

What Every Therapist Needs To Know About Anxiety Disorders and OCD

October 26, 2019 - Sally Winston PsyD – MDDCSAM Presentation Slide Deck Outline

The Anxiety Disorders

Separation Anxiety
Selective Mutism
Panic Disorder
Social Anxiety Disorder

Specific Phobias
Agoraphobia
Generalized Anxiety Disorder
Anxiety caused by substances/medical/other

Obsessive Compulsive and Related Disorders

Obsessive Compulsive Disorder
Body Dysmorphic Disorder
Hoarding Disorder
Trichotillomania (hair-pulling) Disorder
Excoriation (skin-picking) Disorder

OCD caused by substances, medical conditions or other
*In OCD, while anxiety is usually present, there may also be prominent **guilt, disgust, shame, dysphoria** or in the case of BFRBs, more of a tic-like phenomenon*

Core Issues

Panic/Agoraphobia *die, go crazy, lose control*
Social Anxiety *humiliation, dysfunction*
Separation *safety apart*
OCD *uncertainty, taboo, safety, responsibility*

Generalized Anxiety *control, worry, tension*
Post-traumatic anxiety *victimization, lost illusions, stuck memories*
Specific Phobia *external danger*

Anxiety Disorders Are Chronic Intermittent Disorders

- They come back in times of physical or emotional arousal or stress. They morph over a lifetime. They are stress-sensitive but **they are not caused by stress**.
- The vulnerability to anxiety and to OCD runs in families and has a biological underpinning. What is inherited is the trait of **anxiety sensitivity** and being prone to “**stickiness of the mind**”. (*Which side of the family does this come from?*)

Principles of Treatment

- Effective treatment of anxiety disorders will focus not on what caused the disorder but on **what processes maintain the symptoms**. Insight alone will not interrupt the factors which exacerbate and maintain the symptoms.
- Neither techniques nor coping skills nor managing stress treat anxiety disorders to recovery. **What must change is the patient’s relationship with his symptoms**

Principles of Treatment



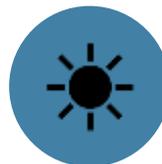
Efforts to avoid, vanquish, counteract or suppress anxiety work paradoxically. The struggle maintains the symptoms.



The most common error in treatment is the application of technique without a shift in attitude towards anxiety



The second most common error is joining the patient in seeking immediate comfort instead of teaching a new paradigm which embraces anxiety.



The beginning of treatment must instill hope

Recovery: When Symptoms No Longer Matter

- When the presence of anxiety causes neither fear nor shame nor reasons to avoid, when they are not front and center and do not interfere with living a full flexible life.
- The focus of treatment is reduction of suffering, not symptoms
- **Acceptance leads to indirect reduction of symptoms**

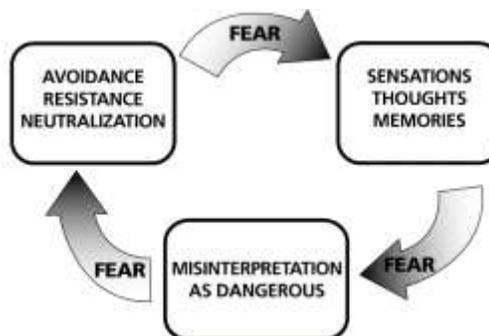
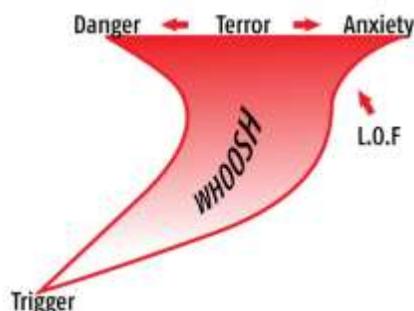
Substance Abuse and Anxiety Disorders

- Substance abuse can cause anxiety (eg MJ can kick off panic disorder or chronic use can induce social anxiety)
- Withdrawal can kick off anxiety disorders in predisposed people
- Anxious self-medicating patients can stumble into addiction
- May simply be comorbid conditions or both be complications of other condition (eg PTSD, bipolar, or medical conditions)

Illusory Help

- Relaxation training
- Positive thinking, affirmations and encouragement
- Avoiding “stress”
- Thought suppression or distraction
- White knuckling “just do it”
- Insight into meaning, origin or secondary gain
- Logical refutation or calculating probabilities
- Compassionate repetitive reassurance
- Lifestyle changes without change of attitude

Getting Hijacked By Imagination



Effective Treatment: Target What Maintains Symptoms

- Bewilderment and Misattribution
- **Meta-cognitions** and False Beliefs
- **Entanglement** with Content
- Anxiety Sensitivity
- **Paradoxical Effort**
- **Avoidance** (emotional and behavioral)
- Affect Intolerance
- Lack of self-compassion/shame
- Biological **Stickiness**

Paradoxical Effort: *What works in the external world fails in the internal world*

- Many sincere patients expend all their emotional energy in trying to “change their thoughts”, control their minds, relax their bodies, affirm their positivity, “relieve stress”, wrestle to fix the content of their thoughts.
- This effort works backwards.
- And the more desperate and *urgent* the effort is, the more backwards and demoralized they go.
- Use metaphors to teach acceptance attitude (drop the rope, car without break)

Anxiety is an Altered State of Consciousness

- It makes **thoughts feel dangerous** (thought/action fusion)
- Blurs the distinction between cognition and behavior: **imagination seems real**
- Asks for a degree of certainty and safety that we don't expect in non-anxious areas of our life. **Risk assessment is distorted**: stakes count, odds don't
- **Resisted thoughts get stickier.**

Question: What works fastest to reduce anxiety? The answer is not Xanax. Or even heroin. It is... The decision to avoid. It works like magic For a while...

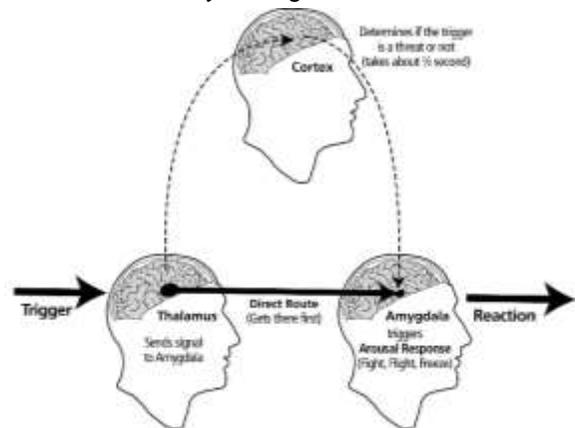
Another Piece of Wisdom: God grant me the serenity to accept the things I cannot change; courage to change the things I can ; and the wisdom to know the difference

Panic Disorder: When “it” happens, I am fearful of....

- Medical catastrophe: heart attack, stroke, smother, pass out
- Lose control of bowel, bladder, vomit, choke
- It means I have cancer, tumour, am going blind
- I will go crazy, start screaming, do something crazy or impulsive
- The panic may never end, I will be unable to function, drive, care for my kids, go back to work

Good Information is Essential

- A panic attack is a false alarm: your body’s fight or flight response to emergency when there is no danger; a cardiac workout you ever asked for; a misinformed brain screaming for action when none is needed; weird intense thoughts and sensations that last only briefly if you don’t struggle with them.
- Reduce bewilderment by explaining symptoms (e.g. people do not faint from a panic attack; depersonalization is anxiety, not the beginning of going crazy; hyperventilation is not the beginning of smothering)



Agoraphobia: A Phobic Reaction to Panic

- Public transportation, elevators
- Open spaces, enclosed spaces
- New places or experiences
- Standing in line or crowd
- Outside of home alone
- Lying down to sleep
- Anywhere panic happened before
- Avoidance or white knuckling possible
- Agoraphobia without panic (complete avoidance, or fear of falling, loss of bowel control, choking, fainting etc)

Chronic Hyperventilation Symptoms

Palpitations	Visual and sensory illusions	Exhaustion, “weakness”
Chest pain or tightness	Nocturnal panic attack	Poor concentration
Shortness of breath	Sighing and air swallowing	Derealization
Dizziness (light-headed)	Heartburn/reflux	Depersonalization
“Faintness”, off balance	Tingling fingers, toes and face	
Sleep disturbances	Muscle cramps/tension	
Nocturnal panic attack		

Hyperventilation: Too Much Air

- What matters is *volume*, which is affected by rate and location.
- A reduced end tidal PCO2 can be experienced differently depending on the sensitivity of the mind and body
- *Breathing retraining is no longer part of the standard protocol.*
- **Psychoeducation about breathing is helpful, but effortful work to change breathing when panicky is not**
- Nocturnal panic attacks are hyperventilatory phenomena
- Biofeedback systems for lowering overall tendency to chronic hyperventilation

Social Anxiety Disorder: Fear of Humiliation

- ***being looked at or judged***
- freezing up, saying something stupid or awkward, looking anxious, sweating, blushing, trembling
- losing respect, getting rejected

- having to leave or never be able to go back
- **“poor self-confidence” “being a loser”**
- constant measurement of hierarchical status
- Highly comorbid with depression, substance abuse and OCD. Often mislabeled GAD

Common Social Phobic Situations

- public speaking
- public bathrooms (paruresis)
- talking to authority figure
- talking to attractive person
- making introductions
- asking for directions
- writing or eating in front of others
- entering crowded room/formal affairs
- speaking in class
- running into friend
- *both anticipatory and evaluation anxiety*
- *excessive empathy is common*

Specific Phobias:

- Animal type (snakes, spiders, dogs)
- Natural environment type (heights, storms, water)
- Idiosyncratic associations
- Situational (airplanes, thunderstorms, bridges)
- Blood-injury phobia (*very different*)
- Trauma-based phobias (authority figures, power tools, the dark strangers, sleeping upstairs)
- **Rule out other anxiety disorders**

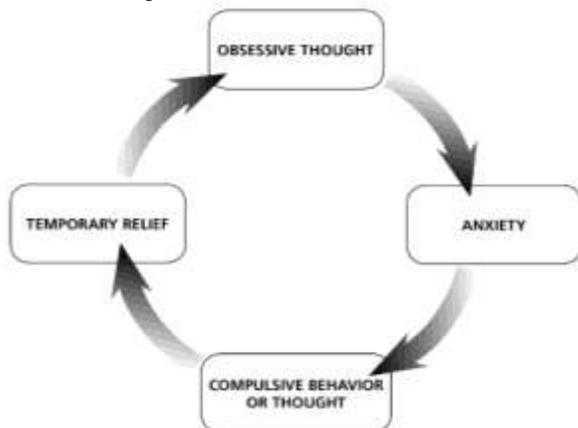
Frequent Under-Diagnosis

- Claustrophobia (panic)
- Germophobia (OCD)
- Emetophobia (OCD)
- Hypochondria (Panic or OCD)
- Indecisiveness, dependency, worrywart, lack of confidence, low self esteem,
- perfectionism (not diagnoses), trouble committing.....
- Misophonia (not an anxiety disorder)
- Fear of being alone or death or failure (not diagnoses)

OBSESSIONS RAISE ANXIETY

- repetitive thoughts or images which feel **uncontrollable**
- **intrusive**, unwelcome, unbidden
- taboo, repulsive, **unacceptable**
- arrives with a “jolt” (*whoosh*)
- **ego-dystonic** (not “my” thoughts)
- arrives with a strong **urge to resist**, control, ignore, suppress or dismiss it

The OCD Cycle



Obsession Subtypes

- Harm (self or others)
- Contamination (germ or icky-sticky)
- Doubts about unanswerable questions (future, past, existential)
- Doubts about self (motives, feelings, HOCD, ROCD)
- Interpersonal doubting (pathological jealousy, social hypervigilance)
- Incompleteness or “not just right”
- Scrupulosity (religious and secular)
- Hypochondriasis and health anxiety
- Somatosensory obsessions
- Morally repugnant thoughts
- Fear of having made a mistake or might make a mistake
- “Decidophobia” and “commitment phobia”
- Extreme harm avoidance

Initial Presentations of OCD: Easy to Miss

- I might be a pedophile
- My kids tell me I am a control freak
- I am indecisive, have low self esteem and no confidence
- I am questioning if I am gay

- I am late for everything
- I have dark thoughts; I think I must be depressed
- I can't commit to marry my girlfriend
- I have a bridge phobia
- I am eating healthy and exercising but I am stressed anyway

An Obsession is NOT Defined By Content

- It is identified by how it **FEELS and ACTS**
- It has a functional relationship to neutralization (compulsion, ritual). **All obsession is maintained by compulsion**, which may be subtle
- There is a sense of being ego-dystonic.

An Obsession is Just a Stuck Thought: It is the Opposite of a Wish.

- The content itself is meaningless in the context it occurs . Resisting or interpreting the content is the entry to the rabbit hole.
- It is not randomly “chosen”: it is the **most resisted thought**. Thus, people with harming obsessions value non-violence, people with blasphemy obsessions are religious, people who worry about blurting out something rude are polite people, people who worry about ego-dystonic suicide love life.

Compulsions Temporarily Relieve Anxiety

- May be observable behavioral rituals or internal thoughts such as self-reassurance, avoidance planning, counting or “rationalizing”.
- They may feel driven, irresistible, needed
- They may seem rational or irrational to the sufferer
- Repetitive, they are intended to create safety, calm, balance, morality, health or order
- **Most compulsions are NOT OBVIOUS:** Also called neutralizing, ritual or safety behaviors, or “coping skills”

Compulsions– A Partial List

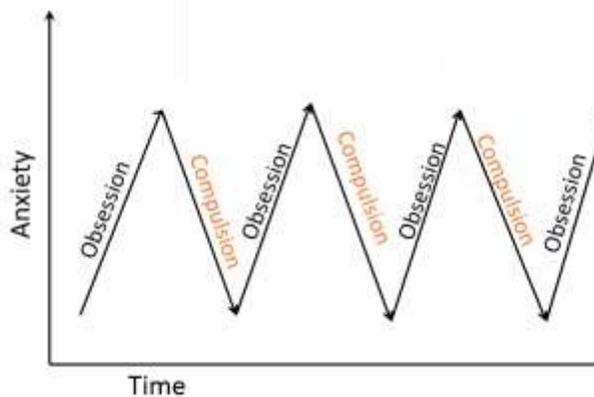
Behavioral (Overt)

- Washing
- Checking
- Ordering
- Arranging
- Repeating
- **Seeking reassurance**
- Undoing
- Confessing
- Avoiding decisions

Mental (Covert)

- Counting
- Memory checking
- **Self reassurance**
- Mental undoing/repeating
- **Arguing internally**
- Ritualized prayer
- Monitoring
- “Planning”
- Experiential avoidance

Ups and Downs of OCD



Obsessions Can Be Mundane or Bizarre

- I can't concentrate or remember properly.
- Did I get the best deal on this TV?
- Am I really a good person? Am I feeling what I should be feeling?
- Did the condom leak and I did not notice?
- I think I made a mistake a few years ago.
- Did I run over someone with my car?
- Did I lock my child in my freezer? Did I poison my dog?
- Is my sister looking at my genitals? Am I looking at my sister's genitals?
- I keep seeing an image of me stabbing you in the eye.
- Are we all dead?

Intrusive Thoughts: *We all have them, it depends how we react to them*

- Sitting at a stoplight (homicide)
- Yank the wheel, jump subway platform (suicide)
- Walking past an obese couple (judgmental, perverse, unacceptable)
- Suddenly recalling a dream (weird)
- Deceased cat needs feeding (psychotic)
- Suddenly self-conscious or self-critical thought

Entanglement with Obsessive Content is the Trap

- Use metaphors to illustrate disentanglement (walking past the sketchy guy, uninvited guest at the party, bug on the windshield)
- It is exceedingly easy to fall into **co-compulsing** with the patient. Try content discussion once, then step back.
- "I am having the thought that..."

OCD : Overcontrol Not Undercontrol

COMPULSIVE

- Risk Avoidance
- Hypervigilance and doubting
- Stimulus averse
- Compulsions are miserable

IMPULSIVE

- Risk-seeking
- Stimulus-seeking
- Antisocial or self-destructive
- Behaviors are pleasurable

Generalized Anxiety Disorder (GAD)

- Excessive and difficult to control anxiety and worry
- Three of six symptoms: restlessness, fatigue, difficulty concentrating, irritability, muscle tension, sleep disturbance
- Distress and/or impairment
- Associated sympathetic (muscle twitches, soreness) and parasympathetic (sweating, nausea, IBS) symptoms as well as headaches and aches and pains
- **Not explained by another disorder: 90% comorbidity**

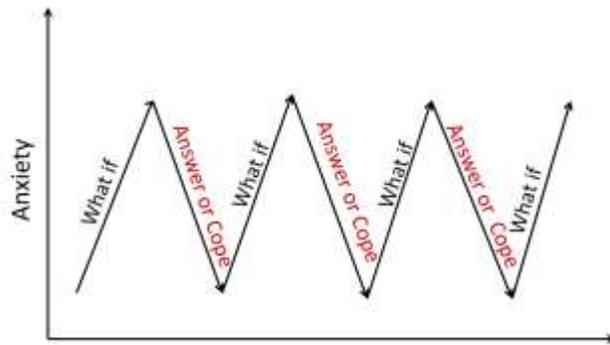
Productive, Unproductive Worry and Meta-Worry

- Productive: There is something to DO, planned or immediate, to take care of the worry and it does not come right back with a "yes, but". It is actionable.
- Unproductive: Some of the most important questions are unanswerable: **seeking certainty is a looping dead end**
- Worry about worry : "I can't stand this", "I am going crazy", "why can't I stop worrying?"
- Associated with **trait of excessive empathy, intolerance of uncertainty and ambiguity as threat**

Worry Has Two Components

- The first part of worry is the anxiety or distress-raising question. (what if...[*something bad?*])
- The second part of worry is the attempt to deal with it and make the distress go away and functions as a negative reinforcer. It can include analyzing, refuting, planning, arguing, reassuring, distracting, "coping".
- The two parts oscillate back and forth repetitively over time

Ups and Downs of GAD



Anxiety and Depression Together

- More disability, suicidality and relapse; poorer response to all treatments
- Beware **agitation: it is not anxiety**. It indicates a mood disorder (major depression or a mixed bipolar state) or some other biological condition such as drug withdrawal or illness.
- Untreated demoralizing anxiety or OCD is a risk factor for major depression.
- Look at anhedonia, sleep patterns and vegetative signs, withdrawal vs avoidance, family history

Review: Components of CBT-based Treatment

- Psychoeducation
- Attitude of acceptance: affect tolerance, cognitive disentanglement, mindfulness, metacognitive distortions
- Exposure and response prevention
- Elimination of safety behaviors
- Relapse prevention

Meta-Cognitive Beliefs Must be Challenged

- Every thought is worth thinking about or has meaning
- I am morally responsible for my thoughts & I am responsible for any outcome if I have imagined it
- Not feeling certain about something signals danger or warning
- One ought to be able to control one's thoughts
- Worry is problem solving or preparation for calamity.
- Worry keeps us safe. Worry is loyalty, caring or being responsible.

Exposure Should Address Underlying Fears

- Panic disorder exposures are to sensations and thoughts of panic. (interoceptive exposure)
- OCD and GAD exposures are to the thoughts and images that provoke doubts or distress
- Social anxiety exposures are to the avoided feelings, such as embarrassment
- Specific phobia exposures are to the external phobic objects.
- *Learn not just that bad things will not happen, but I can tolerate discomfort, uncertainty, distress and my own imagination*
- Willingly evoke discomfort, no neutralization allowed, let time pass. Beware of subtle avoidances.

Self regulation skills like breathing retraining, meditation and regular exercise

- For lowering overall level of sensitization (daily practice, **not emergency coping**)
- During management of **anticipatory anxiety** if done with attitude of non-urgency
- **“While” you have symptoms, not “in order to” stop or fix or prevent symptoms**
- Switch from cognitive to **sensory mode**

Relapse Prevention: Mood, Stress and Fatigue

- | | | |
|----------------------|--------------------------|-----------------------|
| • Exercise/play | • Mindfulness meditation | • Anger management |
| • Diet/sleep hygiene | • Self-compassion | • Conflict resolution |
| • Caffeine/alcohol | • Time management | • Spiritual practice |
| • Family issues | | • Nurture friendships |

Anxiety Disorder is a Family Affair

- It runs in families and is multigenerational: everyone is affected, children are at risk
- Family processes may maintain symptoms: well intended “help” can be maintaining avoidance and paradoxical effort
- Recovery takes place in a family context: overprotection, chronic stress, accommodation and shaming

Has the Patient Had a Physical? Medical Conditions That Can Present with Anxiety

- Hyper and hypothyroidism and other endocrine disorders, also neuroendocrine (pheochromocytoma)
- COPD, asthma and other pulmonary conditions
- Cardiovascular disorders
- Neurological, vestibular and vitamin deficiency disorders (brain tumour, Lyme, autoimmune disorders, anemia, Parkinson's, epilepsy, folic acid deficiency etc)
- Substance use or abuse, legal or illegal, OTC or prescribed (asthma meds, steroids, caffeine, decongestants, stimulants, side effects)
- Substance withdrawal (ETOH, nicotine, BZDs, SSRIs)

Anxiety Patients and Medications

- They are more afraid of side effects
- They HAVE more side effects, from both prescribed and OTC medications
- They may need homeopathic starting doses
- Titrating down and off medications may have to go very slowly
- PRN medications can seriously undermine treatment

PRN Medications and Anxiety Disorder: Not Recommended

- OK in one-time emergency (patient needs MRI now, funeral of father in California, stuck in dangerous situation)
- State-dependent learning attributed to the medication
- Last resort: "I took the pill, it did not work, now what?" (take more? drink? give up? what if it is not anxiety but a medical emergency? avoid?)
- Shame: Does this level of anxiety merit a prn? If I take the pill, I will have failed. Do I deserve this relief? I am trying to hold out but I can't.
- **May get patient through a situation, but this has done nothing to change the relationship with the anxiety, fear of it or struggle against it.**
- Use BZDs only briefly and non-prn during upwards titration of SSRIs if needed

Good Things to Say in Eight Minute Contact

- You have an anxiety disorder or OCD. This feels miserable, may impact your life considerably if untreated, but it is NOT SERIOUS and HIGHLY TREATABLE.
- Which side of the family does this come from?
- Of course you are not better. The things you have been diligently trying to do (avoid stress, try to relax, try to plough through) don't work for this. This is not your fault.
- Explain physical symptoms, don't just call them "anxiety". E.g. digestive tract is full of neurotransmitters, over-breathing causes this kind of chest pressure/weird feeling/feeling fainty, your eyes blur because of adrenalin. Even a thought can provoke an adrenalin surge.
- How do you like to get your information? (youtube? book? website? talking to expert?) do you want your family involved?
- Offer a metaphor or a story.

Metacognitive Insights: things to tell patients you only see a few times

- **Certainty is a feeling. It does not reflect reality. It is impossible to eradicate doubts**
- **Images and thoughts are not facts. This is your brain reacting to your imagination**
- **Intrusive thoughts are not messages or warnings. "I am having the thought that..." puts it in perspective.**
- **A worry thought is not a danger signal**
- **Anticipatory anxiety is not a predictor: don't bleed before you are cut.**
- **Your risk assessment tool is broken, how risky things feel is not reliable**

Acceptance, Not Control: What you resist persists

No technique or coping skills or practice will ultimately work if the patient is still terrified of the sensations and intrusive thoughts of anxiety and still struggling to keep them from occurring. Uncertainty and discomforts are inevitable and without some risks, there is no full living.