  - May not identify behaviors as problematic
    - Do not see their rigidity as a problem
    - “life would be easier if everyone were like me”

Etiology of OCD: Diathesis-Stress Model

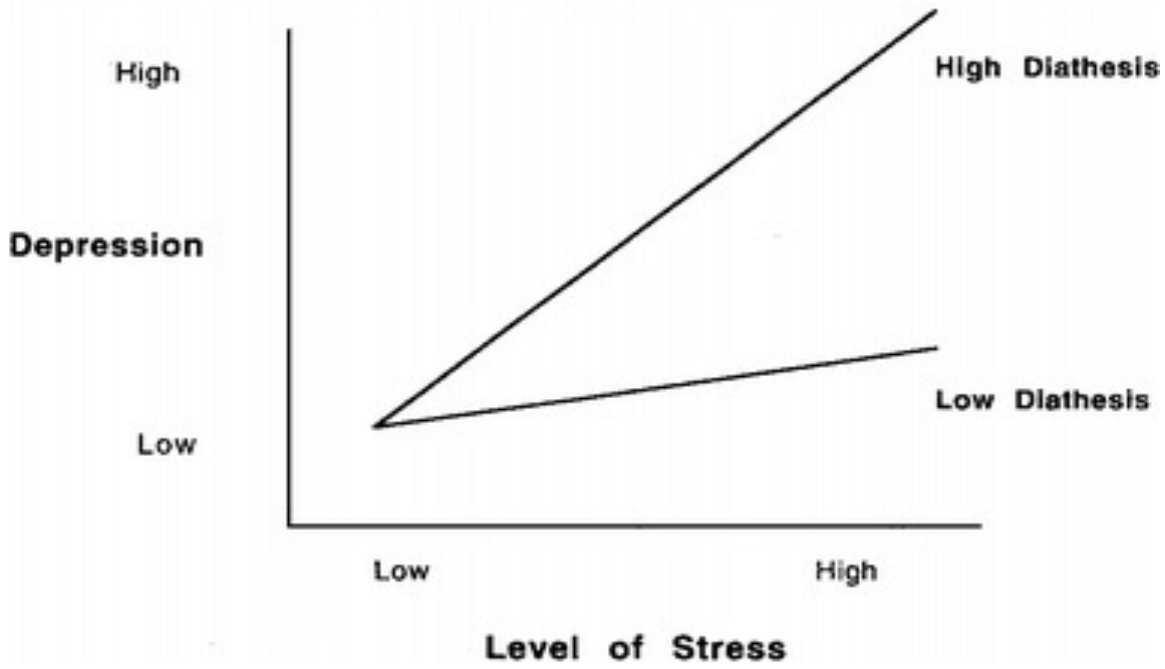
Diathesis

- Genetics?
  - 20% of first-degree relatives will have OCD
  - Additional 15% will have “subclinical” symptoms
  - Does not appear to be learned

    (phenotypes often different)
- Serotonin?
  - Medications that reduce OCD symptoms increase available levels of serotonin

Stress:

- *Stress over time* vs single event
- Insidious onset

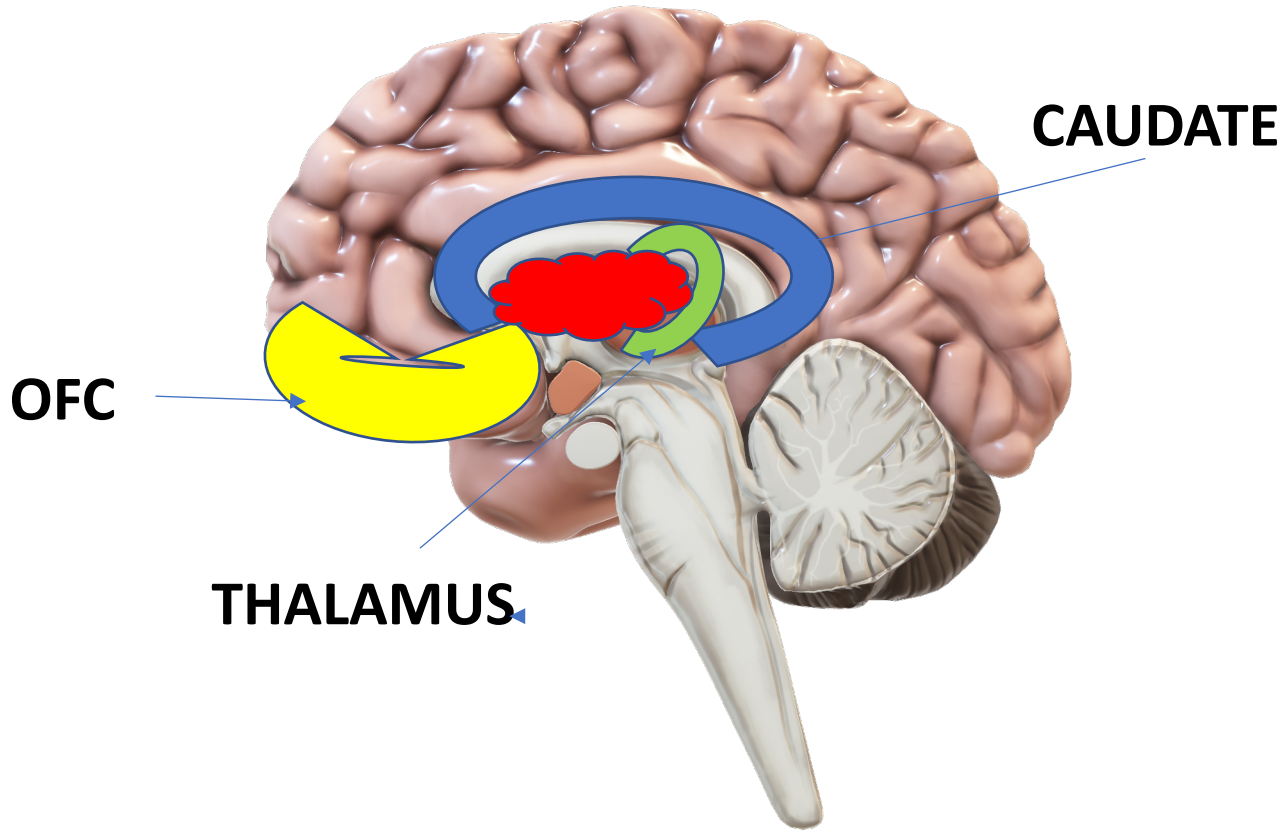


Pathology and Mechanism

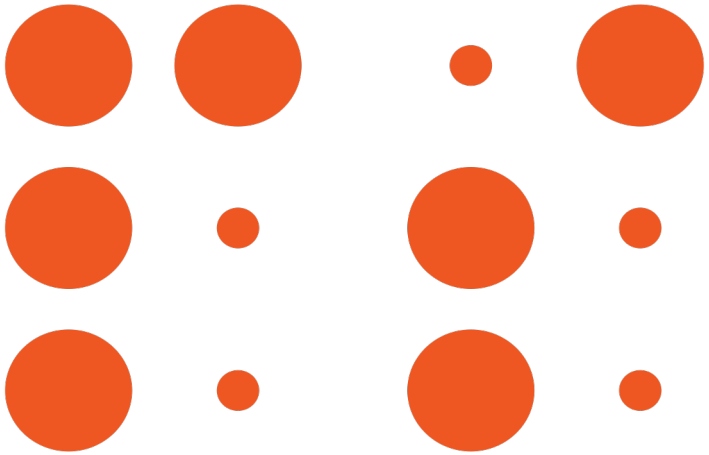
NEUROTRANSMITTERS

Serotonergic

Noradrenergic



Assessments



Case I

12 yo male with history of increased obsessions and compulsions from last two years. Symptoms are progressively getting worse. Fear of germs, peanuts, vomiting, getting sick, using public bathrooms, others getting hurt. Seeking constant reassurance, taking 3-4 days to complete tests or school-work, washing hand 10-15 times a day but for long duration of time.

Assessments Scores

- *CASI:* 33
- *LSAS-CA:* 80
- *CY-BOCS: 29*
- *PSWQ-C:* 31
- *IUSC:* 76

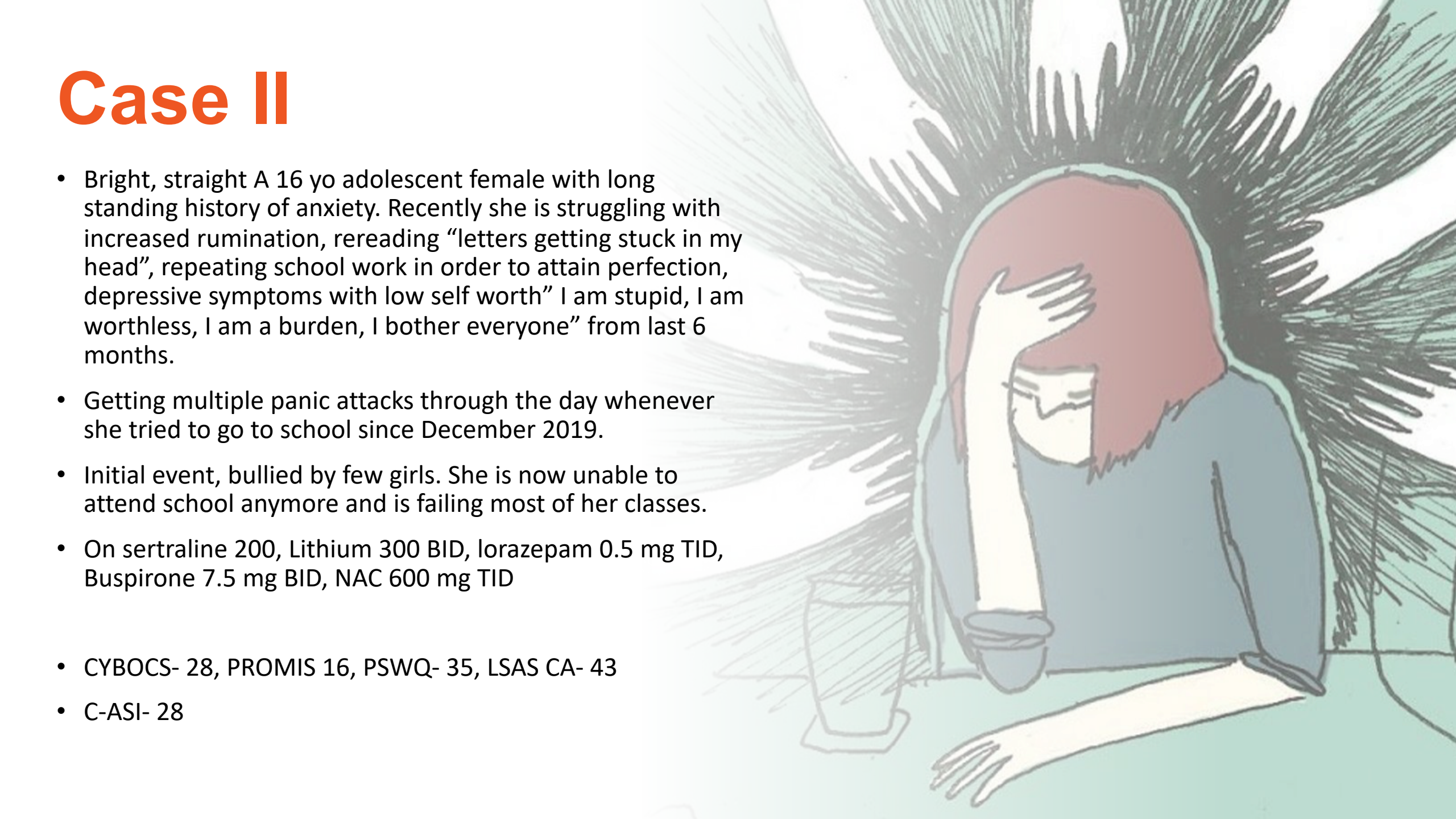
Other Clinical Assessment Scores:

PDS/QIDS- 12

Case II

- Bright, straight A 16 yo adolescent female with long standing history of anxiety. Recently she is struggling with increased rumination, rereading “letters getting stuck in my head”, repeating school work in order to attain perfection, depressive symptoms with low self worth” I am stupid, I am worthless, I am a burden, I bother everyone” from last 6 months.
- Getting multiple panic attacks through the day whenever she tried to go to school since December 2019.
- Initial event, bullied by few girls. She is now unable to attend school anymore and is failing most of her classes.
- On sertraline 200, Lithium 300 BID, lorazepam 0.5 mg TID, Buspirone 7.5 mg BID, NAC 600 mg TID

- CYBOCS- 28, PROMIS 16, PSWQ- 35, LSAS CA- 43
- C-ASI- 28



CASE III

- 39 yo male. anxiety increased after April or May of 2019. symptoms started at age 34.
- hand washing would lead to bleeding. Patient reported that his anxiety increased after his abdominal surgery.
- symptoms interfere with schoolwork and social interactions: would double/triple check his work, reread a paragraph or instructions up to 5x and staying up to 4am in the morning to complete schoolwork.
- Now he is showering up to 6x a day and "anytime I feel the need to" and that he will shower before and after programming.

Assessments Scores

YBOCS : 28	*BADS Activation :* 20
PSWQ : 45	*BADS Avoidance :* 5
LSAS : 83	*BADS Total :* 33
ASI : 54	

Diagnosis and Assessment

- Yale-Brown Obsessive-Compulsive Scale (Y-BOCS; Goodman et al., 1989)
  - 60 symptom checklist (past and current)
  - 10 item severity rating scale (0-4)
  - 5 questions regarding obsessions
  - 5 questions regarding compulsions
  - Mean score for severe OCD >24

Y-BOCS
(continued)

0	-	7	=	subclinical
8	-	15	=	mild
16	-	23	=	moderate
24	-	31	=	severe
32	-	40	=	extreme

Y-BOCS Versions

- Clinically Administered Interview Version vs. Self-Report Version
  - Self-report found to be as accurate
- Adult Version vs. Childhood Version (CY-BOCS)
  - Self-report version with kids found to be as accurate (Conelea, Schmidt, Leonard, Riemann & Cahill, 2012)

Instruments

ADULTS

- **YBOCS**- 8-15 = Mild OCD; 16-23 = Moderate OCD; 24-31= Severe OCD; 32-40 = Extreme OCD
- **QIDS**- 6-10 Mild 11-15 Moderate 16-20 Severe 21-27 Very Severe
- **LSAS-** 55-64 Moderate 65-79 Marked 80-94 Severe 95-144 Very Severe
- **Intolerance of Uncertainty Scale**
- **PSWQ**
- **REISS- ASI**

<18 Years old

- **CY-BOCS:** 8-15 Mild 16-23 Moderate 24-31 Severe 32-40 Extreme
- **PROMIS:** <55 None to Slight 55-60 None to Mild 60-70 Moderate >70 Severe
- **QIDS:** 6-10 Mild 11-15 Moderate 16-20 Severe 21-27 Very Severe
- **LSAS-CA:** 55-64 Moderate 65-79 Marked 80-94 Severe 95-144 Very Severe
- **CASI:** 25-29 Consider Interoceptives 30+ Interoceptives Needed
- **PSWQC:** 27+ Excessive Worry

Other Measures

- PQLESQ, IUSC, HRQOL
- The progress ones are the CYBOCS, PDS or QIDS (depending on age), LSAS-CA, PSWQ-C, and CASI.

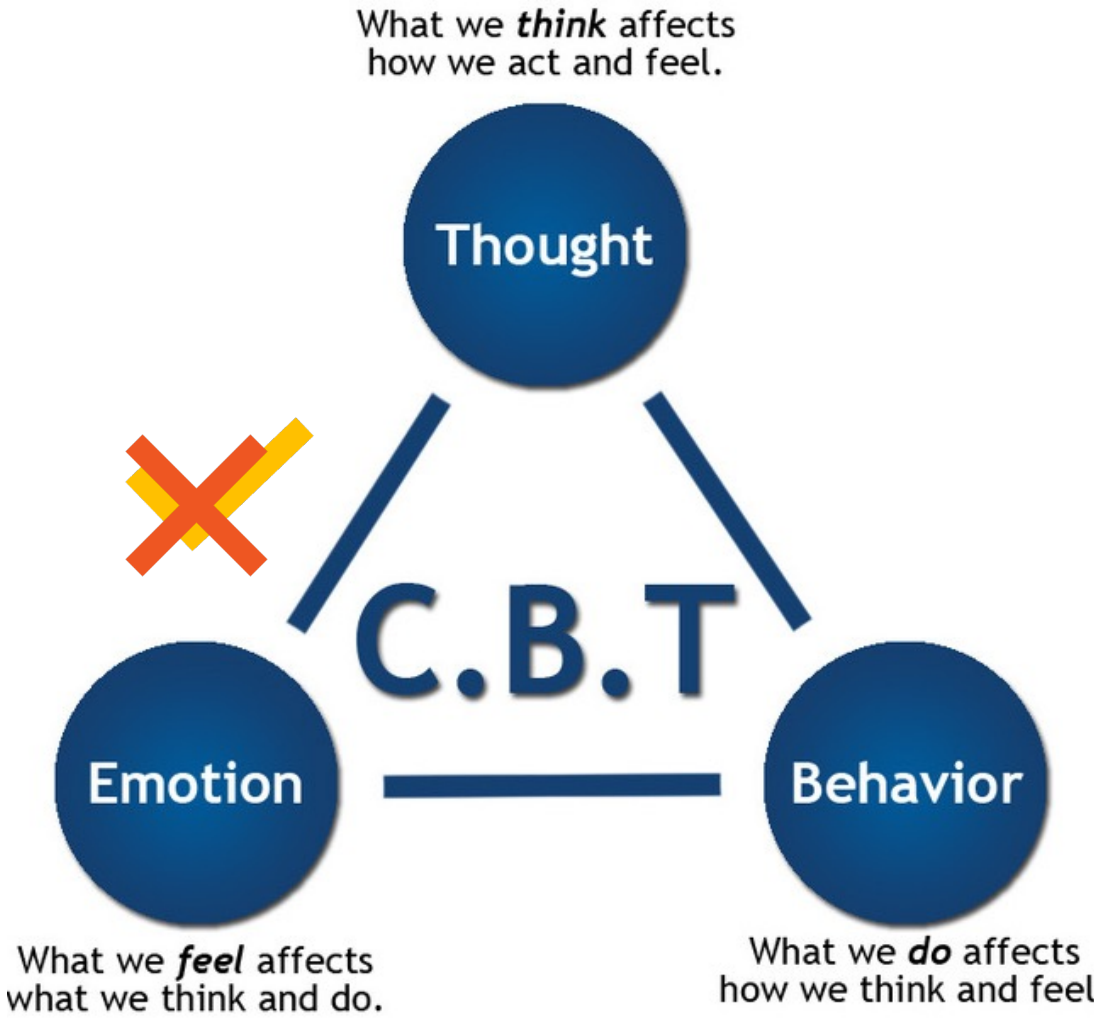
Children 8 year and older

- Multidimensional Anxiety Scale for Children (MASC)
- Screen for Child Anxiety Related Emotional Disorders - screening and monitoring response to treatment(SCARED, Child and Parent form)- 41 question scale
- Spence Children's Anxiety Scale (SCAS Child and Parent Report)- 45 question

Common Treatments For OCD and Anxiety Disorders

Treatments of OCD and Anxiety Disorders

- Medications
- CBT and Exposure and Response Prevention (ERP)
- Combination of medications and Psychotherapy



Cognitive-Behavioral Model

Cognitive Behavioral Therapy

➡ **Behavioral interventions**

❖ Relaxation training- diaphragmatic breathing, muscle relaxation

❖ Exposure

- graduated exposure- classical conditioning paradigm

- intensive exposure(Mowrer two factor theory)- fears are acquired by classical conditioning but maintained by operant conditioning. So, Elimination of fearful behavior is based on extinction model.(within session and between session habituation)

❖ Social skills training- social phobia

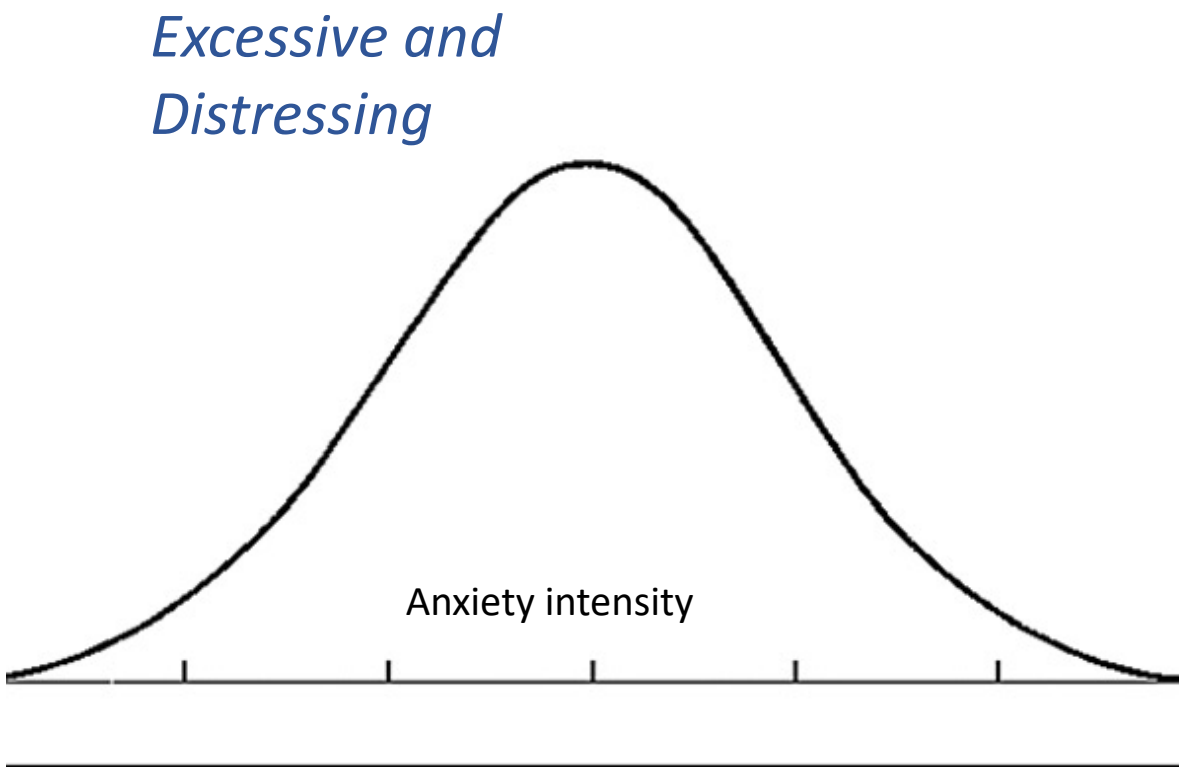
➡ **Cognitive restructuring**(mainly applicable in older children or adolescents)- “think about thinking”/ metacognition

➡ Contingency management- reinforcing reward behaviors

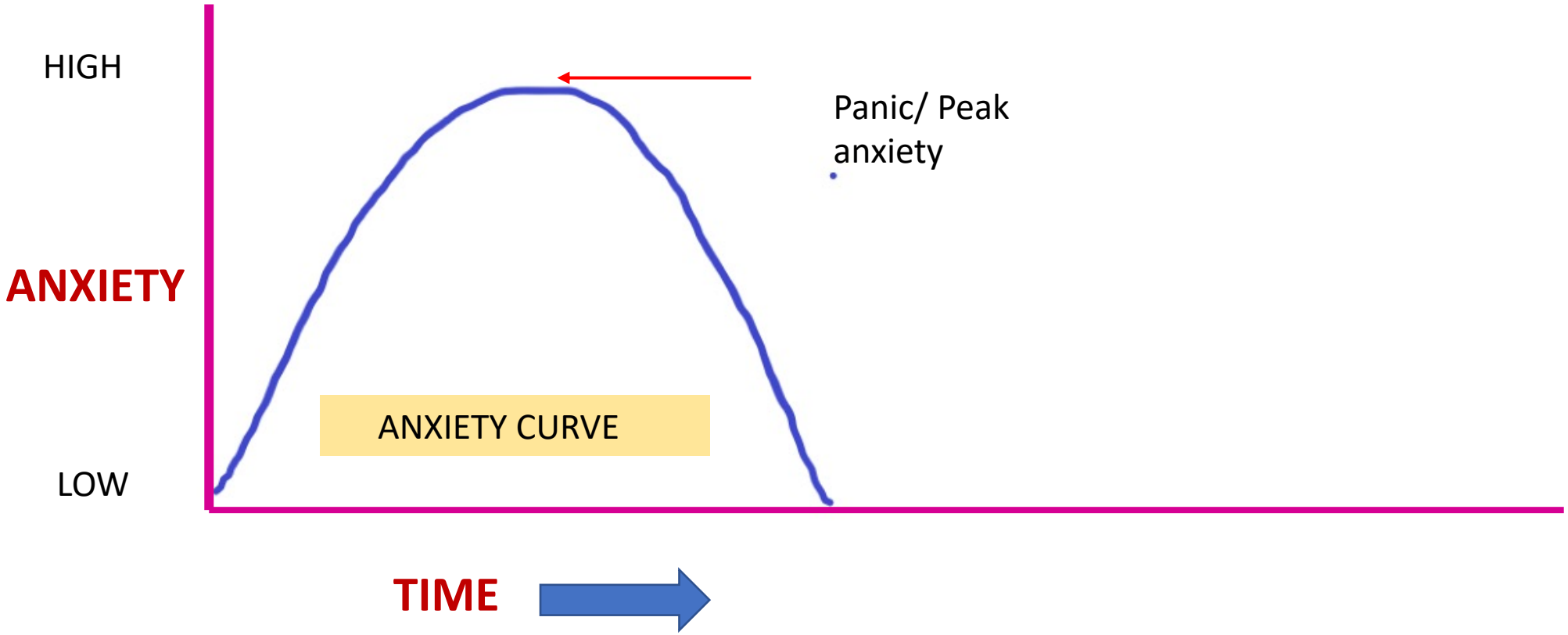
Brain tricks by catastrophizing.

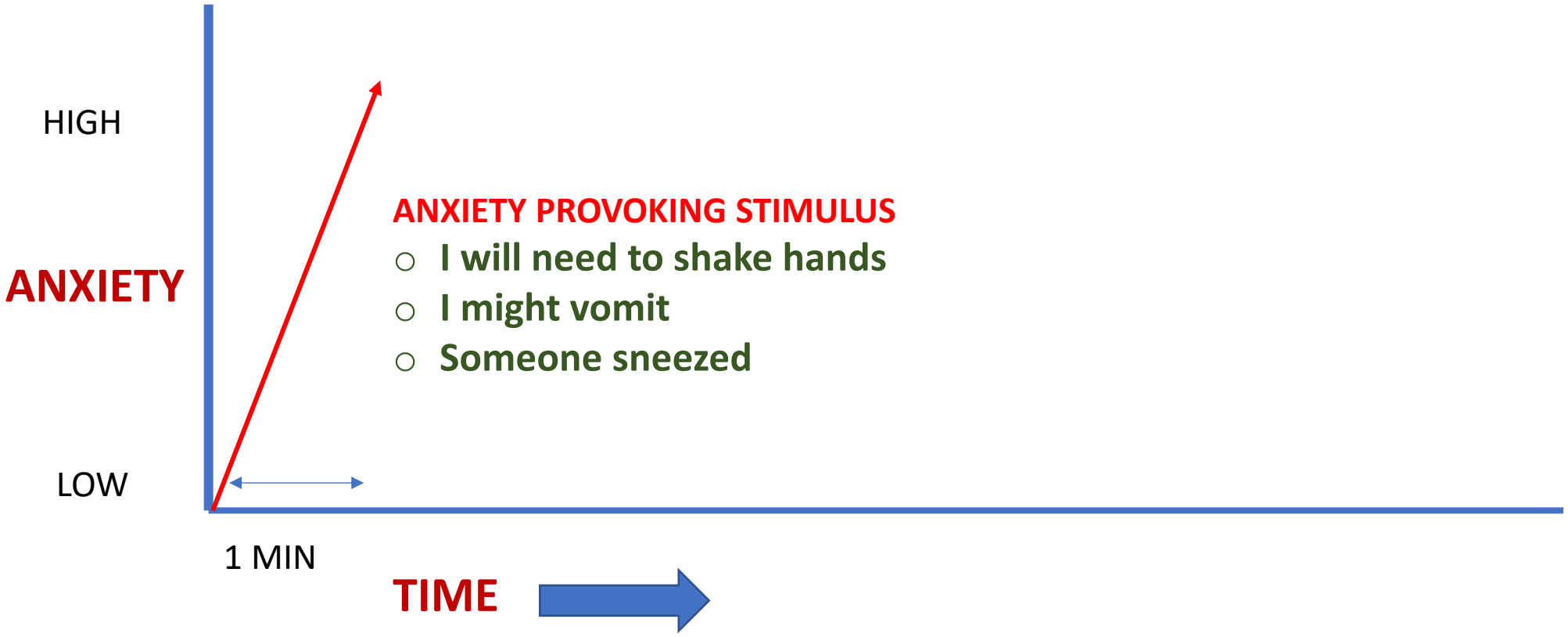
Intro to CBT: Effect

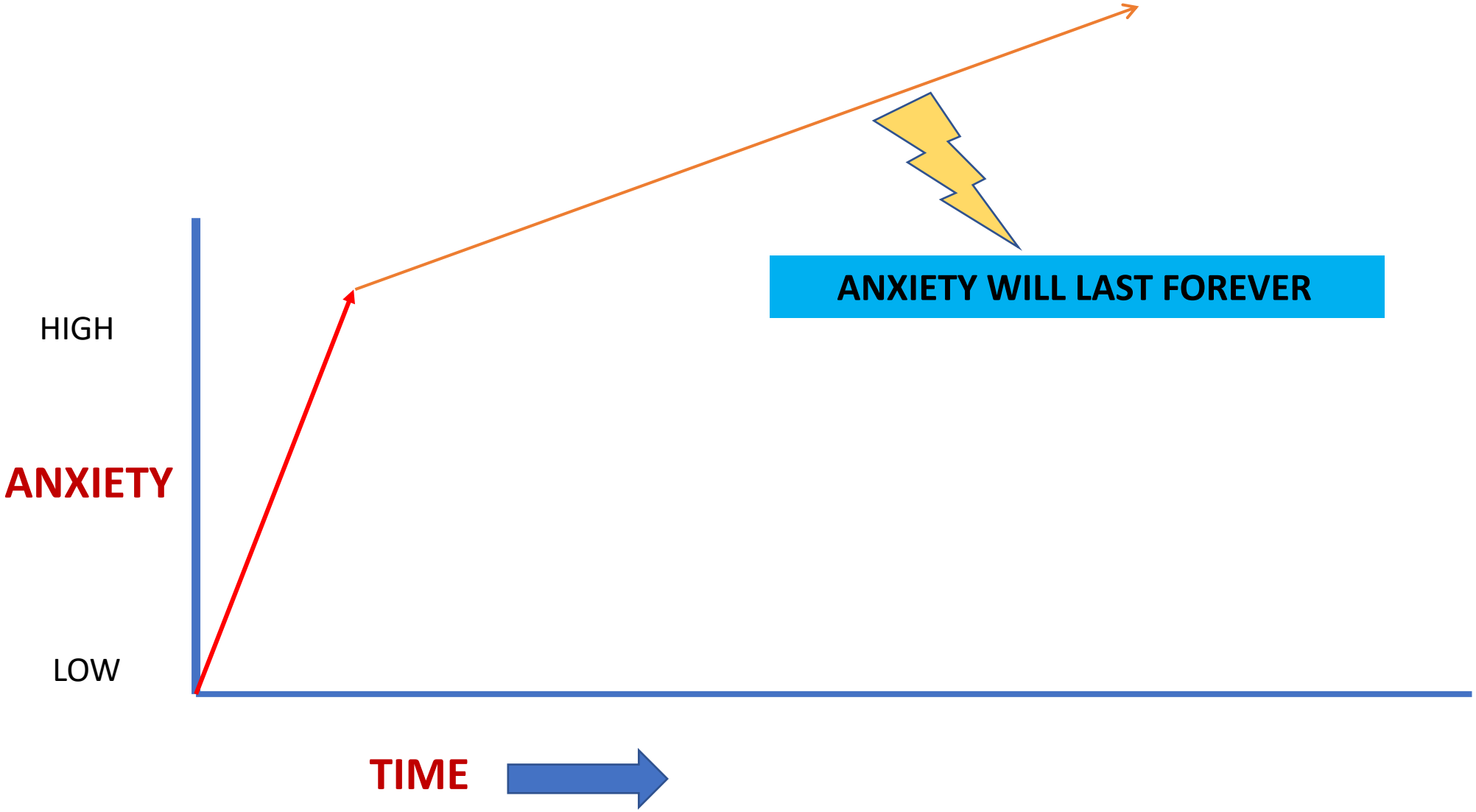
- **Short-term:**
  - Anxiety drops quickly with safety behaviors hence providing relief
- **Long-term:**
  - Maintains fear/bias interpretation
  - Makes anxiety worse
    - Vicious cycle

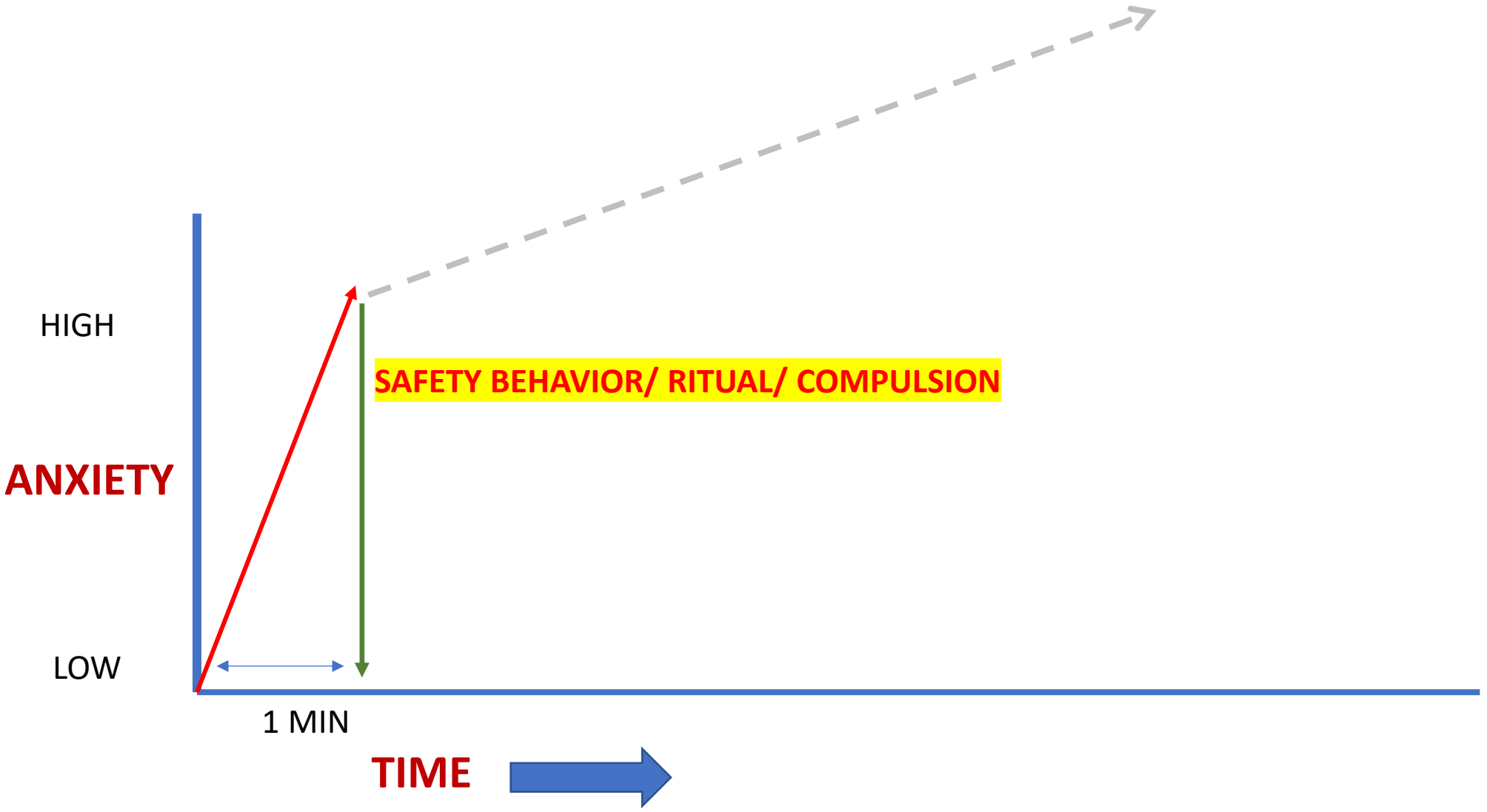


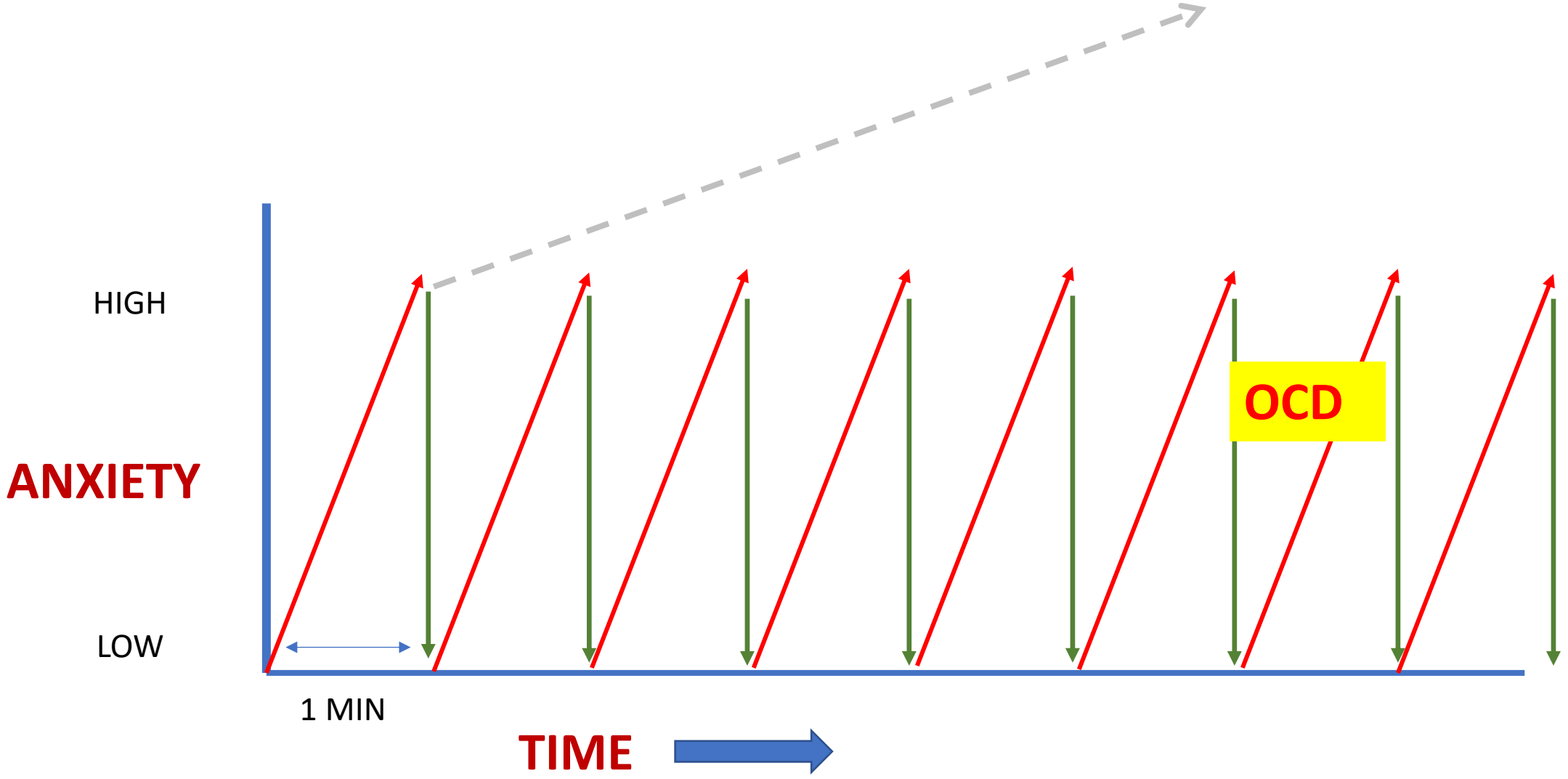
ANXIETY TRAJECTORY




HIGH
ANXIETY
LOW
1 MIN
TIME
ANXIETY PROVOKING STIMULUS
I will need to shake hands
I might vomit
Someone sneezed


ANXIETY WILL LAST FOREVER
HIGH
ANXIETY
LOW
TIME

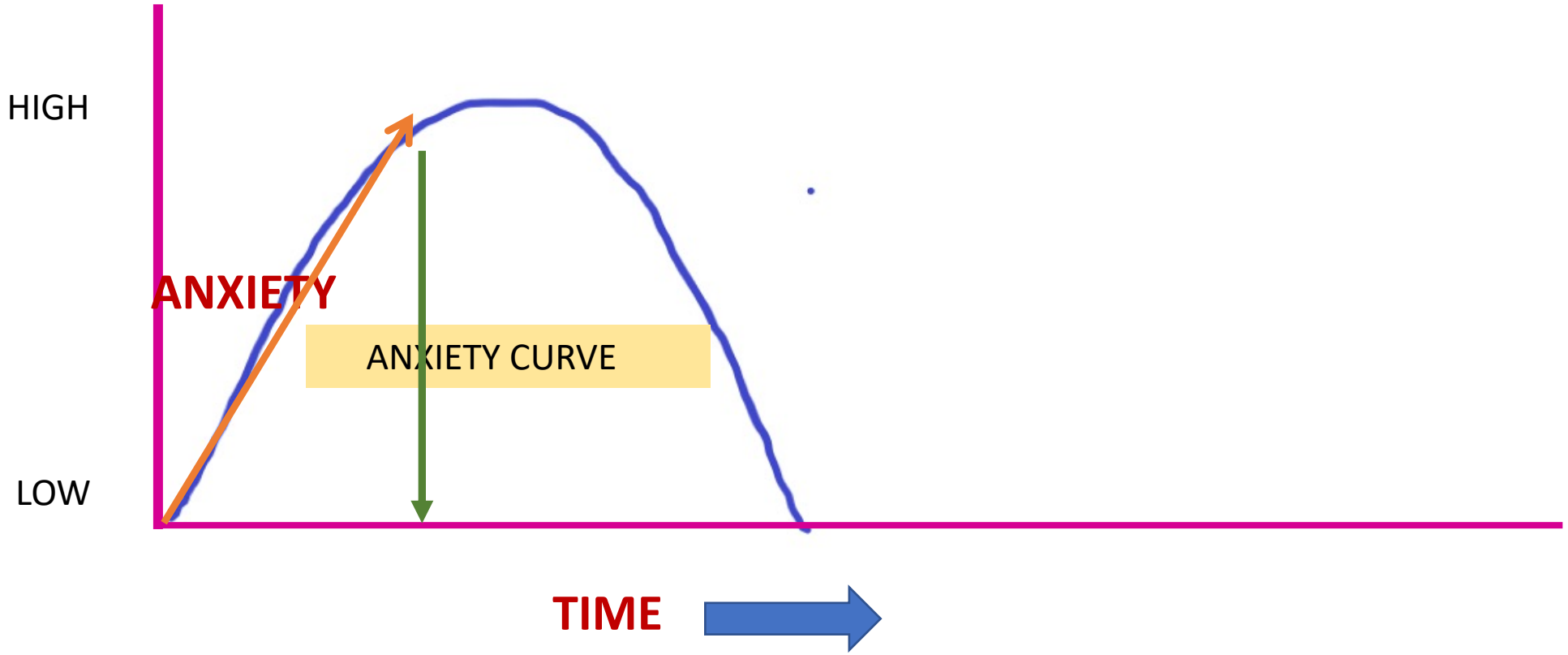

HIGH
ANXIETY
LOW
SAFETY BEHAVIOR/ RITUAL/ COMPULSION
1 MIN
TIME


HIGH
ANXIETY
LOW
OCD
1 MIN
TIME

Cognitive-Behavioral Model

- Life constricts around rituals
  - Avoidance of anxiety-provoking situations
  - Symptoms worsen
    - Anxieties continue to grow (generalize)
- What patient learned?
  - Anxiety can only be controlled by safety behaviors
  - Nothing bad happened, because of safety behaviors

Cognitive- Behavioral Approach



Crows present in corn field

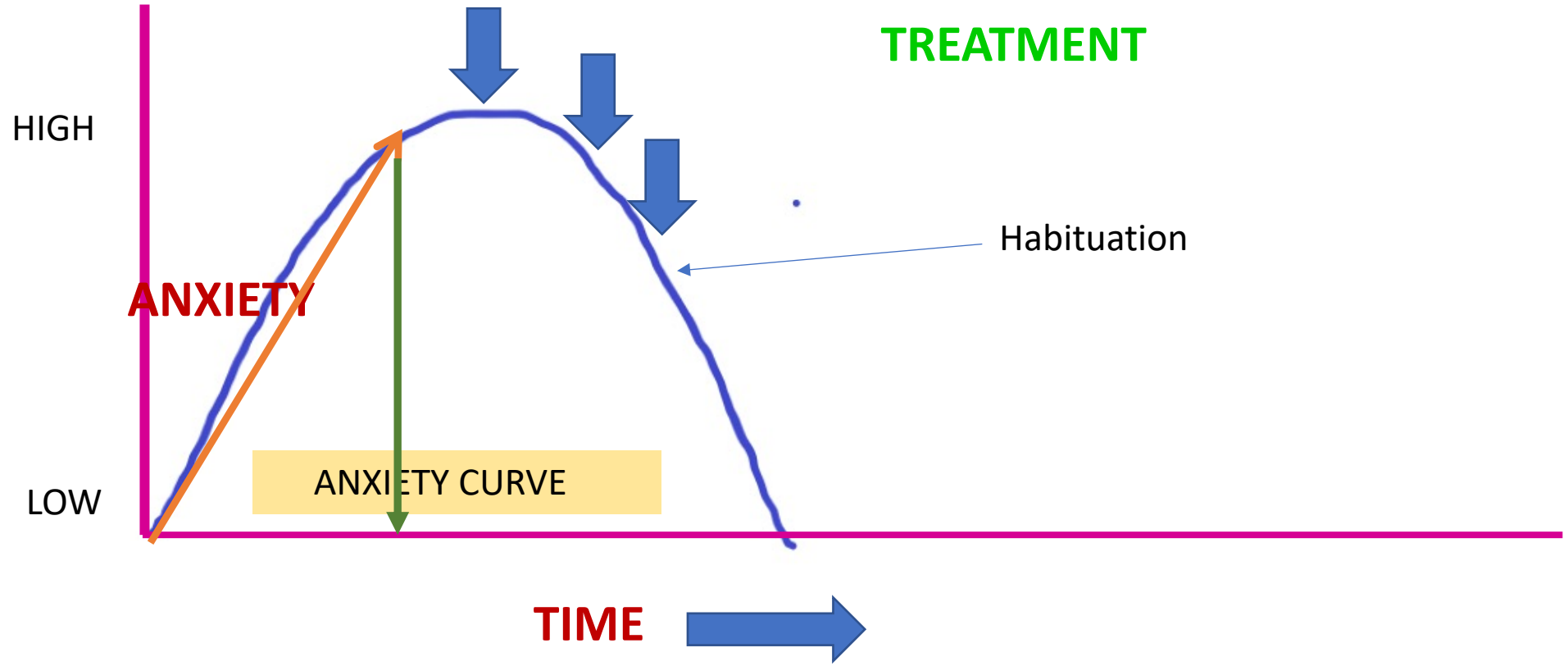
Introduction of scarecrow

Prolonged exposure to scarecrow

Habituation
Biological basis of habituation
sympathetic nervous system

EXPOSURES ARE EFFECTIVE BECAUSE….

Cognitive- Behavioral Approach



Exposures

- Exposure is placing an individual in feared situations
    - Exposure – Targets obsession
        - Need to understand the core fear

- Use “subjective units of distress scale” (SUDS) to rate anxiety.

Example of Subjective Anxiety Rating Scale

0	1	2	3	4	5	6	7
Calm: No anxiety or urge	Few urges, but can manage	Little hard to resist but can still manage	Difficult to control urges. Close to ritualize but resisted	Very hard to resist. Unsure	Challenging, Extremely hard to resist. Strong Anxiety or uncomfortable feelings	Near panic. Extremely anxious	panic state
examples							

Low anxiety: resist the urges to ritualize

Medium anxiety: try hard to resist

High anxiety: resisting is extremely difficult.

Hierarchy
(i.e., the antecedents to rituals/avoidance)

- Typical place to start: Y-BOCS Symptom checklist
  - Gather information about
    - **External/environmental stimuli: situations that elicit anxiety**
      - "What situations make you anxious related to your fear of ____?" "What situations or stimuli do you avoid because of your fear of____ or fell you have to use safety behaviors to get through?"
    - **Internal stimuli: physical sensations and/or thoughts that elicit anxiety**
      - "What bodily symptoms are you concerned with?" "What happens to your body when you feel afraid?"
      - Assessment: Anxiety Sensitivity Index (ASI)
    - **Intrusive thoughts:**
      - "What upsetting thoughts or memories trigger your anxiety?" "What thoughts do you try to avoid or get rid of?" "What is it that triggers the thoughts/memories?"

Contamination Exposures

Urinate no hand wash.
Defecate no hand wash.
Imagine touching toilet seat no hand wash.
Touch home toilet seat no hand wash.
Touch public toilet seat no hand wash.
Imagine touching toilet flusher no hand wash.
Imagine touching inside of a urinal and not hand washing.
Imagine getting urine on hands and not hand washing.
Touch public soap dispenser no hand wash.
Touch the bottom of shower/tub no hand wash. (home; gym)
Touch home bathroom floor by door no hand wash.
Touch home bathroom floor by toilet no hand wash.
Touch home bathroom floor by sink no hand wash.
Touch home bathroom sink handles no hand wash.
Touch public bathroom floor by door no hand wash.
Touch public bathroom floor by toilet no hand wash.
Touch public bathroom floor by sink no hand wash.
Touch public bathroom sink handles no hand wash.
Put hands in bathroom sink no hand wash.
Put hands in kitchen sink no hand wash.
Staff coughs into hands – then shake hands.
Cough into hands then shake hands with staff.
Touch bottom of shoes – no hand wash.

Touch rim of bathroom garbage can – no hand washing.
Touch outside of kitchen garbage can – no hand washing.
Touch rim of bathroom garbage can – no hand washing.
Imagine hands sticky and not washing.
Sticky substance on hands – no hand washing.
Touch unknown sticky substance – no hand washing.
Share a cup of water with family member/spouse – drinking out of opposite sides.
Clean home toilet with toilet brush – no barriers or hand wash.
Use hand towel at a friends or family house that others use.
Use toilet stall in public where you see someone exit.
Touch public bathroom doorknob no hand wash.
Touch home bathroom doorknob no hand wash.
Hands on low traffic floor no hand wash.
Hands on medium traffic floor no hand wash.
Hands on high traffic floor no hand wash.
Imagine eating food off the floor.
Imagine staff touching your food then eating it.
Staff touches your food - then eat it.
Imagine touching food then giving to staff to eat.
Touch food then give to staff.
Shake hands with staff after they use the bathroom.
Shake hands with staff.

Disease or Illness Related Exposures

Read about symptoms of HIV/AIDS
Write or say “HIV/AIDS.”
Write or say “I have AIDS.”
Write or say “I might have HIV/AIDS.”
Write or say “I might have given someone HIV/AIDS.”
Imagine being told you have HIV/AIDS.
Think you may have given someone HIV/AIDS.
Read someone’s personal story of HIV/AIDS.
Watch movie about HIV/AIDS. (Philadelphia)
Watch mystery diagnosis.
Imagine having an incurable disease.
Write or say “I have an incurable disease.”
Read about brain aneurysm.
Read about brain aneurysm while having a headache.
Read personal story of brain aneurysm.
Read about symptoms of a brain aneurysm.
Write or say “cancer.”
Write or say “I have cancer.”

Write or say “I might have cancer.”
Read someone’s personal story of cancer.
Watch movie about cancer. (Stepmom)
Look at a picture of a hospital.
Imagine going to a hospital.
Think of being admitted into a hospital.
Go to a hospital.
Sit in ER waiting room.
Read about swine flu.
Read about symptoms of the flu.
Read about symptoms of swine flu.
Staff coughs into hands – then shake hands.
Cough into hands – then shake hands with staff.
Imagine giving a cold/flu to someone.
Touch an unused needle.
Touch a used needle.

Types of Exposure

- Imaginary exposure (when *in vivo* dangerous, impractical, or anxiety unmanageable)
  - Conduct exposure in imagination
  - Conduct exposure with taped scenarios

- *In vivo* Exposure (*Preferred, if possible)*
  - Real-life exposure
  - more effective

Types of Exposure

- Self-exposure
  - Conducted by patient alone
- Therapist-aided exposure
  - Both therapist and patient perform or while therapist is present
    - Watch for reassurance

Successful Exposures

- Exposures should be planned and structured
- Exposure practices should be repeated frequently
- Exposures should be introduced gradually
- Do not fight the discomfort or use subtle avoidance behaviors
- Use exposure to test negative predictions because of facing the exposure
- Keep track of fear or anxiety level
- Exposure would last until anxiety has significantly decreased
- Practice exposure by yourself

3 Keys To Exposure Therapy

They need to be **prolonged** enough

Should lead to ***within trial*** habituation (at least 50% reduction in anxiety)

Needs to be **repetitive** enough to lead to ***between trial*** habituation

(until causes minimal to no anxiety)

3 Keys To Exposure Therapy

Needs to be **graduated** (increases compliance)

- Compliance with doing the exposures
- Compliance with doing the ritual prevention

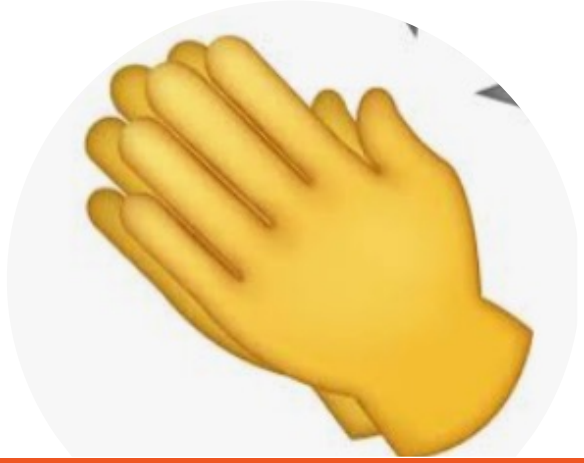
- Start people in their 3's (considered challenging but manageable)
    - Maximizes compliance

Response Prevention

- Behaviors *aimed* at reducing anxiety
- Blocking the typical response or ritual *before, during,* and *after* exposure so **habituation** can take place
  - Ritual Prevention: Target compulsions (***all of them***)
  - Replace the ritual with habituation
  - *Learn* a new way of responding to anxiety
    - Rituals are unnecessary

Response Prevention

- Submit
  - I had the urge to ritualize, and I did
- Resist
  - I had the urge to ritualize, and I did NOT
- Undos
  - I had the urge to ritualize, and I did, but then I did something that brought back the urge at a challenging but manageable level
    - Not as good as a resist
    - Reintroduce an anxiety provoking stimuli after a ritual



Ban Books

DATE	HAND WASH			
	URGES	SUBMITS	RESISTS	UNDO'S
3/28	100	30	70	15
	(S + R)			(should = S)
4/4	100	15	85	15

Follow Up Scales

- **YBOCS** (OCD):
  - 0-7=Subclinical
    8-15=Mild
    16-23=Moderate
    24-31=Severe
    32-40=Extreme

- **QIDS** (Depression):
- 0-5=None
- 6-10=Mild
- 11-15=Moderate
- 16-20=Severe
- Above 21=Very Severe
- #12= Suicidality Question

- **PIOS** (Scrupulosity)
- Range 0-76, 19 is mean

- **LSAS** (Social Anxiety):
- 55-65=Moderate
- 65-80=Marked
- 80-90=Severe
- Above 95=Very Severe

- **PSWQ** (Worry):
- Under 60=Normal,
- 60-65=Mild,
- 66-72=Moderate,
- 73-78=Severe,
- 79-80=Very Severe

- **ASI** (Anxiety Sensitivity): Above 32=Interoceptive Exercises

Patient Name_____ DOA_____

Biweekly Assessment Scores

Date							
Y-BOCS							
LSAS							
ASI							
QIDS							
PSWQ							
PIOS							

Patient Name_____ DOA_____

Weekly Exposure Hierarchy Completion

Date								
# completed								
# total on hierarchy								
% completed								

Protocols

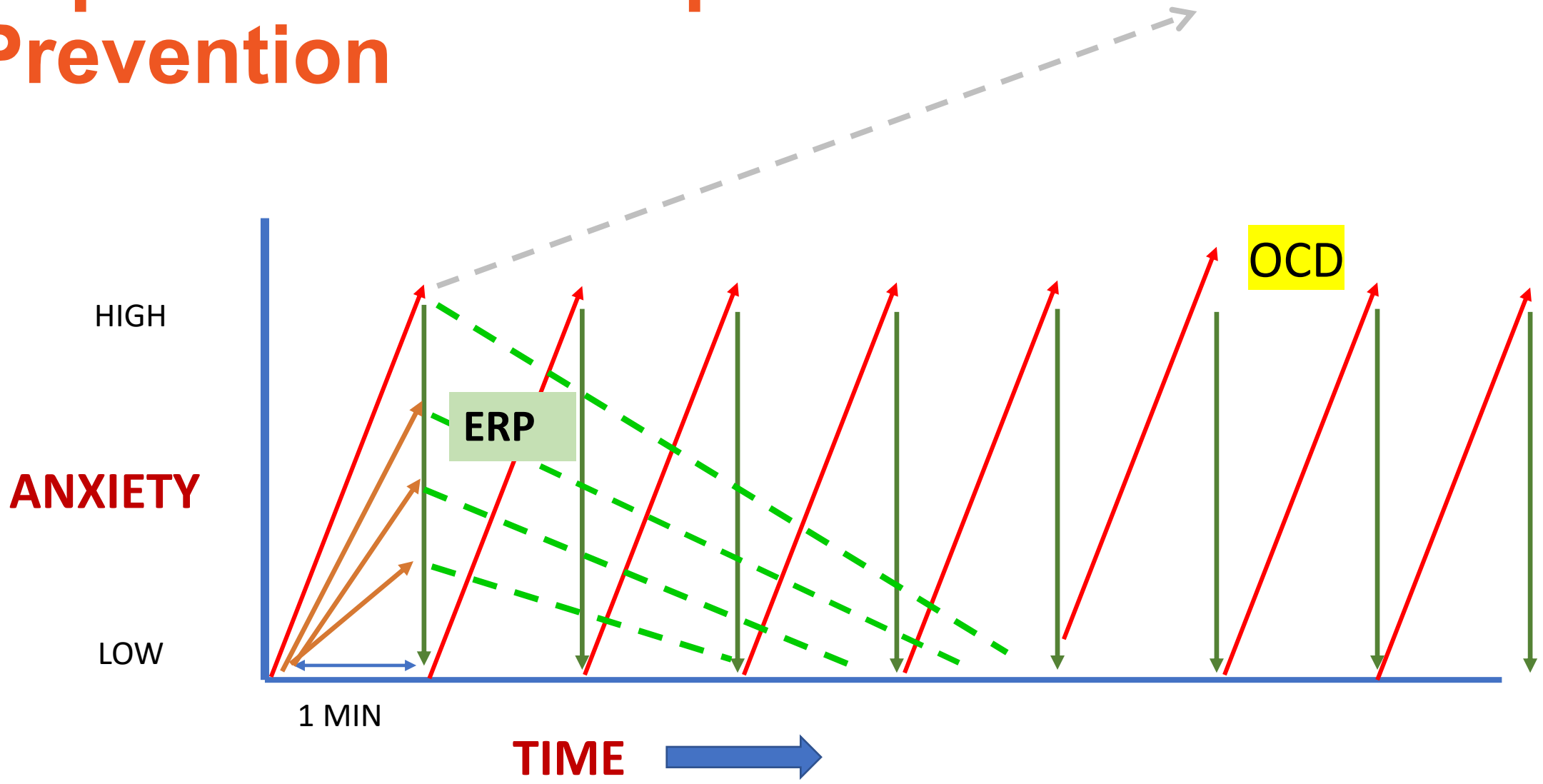
- Cannot give up ritual “cold turkey” → use a protocol
  - Gradually reduce the frequency, duration, and intensity of a ritual
- Sets expectations/limitations on compulsions
  - Showers
  - Hand washes
  - Medication compliance
  - Cleaning/organizing
  - Checking
- All submits should be done using the protocol
  - Ritual should not eliminate anxiety completely

Behavior Therapy

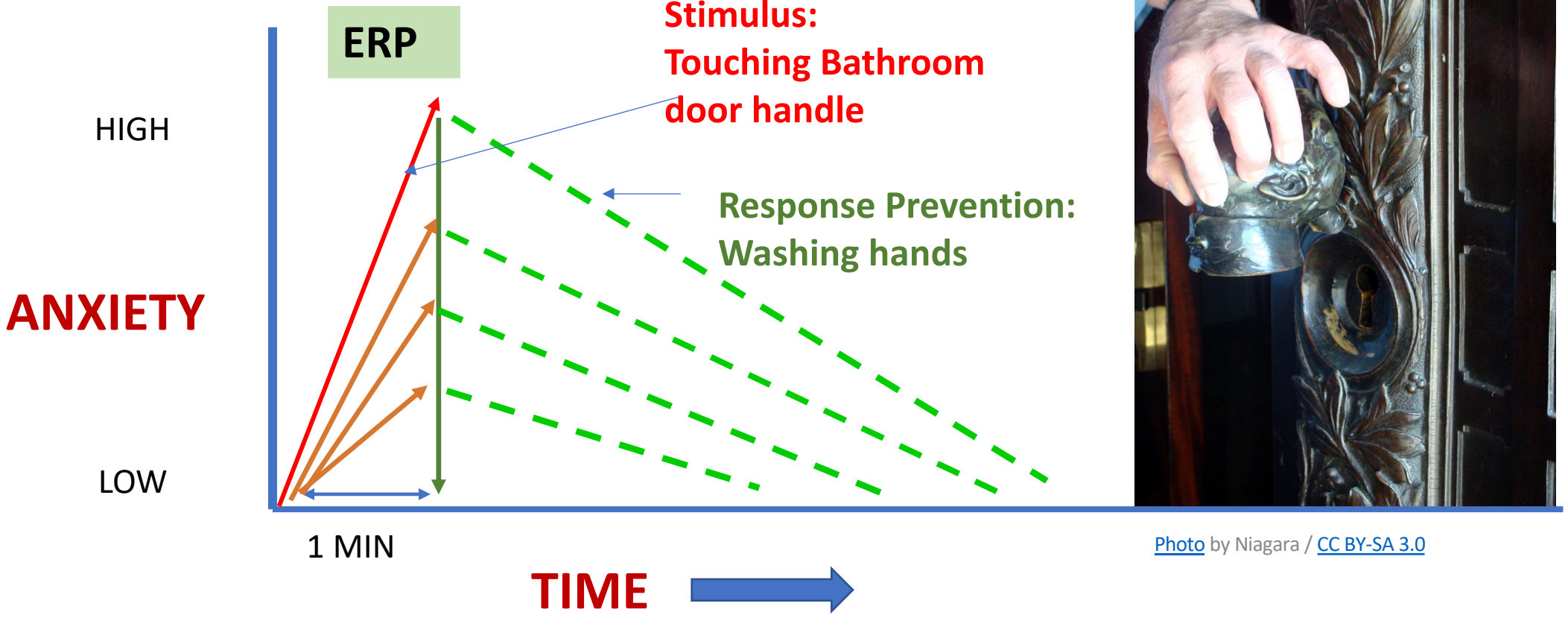
- For O CD both E and RP are necessary

- As problem has two parts (obsessions and compulsions, so it the solution.
  Need both E and RP!

Exposure and Response Prevention



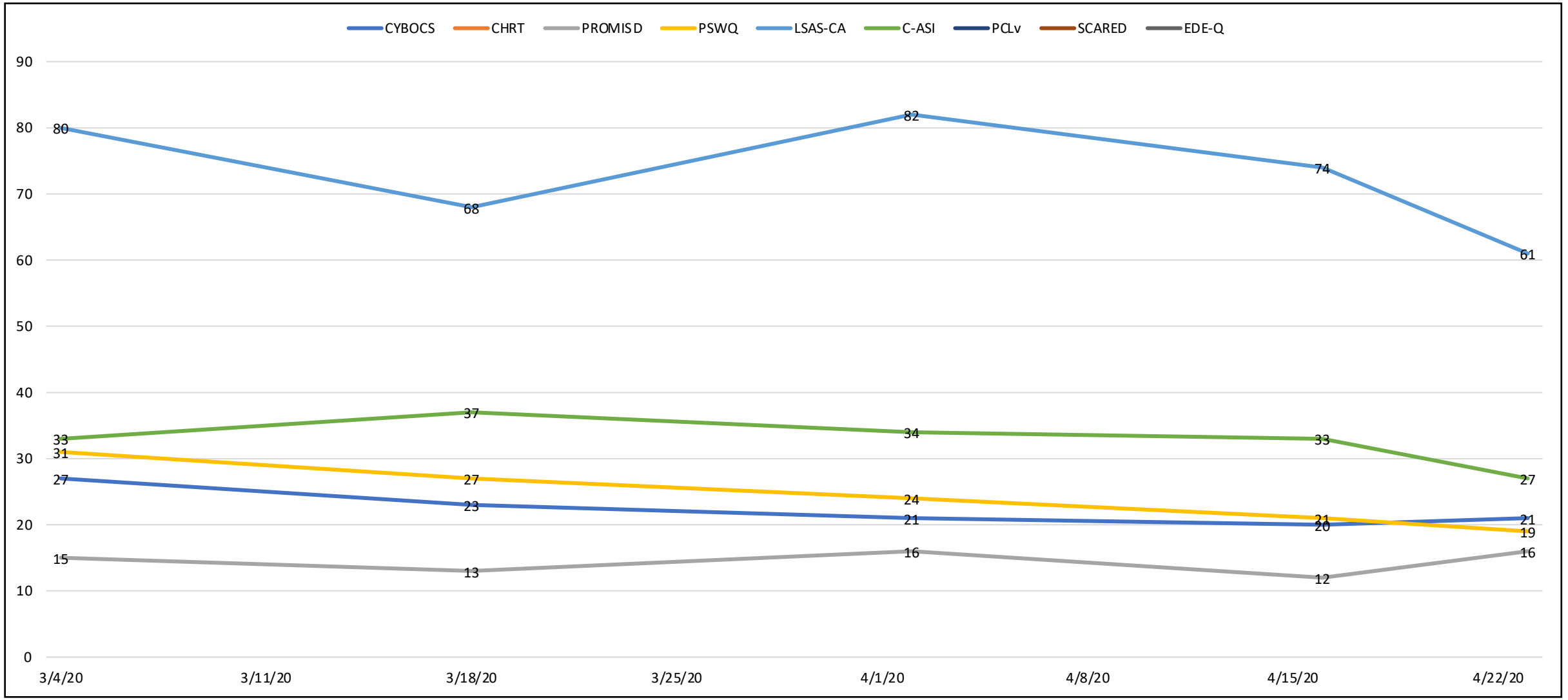
Exposure and Response Prevention



Case I

Date	Hierarchy Completion %age	CYBOCS	CHRT	PROMISD	PSWQ	LSAS-CA	C-ASI
3/4	0%	29		15	31	80	33
3/18		23		13	27	68	37
4/2	25%	21		16	24	82	34
4/16	42%	20		12	21	74	33
4/23	49%	21		16	19	61	27

Case I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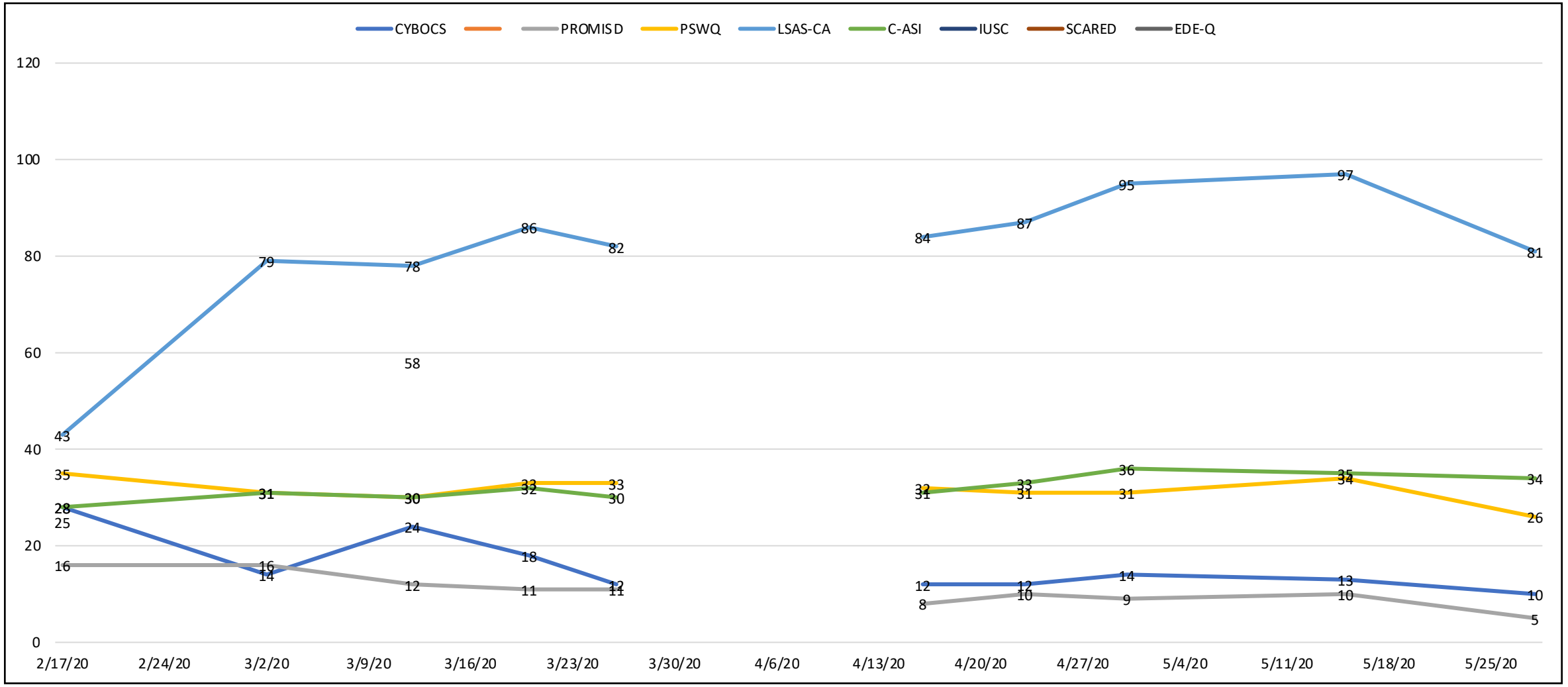
Case II

Date	Hierarchy Completion %age	CYBOCS		PROMISD	PSWQ	LSAS-CA	C-ASI	IUSC	SCARED
2/17	0%	28		16	35	43	28		25
3/2	1%	14		16	31	79	31		
3/12	3.50%	24		12	30	78	30	58	
3/20	3.50%	18		11	33	86	32		
3/26	10%	12		11	33	82	30		
4/3	18%								
4/16	22%	12		8	32	84	31		
4/23	26%	12		10	31	87	33		
4/30	26.50%	14		9	31	95	36		
5/15	31%	13		10	34	97	35		
5/28	39%	10		5	26	81	34		
5/28	BA 31%								
6/4	46%								
	BA 43%								
6/11		10		6	30	78	32		
6/18	54%	10		4	26	86	34	48	
6/26	58%	9		4	29	77	31		
7/3	61%	7		4	23	79	33		
7/9	64%	10		5	27	89	34		
7/23	69%	9		7	29	74	33	64	

Case II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Effectiveness of ERP

- Produces roughly 60% symptom reduction
- Produces on average an 11.8 point reduction in Y-BOCS scores
- Low relapse rates

Advantages of ERP

- Effective and robust
- “Only” side effect is increased anxiety during treatment
    - can manage by conducting graduated exposure
- Quick improvements
    - many after first week of treatment

EXPOSURES ARE EFFECTIVE BECAUSE….

- Self reliance

Disadvantages of ERP

Hard work!

- ***Gradually***
- *It can be challenging but is manageable*

Residual symptoms

Will need to be aware of potential future challenges that will provoke OCD concerns and behaviors

Noncompliance

Family Accommodations

Providing Care for Individuals with OCD

- If on assessment, if significant impairment is identified in an individual, refer to ERP trained therapists.
- If needed, start and titrate medications for anxiety/ OCD.
- ERP trained therapist are able to continue exposures in outpatient settings if symptoms are in moderate range
- Many times higher level of services, residential or partial/ IOP are needed when symptoms are severe.
- For children and adolescents, include parents coaching sessions to help them identifying avoidance behaviors, and parental accommodations which can prevent in obtaining full benefits of ERP.
- International OCD foundation.

Treatments

	Medications	Psychotherapy/ behavioral interventions	Multimodal treatment
Separation anxiety disorder	SSRI/ SNRI	CBT PCIT <7 years	81% with comb 60% with therapy 55- 60 % with Meds
Specific Phobia		Systematic desensitization	
GAD	SSRI/ SNRI, Buspirone, BZDs.	CBT, Child focused interventions parental anxiety mx.	Combination is better
Panic d/o Agoraphobia	SSRI/ SNRI	CBT Techniques, Interoceptive exposure, cognitive coping and gradual exposure to agoraphobic situation	Comb
Social phobia	SSRI/ SNRI	CBT, ERP, Behavior Interventions	Comb
Selective mutism	2nd line	Verbal/ nonverbal skills Behavior interventions: ❖ Reward social interactions, comm with hierarchy of feared situations ❖ Adults should not speak for the child. ❖ stimulus fading, Target comm deficits, developmental delays	

Psychotherapeutic Interventions

Cognitive behavioral Therapy (CBT)	Psychoeducation, somatic management(diaphragmatic breathing), Cue controlled relaxation, cognitive restructuring, problem solving and relapse prevention
Parent Child Interactive Th(PCIT)	Child and parent driven sessions
Systematic desensitization	Induction of muscle relaxation, developing fear producing hierarchy, paring of hierarchy with relaxation
Interoceptive exposure	Gradual exposure to somatic sensations such as dizziness, SOB and sweating
Stimulus fading	Gradual removal of people or objects that increase child comfort

Family Based Interventions

- Only child focused interventions are less likely to be successful if parental anxiety, parenting styles, insecure attachment, and parent-child interactions are present. **Focus of improving parent-child relationships**, strengthen family problem solving, reduce parental anxiety, and foster parenting skills that differentially reinforce adaptive coping and appropriate autonomy in the child are often incorporated.
- Parent component added to child CBT showed significant improvement in outcome measures.
- Anxious parent- Adding **parental anxiety management** to child CBT if there was an anxious parent
- **Family therapy** - family structure and process rather than focusing on an individual.

Assisting Children and Adolescents

During high anxiety moments:

younger children- fidget toys, positive reinforcement, contingency, deep breathing.

adolescent- deep breathing, positive reinforcement, encouraging to talk about anxiety, taking a break, mindfulness, coping ahead, acceptance.

Long term- consistent sleep(uninterrupted sleep) schedules, adequate nutrition, psychotherapy/ medication interventions and utilizing learned skills

Parents

IN THE MOMENT

- **X** Avoid accommodations or need to rescue the child.
- **X** Don’t talk for your child and allow them to express
- **X** Don’t dismiss their feelings
- Acknowledge feelings and use words of encouragement to face/ live through high anxiety moments.
- Set realistic expectations and follow through
- Identify your child’s triggers, if sudden transitions make them anxious then prepare them but if information overload provokes anxiety then shorten anticipatory phase. Talk to your child about expected triggers and how to address them
- Deep breathing, mindfulness, positive statements, coping ahead, acceptance, positive rewards

Parents

LONG TERM
Monitoring screen time, having consistent sleep schedule for their children
Engage children and adolescents in recreational activities.
Acknowledging anxiety, providing reassurance and encouraging to continue
If concerns are physical symptoms are from anxiety, rule out medical possibilities before labeling anxiety. If confirmed, validate and normalize.
Include more family time
Limit accommodations and do not encourage avoiding behaviors.
Managing your own anxiety
Seeking PCIT, Family therapy and parent therapy

Counselors and Teachers

Ongoing
Communicating with families, avoid calling out anxious students in class,
Identifying triggers, developing plans with families and treatment teams and utilizing strategies that help students calm down.
Immediate
Validating students with anxiety and yet normalizing
Remaining consistent in identified responses based on plans.
Breaks should be small.
Reminding students about things or skills can help them calm down.
Deep breathing, mindfulness, positive statements, coping ahead, acceptance

Counselors and Teachers

Long term

- Identifying students timely and encouraging parents to seek help
- If student is at school nurses often with vague physical symptoms, do not dismiss. Those physical symptoms can be frightening enough for students.
- Collaborating with families and treatment teams about recommendations.
- Avoid contacting parents or sending children home.
- Changing schools or home- schooling is not recommended for social anxiety leading to school avoidance.
- Supporting and guiding parents in managing their own emotions.

Resources for Families and Counselors

- Crist, J. (2004). What to do when you are scared and worried: A guide for kids.
- Dacey, J. S., & Fiore, L. B. (2000). Your anxious child: How parents and teachers can relieve anxiety in children.
- Eisen, A. & Engler. L. (2006). Helping your child overcome separation anxiety or school refusal.
- Coping Cat workbook
- Coping Cat parent version
- The C.A.T. Project Workbook for the Cognitive Behavioral Treatment of Adolescents.

Summary

- ***OCD and Anxiety disorders are a treatable!***
  - Work together on approaching feared situations in a challenging, yet manageable way, without using safety behaviors to reduce anxiety

    - *Goals are to:*
      - *Learn* that you are able to do it and cope with anxiety (self-efficacy)
      - *Learn* that safety behaviors are unnecessary

Other References

- Cervin, M., Perrin, S., Olsson, E., Claesdotter-Knutsson, E., & Lindvall, M. (2021). Involvement of fear, incompleteness, and disgust during symptoms of pediatric obsessive–compulsive disorder. *European Child & Adolescent Psychiatry*, *30*(2), 271–281. https://doi-org.rosalindfranklin.idm.oclc.org/10.1007/s00787-020-01514-7

- Macul Ferreira de Barros, P., do Rosário, M. C., Szejko, N., Polga, N., Requena, G. de L., Ravagnani, B., Fatori, D., Batistuzzo, M. C., Hoexter, M. Q., Rohde, L. A., Polanczyk, G. V., Leckman, J. F., Miguel, E. C., & de Alvarenga, P. G. (2021). Risk factors for obsessive–compulsive symptoms. Follow-up of a community-based youth cohort. *European Child & Adolescent Psychiatry*, *30*(1), 89–104. https://doi-org.rosalindfranklin.idm.oclc.org/10.1007/s00787-020-01495-7

- Rough, H. E., Hanna, B. S., Gillett, C. B., Rosenberg, D. R., Gehring, W. J., Arnold, P. D., & Hanna, G. L. (2020). Screening for Pediatric Obsessive–Compulsive Disorder Using the Obsessive–Compulsive Inventory-Child Version. *Child Psychiatry & Human Development*, *51*(6), 888–899. https://doi-org.rosalindfranklin.idm.oclc.org/10.1007/s10578-020-00966-x

- Wheaton, M. G., Schwartz, M. R., Pascucci, O., & Simpson, H. B. (2015). Cognitive-Behavior Therapy Outcomes for Obsessive-Compulsive Disorder: Exposure and Response Prevention. *Psychiatric Annals*, *45*(6), 303–307.

- Law, C., & Boisseau, C. L. (2019). Exposure and response prevention in the treatment of obsessive-compulsive disorder: Current perspectives. *Psychology Research and Behavior Management*, *12*. https://doi-org.rosalindfranklin.idm.oclc.org/10.2147/PRBM.S211117

Thank You!

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