Introduction to Compulsive Behavioral Disorders

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Summary

Obsessive Compulsive Disorder (OCD) and its relatives affect a surprisingly large portion of the general population, despite being underreported. The primary focus of treatment is on improving quality of life, which is largely accomplished through increasing behavioral/psychological flexibility; not necessarily by eliminating obsessive discomfort or compulsive behaviors. This workshop discusses the behavioral treatment of OCD and related disorders (Tourette's, BFRB's, and FND) as well as practical considerations for clinicians as they work to identify, treat, and educate. Though we will be focusing on treatment for adolescents and adults, many of the same concepts and considerations are applicable to children as well with some adaptation.

Welcome!

Disclosures

- Not commercially supported
- Presenter has no affiliation with the cited references
  - I am affiliated with the TS professional group out of Vanderbilt (a resource, not a reference)
- No conflicts of interest to report
- Presenter is a practitioner in the local area and serves the populations discussed
- Presenter is seeking to increase availability of resources for the community by increasing knowledge and proficiency of local practitioners

Utility and Limitations

- The information contained reflects peer-reviewed research conducted within the past 10 years and is thus regarded as accurate to the presenter's knowledge
- The field continues to develop, especially with respect to process-based understanding of the mechanisms underlying compulsive behavioral disorders
- We are still researching and building our understanding in light of recent events (i.e., COVID pandemic and subsequent FND epidemic), which appears to be affecting our knowledge of behavior
- The current presentation focuses on behavioral and therapeutic knowledge from the field of psychology and behavior science. It may not account for knowledge in adjacent fields of neurology or medical science
- Potential risks in treatment of compulsive behavioral disorders are highlighted and discussed in the presentation

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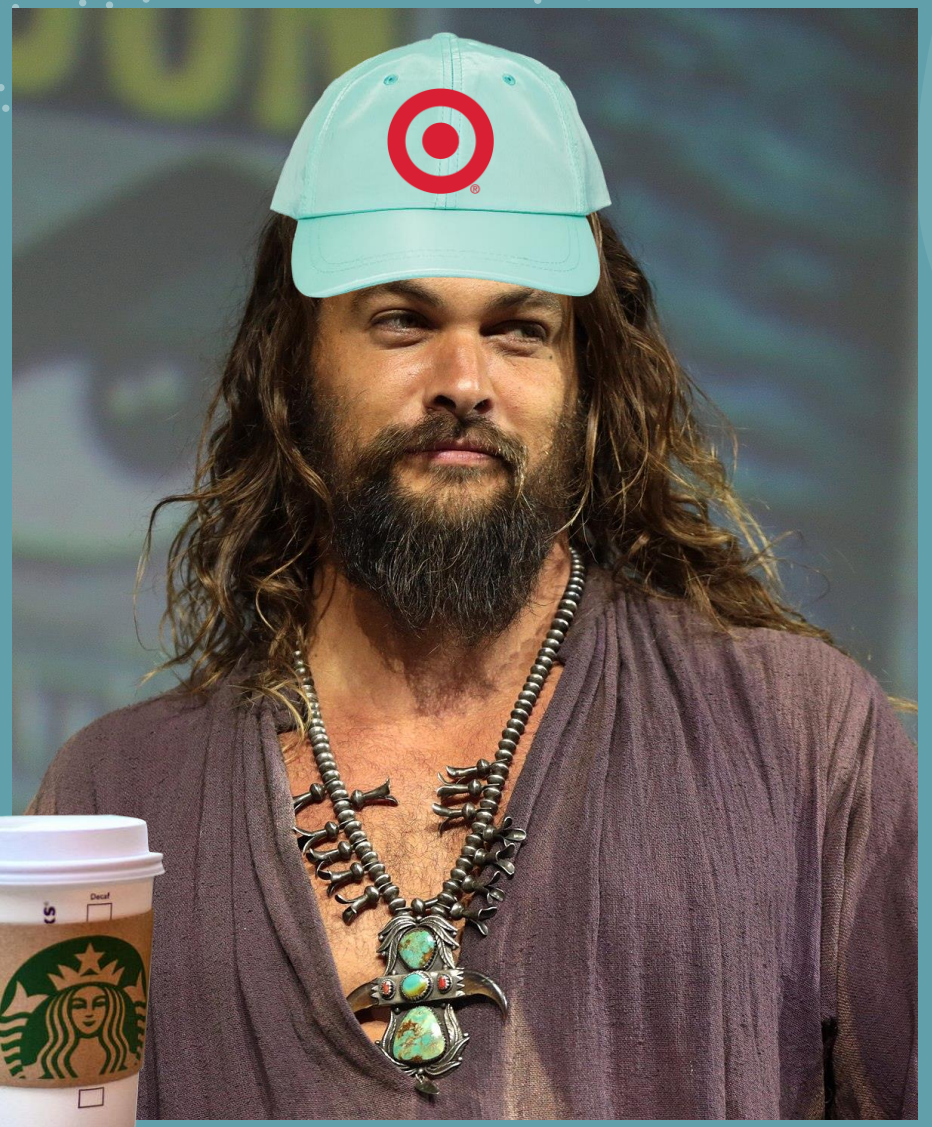


Learning Objectives

- Participants will become more knowledgeable about the etiology, identification, and treatment of compulsive behavioral disorders:
  - Participants will be able to describe the behavioral mechanisms underlying OCD, TS, and BFRBs
  - Participants will be able to perform a functional analysis of client behaviors to create a treatment plan
  - Participants will be able to describe the primary differences between OCD, TS, and BFRBs to discriminate between conditions and identify appropriate treatment methodologies

A few basics first

- Behavior tends to be largely avoidant.
  - That's normal. That's healthy.
  - It's kept humans alive as a species.
  - It usually works as long as we know what to do.
  - We try harder before we give up.
- Once a behavior is acquired, it is always an option.
- Punishment is not well supported (Adams, 1978)
  - More likely to condition avoidant behaviors.
  - Otherwise absence of reinforcement.
  - This has been known since early 1900's but we keep forgetting (see Thorndike Law of Effect)!

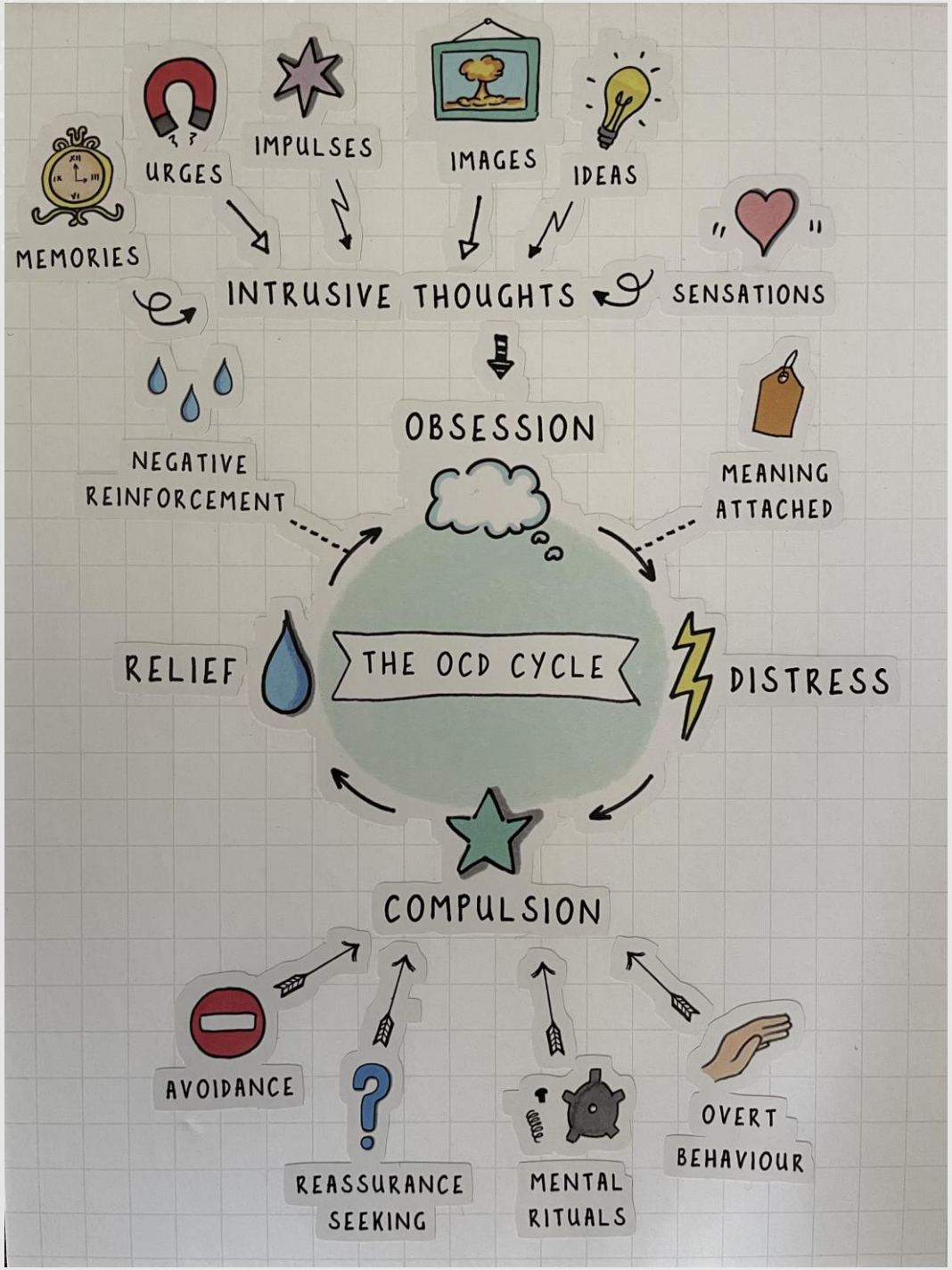
Many varieties of compulsive disorders

- Obsessive-Compulsive Disorder
- Tourette's Disorder and Persistent Tic Disorders
- Excoriation Disorder
- Trichotillomania
- Transient Tic Disorders
- Functional Movement Disorder

What are we talking about?

- Inflexible patterns of behavior maintained by powerful reinforcement feedback loops
- Produce a significant adverse life impact
  - Emotional Health
  - Social Function
  - Physical Health

Feeding the Machine



What's the difference?

- Mostly characterized by differences in frequency of behaviors, topography of behaviors, and reported premonitory experiences
- Tic disorders: high frequency, premonitory sensory phenomenon, often relatively simple behaviors (though not always), and high variety of behaviors
- OCD: more closely bound to triggering stimuli, premonitory experiences may involve more elaborate cognitive component, frequency may be lower compared to tics, and high variety of behaviors
- Body-focused repetitive behaviors: high frequency, premonitory sensory phenomenon, more closely bound to triggering stimuli, relatively simple behaviors, lower variety of behaviors

Onset and Development

- Tics tend to show up earlier in development, though many are transient (estimates of about 30% of children exhibit transient tics as part of brain development)
- TTM and excoriation also may manifest transiently in children but persistent patterns not uncommon in children around 6-7 years
- When compulsive behaviors attributable to OCD manifest in younger children, they are often preceded by emotional agitation/discomfort without more explicit obsessive thoughts

Obsessive-Compulsive Disorder

- Obsession -> Compulsive Behavior + Life Impact = OCD
  - Note: OC Behavior + Life $\text{Impact}_{\text{Insuff}}$!= OCD
  - Most people like to have things “a certain way”
  - Some more rigid in their behaviors or more sensitive to emotional agitation
- Specificity of Behavior vs Generalized Behavior
  - OCD tends to be specific - Anxious behavior tends to be more general
  - E.g., ordering/arranging set of figurines in room vs organizing everyone’s pens or feeling agitated with clutter
- Rational Anticipation/Avoidance vs Irrational Behavior
  - “I must set this down the right way three times in a row or I’m going to hell.”

Stop the match or put out the fire?

- Some antecedent events may trigger manifestation of compulsive behaviors
- Once it is present, then it must be addressed
- Addressing the antecedent may help prevent future recurrence but not present

Types of OCD

- Ego Dystonic cognitions
- External and internal stimuli as triggers
- Perfectionism, rumination, body-focused, contamination, hoarding
- All compulsions can be functionally useful – evaluate it
- Suppression experience: anxiety, panic, anger…

What OCD isn’t

- Media portrayals
  - At best represent small percentage of cases
  - OCD often more subtle/insidious in its effects
- Trauma/PTSD
  - These challenges may aggravate or intensify symptoms but not explain
- Anxiety/Panic Disorder
  - Strong comorbidity but not the same thing
- Hormone-related changes – “It’s not but it can be”
- Voluntary, rational, or logical

Relationship of OCD and other Dx

- Autism Spectrum Disorder
- Avoidant-Restrictive Food Intake Disorder
- Attention-Deficit/Hyperactivity Disorder
- Obsessive-Compulsive Personality Disorder
- Body Dysmorphic Disorder

Treatment of OCD

- “Just stop doing it!” – Asking for pain
- Exposure and Response Prevention
  - Requires identifying triggering stimuli
  - Awareness of premonitory sensations
  - If clear obsessive thought, then identifying anticipated consequences
  - Identifying antecedent stimuli: people, place, activity, mood, “the day”
  - Developing incompatible response – CAUTION
  - Developing reinforcement plan for treatment compliance (not for success)
- Be aware of natural waxing and waning and of life context
- Be aware there is more to the individual than their OCD (seems obvious, but…)

More on OCD treatment

- Integrating CBT, ACT, Mindfulness beneficial
  - Caution about thought-stopping/challenging
  - Focus on experiential work – learn by doing
  - “Easier to do better than to feel better”
- Use categorization in treatment planning
  - “Just right”
  - Gender/sexual issues (identity, ego dystonia)
  - Contamination/disgust
- Functional behavior analysis essential

Habituation vs Inhibitory Learning

- Inhibitory Learning: retraining the brain to engage in a different behavior in response to presence of triggering stimuli
  - Differential Reinforcement – reinforcement for engaging in a different behavior
  - Alternative behavior – a different behavior than previous
  - Incompatible behavior – old behavior cannot be performed because of new behavior
  - Lower rate of behavior – reinforcement for engaging in old behavior at a lower rate
- Habituation/Desensitization: reducing intensity of behavioral response in presence of triggering stimuli
  - Assumes intensity will diminish with repeated exposure to triggering stimuli
  - Relies primarily on extinction – reinforcement either withheld or reinforcing value diminished due to satiation

Cognitions and OCD applied to Treatment

- Some evidence that intensity of symptoms affects efficacy of treatment strategies
- Cognitive distress may differ in OCD vs Gen Anxiety
  - Inflated feeling of responsibility observed more in mild OCD severity
  - Feeling that things *really* matter – more predictive in severe OCD
  - Excessive internal locus of control – also more predictive in severe OCD
  - Latter two also implicated more in generalized anxiety
- These phenomena consistent with cognitive fusion and rigid efforts to control cogs/emos as treatment targets

Special cautions in OCD

- Ego Dystonic obsessions
  - Intrusive, distressing, personally meaningful
  - Sexually taboo - fear of “being deviant” – disclosure concerns
  - Trust with therapist essential and may be slow
- Suicidal and homicidal ideation and OCD
  - Know when duty to warn arises (tricky to not violate trust)
  - Defusion from intrusive thoughts important
- Suicide and OCD
  - What to watch for
  - How to respond
- More about trauma and OCD – treatment cautions

Therapist Challenges in OCD

- Working with OCD clients likely to trigger own worries, fears, revulsions
- Hard to see others suffer (exposure is suffering)
- Watch for own urge to give reassurance
- OCD generally irrational behavior or rational behavior to irrational extreme
- Watch out for lecturing (too much psychoed), rationalization, and justification urges

Example

- Client is a child and reports obsessive thoughts that cannot be alone with father because father wants to have sex with her
- Feels intense fear that this is what will happen and refuses to be within certain distance or alone in same room
- Client also reports no history of abuse and that this has never happened; parents also report no history of abuse
- Client experiences intense panic when required to sit by father or if left in same room alone
- How to interpret this? OCD, trauma? How to assess without violating trust of client?
- Notice how you feel as a therapist hearing this?

Some little wrinkles

- Rumination may be a compulsive behavior (covert vs overt behaviors)
- Normalizing is valuable, but…
  - Can risk invalidating or minimizing experiences
  - Reassurance seeking is a relatively common compulsion
- People with OCD have their entire brain's resources to devote to fulfilling the compulsive urges and may do that without awareness
- Arguing with the brain is typically not productive – an individual can say they agree to reduce discomfort temporarily
- Improvement in-session doesn't generalize unless practiced in other settings too (diverse contexts)

Tourette's Disorder (aka TS or GTS)

- (Motor tics + Vocal tics) > 2 = Tourette's!
- "Tourette's is not the tics, it's the urge preceding the tics" – (D. Isaacs, personal communication, 2020)
- Many comorbidities: Primary and Secondary
- Primary: neurological correlates - OCD, ADHD, SLD, Anger, Anxiety
- Secondary: social impact, challenging behaviors, depression
- Typically begins between 4-7 years of age
- Intensifies in early adolescence, typically levels off or diminishes in late adolescence
- May be latent until exacerbated
- More boys than girls (of course!)

Particular Challenges of TS

- Non-persistent tics are common in children
  - About 1 in 5 children
- Social stigma
  - Parental acceptance
  - Teacher response – “That’s deliberately disruptive.”
  - Peer response – “Why do you do that? That’s weird!”
  - Media portrayal – “The swearing disease”
- Elevated Anxiety
- Oppositional/Defiant Behavior (Secondary Comorbidity?)
- Anger (“Rage Attacks”)
- Depression

Managing and Treating TS

- Education
- CBIT – Comprehensive Behavioral Intervention for Tics
  - Enhance with:
    - ACT – Acceptance and Commitment Therapy
    - ERP – Exposure and Response Prevention
- Parent Behavior Consultation
- Teacher/Professional Consultation
- Section 504 Plan or IEP for School

Some Resources

- Tourette Association of America: https://tourette.org
- Vanderbilt Tourette Syndrome Clinic https://www.childrenshospitalvanderbilt.org/clinic/tourette-syndrome
- Vanderbilt – TS Education Day 2022: https://redcap.link/tseducationday2022
- Woods et al. (2008). *Managing Tourette Syndrome: A Behavioral Intervention for Children and Adults*. Oxford University Press.
- Conners, S. *The Tourette Syndrome and OCD Checklist*. Jossey-Bass.
- Buffolano, S. *Coping with Tourette Syndrome*. New Harbinger.
- Walkup, J. Y., Mink. J. W., McNaught, K. St. P. *A Family's Guide to Tourette Syndrome*. Tourette Syndrome Association.

Functional Neurological Disorders

- Conversion Disorder
- “It’s all in your head” – so is everything! (Fiona Apple)
- Real distress and impact
- Responsive/distractible tics
- Unusually high diversity and frequency may indicate functional disorder
- Treatment focuses on identifying antecedent events, psychoeducation, addressing emotional dysregulation
- Caution about excessive assessment or treatment changes

Cognitive Approach to FNDs

Some evidence that more cognitively-oriented approaches may prove more effective for functional movement disorders

FND's and Tic Attacks more similar to panic

Address with training awareness and acceptance (desensitization to covert stimuli and inhibitory learning)

(Robinson & Hedderly, 2016)

Diagnostic Presentation

- 1. Neurological symptoms involving motor disturbance, sensory or loss of consciousness
- 2. No evidence of organic disease to explain symptoms
- 3. Associated psychological stressors relevant to onset of symptoms
- 4. Feigning or malingering is excluded

History of the Disorder

- Long history of documentation, but only formally studied in 19th century.
- Charcot, French neurologist studied "Hysteria", hypnosis, neuroanatomy
- Coined Conversion as "functional" as no pathology was evident, but clearly impacted the individual.
- Historical terms for this: Hysteria, Psychogenic, Pseudoseizures, Idiopathic, Non-Organic etc. (Current is non-epileptic seizures).
- Freudian model: unwelcomed experiences are repressed and then manifested physically
  - This model moved the understanding of Conversion as something akin to Migraine, to a psychiatric disorder.

Current Understanding

- The psychiatric paradigm remains the dominant method for understanding
- There is a renewed emphasis to understand the neurological bases of the disorder.
- Push to reclassify the diagnosis as a dissociative disorder, as highly comorbid with childhood physical and sexual abuse, PTSD, dissociative features and other mood disorders.

Current Quandary

- Based on the current diagnostic criteria and understanding, we should be able to distinguish conversion with organic neurological condition, with psychological conditions leading to diagnosis.
- Can we always make this distinction?
- Does conversion always involve an underlying psychological etiology aside from the distress caused by the actual neurological symptoms?
- Can become even more difficult with comorbid neurological diagnosis.

Neurological Distinctions

- Voon (2010) within group study of conversion tremor
  - Used FMRI during involuntary tremor activity, and then again when subjects were asked to voluntarily mimic the tremor.
  - FMRI showed same voluntary motor pathways (right temporal) in both trials.
  - Conversion blindness: Hypoactivity in visual cortex
  - Conversion paralysis: Hypoactivity in motor areas
  - Conversion anesthesia: Hypoactivity in somatosensory areas
  - Voluntary pathways are activated, but experienced as involuntary
    - i.e. Nervous foot tapping, wringing hands, arms crossed etc.

Treatment?

- One of the most important predictors is the way in which the diagnosis is presented.
- Common problem with diagnosis given: “There is nothing wrong with you. This is all in your head. You need to see a therapist.”
- Stigma in medical community
- Helpful to start with discussing physical etiology and then psychological.
- May undergo spontaneous resolution following diagnosis and explanation
- Education on mind/body connection

Psychotherapy

- No gold standard modality
  - Any approach that tends to be effective in treating comorbid depressive/anxiety features will be helpful.
  - Many studies using CBT, Psychodynamic, EMDR shown to be helpful.
  - Need interdisciplinary team
  - Anticonvulsants contraindicated in pseudo seizure
  - Good response to traditional psychopharm tx.

Trichotillomania and Excoriation Disorder

- Compulsive hair pulling or skin “picking”
- Trichotillomania aka “TTM”
- Also also known as “Body Focused Repetitive Behaviors” (BFRB)
- “Seek and destroy!” – finding subjective imperfections
- Transient BFRB not uncommon in younger children (nose-picking!)
- Can be observed in very young children (e.g., age 2-3 years)
- Not often tied to intrusive thoughts or explicit worries
    - Mostly just “a feeling it’s not right”

Treating TTM and Excoriation

Functional analysis and topographic analysis of behaviors

- There is a chain, see how early you can go in the chain
- Seeking/looking (tactile or visual) typically earliest behavior
- Identify contextual antecedents (including mood, setting, activity, people…)
- Disrupt the chain – go right up to the limit and stay there
- Build physiological awareness for client

Manage successes and failures

- Reinforce for compliance regardless of outcome
- Steer client away from focus on outcome (though validate that too)
- Focus on one area at a time (e.g., scalp, face, forearm, lower leg…)

More about Treating TTM and Excoriation

MOST RECENT PROTOCOLS INDICATE ERP + ACT

ERP PROTOCOL MAY FOCUS ON CONTROLLABLE ANTECEDENT STIMULI

HABIT REVERSAL TRAINING (HRT)

PRACTICE EXPOSURE WITH INCOMPATIBLE BEHAVIORAL RESPONSE (HRT)

IDENTIFY COVERT RESPONSE AND DISCOMFORT

PRACTICE ACCEPTANCE BEHAVIORS WITH REINFORCEMENT FOR REHEARSAL

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More useful materials and resources

- Walkup, J. Y., Mink. J. W., McNaught, K. St. P. A Family's Guide to Tourette Syndrome. Tourette Syndrome Association.
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- Woods, D. W. and Twohig, M. P. (2008). *Trichotillomania: An ACT-enhanced Behavior Therapy Approach*. Oxford University Press.

- McKay – articles on trauma and OCD; OCI-12
- Heady – workshop, esp inhibitory learning
- Unified Protocol for trans diagnostic approach
- Hershfield, J. & Corboy, T. The Mindfulness Workbook for OCD