Family Inclusive Treatments (FIT's)

"Treating children and teens for OCD (and other anxiety disorders) without the inclusion of parents makes no sense to me."

--Lynn Lyons, LICSW

"Indeed, higher levels of family accommodation are associated with increased OCD symptoms, increased functional impairment, and poorer treatment outcome in both children and adults (Amir, Freshman, & Foa, 2000).

--Thomson-Hollands, et al., 2014

Tackling OCD in families:

1) Accurate diagnosis
2) Psycho-education…clear, blunt, up front
3) Solid treatment approach (which is a family approach)

Some OCD information…

- About 1/200 children with OCD
- Strong evidence for genetic component, but interaction of genes, biology, environmental and other factors not clearly understood
- Early-onset OCD thought to be more genetic

Medications and Ped OCD

- SSRI's are the meds of choice.
- Zoloft/Sertraline studied and prescribed most frequently
- Four meds approved for OCD in kids/teens:
  - Anafranil (clomipramine) age 10 and up
  - Prozac (fluoxetine) age 7 and up
  - Luvox (fluvoxamine) age 8 and up
  - Zoloft (sertraline) age 6 and up

Medications and Ped OCD

- Research supports CBT and E/RP as first line of treatment for all but most severe
- 30-40% decrease in symptoms from meds
- When meds stopped, symptoms return within months
- Gains made with CBT continue after treatment is ended
- Meds can take 8-12 weeks; CBT improvement often seen within a few weeks

"From direct comparisons of CBT and SRI treatments, we conclude that CBT has the superior efficacy. COMBO versus CBT shows that SRI treatment adds little to concomitant CBT, while COMBO shows favourable outcome versus SRI alone."

Ivarsson, et al., 2015

The place of and evidence for serotonin reuptake inhibitors (SRIs) for obsessive compulsive disorder (OCD) in children and adolescents: Views based on a systematic review and meta-analysis. Psychiatry Res. 2015 May 30;227(1):93-103

Comorbidity with OCD

- Tic disorder & Tourette's Syndrome
- Attention Deficit/Hyperactivity Disorder
- ASD and Non-Verbal Learning Disability (NVLD)
- Depression
- Other anxiety disorders

Early onset (age 7 or so)

- Symptoms more severe and harder to treat
- More boys than girls

BUT…

- A 2015 study showed something else…

"Our hypotheses about a relationship between symptom severity on the one hand and age of symptom onset and gender on the other***, were not supported.***" *(Italics mine)*

"However, an unexpectedly strong negative relationship between family functioning and symptom severity emerged. Indeed***, family functioning stands apart from the other predictors in the strength of its relationship to symptom severity.***" *(Italics mine)*

Kenyon, K. M., & Eaton, W. O. (2015). Age at child obsessive-compulsive disorder onset and its relation to gender, symptom severity, and family functioning. *Archives of Scientific Psychology, 3*(1), 150-158.

The issue of comorbidity

- OCD and ADHD?
  - Stats vary, ranging from 0%-60%
  - Clinically, children often diagnosed with "attention and focus" issues
  - Attention given to executive functioning issues

BUT…

BUT…

- It's rare to have an adult diagnosed accurately with comorbid OCD and ADHD
- OCD is considered an internalizing d/o
- ADHD is classified as an externalizing d/o
- OCD is on the opposite end of the impulsivity scale, with behavioral inhibition and avoidance prominent

"These profound differences seem to challenge the possibility of a genuine comorbidity between the two conditions, at least on the theoretical level." (Abramovitch, et al, 2015)

The Executive Overload Model of OCD

- Is the child able to perform consistent rituals with the OCD?
- What meds are being prescribed?

Abramovitch A., Dar R., Mittelman A., Schweiger A., (2013). "Don't judge a book by its cover: ADHD-like symptoms in obsessive compulsive disorder," Journal of Obsessive Compulsive and Related Disorders, 2(1) 53–61.

ASD and OCD

- The presence of cognitive rigidity and ritualized behavior often leads to diagnosis of ASD and OCD.

BUT…

- Kids with ASD are NOT disturbed or distressed by the rituals and don't see them as intrusive!

OCD is a ***DOUBT FACTORY***

Obsessions
Repetitive, negative thoughts, images or impulses

Distress
Anxiety, fear, disgust, shame

Compulsions
Repetitive thoughts, images or actions

Relief
Distress subsides temporarily

Like All Anxiety Disorders, OCD Demands TWO Things:

- *Certainty: "I have to know what's going to happen next…and I want to control it!"*
- *Comfort: "I want to feel safe and comfortable…or else I want out!"*

Critical Concepts as we face anxiety…

- CONTENT is far less important than PROCESS
- We are eliminating NOTHING
- We have to teach an OFFENSIVE rather than a DEFENSIVE position

CO-COMPULSING

Are you as the clinician...

DOING THE DISORDER?

Types of Obsessions

- Contamination
- Sexual thoughts
- Fear of doing something awful…something against your values (What if I impulsively act on that thought I had?)
- Doing harm through carelessness or irresponsibility
- Scrupulousity/religious obesessions
- Perfectionism:
  - Exactitude, symmetry, fear of throwing things out b/c might be important, forgetting important information
- Getting a disease (health concerns)
- Lucky numbers, signals, etc.

Types of Compulsions

- Washing
- Checking
- Repeating
- Mental/internal compulsions:
  - Counting
  - Cancelling or undoing
  - Praying
  - Mental reviewing
- Confessing or seeking reassurance

The Content Trap

Content (not good)	Process (good!)
• Focus on & talk about how to fix SPECIFIC obsession	• Focus on HOW OCD operates & what it's up to
• Reassure about that SPECIFIC worry	• Cue "OCD-managing" strategies
• Talk rationally and try to problem solve	• Be general: "That sounds like your OCD to me…"
• Go over plans & specifics repeatedly	• Prompt detachment and movement forward (not elimination!)

Entanglement

The process of "fashioning meanings and warning signals out of passing mental detritus."

--Seif & Winston (2016)

Immediate Goals:

- Psycho-education
- Simplify and De-Catastrophize
- Positive Expectancy
- Begin shift in both ATTITUDE and FAMILY PATTERNS

FRONTLOADING
with
psycho-babble-free
psycho-education

Psycho-education

- With child and parents together (or at times parents alone)
- Poke around in family history a bit
- Blunt, simple, and upfront
- Use the term "OCD" rather than euphemisms
  - "This is the O, this is the C, and the D means it's not working for you…"

The importance of working as a family and DECREASING EMOTIONAL INTENSITY

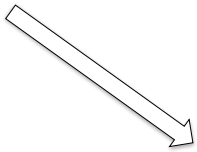
In the context of **family involvement** in cognitive-behavioral therapy:

Families low in conflict and blaming, and high in cohesion showed an average 93% response rate.	Families high in conflict and blame and low in cohesion showed only a 10% response rate.

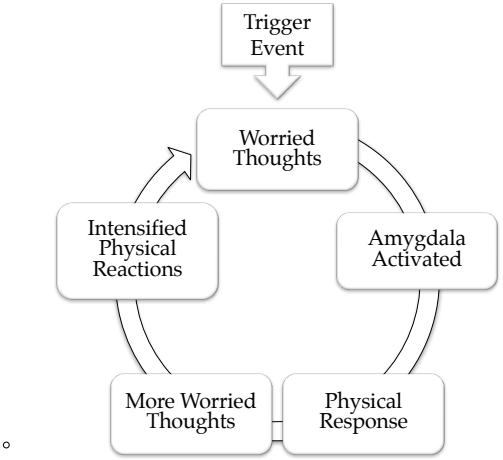
(Peris et al., 2012).

We want to demote OCD & worry…

- **CRISIS**



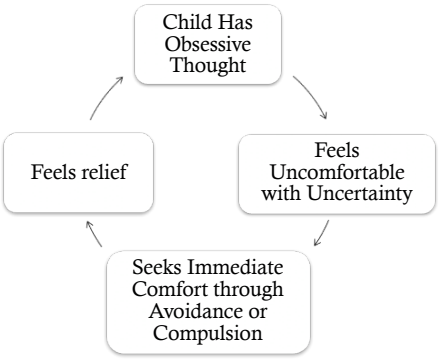
- **Expected and predictable**
- **Part of this family's life**
- **Even annoying!**



How OCD Controls Kids

Obsess	• Did I/could I do something wrong?" • "Something bad could happen"
Fear	• "I'm scared. I've got to get rid of this thought/ image/impulse.
Ritual	• Wash, check, repeat actions, etc.
Relief	• "That worked. I feel better."

So what's wrong with getting comfortable?



Cycle of Obsessions & Compulsions

Exposure and Response Prevention

E/RP

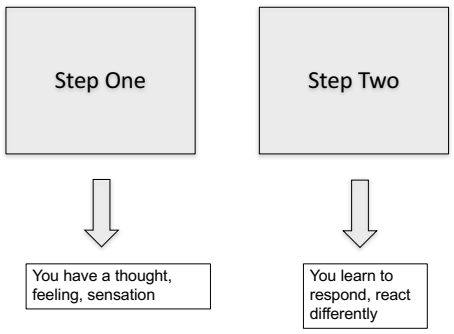
Of note…

"One quarter to one third of OCD'ers have a poor response to E/RP and will need additional treatment of some kind."

This means that 66% to 75% do well with it.

The average effectiveness of antidepressants is less than 30% in adults, and much lower in children, and yet many consider and use these drugs as the primary treatment for depression.

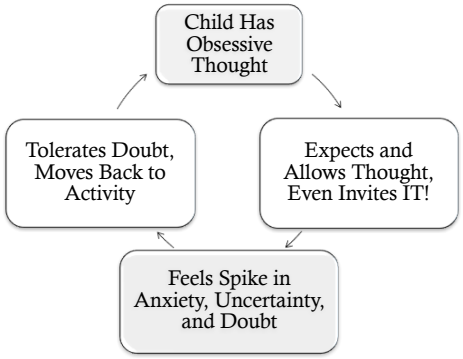
HMMMM….



Exposure and Response Prevention

E/RP with a dose of
ATTITUDE

Let's step into doubt and play a different game!



Cycle of Obsessions & Compulsions

Expect to worry

- Expect OCD thoughts and doubt to appear in certain situations
- Employ your new information about worry and your OCD thoughts
- Downgrade the OCD from CRISIS to annoying

OF COURSE

you're going to have these thoughts…

WHY?

1. Because you have OCD and this is what OCD does
2. You've been treating the thoughts AS IF they are real
3. So you want to get rid of them because they are bossy and even scary and sometimes weird

Externalizing OCD

The Goal: Create separation between the child and the OCD thoughts

- Name it
- Draw it
- Give it a voice
- Speak about OCD in the third person

Practicing What to Say

- Phrases are practiced and role played
- Write down phrases on index cards
- Stay free of content-based reassurance and rational arguments
- Use the language of *allowing* rather than eliminating
- Inject a tone of playfulness and energy

Exercise for Families: How does OCD get in the way?

- How does OCD control the family?
- Who in the family is in the OCD cult?
- What would you do if OCD wasn't in charge?
- What did you USED to do that OCD no longer allows?
- If you could pick one OCD to get rid of, what would it be?

Being uncomfortable & uncertain…

- Doubt is the price you pay for moving out of the OCD cult.
- In order to grow, you need to move into new territory and break old patterns.
- Allowing the OCD thoughts and handling uncertainty & discomfort will quiet the power of OCD so you can do what you want to do.

CRITICAL ATTITUDINAL SHIFT!

IF I'M UNCOMFORTABLE OR UNSURE OR NERVOUS AS I'M LEARNING SOMETHING NEW OR MOVING THROUGH MY DAY, I'M ON THE RIGHT TRACK…

Total Cra-Cra versus Tidbit of Truth

E/RP Interventions/Homework:

shake up the existing patterns and create new responses

Homework should:

- Be experiential and active and novel
- Illustrate the larger process(es) that you're teaching**… (it's NOT about content!)**
- Change/create the emotional tone of therapy (and often the tone of the anxious/depressed family)
- Be the basis of your treatment, not an adjunct to it

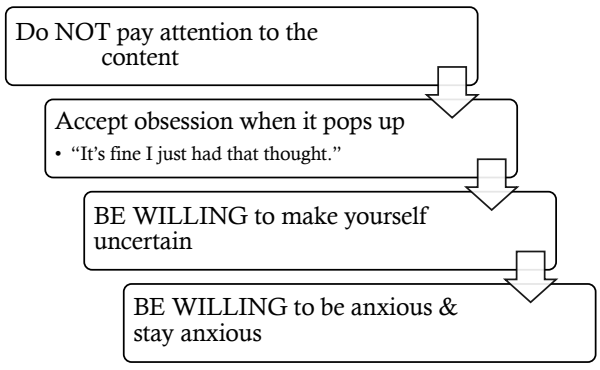
Creating an Assignment

- Be collaborative…
  - What OCD pattern would you like to start with?
  - Would you like to a small one or a big one?
- Role play with the OCD.

Creating an Assignment

- Predict with parents and child what OCD will do.
  - "What will the OCD say?"
  - "How will the doubt make your body feel?"
  - "What will your parents do if they get sucked back into the cult?"
  - "What will happen if you move on when OCD shows up?"
- Emphasize that we expect and *want* OCD to show up.

Handling OCD



Problems at School:

- School unaware of diagnosis
- Lack of information/knowledge in general about OCD
- Staff unknowingly reinforces OCD (particularly perfectionism)
- OCD intrusive thoughts treated as dangerous
- Accommodations are avoidance-based and content-based

Traps to watch out for…

- Accommodations with no weaning off plan
- Creating "escapes" that are warm, safe, & cozy… and support avoidance
- Diminishing anxiety by creating certainty (responding to questions, giving information, consistently reassuring)

How do we teach and cue a different response?

- Expectations and normalizing
- Externalization and talking back
- Moving toward rather than backing out
- TRAPS:
  - Accommodation
  - Reassurance
  - Content!
  - Certainty
  - Avoidance

To make OCD/worry stronger…

- Talk about the content of the obsessions
- Analyze and examine
- Search for and discuss the WHY
- Promote calmness as the prerequisite for moving forward

Changing the reaction to the OCD thought….

- ***Expect:*** *When does OCD show up? What does OCD say? What is the consistent theme?*
- ***Externalize:*** *Create distance from your OCD thoughts and observe them, but let them be there*
- ***Experiment:*** *Take action, shift your attitude, change your reactions…do the OPPOSITE and be on OFFENSE*

Information Stuff

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