# The Ins and Outs of Treating OCD

**Common obsessions:**

- contamination fears, worries about harm to self or others, the need for symmetry, exactness and order, religious/moralistic concerns, forbidden thoughts (e.g., sexual or aggressive), or a need to seek reassurance or confess.

**Common compulsions include:**

- cleaning/washing, checking, counting, repeating, straightening, routinized behaviors, confessing, praying, seeking reassurance, touching, tapping or rubbing, and avoidance.
- Unlike in adults, children need not view their symptoms as nonsensical to meet diagnostic criteria.

Children and adolescents are more likely to include family members in their rituals.

Often see disruptive and oppositional behaviour and even episodes of rage

Highly demanding of adherence to rituals and rules

Youth with OCD are generally more impaired than adults with the same type of symptoms.

# EX/RT and CBT Treatment Components

**Cognitive Therapy:**

- Teach the child and the parent to respond differently to the obsessions.
- Cognitive Therapy isn't mental distraction, challenging the obsession, ignoring them, rationalizing the thought or replacing the obsessive thought with a positive one.  OCD will only "yeah but" you or make you feel guilty or bad.
- It is recognizing the obsession, accepting the thought as a possibility (nothing in this world is certain), and being okay with the emotional response.
- You will habituate to the discomfort if you don't fight the obsession.
- Child/teen can respond, but only by saying things like this:
  - Hi OCD! I choose not to listen to you.
  - You can't predict the future!
  - Sure, yeah, that's right, if I don't do XYZ, then I will die.

# Treatment Components Continued

## Behavioural Therapy (or the EX/RT)

- Teach the child to change what they do when OCD is making them anxious/distressed
- Teach the child to habituate to the discomfort "not doing" causes
- Teach the amygdala that it doesn't need to "feel" afraid and to stop sending the false alarm

## Psychoeducation

- The three parts of Anxiety (Thinking, Feeling, Doing)
- The OCD Loop
- How OCD affects/impacts the child (essentially mapping out where the OCD is creating impairment)

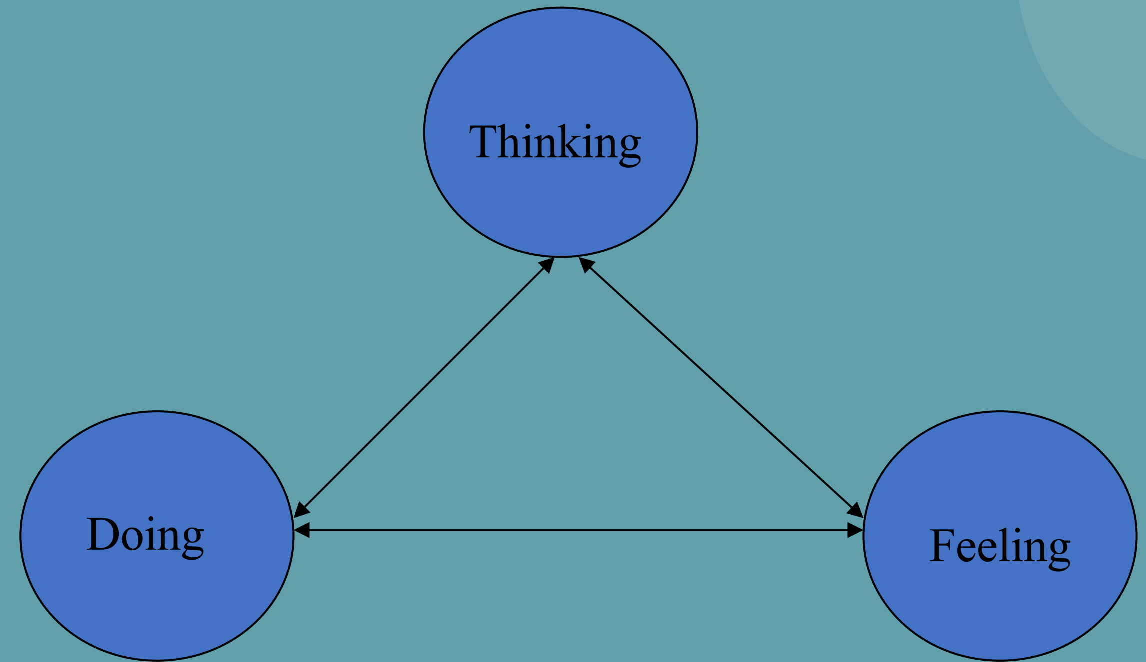
## Common language for EX/RT and CBT (Dr. Aureen Wagner – Up and Down the Worry Hill)

- R = "Recognize" OCD
- I = "Insist" you are in charge, not the OCD
- D = "DO" the opposite
- E = "Enjoy" your success

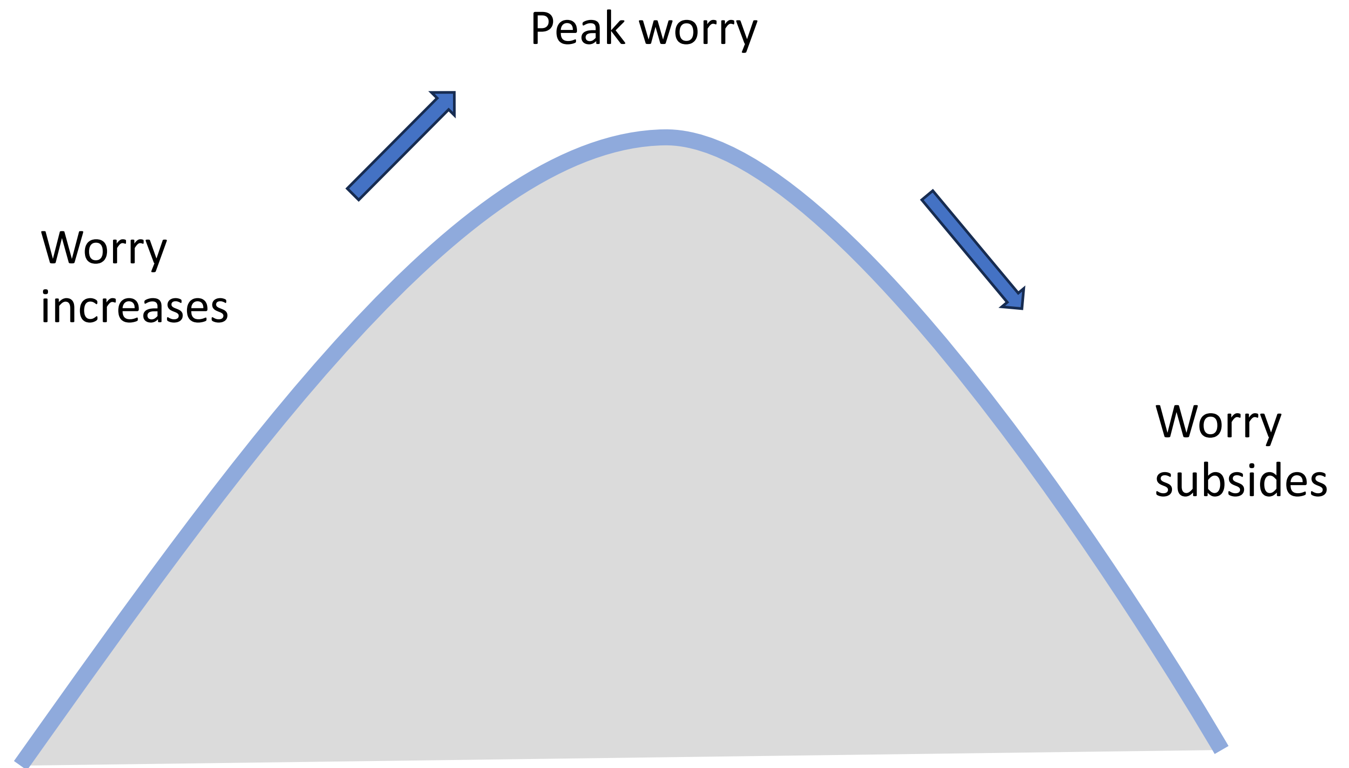
## SUDS ratings

- General rule of thumb is to start EX/RT at a 5, 6, or 7. If EX/RT is an 8, 9, or 10 – wait, it is too hard.

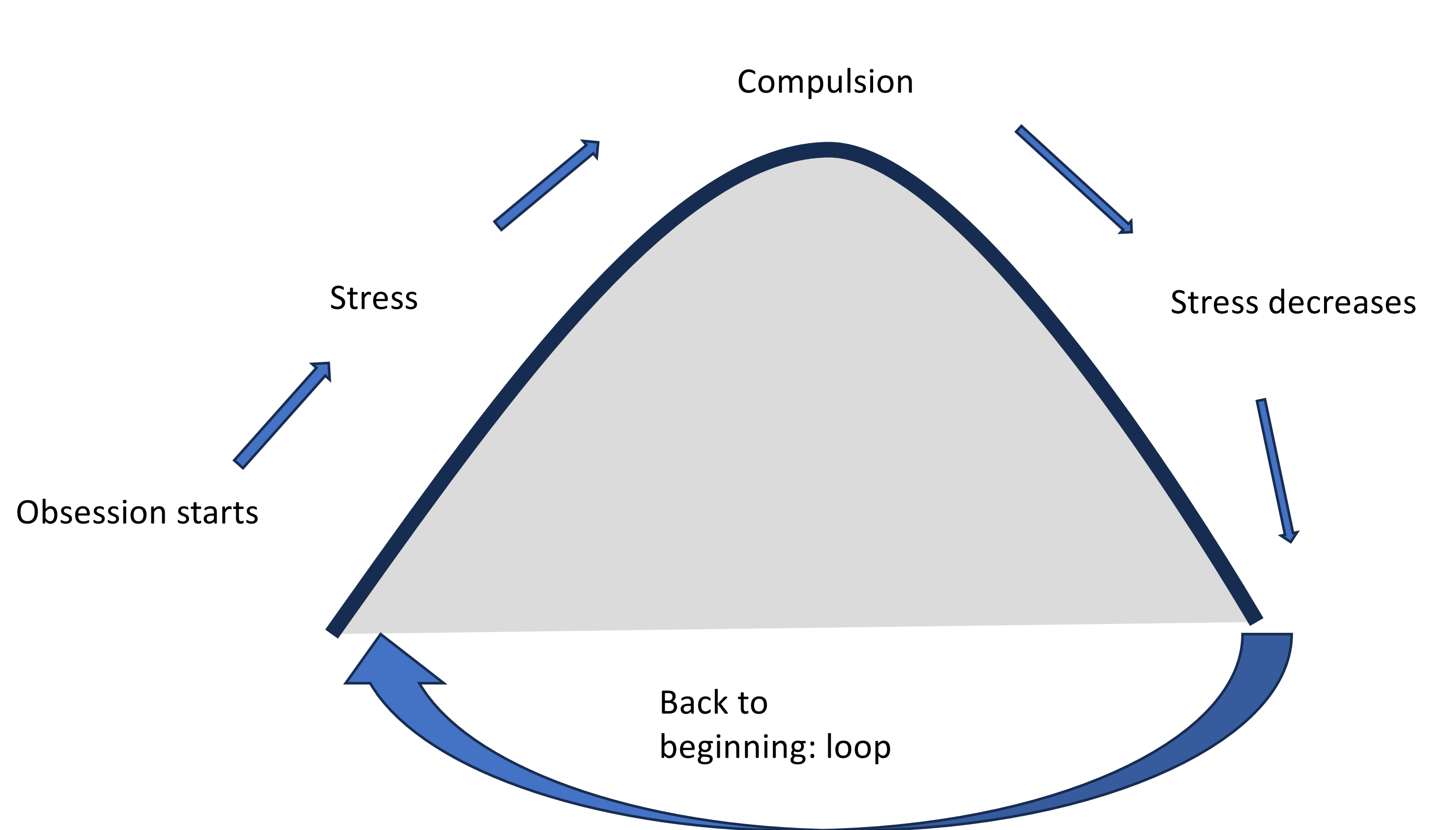
# Three Components of Anxiety



# The Worry Hill: Up and Down



# The OCD Hill/Loop



# Review of Treatment Steps

**Psychoeducation has been completed.**

**You have introduced how to respond to the obsessions.**

**Child/teen and family know the RIDE (or another analogy you like).**

**You have an EX/RT target list**

**Fear Hierarchies for each target:**

Contamination

Checking

Touching/tapping

Rituals

Religious/scrupulosity

Thought Exposures

# Case Examples

12 year old with compulsive hand washing/avoidance of one parental figure as they are "dirtier". Obsessions are fear of germs/contaminants and getting others sick.

14 year old with obsession that they will "hurt their sibling" and they avoid any being around their sibling.

8 year old that counts when they walk and avoids stepping on cracks of any sort on the floor (tiles, hardwood floor). They are able to articulate that if they do so, something bad will happen.

6 year old who has a bedtime routine where parents have to follow a complex routine. If any part of it is not followed, massive meltdown occurs. Not able to articulate why, just that it "needs to happen".

# The Ins and Outs of Treating Tic Disorders

# Tic Disorders – Treatment Dos and Don’ts

**Children with tics often report that it isn’t the tic themselves that bothers them, it is the responses of others.**

Parents often say things like “stop” or “that’s annoying”

Other kids ask questions that the child with tics doesn’t know how to answer

**Acting like nothing happened, is just as confusing with children with tics as worrying about what other people might do.**

**Please don’t tell a parent to ignore the tic – what we need to teach is how to “not give attention” to a tic**

**Education about tics is the most important first step**

**Often we need to treat comorbid diagnoses before we treat tics.**

# Teaching about Tic Disorders

Children/teens need to know what tics are and know they can learn to stop them

Attention often increases tics, so parents/ teachers/students need to avoid:

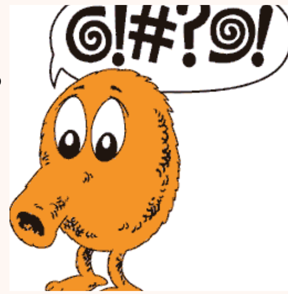
- Commenting about tics
- Asking if the child is “ok”
- Making a fuss
- Treating them differently

The child or parent can initiate a conversation, much like we would do if you or the child had a headache or didn’t look well.

Talking about tics is not taboo, but it is better if it is child led or if parents check in every so often

# Facts about Tourette's

**People with Tourette's always blurt out obscenities:**

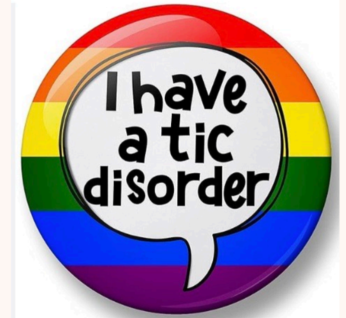



Known as coprolalia, this only affects about 1 in 10 people with Tourette's. Coprolalia is a complex tic that is difficult to control or suppress, and people who have this tic often feel embarrassed by it.

**People with Tourette's often lead rich and fulfilling lives.**

People with Tourette's may have difficulties throughout their lives, but many are very successful.

**Having a tic doesn't mean that you have Tourette's.**




A person can have tics ranging from simple, temporary tics lasting a few weeks or months, to having many complex tics that are long-lasting. Tics can also range from mild and hardly noticeable to severe and disabling. To have Tourette's means that a person has at least two different motor tics and at least one vocal tic and has had tics for over a year.

# EX/RT and CBIT as Treatments for Tic Disorders

- Children/teens need to find the tic annoying/painful/bothersome in some way.
- If parents don't like a particular tic, help the parents learn to cope.
- Treatment focuses on helping decrease the frequency of a tic not supressing a tic
- Children/teens need to develop self-awareness of their tics – we can do this with the help of ABCs.
- Antecedents (what makes the tic worse?) and see if you can change or alter elements
- Consequences of doing the tic (what happens after the child tics?)

# EX/RT and CBIT as Treatments for Tic Disorders

Behavioural Description i.e., what is the tic.

Children and teens often find some sort of relaxation technique helpful.

Develop a competing response or tic blocker for **one tic at a time**

When a person does the right competing response in a calm focused manner, the tic gets better, and they feel better and more in control, not frustrated and irritable.

CBIT does not teach voluntary suppression. It teaches techniques to control other behaviors that are incompatible with ticcing until the urge to tic or the tic decreases or goes away. Practicing behaviors that are incompatible with ticking is different from voluntary suppression.

# EX/RT and CBIT as Treatments for Tic Disorders Continued

## Tic Blockers / Competing Responses:

- Can't do the tic when you are doing the CR/TB
- Can do the CR/TB for a minute or until the urge passes, which ever is longer
- The CR/TB can be done pretty much anywhere
- The CR/TB can't be more socially awkward or embarrassing than the tic itself

You reward compliance to the CR/TB, not the decrease in frequency of the tic

You do the CR/TB when you the antecedent happens, you feel an urge, or when you do the tic.

# Examples of CR/TBs

## Vocal tics

Almost always focus on breathing patterns.

## Motor tics

You have to get innovative

You have to do the tic to help the child figure it out

## Tourettic Compulsions

It is a mixture of CR/TBs and EX/RP