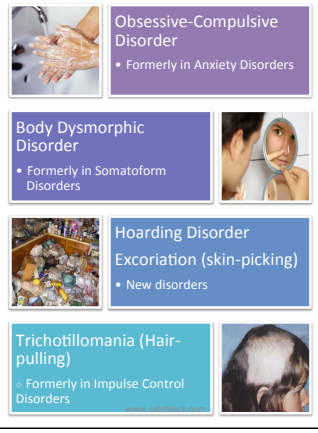
Evidence-Based Treatments for Obsessive-Compulsive & Related Disorders

Caleb W. Lack, Ph.D.
Associate Professor / Clinical Psychologist
University of Central Oklahoma
www.caleblack.com

Major Changes in the DSM-5

- The fifth edition of the DSM included a new chapter titled "Obsessive-Compulsive and Related Disorders"
- Pulled together both diagnoses from multiple previous categories and new diagnoses



OC&R Disorders

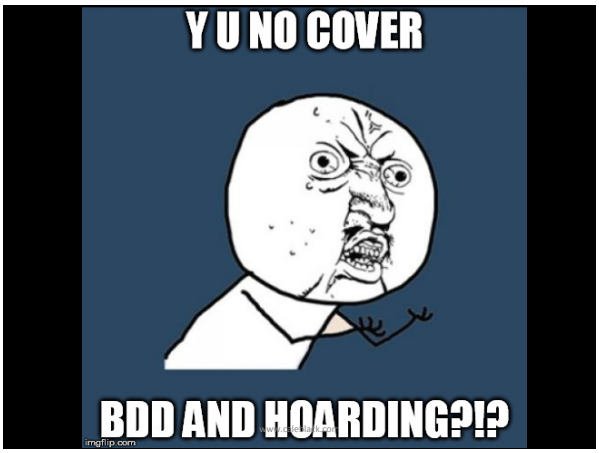
- Somewhat controversial, but reorganized for two primary reasons
  1) to reflect the increasing evidence of these disorders' relatedness to one another and distinction from other anxiety disorders
  2) to help clinicians better identify and treat individuals suffering from these disorders
- Chapter is placed next to Anxiety Disorders to reflect similarities and overlap between these

OC&R Disorders

- All have features in common such as an obsessive preoccupation and repetitive behaviors
- They have enough similarities to group them together in the same diagnostic classification
- But also, have enough important differences between them to exist as distinct disorders

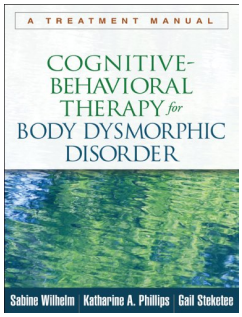
Outline of Workshop

- Obsessive-Compulsive Disorder
  - What is OCD?
  - How do you treat it effectively?
- Body-Focused Repetitive Behavior Disorders
  - What are hair-pulling and skin-picking disorders?
  - How do you treat them effectively?
- Tic Disorders
  - What are Tourette's and Persistent Tic Disorders?
  - How do you treat it effectively?



But…where's BDD?

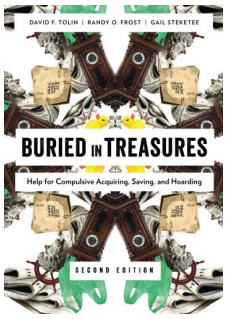
- Body Dysmorphic Disorder isn't commonly observed in youth, so we aren't going to cover it today
- I recommend this book, though!



www.caleblack.com

But…where's Hoarding?

- Hoarding Disorder also isn't commonly observed in youth
- Here's a recommended book covering it!



www.caleblack.com

What is Obsessive-Compulsive Disorder?

Operational Definition

A. Presence of obsessions, compulsions, or both:

- Obsessions as defined by (1) and (2):
  1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted and that in most individuals cause marked anxiety or distress
  2. The person attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion)

Common Obsessions

- Unwanted thoughts of harming loved ones
- Persistent doubts that one has not locked doors or switched off electrical appliances
- Intrusive thoughts of being contaminated
- Morally or sexually repugnant thoughts

Operational Definition

- Compulsions as defined by (1) and (2):
  1. Repetitive behaviors or mental acts that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly
  2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive

Common Compulsions

- Hand washing
- Ordering
- Checking
- Praying
- Counting
- Thinking good thoughts to undo bad ones

Operational Definition

B. The O/C are time consuming (for example, take more than 1 hour a day) or cause clinically significant distress or impairment in functioning.

C. The O/C symptoms are not due to the direct physiological effects of a substance or a GMC

D. The content of the obsessions or compulsions is not restricted to the symptoms of another mental disorder

OCD Specifiers

- *Good or fair insight*: Recognizes that OCD beliefs are definitely or probably not true, or that they may or may not be true
- *Poor insight*: Thinks OCD beliefs are probably true
- *Absent insight/delusional beliefs*: Completely convinced OCD beliefs are true
- *Tic-related OCD*: The individual has a lifetime history of a chronic tic disorder

OCD Subtypes

- Tic-related OCD
  - May account for up to 40% of pediatric cases
  - Often male-dominated
  - High incidence of symmetry/exactness/ordering
  - Lower cleaning/contamination
  - High rates of trichotillomania and DBDs

Leckman et al. (2010)

OCD Subtypes

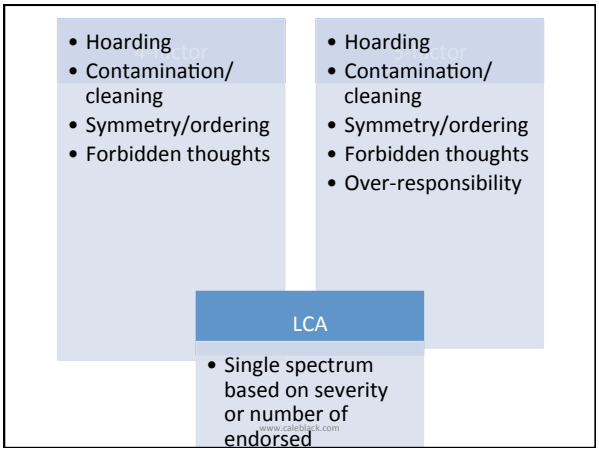
- Early-onset OCD
  - Pre-pubertal onset of OC symptoms
  - Similar nature of OC symptoms
  - Dominated by males
  - Substantial portion will remit by adulthood
  - Increased risk of tics and trich
  - Confounded/overlapping with tic-related OCD

Leckman et al. (2010)

OCD Symptom Dimensions

- Some disagreement over how many dimensions are present
- Factor analytic and latent class analysis models have come up with different dimensions
- Dimensions appear to be temporally stable

Abramowitz et al. (2009); Leckman et al. (2010)



OCD Prevalence

- Around 1% in pediatric population
- Between 2-3% in the adult population
  - Large number of "sub-clinical" cases (5%)
- 96%+ of patients have both O and C

Abramowitz et al. (2009); Leckman et al. (2010)

OCD Course

- Usually gradual onset
- Chronic, unremitting course if untreated
- Symptoms can change across time, but will rarely disappear

Abramowitz et al. (2009);

Gender Differences

- Many more male youth are diagnosed, but no sex differences in adults
- Among men, hoarding associated with GAD and tic disorders, but in women with SAD, PTSD, BDD, nail biting, and skin picking

Vesaga-Lopez et al. (2008)

SES & Cultural Differences

- Similar symptom categories across cultures, but can impact content of O/C

Abramowitz et al. (2009)

Comorbidity

- Up to 75% present with comorbid disorders
- Most common in pediatrics are ADHD, DBDs, depression, and other anxiety disorders
- Presence of comorbids predict QoL, more so than OCD severity

Lack et al. (2009)

Comorbidity

- Different primary O/C are associated with certain patterns of comorbidity
  - Symmetry/ordering: Tics, bipolar, OCPD, panic, agoraphobia
  - Contamination/cleaning: Eating disorder
  - Hoarding: Personality disorders, especially Cluster C
- Most prevalent adult comorbids are SAD, MDD, alcohol abuse

Leckman et al. (2010)

Impact of OCD

- Almost *all* adults and children with OCD report obsessions causing significant distress
- Pervasive decrease in QoL compared to controls
- Youth show problematic peer relations, academic difficulties, and participate in fewer recreational activities

Lack et al. (2009); Fontenelle et al. (2010)

Impact of OCD

- Lower QoL in pediatric females
- Compared to other anxiety/unipolar mood:
  - Less likely to be married
  - More likely to be unemployed
  - More likely to report impaired social and occupational functioning

Lack et al. (2009); Abramowitz et al. (2009)

Etiology

- Modestly heritable for adult onset (27-47%)
- Higher heritability for child onset (45-65%)
- Obviously, environment is still very important contributor to OCD

Abramowitz et al. (2009)

Etiology

- Serotonin, glutamate, and dopamine dysfunctions all implicated
- Seems to be highly mediated by frontal cortico-striatal circuitry
- Overactivity of the direct pathway thought to be associated with OCD symptoms

Abramowitz et al. (2009)

Etiology

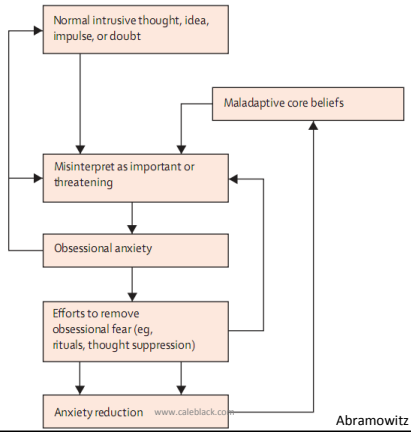
- CBT model proposes that O/C arise from dysfunctional beliefs
- The stronger the beliefs, the greater chance a person will develop OCD
- Basis is the finding that unwanted cognitive intrusions are experienced by most people, with similar contents to clinical obsessions

Abramowitz et al. (2009)

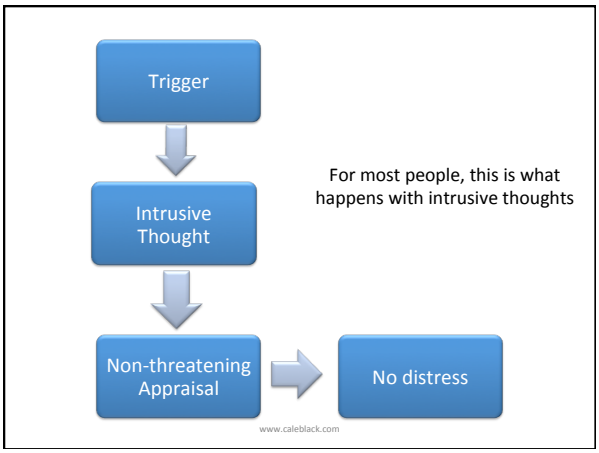
Etiology

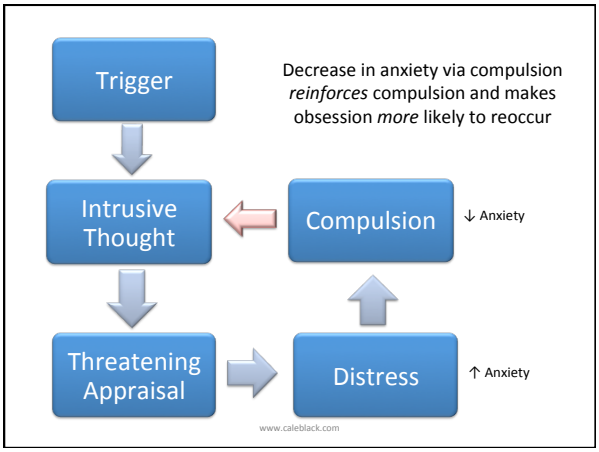
- Intrusions become obsession if appraised as
  - Personally important
  - Highly unacceptable or immoral
  - Posing a threat for which the individual is personally responsible
- One then attempts to alleviate distress this causes via compulsions

Abramowitz et al. (2009)



Abramowitz et al. (2009)





Pharmacology for OCD

- Overall, pharmacology (SRIs) shows large effect sizes in adults (0.91), but…
  - Most treatment responders show residuals
  - Very high relapse rate (24-89%)
- Only moderate effect sizes in youth (0.46)

www.caleblack.com

Abramowitz et al. (2009)

Pharmacology for OCD

- SRIs can be adjuncted with antipsychotics, but only 1/3 will respond
- Presence of tics appears to decrease SSRI effects in children, unclear in adults
- OCD w/ tics responds better to neuroleptics than OCD w/o tics

Abramowitz et al. (2009); Leckman et al. (2010)

CBT for OCD

- The treatment of choice, for both adult and child OCD; superior to meds alone
- Primarily focuses on EX/RP, which has shown effect sizes of 1.16-1.72 (88-95% improve)
- Low (12%) relapse rate, but up to 25% will drop out prior to completion of treatment

CBT Outcomes

- Those with hoarding symptoms appear to respond less well to treatment
- May need to add motivational enhancement techniques for those who are reluctant to engage in exposures
- Group therapy is as effective as individual

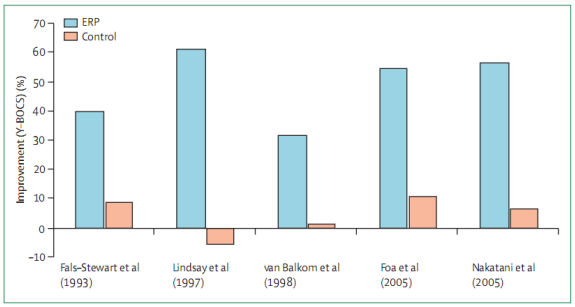
Abramowitz et al. (2009)

CBT Outcomes

- Those with comorbidity present higher severity, but respond equally well to EX/RP
- Comorbid anxiety or depressive symptoms tend to show improvements as well, even if not specifically targeted

Storch et al. (2010)

CBT Outcomes

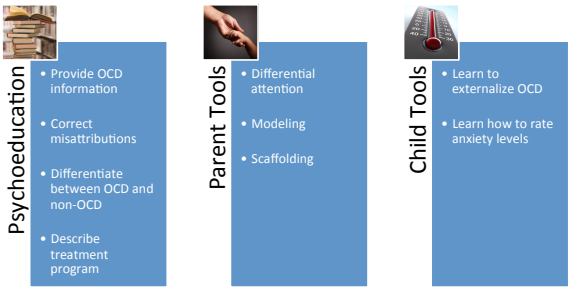


Cognitive-Behavioral Therapy for Obsessive-Compulsive Disorder

Outline of CBT Treatment

- Typically between 10-16 sessions
- Includes parent and child in all aspects of treatment
  - May need to include other family/support persons
- Three primary components
  - Psychoeducation, parent education, EX/RP with cognitive strategies

www.caleblack.com



www.caleblack.com

Considerations

- Keep information and activities developmentally appropriate
  - For young children (under 8), they may not need/ benefit from the education portion
  - Older children and adolescents, however, should be included
- Deliver treatment "with the child" and not "to the child"

www.caleblack.com

Session Sequence

- An initial assessment should be conducted prior to therapy starting
- Complete a clinical interview (KSADS, ADIS-C) and symptom measures (CY-BOCS, FAIS-C)
- Helps determine differential or comorbid diagnoses and impact of OCD symptoms on functioning

www.caleblack.com

Session 1

- Results of assessment
- Provide education on
  - Etiology and course of OCD – Cormorbidity
  - OCD vs non-OCD behaviors
- Give overview of treatment program
- Homework – daily record of OCD symptoms

www.caleblack.com

Instructions: Please keep a *daily* record of **TWO** of your child's OCD symptoms. In the space provided below (feel free to use additional space if necessary) record the date, the specific symptom, the amount of time your child spent engaging in that symptom, how much disturbance it causes in the family, and how the parents are involved in the symptom.

Date	OCD symptom	Time spent	Family disturbance	Parent's involvement
T 3/17	At dinner, looked at roll for mold	5 min	Made us run late for basketball	Answered many questions
W 3/18	Refused to eat muffin for breakfast	10 min	Fought on way to school	Yelled at her
W 3/18	Asked if she would get sick from Lysol	1 min	None	Told her not to worry (2x)
Th 3/19	Looked at bagel for mold	4 min	None	Answered many questions
F 3/20	Asked about bottle of Windex	1 min	None	Told her not to worry (2x)
Sa 3/21	Looked at dinner roll for mold	1 min	She cried	Answered many questions
Su 3/22	Asked if she would get sick from Windex	1 min	None	Told her not to worry
M 3/23	Refused to eat toast	5 min	Late to school b/c made eggs	Answered many questions

www.caleblack.com

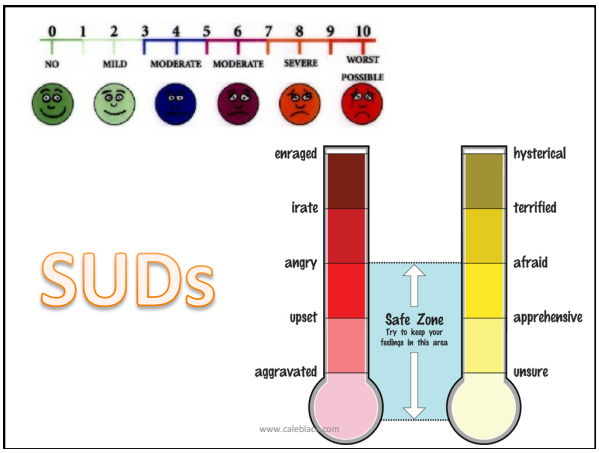
Session 2

- Review past session
- Start development of hierarchy
- Give overview of parent and child tools
- Introduce differential attention and reward plan
- Homework – Track two O/C symptoms, prepare rewards and rewards chart

Ranking	Description of Symptom	Label (O, C, ?)	Notes
1.	Worries about household cleaners	O	
2.	Avoiding eating off recently cleaned surfaces	C	
3.	Questioning parents about use of household cleaners	C	
4.	Worries about mold on food	O	
5.	Examination of food for mold	C	
6.	Worries about whether she had swallowed objects (e.g., paper clip)	O	
7.	Avoiding eating certain foods	?	Need more info

Session 3

- Review last week
- Introduce child to reward program
- Review OCD symptoms with child
- Introduce feeling thermometer/symptom tracking (child tools)



Session 3

- Discuss praise & encouragement
- Review level of family involvement in and accommodation of OCD symptoms
- Homework – Monitor symptoms, start reward chart for doing so
- New hierarchy (by therapist between sessions)

www.caleblack.com

Exposure Techniques

- The common thread in effective anxiety treatments is hierarchy-based exposure tasks
- Controversy over exactly *why* exposure therapy works so well for anxiety
- Does *not* require extensive preparation to be effective and long-lasting

www.caleblack.com

Rosqvist (2005)

Exposure Techniques

- Begin by constructing a fear hierarchy
  1. Generate specific feared situations
  2. Rate them using Subjective Units of Distress
- Continue by actually doing the exposures, working from lower to higher SUDs situations

Sample Fear Hierarchy

Situation	*Fear Rating*
Driving over the Steel Bridge at rush hour	100
Driving on the highway at rush hour, at dusk, and in poor weather	90
Driving on the highway at rush hour, in good weather	80
Being a passenger on the highway during rush hour	75
Driving on the highway in the middle of the day, in good weather	65
Driving on a city street at midday, when it is raining	65
Driving on a city street at midday, when the sky is clear	50
Turning onto a city street during traffic hours	45
Driving in a busy parking lot during business hours	35
Driving in an empty parking lot during "off" hours	25

Exercise!

- You will now create your own fear hierarchies
- Should include a wide range of fears and/or situations that are distressing
- Use SUDs rating to distinguish and order the hierarchy

Trigger	Obsession	Compulsion	Rating
Smelling cleaner, seeing the bottle, or seeing shiny or wet surfaces in the kitchen	Worries about being poisoned by household cleaners	Avoiding eating off recently cleaned surfaces	
Smelling cleaner, seeing the bottle, or seeing shiny or wet surfaces in the kitchen	Worries about being poisoned by household cleaners	Repeated questioning parents about use of cleaners (verbal checking)	
	Worries about mold on food	Examination of food for mold (self)	
	Worries about mold on food	Asking family member to examine food for mold	
	Worries about mold on food	Avoiding eating food that is likely to be moldy (e.g., bread, muffins)	
	Worries about whether he had swallowed objects (e.g., paper clip)		
	Worries about touching dirt on the floor		

www.caleblack.com

Session 4

- Review last week
- Problem solve homework or reward program
- Continue hierarchy development
- Introduce arguing with OCD
- Conduct in-session exposure

www.caleblack.com

Exposure Types

- Imaginal exposure tasks
  - Often used in the beginning, or when the child has abstract worries / fears
  - Allows for practicing coping skills before confronting the real situation
- In vivo exposure tasks
  - Often follow imaginal exposures, use a "live and in person" version of the feared situation

www.caleblack.com

Exposures

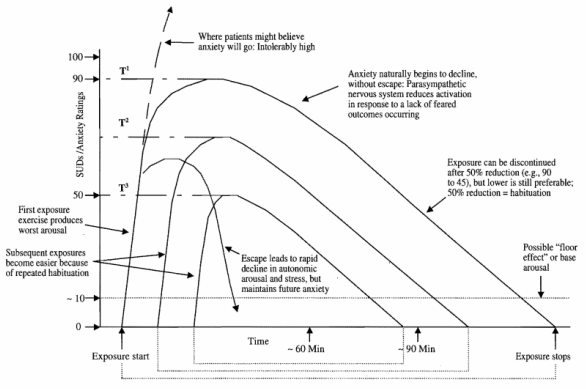
- Exposure occur both in and out of session
- Requires cooperation of parents to facilitate successful homework exposures
- Should be similar to what is being done in session, using a hierarchy and SUDs ratings
- Internal and external rewards for successful exposure completion should be discussed beforehand

www.caleblack.com

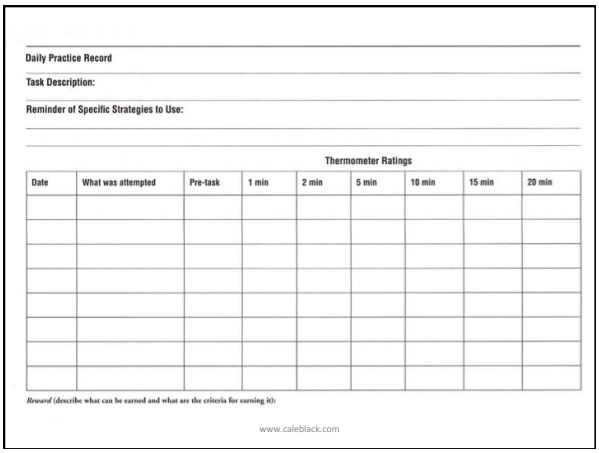
Exposures

- Ideal exposures are prolonged, repeated, and prevent the use of distraction behaviors
- SUDs decrease of at least 50%, with more being better
- May require shaping up to the more difficult situations, in terms of both time and use of distractors

www.caleblack.com



www.caleblack.com



Daily Practice Record

Task Description:

Reminder of Specific Strategies to Use:

Thermometer Ratings

Date	What was attempted	Pre-task	1 min	2 min	5 min	10 min	15 min	20 min

Reward (describe what can be earned and what are the criteria for earning it):

www.caleblack.com

Therapist Tasks

- Realize long-term benefits outweigh short-term distress, and communicate this effective to the family
- Work collaboratively with the child and family to plan and execute the exposures
- Maintain rapport during exposures by building upon pre-established rapport

www.caleblack.com

Therapist Tasks

- Do not allow avoidance or distracter behaviors during the exposure
- Modeling how to conduct exposures for the parents, so that they can perform them at home
- Be flexible and creative when dealing with less than optimal exposures and resistance

www.caleblack.com

Obstacles for the Therapist

- I'm making my client more upset / anxious
- It's difficult to see people in distress
- Can be emotionally draining for some therapists
- May have to do exposures that you are not comfortable with

Exercise!

- Now for an in vivo demonstration of EX/RP
- Everyone please welcome my good friend Monty T Python!

Session 4

- Discuss differential attention again – especially ignoring
- Review family involvement in OCD symptoms
- Problem solve homework compliance obstacles
- Homework – EX/RP task completion, parents use positive attention and ignoring

Session 5

- Review last week
- Problem solve homework tasks
- Revise hierarchy of symptoms
- Review arguing with OCD
- Conduct in-session exposure

Session 5

- Discuss modeling
- Homework
  - Parental modeling, use of differential attention
  - Child completes EX/RP task(s) each day

Session 6

- Review last week
- Problem solve homework tasks
- Review disengagement efforts
- Revise hierarchy of symptoms & arguing
- Introduce scaffolding/coaching

Scaffolding

- Step 1 – Find out how child feels and empathize with the child
- Step 2 – Brainstorm with child how to approach the situation
- Step 3 – Choose option from Step 2 and act on it
- Step 4 – Evaluate and reward

Session 6

- Conduct in-session exposure
- Review scaffolding/coaching steps
- Homework
  - Parents use modeling, DA, scaffolding, continue disengagement, reward task completion
  - Child completes ERP task(s) each day

Session 7

- Review past week
- Problem solve homework
- Review disengagement
- Revise hierarchy of symptoms & check arguing
- Conduct in-session exposure to check parental scaffolding

Session 7

- Expand use of scaffolding outside of EX/RP practice tasks
- Homework
  - Encourage use of all parental tools
  - Have parents apply scaffolding outside planned practice times
  - Child complete ERP task(s) each day

Sessions 8-10

- Review past week
- Problem solve homework
- Review disengagement
- Revise hierarchy of symptoms & arguing
- Conduct in-session exposures
- Homework assignments

Further Sessions

- Take place two weeks after previous sessions
- Similar to sessions 8-10
- Focus on how to handle OCD future problems
  - Relapse prevention strategies
  - Dealing with symptom reappearance

Ending Therapy

- Sessions should be spaced further apart
- Some families may need more booster sessions than others
- Plan on having long-term follow-up visits to check progress and troubleshoot

What are Body-Focused Repetitive Behaviors?

BFRBs

- Repetitive self-grooming behaviors in which pulling, picking, biting or scraping of the hair, skin or nails result in damage to the body
- Common BFRB behaviors include skin picking (of scabs, acne, or other skin imperfections, for example), cuticle or nail biting or picking, and lip or cheek biting

OC&R and BFRBs

- Two of the OC&R disorders are also BFRBs
  - Trichotillomania (hair-pulling disorder)
  - Excoriation (skin-picking disorder)
- Distinct from OCD and not the result of some "deeper" disorder or trauma

Symptoms of BFRBs

- Pulling/picking most often occur when sedentary
  - Lying in bed, reading, listening to a lecture or in class, riding in or driving a car, using the bathroom, talking on the phone, using the computer or sitting at a desk at work
- Can be planned or accidental

Symptoms of BFRBs

- Some have sensations that "pull" fingers to the sites, some do not
- Many report they are search for "wrong" hairs or skin in order to remove/fix the perceived problem
- For many, these searching behaviors are part of the process

Etiology

- Typically begin around puberty
  - Can be seen among infants, but is less likely to develop into a long-term problem behavior
- Some evidence for genetic or epigenetic component
- Strong environmental influence (family stress, in particular)

What is Trichotillomania (Hair-Pulling Disorder)?

Operational Definition

A. Recurrent pulling of one's hair, resulting in hair loss

B. Repeated attempts to decrease or stop hair pulling

C. The hair pulling causes clinically significant distress in social, occupational, or other important areas of functioning

Operational Definition

D. The hair pulling or hair loss is not attributable to another medical condition

E. The hair pulling is not better explained by symptoms of another mental disorder

TTM Prevalence

- 1-2% in adolescents and adults
- Females outnumber males 10:1 in adult samples
- Equal number of males and females in childhood

What is Excoriation (Skin-Picking) Disorder?

Operational Definition

A. Recurrent skin picking resulting in skin lesions

B. Repeated attempts to decrease or stop skin picking

C. The skin picking causes clinically significant distress in social, occupational, or other important areas of functioning

Operational Definition

D. The skin picking is not attributable to the physiological effects of a substance another medical condition

E. The skin picking is not better explained by symptoms of another mental disorder

Excoriation Prevalence

- Rates of 1-2% in adults, with at least half of cases starting in childhood
- 3:1 female to male ratio

Treatment for BFRBs

Behavioral Therapy

- Several different therapeutic approaches have been used with BFRBs, all variations of CBT
- Habit Reversal Training, Comprehensive Behavioral Treatment, Acceptance & Commitment Therapy, and Dialectical Behavior Therapy have all been used
- HRT and ComB are more well studied, ACT and DBT are considered adjunctive

FLOW CHART FOR TRICHOTILLOMANIA TREATMENT

PHASE 1: ASSESSMENT AND FUNCTIONAL ANALYSIS
Decision to target pulling and orientation of client
Identification of functional components
Begin self-monitoring

↓

PHASE 2: IDENTIFY AND TARGET MODALITIES
Identification of potential modalities to be targeted
Selection of target modalities

↓

PHASE 3: IDENTIFY AND IMPLEMENT STRATEGIES

Identify potential treatment strategies within the targeted modalities
Identify the specific strategies most likely to be used by the client
Train client in the use of strategies/implement for at least 1 week

↓

PHASE 4: EVALUATION AND MODIFICATION

Evaluate effectiveness of the strategy
Select and implement next step in treatment

www.caleblack.com

Habit Reversal Training

- Most well-researched method to date
- Three critical components
  - Awareness training
  - Competing response training
  - Social support

www.caleblack.com

Awareness Training

- Involves making clients more aware of when and where the pulling/picking is most likely to occur
- First step is a complete operational definition of the BFRBs
  - Describe where it occurs, which hand(s) are used, typical location(s), typical mood state(s)

www.caleblack.com

Awareness Training

- Then, any environmental functions of the behavior need to be identified
  - Socially mediated positive reinforcement
    - Gaining attention
  - Socially mediated negative reinforcement
    - Escaping from unwanted situations/actions
  - Automatic reinforcement
    - Physical/emotional changes that happen from behavior

www.caleblack.com

Awareness Training

- For homework, clients are to keep an ongoing log of all pulling/picking episodes
- Typically includes severity, duration, triggers, emotions, sensations, thoughts, location

www.caleblack.com

Date	Time Began	Location (Where were you?)	Activity (What were you doing?)	Strength of Urges (0-10)	Degree of Awareness (0-10)	Notable Feelings	Notable Thoughts	Notable Sensations	**Site** S=Scalp B=Brows L=Lashes P=Pubic O=Other	Strength of Effort to Resist (0-10)	No. Pulled

www.caleblack.com

Competing Response Training

- In this phase, you teach and practice doing behaviors that are physically incompatible with the picking/pulling behavior
- Ultimate goal is to desensitize client to the "urges" that often occur, as well as continue to raise awareness

Competing Response Training

- CRT is very similar to doing EX/RP for OCD – it's all about prevention of typical responses and letting discomfort naturally dissipate
- May need to get highly creative to develop appropriate competing responses

Competing Response Training

- Typically begins by doing "practice" phase where spend 30 minutes a day practicing pulling and doing CRs
- Identify the most problematic behavior and resultant picking/pulling site to target first

Competing Response Practice

1) Based on prior operational definitions, you begin the picking/pulling behavior
2) Start the behavior, but do not complete it
3) Do CR immediately
4) Hold the CR for 1 minute or until urge goes away, whichever is longer
5) Rinse and repeat

Social Support

- Involves bringing loved ones and family members into the therapy process to:
  - Provide positive feedback when the individual engages in competing responses
  - Cue the person to employ these strategies
  - Provide encouragement and reminders when the individual is in a "trigger" situation

Session Breakdown for HRT

- Session 1 - Interview
- Session 2 - Awareness training
- Session 3 – Competing Response Training
- Session 4 – CR Generalization

Session 1 - Interview

- Functional assessment of BFRBs
- Assessment of comorbid issues
- Establish ongoing assessment plan
- Discuss treatment outline

www.caleblack.com

Instructions: For each item, pick the one answer which best describes the past week. If you have been having ups and downs, try to estimate an average for the past week. Please be sure to read all answers in each group before making your choice.

(1) How often do you feel the urge to pick your skin?
0 No urges
1 Mild, occasionally experience urges to skin pick, less than 1 h/day
2 Moderate, often experience urges to skin pick, 1–3 h/day
3 Severe, Very often experience urges to skin pick, greater than 3 and up to 8 h/day.
4 Extreme, constantly or almost always have an urge to skin pick

(2) How intense or "strong" are the urges to pick your skin?
0 Minimal or none
1 Mild
2 Moderate
3 Severe
4 Extreme

(3) How much time do you spend picking your skin per day?
0 None
1 Mild, spend less than 1 h/day picking my skin, or occasional skin picking.
2 Moderate, spend 1–3 h/day picking my skin, or frequent skin picking.
3 Severe, spend more than 3 and up to 8 h/day picking my skin, or very frequent skin picking.
4 Extreme, spend more than 8 h/day picking my skin, or near constant skin picking.

(4) How much control do you have over your skin picking? To what degree can you stop yourself from picking?
0 Complete control. I am always able to stop myself from picking.
1 Much control. I am usually able to stop myself from picking.
2 Some control. I am sometimes able to stop myself from picking.
3 Little control. I am rarely able to stop myself from picking.
4 No control. I am never able to stop myself from picking.

(5) How much emotional distress (anxiety/worry, frustration, depression, hopelessness, or feelings of low self-esteem) do you experience from your skin picking?
0 No emotional distress from picking.
1 Mild, only slight emotional distress from my picking. I occasionally feel emotional distress because of my picking, but only to a small degree.
2 Moderate, a fair amount of emotional distress from my picking. I often feel emotional distress because of my picking.
3 Severe, a large amount of emotional distress. I almost always feel emotional distress because of my picking.
4 Extreme, constant emotional distress. I feel constant emotional distress and see no hope of this changing.

(6) How much does your skin picking interfere with your social, work (or role functioning)? (If currently not working determine how much your performance would be affected if you were employed.)
0 None
1 Mild, slight interference with social or occupational activities but overall performance not impaired
2 Moderate, definite interference with social or occupational performance, but still manageable.
3 Severe, causes substantial impairment in social or occupational performance.
4 Extreme, incapacitating

(7) Have you been avoiding doing anything, going any place, or being with anyone because of your skin picking? If yes, then how much do you avoid?
0 None
1 Mild, occasional avoidance in social or work settings.
2 Moderate, frequent avoidance in social or work settings.
3 Severe, very frequent avoidance in social or work settings.
4 Extreme, avoid all social and work settings as a result of the skin picking/scratching.

(8) How much skin damage do you currently have because of your skin picking? Only consider the damage produced by the behavior of picking.
0 None (no skin damage from picking)
1 Mild (Slight damage in the form of small scabs, sores, scrapes etc. Damage covers a very small area and no attempts are made to cover or treat the damage).
2 Moderate (Noticeable scars, scabs, or small open sores[< 1 cm in diameter]). Picking results in attempts to cover or treat the damage with in-home remedies (e.g., bandages, creams, ointments) that do not require the assistance of a physician.
3 Severe, (Large scars, scabs or open sores (> 1 cm in diameter)), infected areas and/or noticeably disfigured skin. Picking results in extensive attempts to cover the damage and may require periodic treatment by a medical professional (e.g., prescription antibiotics, dermabrasion, etc.)
4 Extreme. (Large open wounds or craters, frequent bleeding, large scarred areas). Damage may require extensive covering and medical intervention (e.g., plastic surgery, stitches, hospitalization, etc.).

Session 2 - Awareness training

- Provide rationale for awareness training
- Get detailed description of pulling/picking
- Discuss "warning signs" of pulling, establish 1-3
- Therapist simulates pulling, client has acknowledge BFRBs

www.caleblack.com

Session 2 - Awareness training

- Repeat process with warning signs
- Homework is to do self-monitoring of pulling/ picking behavior for the next week

Session 3 – Competing Response Training

- Review monitoring HW
- Choose a competing response
- Clinician models CR
- Address concerns about CR
  - Situations it will not possible, worries about it feeling uncomfortable

Session 3 – Competing Response Training

- Teach client the CR
- Social support training
  - Identify support person
  - Have client demonstrate CR
  - Have support person praise (based on therapist modeling)
- Homework is to practice CR for 20-30 minutes daily and continue self-monitoring

Session 4 – CR Generalization

- Review HW, troubleshoot as needed
- Assess self-monitoring data
- Review CR to ensure it's being done correctly
- Ask support person about any problems

Session 4 – CR Generalization

- Introduce use of CR outside of practice
- Determine how support person(s) will let client know when to do the CR (if they don't catch it themselves)
- Practice in session
- Homework – continue self-monitoring and practice, implement general CR use

Sessions 5+

- Review and troubleshoot progress using CR and practicing
- Repeat awareness and CR process for other BFRBs
- Space sessions out to provide contact as needed

Comprehensive Behavioral Treatment

- ComB was developed to individualize BFRB treatment
- Combines HRT with other CBT techniques to maximize generalizablity
- Differs from HRT in that uses not just CRs, but also sensory substitutes

ComB Sensory Substitutes

- All about finding items that achieve the sensation desired when engaging in BFRBs
- If itching at picking/pulling area, use wide tooth comb to provide relief but not have fingers touch skin/hair
- If searching for coarse hair to pull, might roll twine between fingers

ComB Other Aspects

- Cognitive restructuring and correcting faulty thinking
- Interpersonal work due to shame, isolation, and low self-esteem that is often seen in people with BFRBs

What are Tic Disorders?

Why cover Tics?

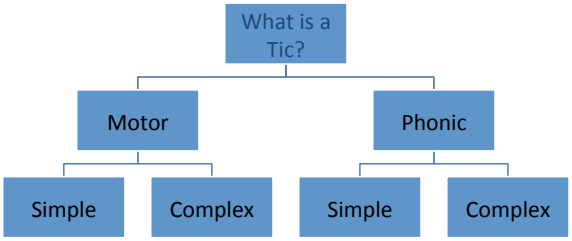
- Tic disorders are in the "Motor Disorder" section of the "Neurodevelopmental Disorders" chapter of the DSM-5
- However, there is huge amounts of comorbidity with OC&R, as well as large amounts of treatment overlap

Operational Definition

- Tourette's Disorder
  A. Both multiple motor and one or more vocal tics that have been present at some time during the illness, although not necessarily concurrently
  B. The tics may wax and wane in frequency but have persisted for more than 1 year since first tic onset
  C. Onset is before age 18 years
  D. The disturbance is not attributable to a substance or other medical condition

Operational Definition

- Persistent (Chronic) Motor or Vocal Tic Disorder
  A. Single or multiple motor or vocal tics that have been present at some time during the illness, but not both motor and vocal
  B. The tics may wax and wane in frequency but have persisted for more than 1 year since first tic onset
  C. Onset is before age 18 years
  D. The disturbance is not attributable to a substance or other medical condition
  E. Criteria have never been met for Tourette's disorder



Motor tics

Simple - sudden brief, meaningless movements

- Eye blinking, eye movements, grimace, mouth movements, head jerks, shoulder shrugs

Complex - slower, longer, more "purposeful"

- Multiple simple tics occurring in an orchestrated pattern, facial gestures, touching objects or self, hand gestures, gyrating or bending, dystonic postures, copropraxia (obscene gestures)

Phonic Tics

Simple - sudden meaningless sounds or noises

- Throat clearing, coughing, sniffing, spitting, animal noises, grunting, hissing, sucking, other simple sounds

Complex - sudden, more "meaningful" utterances

- Syllables, words, phrases ("shut up", "stop that")
- Coprolalia (obscene, aggressive words)
- Palilalia (echo self)
- Echolalia (echo others)

Prevalence

- Tourette's is around 0.77% of children, 0.05% of adults
- Less severe Persistent Tic Disorder may be up to 2-3% for children
- Many more males than females diagnosed
  - 2-5:1 ratio seen

Tourette's Disorder

- Typical age of onset is 5-6 years old
  - Often starts with simple facial tics, then progresses to more complex and motor tics
- Associated with very high levels of comorbid disorders and symptoms

Tic Frequency

- 97.7% Simple motor tics
  - 43.2% Eyes
  - 43.2% Mouth
  - 34.1% Facial
- 75.0% Simple vocal tics
- 13.6% Coprolalia

Tourette's & Comorbidity

- Obsessions and compulsions – 50%
- Depression – 41%
- Attentional problems, hyperactivity – 50-75%
- Learning disabilities – 51%
- Panic attacks – 13%

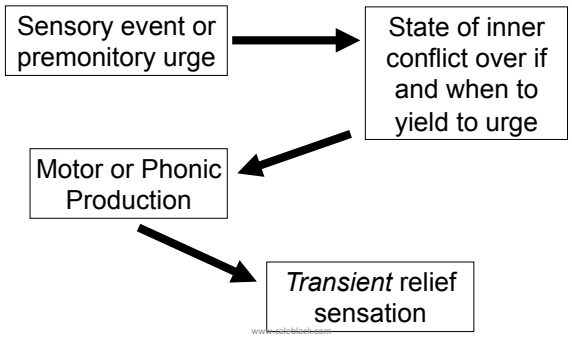
What Causes Tics?

- Appears to be an irregularity of the neurotransmitters dopamine and serotonin
- There is no "cure," but symptoms tend to decrease after adolescence in most people
- Treatment options include drugs and therapy
  - Anticonvulsants and neuroleptics are useful for some, but have very negative side effects

Can't They Control It?

- Short answer: No
- Control and severity waxes and wanes over the day
- Best analogy for most people is a sneeze
  - You can feel it coming on, can hold it off for a little while, but ultimately you have to let it out
  - The longer most people hold it in, the greater the severity when it is let out

How a Tic Happens



Tourette's Related Problems

- Lowered overall quality of life
- Academic problems
- Impaired social interactions
- Number of home-life impairments
  - Increased marital difficulties, substance abuse, family conflict, and parenting frustration

Tourette's Related Problems

- 88% of those with tics report a negative impact on their daily functioning
- Higher unemployment rates and lowered income as adults
- Self-esteem and social anxiety
- Physical damage

Common Triggers for Tics

- Being upset or anxious
- Watching TV
- Being alone
- Social gatherings
- Stressful life events
- Hearing others cough
- Talking about tics

Cognitive-Behavioral Intervention for Tics

CBIT Outline

- Psychoeducation
- Habit Reversal Training
- Functional Intervention
- Reward System
- Relaxation Training

CBIT Psychoeducation

- Phenomenology of tics
- Prevalence of tics
- Natural history of tics
- Common comorbids
- Causes of tics
- Psychosocial impairments

CBIT HRT

- Exact same process as outlined for BFRBs
- Given that there are usually numerous tics, the assessment and CR process usually takes longer

CBIT Function-Based Interventions

- Assessment of antecedents and consequences associated with increase in tics
- Work to develop strategies to reduce tics based on assessment

Functional Strategies

- Minimize or eliminate tic exacerbating situations when possible
- Remove potentially reinforcing consequences to the tic in tic exacerbating situations
- When entering tic-prone situations, the patient should be reminded to use HRT procedures

Functional Strategies

- For tic-prone situations that are not easily modifiable, teach patient strategies to minimize the impact of that situation
  - Teaching relaxation strategies for high stress situations
  - Teaching cognitive restructuring
  - Teaching scheduled activity or breaks
- Minimize the impact of the tics on the child
  - Educate peers, teachers and relatives about the child's condition