


*Treating OCD during COVID-19:
Unique challenges and opportunities*

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Disclosures

Martin E. Franklin, PhD, has disclosed the following financial relationship(s) occurring in the last 12 months with a commercial interest whose products or services may be relevant to the educational content of this CE program presentation:

Commercial Interest Entity Name	Type of Relationship(s) with Entity	Related Product/Service
The Guilford Press	Book royalties	Publisher

Dr. Franklin has declared that he does not have any relevant non-financial relationships. Additionally, all planners involved do not have any financial relationships.

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Learning objectives

Upon completion of the instructional program, participants should be able to:

1. Present at least two components of the empirically grounded theoretical framework for ERP that can be readily understood by patients and families;
2. Identify at least two adaptations to the delivery of ERP for OCD across the developmental spectrum, including navigating challenges inherent in delivering this empirically supported form of treatment via teletherapy;
3. Identify at least two components of the unique role in treatment played by parents of youth with OCD while simultaneously encouraging and promoting the patient's own active engagement in ERP.

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What we'll cover in this webinar

- 1. ERP across the developmental spectrum**
 - Theoretical rationale and empirical foundation
 - Essential components of treatment
- 2. Modifications to ERP in light of COVID**
 - Teletherapy
 - Reduction of ERP opportunities
 - Creative use of other opportunities
 - The special case of ERP pertaining to contamination
- 3. Adaptations of ERP for use with youth and families**
 - Adjusting critical treatment elements (psychoeducation, hierarchy-building, exposure activities) to reflect environmental changes associated with COVID and quarantine
 - Balancing parents' facilitation/involvement and accommodation
 - Reward/contingency systems modifications during stay-at-home orders

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ERP across the developmental spectrum

- Theoretical rationale
- Empirical foundation

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Emotional Processing of Fear: Exposure to Corrective Information

Edna B. Foa and Michael J. Kozak
Temple University

In this article we propose mechanisms that govern the processing of emotional information, particularly those involved in fear reduction. Emotions are viewed as represented by information structures in memory, and anxiety is thought to occur when an information structure that serves as program to escape or avoid danger is activated. Emotional processing is defined as the modification of memory structures that underlie emotions. It is argued that some form of exposure to feared situations is common to many psychotherapies for anxiety, and that confrontation with feared objects or situations is an effective treatment. Physiological activation and habituation within and across exposure sessions are cited as indicators of emotional processing, and variables that influence activation and habituation of fear responses are examined. These variables and the indicators are analyzed to yield an account of what information must be integrated for emotional processing of a fear structure. The elements of such a structure are viewed as cognitive representations of the stimulus characteristic of the fear situation, the individual's responses in it, and aspects of its meaning for the individual. Treatment failures are interpreted with respect to the interference of cognitive defenses, autonomic arousal, mood state, and erroneous ideation with reformation of targeted fear structures. Applications of the concepts advanced here to therapeutic practice and to the broader study of psychopathology are discussed.

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Anxiety treatment: Modifying the fear structure

Foa & Kozak (1986) posited that:

- Two conditions are necessary:
 - Activation of the fear structure
 - Incorporation of incompatible information
- This process is indicated by:
 - Between-session decreases in fear
 - Change in evaluations (cognitions)

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A simplified theoretical approach:

**“Blah, blah, blah,
do the thing you’re afraid of.
Blah, blah, blah,
the more you do it, the easier it gets.”**

Gwen Franklin, age 6, to her father, 2001

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CBT for adult OCD: Current evidence base

- Initial test of CBT protocol by Victor Meyer in 1966
- Theoretical foundation in two-factor theory (Mowrer, 1939, 1960) and in emotional processing theory (Foa & Kozak, 1986)
- Meta-analyses & reviews (e.g., Öst et al., 2015)
- Dozens of published CBT randomized trials including:
 - Foa et al., (2005): Intensive CBT, clomipramine (CMI), and COMB vs. PBO
 - Marks et al., (1980): CMI alone, therapist-aided and self-exposure
 - Simpson et al., (2008): SSRI augmentation w/ CBT vs. anxiety management
 - Simpson et al., (2013): SSRI augmentation w/ CBT, risperidone, or PBO

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CBT for pediatric OCD: Current evidence base

- Extensive adult literature and multiple open trials ERP trials in kids
- Meta-analyses & reviews (e.g., Franklin et al., 2015; Freeman et al., 2014)
- Twenty published CBT randomized trials including:
 - deHaan et al. (1998): CBT vs. clomipramine
 - Barrett et al. (2004, 2005): Individual and Family CBT vs. WL
 - Pediatric OCD Treatment Study I, II, & Jr. (POTS, 2004, Franklin et al., 2011, Freeman et al., 2014)
 - Storch et al (2007): Intensive vs. weekly CBT
 - Bolton & Perrin (2008): "Pure" BT vs. WL
 - Bolton et al. (2011): Brief & full cognitively oriented TX vs. WL
 - Freeman et al. (2008) & Piacentini et al. (2011): CBT vs. REL

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ERP across the developmental spectrum

- Essential components of treatment

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Cognitive behavioral treatment for OCD: Essential components

- Exposure *in vivo*:** Prolonged confrontation with anxiety-evoking stimuli (e.g., contact with contamination)
- Imaginal exposure:** Prolonged imaginal confrontation with feared disasters (e.g., hitting a pedestrian while driving)
- Ritual prevention:** Blocking of compulsions (e.g., leaving the kitchen without checking the stove)
- Cognitive methods:** Correcting erroneous cognitions (e.g., "anxiety won't decrease unless I ritualize;" "If I don't check repeatedly someone will break in and kill my family")

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OCD presentation in children and adolescents

- Emotion regulation may be difficult
- May have less insight for developmental reasons
- Family is often a factor in maintaining the symptoms
- Accommodation makes OCD bearable for the child and thus less dysfunction may be present
- May have greater difficulty verbalizing the problem



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Developmental considerations

<p>Younger children:</p> <ul style="list-style-type: none"> • More directive approach • Use age-appropriate language and metaphors • Greater use of goal-setting and reinforcement • Greater family involvement 	<p>Adolescents:</p> <ul style="list-style-type: none"> • More collaboration in exposure selection • More discussion of risk • More identification of feared consequence, and greater use of disconfirmatory evidence
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Modifications to ERP in light of COVID-19

- Teletherapy
- Reduction of ERP opportunities
- Creative use of other opportunities
- The special case of ERP pertaining to contamination

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Teletherapy (assistance from Kate Fuller, CHOP)

- Thomas et al. (2018). *Psychiatric Services*, 69, 161-168.
Tele-med consults > transport to ER for pediatric psych emergencies in shortening hospital stay, cost reduction, & patient satisfaction
- Hilty et al. (2015). *Psych Clin North America*, 38, 559-592.
Review of multiple studies attesting to tele-psychiatry's efficacy & effectiveness relative to in-person care; also well accepted by providers, patients, and administrators

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Teletherapy

Bashshur et al. (2016). *Telemed J E Health*, 22, 87-113.

- Adolescent migraine
- ADHD
- Obesity
- Anxiety
- Depression
- Substance abuse

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Teletherapy

- Requires Internet access
- “Dry run” preferable up front
- Rules of etiquette also presented up front
- Attention to privacy issues
- Attention to attentional issues



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Reduction of ERP opportunities

- Stay-at-home order in most locations limit what can be done outside the session (e.g., train station exposures)
- Unavailability of people in public spaces requires more in advance planning for exposures requiring another person
- Driving-related exposures likely less anxiety producing b/c of limited pedestrian and automobile traffic
- Work and school restrictions may also limit relevant exposures
- CDC guidelines also limit exposure opportunities, especially with respect to contamination

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Creative use of other opportunities

- Creation of virtual communities for exposure
- Opportunity to strengthen interpersonal connections w/ patients by seeing their homes
- Chance to travel virtually to high-anxiety places within home (e.g., “creepy basement” exposure)
- Increased reliance and focus on imaginal exposure scripts
- Screen sharing can enhance YouTube work (e.g., vomit scenes in movies, essence contamination w/ screen saver)
- “Bringing the exposure to where OCD lives”

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The specific case of contamination OCD

COVID-19 restrictions will limit:

- Close contact exposures
- "Over the top" exposures (e.g., eating grapes off train station floor)
- Proper response prevention/handwashing restrictions
- Re-exposure immediately upon washing/showering w/ "barbecued towel" or other such tricks
- Psychoeducation around what is possible vs. what is probable

Particularly problematic if COVID-19 fear is a primary concern

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Adaptations of ERP for use with youth and families

- Adjusting critical treatment elements (psychoeducation, hierarchy-building, exposure activities) to reflect environmental changes associated with COVID and quarantine
- Balancing parents' facilitation/involvement and accommodation
- Reward/contingency systems modifications during stay-at-home orders

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Adjustments are likely needed to...

- Case selection
- Interpersonal context/parent involvement
- Psychoeducation
- Hierarchy development
- Exposure activities

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Balancing parental involvement with independence

- Developmental considerations as to who is the focus of treatment and who is present in treatment likely more challenging to arrange
- Session structure: How much/how little screen time for parents?
- Potential for arguments/disagreements within session
- Need to continue to foster independence yet also attend to relevant contextual/family issues
- Sensitive content needs to be addressed sensitively

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Accommodation

- Remains a strong predictor of outcome in pediatric OCD (e.g., Wu et al., 2016)
- May be exacerbated by parental fears around patient engagement in exposures or even leaving the house
- “The rising tide raises all boats:” Increased stress/tension at home likely exacerbating negative interactions around OCD as well as in general
- Therapist’s role in addressing accommodation might be made more difficult but can still be maintained (e.g., e-role plays)

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Reward/contingency modifications

- Careful not to promise the world
- Attention to parental vs. child risk of COVID exposure in seeking rewards (e.g., trip to the store)
- Need to continue to attend to the value of more immediate reinforcement vs. postponing rewards for months
- Modifications to time-out procedures where needed
- Ongoing consultation with therapist around reward/contingency management structure and implementation adjustments

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Where to get additional information...



<https://www.coronavirus.gov>



<https://www.nih.gov/health-information/coronavirus>



<https://iocdf.org/covid19>



<https://adaa.org/finding-help/coronavirus-anxiety-helpful-resources>

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About the presenter...



Martin E. Franklin, PhD
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 Martin E. Franklin, PhD, is a nationally renowned expert in the treatment of obsessive-compulsive disorder (OCD), OC-spectrum disorders, and body-focused repetitive behaviors, as well as the study and treatment of anxiety and related conditions. Dr. Franklin is an associate professor emeritus of clinical psychology in psychiatry at the University of Pennsylvania Perelman School of Medicine, where he has been honored for teaching excellence. Dr. Franklin also serves as the clinical director of Rogers Behavioral Health’s Philadelphia location.

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