OCD Spectrum and SUDs: Special Issues with Young Adults

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Specialized in:
SUD’s and Process Addiction
OCD
Anxiety Disorders
Eating Disorders
Avoidant Personality Disorder
Obsession, Compulsion, Hoarding, Suffer, Intrusive, Disorder, Counting, Panic, Nervous, Dirty, Impulses, Psychotic, Fear, Distressed, Anxiety, Germs, Counting, Washing, Behavior, Safety, Habits, Paranoid
● Assess for OCD Spectrum
● Differentiate between anxiety thought rumination versus obsessive thoughts
● Discuss the importance of simultaneous treatment for OCD and SUDs
● Identify gaps in treatment that jeopardize recovery for young adults
● Apply relapse prevention to the entire treatment plan
● Advocate for patients recovery, refer to specialized providers to support treatment and relapse prevention goals
● Examine a case study with diagnosis of OCD and SUDS
What is Obsessive Compulsive Disorder?

**Obsessions** - Intrusive unwanted thoughts; a person becomes mentally stuck

**Compulsions** - external or mental acts (rituals, checking, asking, stating, reassurance or any act to reduce anxiety)

**Avoidance** - Creates a false sense of security

**Severity measured by:** time, distress, interference resistance, control over compulsions with the YBOCS (Yale Brown Obsessive Compulsive Scale)
4 out of 5 people report having intrusive thoughts

The most common reported intrusions for OCD are of a harm and/or sexual nature.

We have to ask uncomfortable questions as young adults are often still figuring out what is normal in the world.
OCD onset is usually by age 25

Onset of OCD in 22.4 and 23.0 of men and women combines

N=18,500
Collected from 5 different major cities
OCD Types

- Perfectionism
- Symmetry, Exactness, “Just Right”
- Relationship OCD
- Sexual Orientation OCD
- Tourettic OCD (can be treatment refractory)
- Magical Thinking/Superstitiousness
- Body-Focused OCD/Sensorimotor
- Suicidal OCD
- Contamination
- Harm OCD (Neglect and/or violence to self or others
- Sexual Intrusions (self others, family, rape)
- Pedophilia OCD (POCD)
- Postpartum/Perinatal OCD
- False Memory OCD
- Emotional Contamination (zombies, inanimate objects, characteristics)
- Religious Theme/Scrupulosity
The OCD Spectrum

Misophonia
Oppositional Defiant Disorder
Body Dysmophia
Hoardings
Autism Spectrum
Anorexia Nervosa 8%
Pathological Gambling
Hypochondriasis

Body Focused Repetitive Behaviors (BFRB’s)
Excoriation (skin Picking, not self harm)
Trichotillomania (hair pulling)
Tourette/Tic 5%
Self Harm
Kleptomania
Social Phobia 11%
- Uncomfortable
- Increased Urges
- Anxiety
- For some this might be intense feelings (anger is common)
- Guilt
- Doubt
- Confusion
- Fear
# Examples of Obsessions/Compulsions

<table>
<thead>
<tr>
<th>Obsessions</th>
<th>Compulsions</th>
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<tbody>
<tr>
<td>Fear of harming oneself or family members due to carelessness</td>
<td>Washing hands until raw</td>
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<tr>
<td>Fear that one’s actions will determine whether something horrible happens</td>
<td>Repeatedly checking the security of a locked door</td>
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<tr>
<td>Fear of offending God or other people</td>
<td>Arranging and rearranging items in a set order</td>
</tr>
<tr>
<td>Fear that one will forget crucial information</td>
<td>Examples of compulsory mental acts</td>
</tr>
<tr>
<td>Fear of losing items</td>
<td>Counting silently</td>
</tr>
<tr>
<td>Fear of illness, injury, or death</td>
<td>Repeating specific words</td>
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<tr>
<td></td>
<td>Recalling positive images (safety images)</td>
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Intrusive thought/Obsession becomes obsessive in which the individual cannot control or suppress the thoughts or images.

The presence of the obsession causes the individual to want not cause any potential harm, so they seek relief through a:

- Compulsion (an action or neutralizing thought)
- Avoidance

The anxiety, the image, the intrusion continues to build increasing anxiety, uncomfortability, continued urges to compulse or avoid. The relief is only temporary.
Exposure and Response Prevention (ERP)

- Intrusion
- Obsession
- Meaning Evaluation
- Compulsion Avoidance

Exposure Intervention
Actually, I would prefer to borrow a crayon or something if you have one.
Thought Rumination vs. Intrusive Obsessions

- **Thought rumination:** repetitive thought without resolution or completion. May be fear based or day to day. Sometimes wanted or recalled intentionally.

- **Intrusive Obsession:** Unwanted, intrusive, thoughts and feelings, ideas, sensations, or behaviors that drive a compulsion.

- Behaviors or thoughts carried out to get rid of the obsession (only temporarily).

These are major distinctions between OCD, Depression, and Generalized Anxiety.
OCD or Anxiety?  
Most don’t know the difference

**Rule out:** BiPolar Disorder, ADHD, or OCPD

**Complete the:**

**Yale-Brown Obsessive Compulsive Scale (Y-BOCS) Symptom Checklist**

**Yale-Brown Obsessive Compulsive Scale (Y-BOCS)**

Children's Yale Brown Obsessive Compulsive Scale (CY-BOCS)

**Does the patient have insight to know the obsessions and compulsions do not make sense?**

- Ask patients what will happen if they do not comply to avoid the fear...
- Ask additional questions about the nature of the obsessions
  - Perform functional analysis of compulsion

**Egosyntonic** - Align with the self and seem acceptable and warranted at times

Behaviors support Intrinsic wishes

**Egodystonic** - Thoughts are distressing, repulsive and inconsistent when intrinsic wishes

Behaviors are avoidant as they are not in line with wishes, are often the opposite of what an individual would “usually” do/desire.
Diagnoses that present as OCD

ADHD
PTSD
Social Anxiety
Generalized Anxiety
Paranoid Personality
Delusional Disorder
Schizophrenia
Psychosis

Stereotypic movement disorder
Aspergers (lack of social queue, regimented bxs)
Tics-Tourettes (confessions)
Motor Disorders
Intermittent Explosive Disorder
BiPolar
Personality Disorders
“......... 24% of individuals with OCD meet lifetime criteria for an alcohol use disorder, 18% meet lifetime criteria for a drug use disorder and individuals with OCD are at increased risk for substance use dependence”

Source: Karno, Golding, Sorenson, & Burnam, 1988 and Regier et al., 1990
Both disorders are neurological abnormalities in the brain.

Behavioral Therapy Models - Habituation and Extinction

Amygdala regulation

Teaching patients to be in their bodies and not in their thoughts.
Warning Signs of Young Adult Use

- Alcohol, smoke or other chemical odors on them or their friends' breath or clothing
- Obvious intoxication, dizziness or bizarre behavior
- Changes in dress and grooming
- Changes in choice of friends
- Frequent arguments, sudden mood changes and unexplained violent actions
- Changes in eating and sleeping patterns
- Sudden weight gain or loss
- Loss of interest in usual activities or hobbies
- School problems such as declining or failing grades, poor attendance, and recent discipline problems
- Trauma or frequent injuries
- Delinquent behavior
- Missing Money, Increased frequency of asking for money
- Talking about depression or suicide; suicide attempts

N=323
Source Mancebo, 2009
Assessments for OCD and SUDs

OCD
Y-BOCS
DOCS-Dimensional Obsessive Compulsive Scale
CY-BOCS (if less mature)
OCI-R
NIMH- GOCS
Substance Brief Intervention- 2

AUDIT-C
MAST
CRAFFT
National Institute on Drug Abuse
Substance Abuse and Mental Health Services Administration
NIDA-Modified NM-ASSIST
Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS)
Brief Screener for Alcohol, Tobacco, and other Drugs (BSTAD)
16.3 million adults with a past year alcohol use disorder (80.7% of adults with an SUD)

2.3 million adults with both alcohol and illicit drug use disorders (11.3% of adults with SUDs)

6.2 million adults with a past year illicit drug use disorder (30.7% of adults with an SUD)

14.0 million adults with an alcohol use disorder only

3.9 million adults with an illicit drug use disorder only

20.2 million adults aged 18 or older with past year SUDs

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2014.
What are the needs for the young adult population?

- OCD’s Presence in treatment centers with clinicians.
- Simultaneous treatment for dual diagnosis (ERP Therapy). Two treatment manuals.
- Careful of the language we use (i.e. obsessed, so OCD and/or Substance addict, junkie, use to work as a team for best patient outcomes.
- More research needed on the connection or prevalence and treatment outcomes dual diagnosis for both protocols.
- Advocacy and psychoeducation for public and families.
- Prolonged exposure for trauma, consistency in treatment protocol for trauma overlap.
- Constant recovery focused planning.
- Teaching Tolerance and Accepting uncertainty- YIKES!
- Suicide Awareness and Prevention, more clinical awareness of bothersome symptoms and need to escape.
- Attention to Nutrition.
- Support after leaving treatment and return to home with triggers.
What are overlaps in Treatment?

- Both treatments are anxiety provoking patients
- Stages of change model applies
- Boundaries are needed
- ERP, SUDs, and ED treatment hold patients accountable for joint effort in sessions/treatment
- Both treatments are an exposure of sorts. Patients have to challenge themselves to resist urges, sit in the moment, and find other ways to manage triggers and anxiety
- Practitioners model healthy coping
- Family involvement in recovery, repairing relationships, and allowing the family to halt rituals or codependent behaviors while supporting recovery of family members
- Cycles are similar
- Recovery plans are necessary
- Coping skills are beneficial
- Recovered living is ongoing
- Acceptance of uncertainty
- Slowing down life
What are the gaps in Treatment?

- Requiring medical stabilization of SUDs or ED before treatment of OCD can begin. Patient readiness is a barrier.
  - Talk therapy is the "go to".
  - CBT is helpful as cognitive interventions, exposure and response prevention is needed in addition.
  - Exposure alone is not enough, response prevention is the most important part of the work.
  - Lack of ERP training in both individual clinicians and treatment providers who treat OCD.
  - Too much reassurance provided by clinicians.
  - Some OCD clinicians and treatment centers do not want risk associated with SUDs and/or ED.
  - Lack of research for the SUDs/ED and OCD on researched based protocols. Neglected area of clinical interest.
  - Not referring patients that are out of practice scope. Seeing OCD as anxiety in general.
  - Neglect of simultaneous recovery and relapse prevention.
What are the difficulties in treating both disorders?

- Lack of Trust
- Perfectionistic or well routed routines/coping
- Low tolerance of anxiety and self defeating belief systems
- Lack of assertiveness
- Lack of emotional Intelligence
- Personality and mood disorders (rigidity)
- Identified as the troubled child, family dynamics play a role
- Risk of relapse, impulsive behaviors to self-soothe, sabotage
- Isolation and lack of support to reinforce relapse, prevention, and exposure plans
Psychoeducation works well
Drop in informational session from campus support to advise of alcohol and drug use a peer to peer forum to learn about D&A
Encouragement of taking drug and alcohol classes
Exposures for those newly looking at their problem, ceasing caffeine, a way to get the population to look at behavior and see what might work for coping tools
Support for friends on campus who want to address other friends use
Support for assertiveness skills
Sober AF Entertainment (campus and off campus sober events for those of the same age)
Support for communication with self and in relationships, conflict
Fun and instant ways for recovery
Options for self assessment and harm reduction
Stages of change are sometimes longer process due to expectation of immediacy- Teaching long term
What will life be like outside of school?
# Technology and Treatment

<table>
<thead>
<tr>
<th>Squirrel Recovery</th>
<th>NOCD</th>
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<tbody>
<tr>
<td>Sober Tool</td>
<td>Live OCD Free</td>
</tr>
<tr>
<td>Pear Reset</td>
<td>OCD Coach</td>
</tr>
<tr>
<td>Happify</td>
<td>iCounselor OCD</td>
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<tr>
<td>I am Sober</td>
<td>Mayo Clinic Anxiety Coach</td>
</tr>
<tr>
<td>GGRO</td>
<td>Offers quick and responsive support</td>
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<tr>
<td><a href="http://www.chrissiehodges.com/gam">http://www.chrissiehodges.com/gam</a> echangersvideo/</td>
<td>Podcasts and inspirational stories</td>
</tr>
<tr>
<td>Middle Finger to Perfection</td>
<td>IntrusiveThoughts.org</td>
</tr>
<tr>
<td>Food Psych</td>
<td>The OCD Stories</td>
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Ethnicity and Culture

Cultural elements of campus life

Recovery is different for different communities

Work on our language around campus and in our interactions with young adults

Be in the know….but not fake’

They can smell a fake from far away

**Young Adult is searching for:**
Fun, dealing with social anxiety, keeping up with demands of school, perfection, friends are the world they know, consequences and warnings are not enough. Learning who they are, interested in experiences of others drug use, having variety of options on campus for non AA related groups.

**Need to know:** how to have hard conversations, making friends, connecting with others that have similar interests, deal with family stressors and returning home during semesters, independence, Transferable skills, focus on small action steps vs. huge plans (Collegiate Recovery, SOBArecovery, Shavahal
ERP Treatment for OCD
Exposure and Response Prevention ERP-
(Paradoxical treatment)

- Hierarchy development based on Subjective Units of Distress
- Identify Triggers and challenge irrational core beliefs
- Exposures to fear are prolonged, graduated, repetitive, and consistent
- VSee, in Home, in community, in office
- Encouraging, not reassuring
- Prevent response of compulsion

- Use of cognitive strategies
- Avoid any Benzodiazepines
- Recovery is simultaneous with ERP protocol
- High Efficacy, high dropout rate
- High need for family involvement
- Distress tolerance
- Coping tools
- Patients must be an active participant and choose exposures
What Exposures Look like

Exposures are anything that increases anxiety or helps a person tolerate uncertainty.

- Exposure to stimuli (in vivo, imaginal, interoceptive)
- Start small and increase as tolerable (values)
- Resist urges and prevent compulsions
- Rate subjective units of distress (SUDs) before/during/after
- Re-Exposure=Increasing anxiety after compulsion
- Habituation/Extinction is not the only goal
- Sit in discomfort as long as the person is willing
- Formula for OCD
1 out of 50 of these thoughts are not able to be reduced.
CBT-ERP Treatment Outcomes

Reduction of symptoms solely with ERP

- 50-60% measured with the YBOCS scale
- Working on dysfunctional beliefs systems.

ERP efficacy solely with ERP

- 25-30% of patients drop out prematurely
- 80% respond positively to treatment
- 20% or more do not
Treatment Measures of ERP

Graph showing anxiety levels over time with different exposures marked:
- 1st exposure
- 2nd exposure
- 3rd exposure
- 4th exposure

Graph showing SUDS rating over minutes with a peak at 7 minutes.
## Adjunct Treatment Options

### Other Adjunct Therapies
- ACT Acceptance and Commitment
- Mindfulness (and CAMSA)
- SSRI
- Glutamate supplement
- Strengths Based Approach
- Metaphors
- Reward Systems
- Group Therapy with ERP
- Prolonged Exposure

### Cognitive Restructuring Therapy (CT)
- Cognitive Strategies
- Distress tolerance (DBT)
- Coping tools
- Uses rational to see the fear is not as powerful as once thought (i.e., murderer versus me)
- Peer support
Peer Support/Peer Recovery Specialists

- Wrap around service
- Patients need support outside of sessions, treatment, and in transitions/step down.
- College setting or being away from home creates more barriers.
- Pressures for young adults to cease use of substances. Some aren’t even of drinking age and cannot commit to abstinence.
- Peer to Peer understanding and real time feedback

- Mindful Drinking
- Different obligation than from sponsor relationship
- Peer support
- Can be shown how to “live in recovery” or “in moderation”
- Peer support works closely with therapist to reinforce session gains.
- Peer Support encourages therapeutic topics.
- Can support eating disorders on college campus or by telehealth
Dual Relapse Prevention Planning

Triggers and warning signs: Use Prior relapse as example

Plan for the worst

Involve trusted people/groups that are not only of disordered eaters/OCD sufferers

Lifestyle goals oriented around values and healthy

Self Assessment and Reflection

Self Talk: Externalize

If you feel overwhelmed with your exposures, what is your plan to keep moving forward without drinking or drugging? Plan for the worst

You have simultaneous plans of treatment

Changing one behavior, cognition, emotion will impact all plans for recovery.

Working on All or nothing thinking

Harm Reduction model is helpful in helping more

Evidence based practice that support recovery

Achieving a 15% Relapse Rate: A Review of Collegiate Recovery and Physician Health Programs (Brown, & Bohler, 2018)
Binge Eating Disorder and OCD - Pre

- 27 y/o female, in a committed heterosexual relationship of 2 years, caucasian, Middle Class from a low SES household growing up. OCD onset age 22 after IP treatment for Alcohol Use Disorder, Sudden intrusive thoughts (sexual, harm, relationship) works in a creative industry freelance photographer. Supported by family, a State University in small college town in Colorado, lives off campus with multiple roommates (also in recovery). From a family of “big drinkers”

- DX: OCD Severe YBOCS scale 27 (moderate insight), Major Depression Mild recurrent, Beck Depression Inventory 19, ED-NOS prolonged periods of restriction behaviors with food especially during binge drinking episodes or alcohol triggers or cravings.

- Issues at work and issues with school grades dropping. Withdrawal from partner ones due to fears of harm and relationship obsessions. Frequent obsessions about relapse. Focused on the theme of “losing control” “emotionally hurting others” “images of children being harmed/abused”

- Lack of treatment in the past addressing OCD, SUDs, and ED at the same time. She was told that anxiety is common and is part of the recovery process. 12+ years in therapy, EMDR, general talk therapy, Emotional Freedom Technique, CBT, SUD’s treatment, Residential 3 times, current Sponsor with AA and has a great relationship with her Sponsor who recommended ERP. No on campus support. Argues with partner.
Behavior

**SUDs**

Fear of binge and losing control on family 10
Thinking about relapse 10
Listening to scripts of fear of losing control 10
Writing down fears of relapse 9
Not asking partner for relationship status 9
Planning Meals for dinner 7
Watching Scary movies 8
Fear of harming family drinking/wasting time 8
Seeing others drink 6
Carrying around photos of children smiling 6
Reading articles of crime against people/children 5
During Treatment

- Psychoeducation about eating cycles, relationships, and OCD/ERP materials sessions 1-2 and ongoing
- Development of Hierarchy sessions 1-4 (continuous development)
- CBT, ERP, ACT, and DBT distress tolerance first 3-4 sessions, workbooks/books outside of sessions.
- Large fear of losing control, explore core fears
- OCD causes her to restrict, searching for the “correct” things to eat
- Fears around sunscreen use, makeup, “healthy” non toxic products
- Teaching and using coping tools for continued recovery, setting up her day and environment around recovery and exposures.
- Exposure to consistent snacking throughout the day
- Explored core beliefs around food
- Gradual changes to utensils, plates, routines around eating at home with support of partner
- More engagement and assertiveness in relationships
Post ERP and Treatment

- Reduction of symptoms: More awareness and psychologically flexible with obsessions
- YBOCS score 12 (from 27), Becks Depression Inventory 10 (from 19), Beck's Anxiety Inventory 20 (from 42). No medication
- Patient was able to stop asking partner for reassurance, both felt better about relationship
- Partner was supportive with boundaries with friends, family, and sponsees.
- Increased eating consistency and mindful awareness of hunger feelings, mindfulness practice, and mindful eating exposures.
- Obsessions are still present, less impactful, able to move forward with a different task amidst the anxiety, less avoidance.
- Feels in normal behaviors and thoughts around food, no restriction behaviors for 6+ months.
- Increased insight to symptoms not seeing them as a personal default, able to remain in the fear when new symptoms increase
- Shared about OCD with friends, increased connection and understanding of Harm related OCD thoughts
Questions?
Resources Continued


– SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2015.
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