Behavioral Health Webinar Series for Primary Care

Thursday, April 18, 2019
Noon to 1:00 p.m.

Sheldon Cooper's in my office, now what? Anxiety and OCD in clinical practice.

Presented by: Heather Yardley, PhD

Heather Yardley, PhD

Join by Phone: 1-240-454-0887 Conference ID: 644 137 993
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This session is eligible for 1.0 Category 1 CME credit upon completion of the CME Evaluation Survey
A link to the survey will be shared just prior to the presentation

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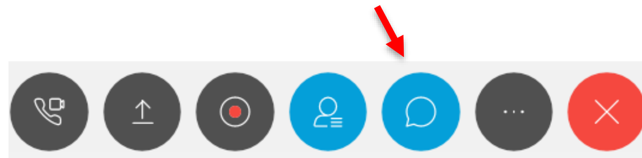
Reminders

•We have **muted** all participants.

•**Chat with us during the webinar.** To **type a question or comment** for the speaker or a facilitator, type directly into the WebEx chat box.



•This webinar is being recorded.

Sheldon Cooper's in my office, now what? OCD and anxiety in clinical practice

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https://www.youtube.com/watch?v=_V8ud3uVzfc

Obsessive-Compulsive Disorder

Obsessions: anxiety-provoking thoughts, impulses, or images

- Subjectively resisted
- Not psychotic
- Not an exaggeration of reasonable worry

Compulsions: overt behaviors or covert mental acts that are intended to reduce anxiety

Insight into excessive or unreasonable nature of O/C (not needed to diagnose in children)

Obsessive-Compulsive Disorder in Adolescents

Obsessions

- Contamination
- Harm
- Mistakes
- Taboo Thoughts
- Symmetry

Compulsions

- Washing
- Checking
- Reassurance Seeking
- Counting
- Body Scanning
- Repetition

(Abromawitz, Taylor, & McKay, In Press)

OCD Characteristics

Prevalence by late adolescence 1% to 4%

80% of adults with OCD exhibited the disorder in childhood

Gender distribution: Generally believed even, very slightly higher in girls

Comorbidity

Approximately 75% have comorbid diagnosis.

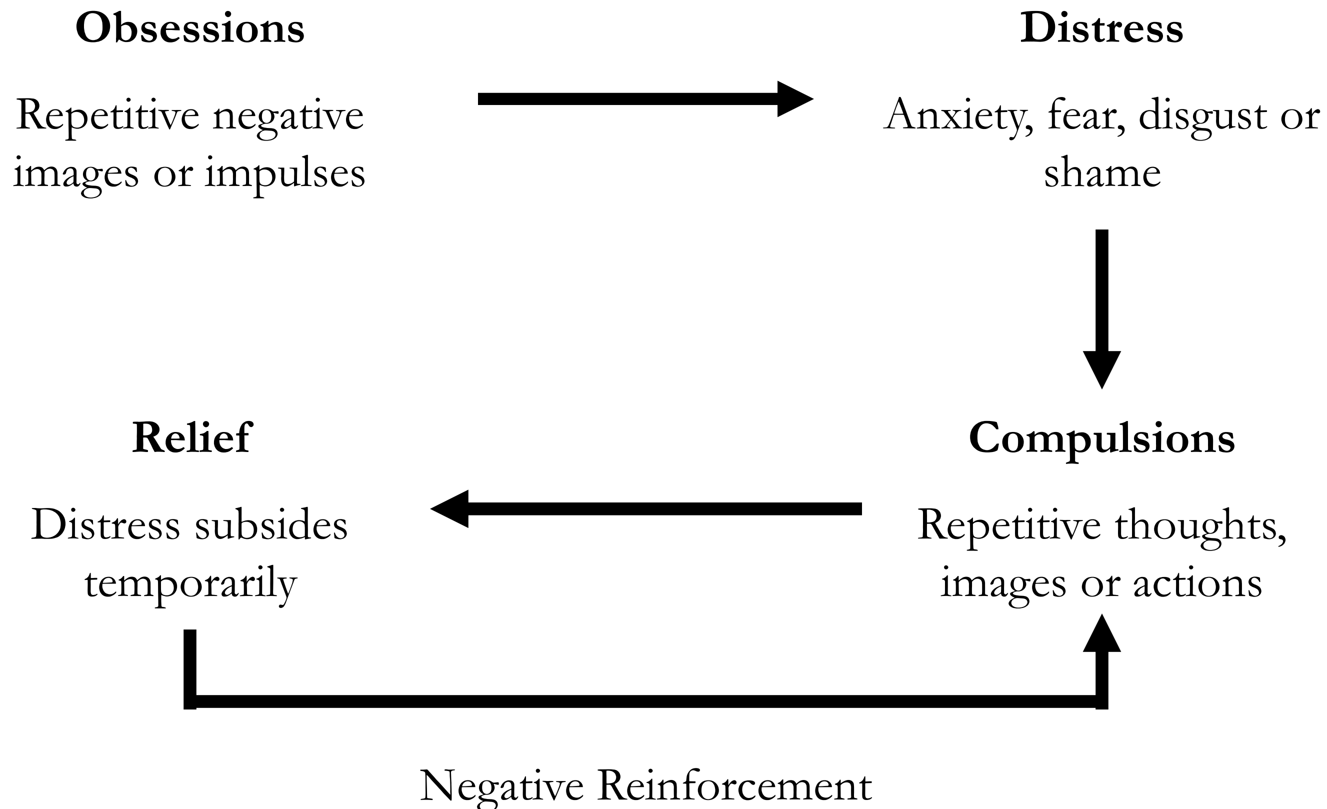
- 40-50% Anxiety Disorders
- 35% Attention-deficit/Hyperactivity Disorder
- 35% Depression
- 30% Tic Disorders
- 26% Developmental Disorders
- 11% Oppositional Defiant Disorders

Other OCD spectrum disorders

- Trichotillomania
- Body Dysmorphic Disorder
- Bulimia

(AACAP; 1998)

A CBT Model of OCD



From Piacentini & Langley, 2004

Treatment Options

Cognitive-Behavioral Therapy (CBT)

- Exposure
- Cognitive therapy

- Psychotherapy has been given a bad name
  - Play based or supportive therapies have little empirical support.

SSRI Medication

Assessment

Clinical Interview

- How long for symptoms? Who else is involved in the rituals? Impact on family? What has been tried already (meds, tx, parenting)? Family history?

CYBOCS

- Gives guidance and direction for hierarchy
- Cutoff score for mild OCD is >8
- Indicates the severity of the symptoms

Other Measures?

- Family accommodation
- Other measures of anxiety or depression
- CGS/CGI (post tx or ongoing to measure progress)

Assessment in the Clinic

Quick questions to ask

- Are there things that you feel like you have to do in a certain way?
- Can you do it a different way?
- What happens if you get interrupted?
- What happens if you can't do it?
- Ask about all types of behaviors: cleaning, self-care (showering, grooming, dressing), eating, homework, arranging, reading, writing

Anxiety vs OCD

Anxiety and OCD both involve worry

- Anxiety does NOT include rituals
- Type of worry may be different:
    - OCD worries tend to be unrealistic or diffuse
    - General anxiety tend to be tied to real life situations

Anxiety

- Can be worry, fear, or concern about a specific event, topic, or situation
- Combines physiologic and psychological symptoms
- Includes
  - ***Panic Attacks***
  - ***Specific Phobia*** (e.g., animal, environment, blood/shot/injury)
  - ***Social Phobia***
  - ***Obsessive Compulsive Disorder***
  - ***Posttraumatic Stress Disorder***
  - ***Acute Stress Disorder***
  - ***Generalized Anxiety Disorder***

Treatment Overview

- Typically 12 to 15 sessions weekly (some programs have intensive services – daily sessions)
- 60 to 90 minute session depending on time/availability/flexibility/financing
- Parent involvement is critical
- Psychoeducation, cognitive strategies, hierarchy, exposures, repeat
- Long term planning and relapse prevention

Psychoeducation Topics

Obsessions and Compulsion

- Finding language that fits for the family, or what they are already using

Prevalence data/normalizing

- Famous people who have OCD

How OCD symptoms work

- Analogies: "Push the button," Caveman, False Alarm

How OCD intensifies/spreads

- Tree growing (old symptoms have long roots, new ones do not)

OCD as something outside of self

- Weird at first but lets us have something to work/fight against

Treatment as tools to be used in the long run

- OCD is never gone completely, may remit for a while but may come back

Cognitive Activities

- Cognitive Distortions
- Thought Records
- Evaluating Thoughts
- Misattribution of Physical Symptoms

Common Cognitive Errors

- Doubt/Uncertainty
  - "I can't remember if I checked my door lock."
- Thought Action Fusion
  - "If I think about having sex with my cat, I must want to do it."
- Overestimating probability
  - "I could get HIV from sitting on a public toilet seat."
- Catastrophic thinking
  - "I'll get sick and die if I go near sick people without washing afterwards."
- Responsibility
  - "If my mom develops cancer, it is my fault."
- Distorted automatic thoughts
  - Catastrophizing, labeling, dichotomous thinking, overgeneralizing
- Maladaptive assumptions
  - "I need to get rid of all anxiety immediately" "Anxiety is a sign of weakness"
- Dysfunctional schemas
  - Biological threat, humiliation, control, autonomy, abandonment

Cognitive Restructuring

- Based on notion that symptoms arise from inaccurate beliefs about related stimuli.
- Teaches the patient to identify and correct anxiety provoking thoughts that motivate compulsive behaviors.
- The way one interprets events is important.
  - Goal of CT is to modify anxiety provoking thoughts.

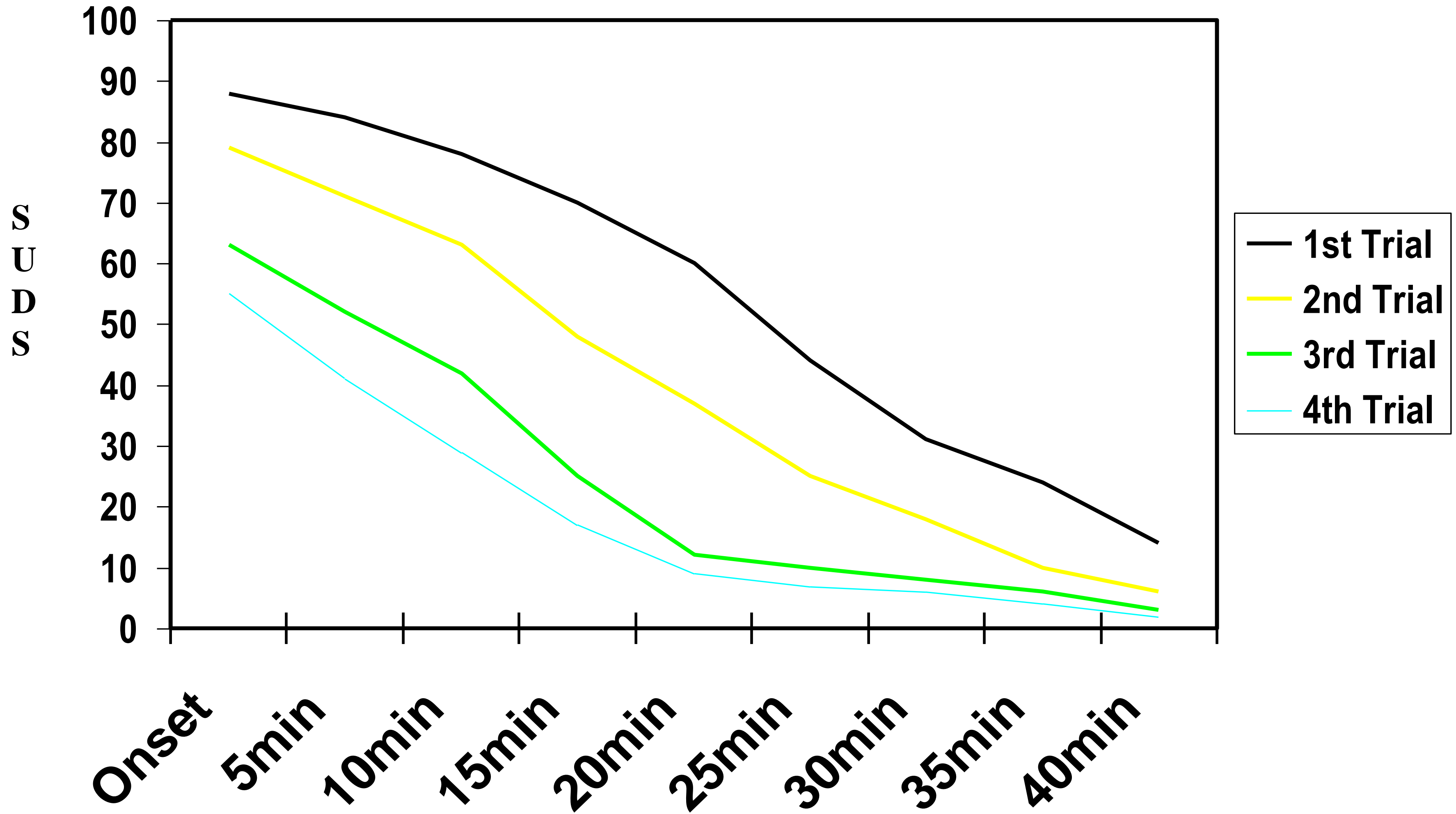
Behavioral Activities

Hierarchy

Exposure and Response Prevention

- Rules of exposure
- Alternate types of exposures

How ERP Works



Working with the Psychologist

When the exposures are physical in nature or related to a medical condition, the psychologist will often seek input on what is safe/reasonable/expected

Medication Options

Medication Management

- Serotonergic Medication
- Tricyclics (for OCD)
- Antipsychotic Medication (for OCD)
- Benzodiazepines: often not indicated

Cautions

- Black Box Warning
- FDA has only approved several

Accommodation

Families may inadvertently maintain symptoms—either to stop the child from performing rituals, to decrease the child's distress, or to hurry the child along

Over 89% of families note hardship to siblings or marital discord related to child's OCD (Storch et al., in press)

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Reassurance Seeking

Repeated questions to parent/care giver seeking information or reassurance about something

- Am I OK? Are you OK?
- What is going to happen next?
- This isn't bad, is it?

Wean them off the questions

- That's an OCD question, provide answer
- That's an OCD question, answer one time (and after "I have already answered that")
- That's an OCD question, I am not going to answer
- Ignore

Recommendations for Parents

- While waiting for treatment, parents can:
  - Start to document rituals and “high risk” times/situations
  - Look for the worries under the rituals
  - Start to do some education of their own (see resources list)
  - Think about if they may also need treatment
  - Prepare their child for treatment
    - Help them understand why they are seeing someone
    - Normalize the experience of going to therapy
  - Remember ITS NOT THEIR FAULT

What We Do

Community-Based Services

Home Based Team

- Helps families at risk of temporarily losing custody of their children due to inappropriate discipline, DV, and/or abuse history
- PCIT is primary intervention model and family preservation strategies to keep the family whole.

Early Childhood Mental Health Team (ECMH)

- Provides screening, assessment and treatment for families with children 0-6
- Services include consultation and training for educators and behavioral health providers
- Intervention services in school and home settings

Family Support Program (FSP)

- Offers office-based and community-based services to youth who have experienced:
    - sexual abuse
    - physical abuse
    - exposure to domestic violence
    - traumatic grief
    - adolescent relationship violence

School-Based Therapy Team

- Provides consultation, assessment and treatment services in various Central Ohio elementary, middle and high schools
    - Offers follow-up in the home as needed
- Part of NCH Care Connection
- Prevention services are also offered in coordination with CSPR

What We Do

Community-Based Services

Integrative Family and Systems Treatment (IFAST)

- Intensive family treatment service offered to youth who have problems in more than one area of their lives, such as home, community and school
- Often involves extended family members, friends, neighbors and teachers.

Family Based Intensive Treatment (FBIT)

- Developed for patients who have had recent hospitalizations due to safety concerns or symptoms of serious emotional disturbance
- Interventions allow youth to safely stay at home with their families and address the behavioral health problems that place them at risk

Multisystemic Therapy (MST)

- Services for the families of youth ages 11-17 whose serious conduct problems make them at risk of being removed from their homes by the legal system
- Youth may have a history of assault; robbery; theft; aggression; running away; drug and alcohol use; and/or school difficulties

Multisystemic Therapy for Problem Sexual Behavior Youth (MST-PSB)

- Focuses on youth with problematic sexual behaviors and their family members
- The primary referral behaviors may be sexual offenses but the interventions are effective in addressing other problematic sexual behaviors as well

What We Do

Outpatient Services

Eating Disorders Program

Experts from Adolescent Medicine and Behavioral Health work with the child and family to stabilize eating behavior and health. The team also addresses concerns that may lead to disordered eating, including medical or psychiatric concerns. A team of dietitians, physicians, behavioral health therapists, psychiatrists, and nurses work together to meet each individual child's needs at each level of care. Programming Includes:

Outpatient Therapy Services

- Therapy is designed to help parents stabilize their child's eating and help parents learn strategies to change behavior and cope with stress. Sessions occur once per week or as needed.

Intensive Outpatient Program (IOP)

- The program provides more structure for adolescents ages 12-18 and families who need additional support than what is provided in outpatient treatment. Treatment includes patients and families attending group, individual and family appointments where they receive counseling, nutritional and medical guidance, psychiatric treatment and occupational therapy.

Partial Hospitalization Program (PHP)

- Highest level of care within the program, designed to help stabilize eating, monitor medical concerns, and provide skills and structure to adolescents ages 12-18 with eating disorders. Patients participate in group, individual and family therapy sessions led by therapists. Nutritional counseling, occupational therapy, massage therapy, nursing care, medical stabilization and psychiatric treatment are also provided. All meals during treatment time are provided on-site and prepared by a chef. All meals have a dietitian and mental health counselor present.

What We Do

Outpatient Services

Mood and Anxiety Program (MAP)

Dedicated to serving the needs of adolescents with a primary diagnosis of a mood or anxiety disorder. Our multidisciplinary team includes psychiatrists, nurses, medical assistants, counselors, social workers and psychologists. Programming Includes:

Outpatient Therapy Services

- The program aims to build the skills necessary to aid in the recovery process by working individually with clients on a weekly or bi-weekly basis

Psychiatry Services

- The MAP program is an integrated treatment program allowing for collaboration between the psychiatrists, nurses and therapists.

Dialectical Behavior Therapy (DBT) Program

- The DBT program requires participation in both group and individual counseling requiring about 3 hours of attendance per week. The program serves adolescents aged 13-18 who typically struggle with emotional regulation, interpersonal relationships, self-harm behaviors or suicidal ideation.

Intensive Outpatient Program (IOP)

- Time-limited skill-based treatment for individuals aged 13-17 whose mood and anxiety symptoms require an intermediate level of care between traditional outpatient and inpatient care. Involves 3-hour group sessions held in the evenings 3 days/week as well as individual and family sessions. Clients will have access to a mix of group and individual counseling, family services, psychiatric services and medication management services as well as crisis services.

What We Do

Outpatient Services

Our **Generalist Outpatient Teams** located in Downtown, Dublin, East, and Westerville are designed to provide children and their families with treatment for a wide range of emotional and behavioral disorders. These services represent the lowest level of care in our service spectrum. Appointments are office-based, typically occurring every other week. Our team of professionals includes Social Workers, Clinical Counselors, Marriage and Family Therapists, and Psychologists.

Programming includes:

- Diagnostic Assessment
- Individual and Family Therapy
- Psychological Testing
- Group Therapy
  - Incredible Years
  - Multi-Family Psychoeducational Psychotherapy (MF-PEP)

What We Do

Pediatric Psychology and Neuropsychology

Pediatric Psychology and Neuropsychology: provide services at our main campus for youth with chronic medical conditions. We provide services inpatient, outpatient, and in medical clinics.

Programming includes:

- Diagnostic Assessment
- Individual Therapy
- Psychological Testing
- Neuropsychological Testing

Resources

Websites:

Obsessive Compulsive Foundation (http://www.ocfoundation.org)

Anxiety Disorders Association of America (www.adaa.org)

Books:

What to do when your brain gets stuck, Dawn Huebner

Up and down the worry hill: A children's book about obsessive compulsive disorder and its treatment, Aureen Wagner

Talking Back to OCD: The Program That Helps Kids and Teens Say "No Way" -- and Parents Say "Way to Go," John S. March

A Video Example

http://www.youtube.com/watch?v=Rn1OYIYzgm8&feature=player_embedded

Howie Mandel:

http://www.youtube.com/watch?v=dSZNnz9SM4g&feature=related

Sometimes those checking compulsions have advantages!

Questions?

Thank you for participating!

If you would like to receive CME credit for today's presentation, please complete the following survey by:

Thursday, April 25, 2019

https://www.surveymonkey.com/r/HXFDHGL

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June 12, 2019 from Noon-1p.m.

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CME Posting

CME POSTING

Series Name: Behavioral Health Webinar Series for Primary Care

Date: April 18, 2019 / Noon-1PM

Presentation Title: Sheldon Cooper's in my office, now what? Anxiety and OCD in clinical practice.

Speakers Name(s): Heather Yardley, PhD

Planning Committee: Jennifer White, MD; William Long, MD; Nancy Cunningham, PsyD; Alex Bishara; Megan Rhodes; Sherry Fletcher; Jessica Dudley

- No one in a position to control content has any relationships with commercial interests

Session Objectives:
At the conclusion of this activity, participants should be able to:

1. Identify anxiety and OCD in patients presenting in their clinic.
2. Provide appropriate treatment recommendations to patients as they wait for mental health treatment.
3. Make appropriate mental health referrals for youth who can not manage symptoms on their own.

Commercial Support: N/A

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