Co-occurring OCD and PTSD: Conceptualization, assessment, and treatment

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Chad T. Wetterneck, PhD [he/him/his]

Tuesday, June 29, 2021

ROGERS Behavioral Health

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Quick overview of logistics

Our speakers will give a 75-minute presentation.

Following the presentation, there will be a dedicated time to answer your questions.

- Please use the **Q&A feature**, located in the toolbar at the bottom of your screen, to send your question to the moderator.
- The moderator will review all questions submitted and select the most appropriate ones to ask the presenter.

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Disclosures

Caitlin M. Pinciotti, PhD, and **Chad T. Wetterneck, PhD,** have each declared that they do not, nor does their family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation. Drs. Pinciotti and Wetterneck each declared that they do 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. Recognize three developmental pathways between comorbid trauma and OCD as they present in the real world.
2. Differentiate two classes of similar symptoms of OCD and PTSD (phenotype and function).
3. Identify two or more treatments and relevant treatment modifications for clients with OCD and trauma/PTSD.

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What we'll cover in this webinar

Conceptualization

- Clinical picture
- Intersection of trauma and OCD
- Development and maintenance of PTSD and OCD

Assessment considerations

- Symptom similarities and differences
- Differential diagnosis questions to consider
- Examples

Treatment considerations

- Treatment complications
- Treatment recommendations
- Brief overview of PE and ERP

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Conceptualization

Caitlin M. Pinciotti, PhD

Please use the Q&A feature to send your questions to the moderator.

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Criterion A trauma

Trauma is:

Actual or threatened death, serious injury, sexual violence that is…

Directly exposed, *or*

Witnessed, *or*

Learned about, *or*

Exposure to details

Trauma is not:

Stressful life events

Death that is not sudden, unexpected, or violent

Intrusive thoughts

Witnessing something on TV

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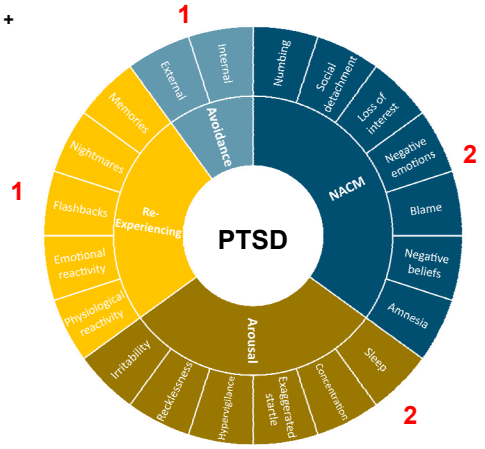
Criterion A trauma +



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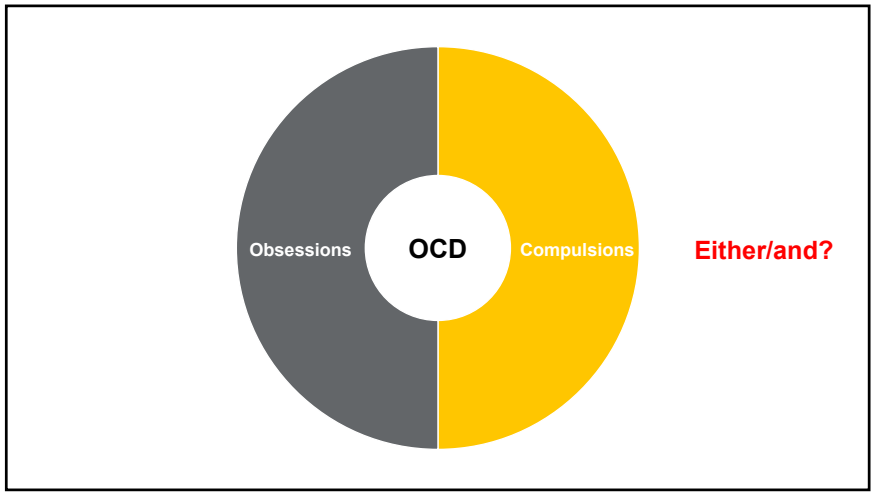

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Diagnostic prevalence

- 19-25% of OCD with PTSD
  (Brown, Campbell, Lehman, Grisham, & Mancill, 2001; Fontenelle, et al., 2012; Torres, et al., 2016)
  - 7% lifetime (Ozer, Best, Lipsey, & Weiss, 2003)
- 31-41% of PTSD with OCD (Brown et al., 2001; Nacash, Fostick, & Zohar, 2011)
  - 1-2% lifetime (Ruscio, Stein, Chiu, & Kessler, 2010)
- PTSD onset about equal:
  - 20.7% in same year
  - 39.9% preceding OCD
  - 39.4% following OCD (Ruscio et al., 2010)

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Trauma prevalence

- Over half of individuals with OCD experience trauma
  (Cromer et al., 2007)
- Equal risk for OCD following natural and human-made disasters
- Risk for OCD increases with cumulative trauma
  (Reifels, Mills, Dückers, & O'Donnell, 2019)
- Trauma exposure independently related to OC symptoms after controlling for PTSS or concurrent PTSD/depression
  (Boudreaux, Kilpatrick, Resick, Best, & Saunders, 1998; Cromer et al., 2007; Pinciotti, Riemann, & Wetterneck, 2021)
- Effect of childhood trauma on OC symptoms stronger for girls
  (Barzilay et al., 2019)
  - Especially pre-pubescent trauma

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Impact of relative onset

"Pre-traumatic" OCD

- Younger OCD onset
- More severe contamination
- Comorbid alcohol-related and self-mutilation disorders

"Post-traumatic" OCD

- Older OCD onset
- More severe obsessions and compulsions
- Suicidality
- Comorbid agoraphobia and impulse control and panic disorders (Fontenelle et al., 2012)

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Clinical presentation

- Diagnostic onset may impact symptoms
- No unique or expected phenotypic OCD+PTSD presentation when all current symptoms are controlled
- More severe OCD but not PTSD symptoms
  (Pinciotti & Orcutt, 2020; Pinciotti, Wetterneck, & Riemann, 2021)
- Trauma type may impact symptoms
  - Sexual trauma and contamination (Fairbrother & Rachman, 2004)
  - Indirectly experienced trauma and symmetry/just right
    (Pinciotti, Riemann, & Wetterneck, 2021)

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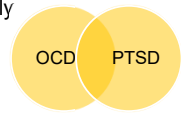
Conceptualization of comorbidity

Static

- Symptoms exist independently
- Can address sequentially

Dynamic

- Functional connection or overlap in symptoms
- Trauma may influence theme/presentation
- Need to address both simultaneously



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Theoretical intersections of trauma and OCD

Theme/content

- Sexual trauma

Function

- Checking locks

Core fear

- I am a bad person

Related emotions

- Guilt, shame

Beliefs

- Inflated responsibility

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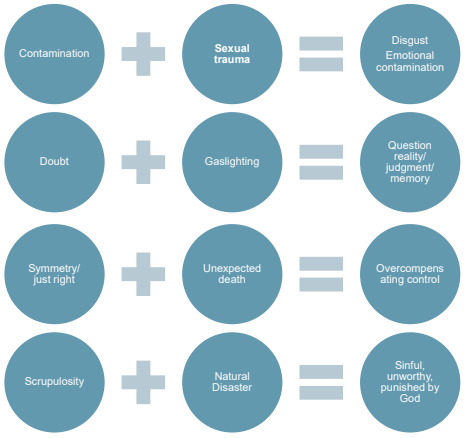

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Development and maintenance of PTSD and OCD

Q&A Please use the Q&A feature to send your questions to the moderator.

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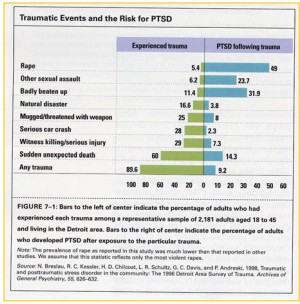
Trauma and risk of PTSD

Prevalence

- 39-50% of adults have experienced a traumatic stressor
  - 6-25% of these later develop PTSD
  - Rape more likely to cause PTSD than injury or accident
- Lifetime prevalence is 10% for women and 5% for men
- LGBTQ+ and indigenous people at risk for sexual trauma (Greenfield & Smith, 1999; James et al., 2016)



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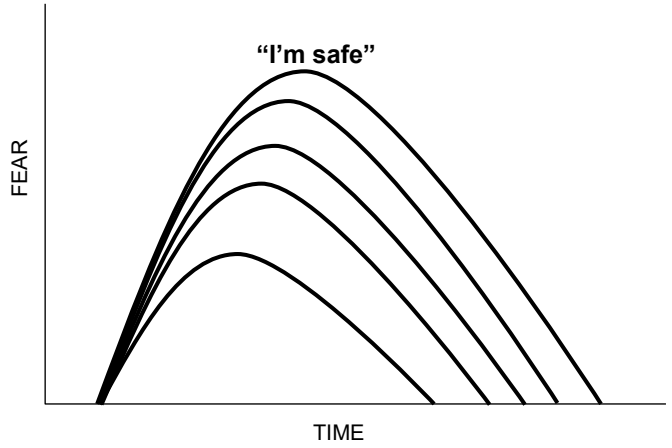

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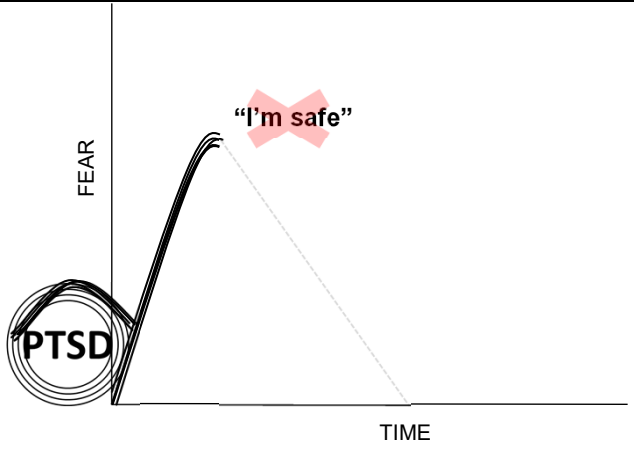

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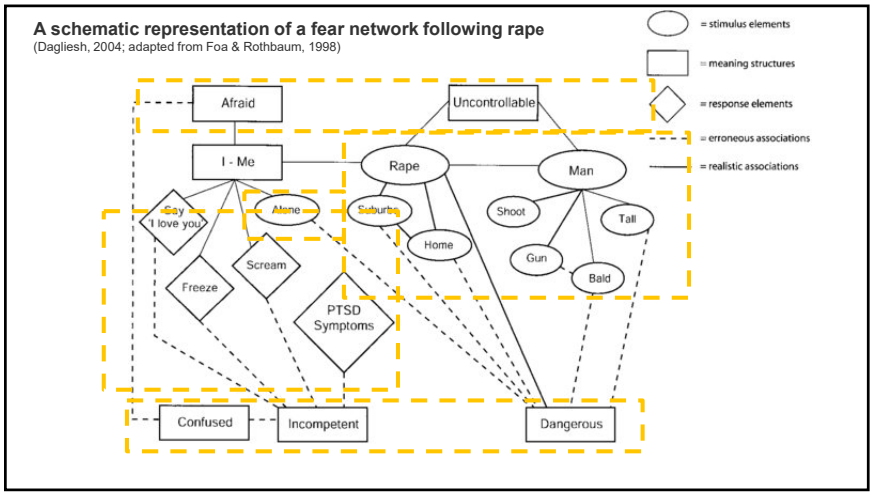
A schematic representation of a fear network following rape
(Dagliesh, 2004; adapted from Foa & Rothbaum, 1998)
= stimulus elements
= meaning structures
= response elements
= erroneous associations
= realistic associations
Afraid
Uncontrollable
I - Me
Rape
Man
Say I love you
Alone
Suburbs
Shoot
Tall
Home
Gun
Scream
Bald
Freeze
PTSD Symptoms
Confused
Incompetent
Dangerous

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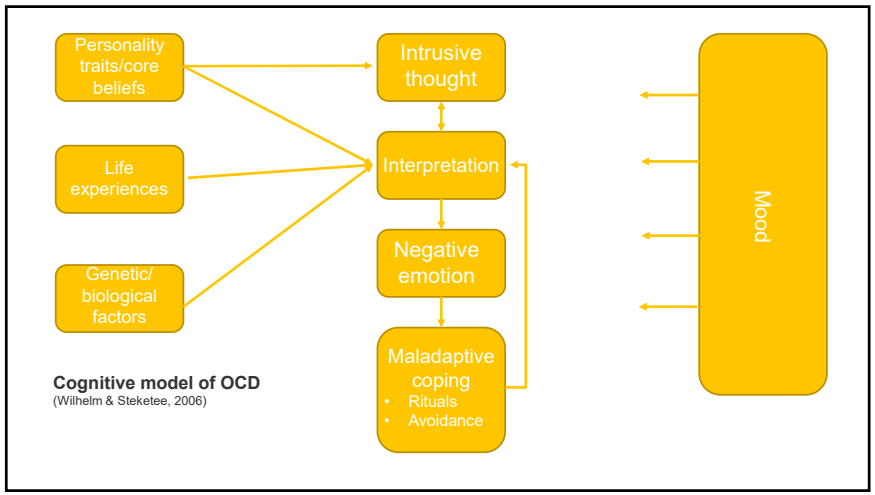
Personality traits/core beliefs
Life experiences
Genetic/ biological factors
Intrusive thought
Interpretation
Negative emotion
Maladaptive coping
Rituals
Avoidance
Mood
Cognitive model of OCD
(Wilhelm & Steketee, 2006)

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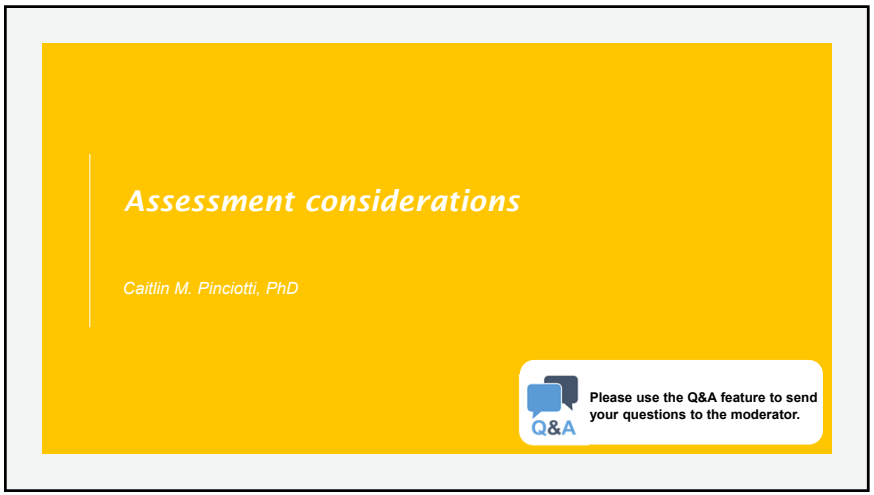
Assessment considerations
Caitlin M. Pinciotti, PhD
Q&A
Please use the Q&A feature to send your questions to the moderator.

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Overlapping features of OCD and PTSD: Intrusions

OCD	Overlap	PTSD
• Often present/future-focused • Often a fear that has not occurred (imagined threat) • Do not have to be anchored to A1 trauma • Usually multiple themes	• Unwanted, intrusive, recurring thoughts/images/ memories • Anxiety, distress, shame, guilt • Can involve traumatic themes	• Past-focused • Focus on A1 trauma and related experiences

(Fletcher, Van Kirk, & Hundt, 2020)

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Overlapping features of OCD and PTSD: Avoidance

OCD rituals	Overlap	PTSD safety behaviors
• Prevent imagined threat • Rigid rules/patterns • Self-doubt, "just right" • Repetitive • Magical thinking • Avoid situations that trigger obsessions or compulsions	• Explicit avoidance • Safety behaviors • Response to/prevent intrusions • Neutralize unwanted thoughts/feelings • Grow over time • Develop reliance ("have to" beliefs) • Reduced self-efficacy • Interfere with learning	• Prevent revictimization • Neutralize current perceived threat • Completed, until next threat • Perfectionistic only when further minimizes threat • Avoid trauma triggers • Avoid trauma memory/feelings

(Fletcher, Van Kirk, & Hundt, 2020)

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Assessment questions to consider

- Trauma-relatedness
  - Content trauma-related?
  - Symptoms start or get worse after trauma?
- Intersection with content (obsessions)
- Intersection with function (compulsions)
- Root of functional impairment and distress
- Onset

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Differential diagnosis: Intrusions

Disturbing intrusive thoughts?

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Differential diagnosis considerations for OCD and PTSD symptoms

(Pinciotti, Fontenelle, Van Kirk, & Riemann, in press)

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OCD symptom	PTSD symptom	Considerations
Obsessions	Intrusive memories	**OCD:** may or may not encompass traumatic themes **PTSD:** must be linked to a criterion A trauma that was directly/indirectly experienced.
Psychological and physical anxiety evoked by obsessions	Marked psychological distress and/or physiological reactions to trauma cues	**OCD:** anxiety/distress triggered by OCD cues **PTSD:** anxiety/distress triggered by trauma cues.
Avoidance/rituals/ compulsions	Avoidance/safety behaviors	**OCD:** rituals are repetitive, rigid in pattern, excessive, illogical, characterized by doubt and/or magical thinking, and are done to prevent imagined threat **PTSD:** safety behaviors are perfectionistic and ritualized only insofar as they prevent re-traumatization.
Pathological doubt	Amnesia	**OCD:** reported gaps in memory will evoke greater anxiety and are more likely a product of self-doubt **PTSD:** may be associated with a sense of confusion or curiosity and may be a product of emotional avoidance (intentional or unintentional).

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OCD symptom	PTSD symptom	Considerations
Core fears underlying obsessions (e.g., "I am a bad person")	Persistent, exaggerated negative beliefs (e.g., "I am a bad/damaged person")	**OCD:** typically provoke anxiety **PTSD:** may provoke additional emotions like guilt/shame/hopelessness. Must have started or gotten worse after trauma.
Inflated sense of responsibility	Persistent, distorted beliefs about the cause or consequences of the event (e.g., self/other blame)	**OCD:** typically provokes anxiety and can include magical associations **PTSD:** may provoke additional emotions (e.g., shame, anger) and is logically connected to the trauma.
Avoidance of previously enjoyed activities	Markedly diminished interest or participation in enjoyed activities	**OCD:** avoidance of OCD triggers or related mood disturbance **PTSD:** diminished interest/enjoyment in the activity. Must have started or gotten worse after trauma.
Social isolation	Detachment or estrangement from others	**OCD:** avoidance of OCD triggers, shame about symptoms, or related mood disturbance. **PTSD:** internal sense of emotional disconnection. Must have started or gotten worse after trauma.

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OCD symptom	PTSD symptom	Considerations
Testing rituals (e.g., engaging in risky sex to test whether they contract a sexually transmitted infection)	Reckless or self-destructive behavior (e.g., engaging in risky sex following a sexual assault)	**OCD:** function is to disprove or obtain control/certainty over a feared consequence **PTSD:** function is to intentionally invoke an adrenaline rush, punish oneself, or re-enact aspects of their trauma with a greater sense of control and empowerment. Must have started or gotten worse after trauma.
Alertness regarding trigger cues (e.g., tracking all people/surfaces that encounter a contaminant	Hypervigilance	**OCD:** specific to OCD cues (e.g., contamination) **PTSD:** specific to trauma cues or a broader need to scan for threat/danger. Must have started or gotten worse after trauma.
Problems with concentration	Problems with concentration	**OCD:** due to obsessions or engagement in mental rituals **PTSD:** due to intrusive thoughts or as "brain fog." Must have started or gotten worse after trauma.
Sleep disturbance	Sleep disturbance	**OCD:** related to hyperarousal, obsessions, and/or compulsions specific to OCD triggers **PTSD:** related to hyperarousal, intrusive thoughts, and/or safety behaviors specific to trauma triggers, or due to fear of nightmares. Must have started or gotten worse after trauma.

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Why does it matter?

- Symptoms are treated differently (e.g., reassurance/thought challenging)
- Want to understand function of symptom
- May impact exposure content

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Treatment complications

Chad T. Wetterneck, PhD

Please use the Q&A feature to send your questions to the moderator.

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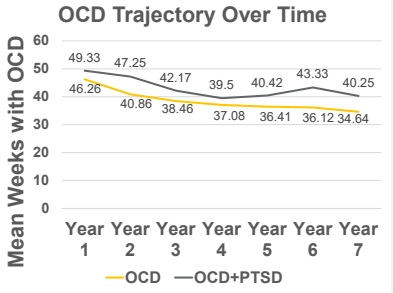
OCD+PTSD treatment complications

- 82% of treatment-resistant OCD reported trauma history
  - 39% of sample met for comorbid PTSD (Gershuny et al., 2008)
- Poorer treatment response, higher dropout, more severe OCD symptomatology (Fontenelle et al., 2012; Gershuny, Baer, Jenike, Minichiello, & Wilhelm, 2002; Gershuny et al., 2008; Ojserkis et al., 2017; Pinciotti & Orcutt, 2020; Pinciotti, Riemann, et al., 2020; Pinciotti, Wetterneck, et al., 2020)



(Ojserkis et al., 2017)

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Co-occurring PTSD on OCD treatment: Potential impact

- OCD and PTSD symptoms overlap
- Core fears overlap
- OCD symptoms decrease, PTSD symptoms increase (vice versa)
- PTSD symptoms interfere with treatment
- Trauma themes/distress triggered by OCD exposures
- OCD symptoms may help "cope" with trauma

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A note on uncertainty…

- Prospective IU partially explained OCD improvement in patients with OCD (Pinciotti, Riemann, & Wetterneck, 2020)
- Patients with OCD+PTSD had:
  - Worse inhibitory and prospective IU
    - Baseline and discharge
  - No improvement in inhibitory and prospective IU across treatment
- IU may be important treatment focus for patients with OCD+PTSD

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Treatment recommendations

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Treatment approaches

OCD

- Exposure and ritual prevention (ExRP) (Foa, Yadlin, & Lichner, 2012)
  - Gold Standard
- Cognitive Therapy (CT)

PTSD

- Prolonged Exposure (PE) (Rothbaum, Foa, & Hembree, 2007)
- Cognitive Processing Therapy (CPT)
- Eye-Movement Desensitization and Reprocessing (EMDR)

- We use a combined exposure approach of ExRP & PE

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Why choose exposure-based treatments?

- ExRP is the *gold standard* for OCD treatment
- PE has the most support in the research literature for the treatment of trauma for adults
  - APA task force most evidence-based therapy for PTSD (along with CPT; EMDR was considered supported but at a lower level than PE & CPT) (APA, 2018)
  - More inclusive diversity in PE trials (Grau, Kusch, Zhang, Loyola, Williams, & Wetterneck, 2021)
- Shared principles of exposure work
- One could choose CT and CPT and benefit from shared principles as well

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ERP and prolonged exposure (PE)

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Integrating ERP and PE

ERP for OCD	Treatment similarities	PE for PTSD
• Maintained through avoidance • Imaginal exposure optional • Must involve RP • Emphasis on uncertainty about safety • No reassurance • Over-correction	• Exposure-based • Habituation, corrective experience, building self-efficacy • Target avoidance • In-vivo exposures • Focus on reducing rituals/safety behaviors	• Maintained through avoidance & beliefs • Imaginal exposure required • Gradually reduce safety behaviors • Emphasis on (re)learning safety cues • Reassurance OK • Over-correction not necessary • Process trauma

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ERP and PE treatment recommendations

- Psychoeducation on OCD/PTSD overlap
- Functional analysis of fears/exposures
  - Which fears activated?
- Exposure to treatment barriers
- "Differential diagnosis" in the moment
  - *To reassure or not to reassure?*
- Dosing
  - 50/50 if possible

https://www.med.upenn.edu/ctsa/workshops_pet.html

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Troubleshooting

- What if the client does not want to do exposure therapy?
  - Understand the client's concerns
  - Review the treatment rationale and success of the treatments
  - Start with very low level exposures to ensure early successes in habituation
  - Utilize cognitive restructuring to "soften up" rigidity of feared outcomes
  - Build in safety behaviors into early exposures (accommodation)
  - Consider a Cognitive Approach to treating both (if you have that training)
- Consult with colleagues that have expertise in one or both areas

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ERP and cognitive processing therapy (CPT)

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Integrating ERP and CPT

ERP for OCD	Treatment Similarities	CPT for PTSD
• Maintained through avoidance • Exposures primary • Etiology of fears unnecessary • Emphasis on uncertainty • Homework emphasis on exposures	• Cognitive-behavioral • Identify core fears/stuck points • Socratic questioning • Treatment informed by core fears/stuck points • Functionality of behaviors/beliefs • Need to address avoidance	• Maintained through maladaptive beliefs • Narrative optional • "Behavioral experiments" • Identify etiology of beliefs • Meaning/impact of event • Emphasis on reframing beliefs • Homework emphasis on worksheets

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CPT handouts

Psychoeducational modules

- Trust, safety, power/control, intimacy, esteem
  - Beliefs related to oneself and others
  - Pre- and post-trauma

Worksheets

- A-B-C
- Challenging Questions
- Patterns of Problematic Thinking
- Challenging Beliefs Worksheet (CBW)
  - Culmination
    - Added: Alternative thoughts; re-rating old thought; rate current emotions

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ERP and CPT treatment recommendations

- Psychoeducation on OCD/PTSD overlap
- Emphasis on OCD triggers involving PTSD stuck points
- "Differential diagnose" in the moment
  - Challenge trauma-related, not OCD-related, stuck points in moment
- Dosing

http://cptforptsd.com/CPT%20Resources/

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Time for questions and answers…

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Three key take-home messages

1. Trauma and PTSD can complicate treatment of OCD
2. Differential diagnosis of OCD and PTSD symptoms is crucial
3. Gold-standard OCD and PTSD treatments can be integrated (important especially for dynamic comorbidity!)

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About the presenters….

Caitlin M. Pinciotti, PhD
Associate Research Psychologist
Dr. Pinciotti is an associate research psychologist whose research focuses on factors that facilitate or impede recovery from trauma, PTSD, and OCD. She has published 22 peer-reviewed articles in scientific journals and presented 25 research projects on the topics of OCD and/or trauma at conferences, earning four awards. In addition to research, Dr. Pinciotti provides trainings and consultations across the Rogers system on trauma, OCD, and LGBTQ+ issues.

Chad T. Wetterneck, PhD
Clinical Director, Trauma Recovery
Dr. Wetterneck is a licensed clinical psychologist who developed the adult trauma recovery programs at the residential, partial hospital, and intensive outpatient levels of care, and helped incorporate a cognitive behavioral therapy-based approach into Rogers' addiction and mental health recovery programs. He has published 80 peer-reviewed articles in scientific journals and one book, mainly on anxiety disorders.

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