



In sickness and in health™

# Treating OCD and SUD: Tools for Effective Treatment

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# Thanks

- Stacey Conroy, MSW, was a HUGE contributor to the slides in this deck. Stacey works in the VA and has been a pioneer in the co-occurring treatment of Anxiety and SUD.

# Obsessive Compulsive Disorder – OCD & Substance Use Disorder - SUD

Obsessive compulsive disorder (OCD) and substance use disorder (SUD) are both neuropsychiatric disorders involving unwanted repetitive behaviors, often with negative consequences on work and/or school, personal relationships, and social activities. In each disorder, an individual seeks to escape from unwanted emotional and/or physical distress by engaging in behaviors that, over time, become unwanted and time consuming.

# Other Anxiety Disorders and SUD

- Social Anxiety Disorder – significant use of alcohol as a way to deal with social situations.
- Generalized Anxiety Disorder – Substance use as a way to drown out the constant worry that people experience.
- Panic – Substance use to keep themselves calm in all situations (Marijuana very common).
- Phobias – Use in very specific instances.
- PTSD – Substance use will depend on the symptoms. May use stimulant to stay awake so that they do not have nightmares or may use depressants to sleep so that they do not have flashbacks.

# OCD and SUD

For OCD, this involves rituals, either overt (behavior anyone can see) or covert (for example mental reviewing or counting).

For SUD, this involves the repeated pursuit of, getting ahold of, and use of a substance (drugs and/or alcohol).

In each instance, the relief is gratifying but temporary and the unwanted symptoms of emotional and/ or physical distress eventually return, leading back to ground zero: obsessional thoughts and the desire to seek relief.

# OCD and SUD

The accuracy of co-occurring statistics are complicated by several factors:

1) OCD treatment programs often refer individuals with SUD to substance abuse treatment as a prerequisite of admission for OCD treatment.

2) SUD programs often do not screen specifically for OCD at intake.

3) Individuals with co-occurring OCD-SUD will often deny or under-report symptoms upon intake to a treatment programs (be it for OCD or SUD), as they are fully aware of the barrier to acceptance represented by the co-occurring disorders.

# OCD and SUD

- While its difficult to determine exactly how many people with OCD are also dealing with an SUD, studies of OCD have found that the lifetime prevalence for a co-occurring SUD is consistently in the range of 25 percent (variation in this estimate are based on which substance was being studied and, in some cases, differed based on gender).

# Assessment for SUD in OCD TX

- OCD therapist, you should consider adding the following questions to your assessment to determine the possibility of a co-occurring SUD:
  - How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?
  - In the last year, have you ever drunk or used drugs more than you meant to? (2 question screening)
  - Have you felt you wanted or needed to cut down on your drinking or drug use in the last year? (Single screening question)
- “Yes” answers to any of the above question would warrant further assessment for SUD, including information on the substance(s) being used, frequency of use (e.g., daily, weekly, or monthly), and how recently was the last use.



# Assessment for OCD in SUD TX

- SUD provider, here are some basic screening questions you could consider to rule in (or out) the likelihood of OCD:
  - Do you have thoughts that make you anxious that you cannot get rid of, no matter how hard you try?
  - Do you do physical behaviors or repeatedly think specific thoughts to undo other intrusive thoughts?
  - Do you check things to excess?
- “Yes” answers to any of these questions would warrant further assessment for OCD. If it appears that OCD may be present, further assessment includes finding out more specific details of the patient’s obsessions and compulsions, including the level of distress associated with each and the degree to which symptoms are getting in the way of functioning.

# OCD and SUD

- Neuroscience research on OCD and SUD has shown that several different brain chemicals (known as neurotransmitters), including serotonin, glutamate, and dopamine may be involved in OCD and SUD.

# OCD and SUD

- Research on the brains of individuals with OCD and/or SUD, for example, show abnormal levels of glutamate in the brain, which may contribute to symptoms of both OCD and SUD.
  - However, research to date has not been able to clarify if this is a cause or a consequence of the disorders.
- The neurotransmitter dopamine is a brain chemical that affects both behavioral control and motivation and is thought to play a role in the development of both OCD and SUD.
  - Loss of behavioral control is a diagnostic feature of both OCD and SUD and often a contributing factor in seeking treatment.

# Substance Use Disorders

- In the substance use disorder chapter of DSM 5, the biggest change from the dependence and abuse diagnosis is the move to **Mild**, **Moderate**, and **Severe**. To determine the severity of the disorder, a criteria 1-11 has been established.
- The presence of 2-3 symptoms out of the 11 is defined as **Mild**.
- The presence of 4-5 symptoms is defined as **Moderate**.
- The presence of 6 or more symptoms is defined as **Severe**.

# Why the Change in DSM 5

- Dependency – medical condition, withdrawal sx
  - All drugs have a withdrawal
  - Few drugs have a medical detox
- Addiction – desire to change emotional and/or physical states
  - Behaviors connected to addiction distinguish it from a medical dependency

# Substance Use Disorder

A problematic pattern of substance use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12 month period:

The substance is often taken in larger amounts or over a longer period than was intended.

There is a persistent desire or unsuccessful efforts to cut down or control the substance use.

A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.

Craving, or a strong desire or urge to use the substance.

Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.

# SUD

Continued Substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

Important social, occupational, or recreational activities are given up or reduced because of substance use.

Recurrent substance use in situations in which it is physically hazardous.

Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

# SUD

Tolerance, as defined by either of the following:

- a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
- b. A markedly diminished effect with continued use of the same amount of the substance.

Withdrawal, as manifested by either of the following:

- a. The characteristic withdrawal syndrome for the substance (refer to criteria A and B of the criteria set for alcohol or other substances withdrawal)
- b. Substance (or closely related substance, such as benzodiazepine with alcohol) is taken to relieve or avoid withdrawal symptoms.



# Mild, Moderate, Severe

- Opioid
  - Mild 305.50 9 (2-3)
  - Moderate 304.00 (4-5)
  - Severe 304.00 (6 - more)
- Alcohol
  - 305.00 Mild (2-3)
  - 303.90 Moderate (4-5)
  - 303.90 Severe (6 or more)
- Cannabis
  - 305.20 Mild (2-3)
  - 304.30 Moderate (4-5)
  - 304.30 Severe (6 - more)

# 12 Step

- Often in OCD-specific treatment, the only attempt to address their SUD symptoms was a referral to an Alcoholics Anonymous-type meeting. While an AA model can be a helpful adjunct to SUD treatment, it is not a substitute.
- Twelve Step Facilitation (TSF)
  - A SAMHSA Evidenced Based Practice (EBP) designed to enhance engagement in 12 step programs.

# Twelve Step Facilitation (TSF)

- An example of a TSF intervention could include actively reviewing
  - The benefits of meetings the patient has been attending. The goal would be to underscore the value of decreased isolation and increased recovery-focused social interactions.
  - Specific self-directed activities to include between sessions, assignments to read and review literature, like chapters from the *AA Big Book*.

# Cognitive Behavioral Therapy (CBT)

CBT based approaches have been shown to be helpful for both individuals with OCD and those with SUD. In a combined model, the therapist can also help the patient to explore the cognitions and behaviors that may increase and/or maintain symptoms of the other disorder. For substance use, this may include exploring the pros and cons of continued use, self-monitoring to identify triggers for cravings, identifying situations that might put one at risk for use, and developing specific coping skills to deal with cravings and high-risk situations.

# OCD

- CBT treatment for OCD can address the patient's reactive response to the experience of obsessions.
  - A CBT therapist in this case might teach the patient how to increase awareness of when they experience obsessions and begin to coach different responses the patient can engage in as opposed to compulsive behavior.

# OCD and SUD

- SUD – CBT might help a person be aware of the stressors, situations, and feelings that lead to substance use so the person can then avoid them or make different choices when they occur.
- People, Places, and Things
  - What people?
  - What places?
  - What things?

# So I'm Cured???

- Key point is that obsession may not go away forever, neither will SUD cravings.
- The response to obsession and/or SUD cravings is what is important.
  - We will want to normalize that some symptoms may remain and that it is not a sign that a person lacks commitment to their recovery from either OCD or SUD.

# Neuro

- OCD – who the heck really knows? Articles talk about roles for Serotonin, Dopamine, and Glutamate.
- May be less about transmitters and more about structure. Basal Ganglia implications:
  - Lesions can create OCD symptoms
  - PANDAS
  - Deep Brain Stimulation
- SUD – Alterations in transmitter output due to the intake of the chemicals. Self-medication to control problems or self-medication to relieve problems?



# Neuro

- OCD and SUD:
  - fMRI results: Striatum over-activity when exposed to cues in both OCD and SUD.
  - Frontal-cortical areas are over active in individuals resisting drug cravings as well as in individuals who are trying to resist doing a compulsion.
  - Please see Fontenelle, L.F., Oostermeijer, S., Harrison, B.J., Pantelis, C., & Yucel, M. (2011). Obsessive Compulsive Disorder, Impulse Control Disorder, and Drug Addiction. *Drug*, 71(7), 827 – 840.
  - But, also consider *Anatomy of an Epidemic* by Robert Whitaker.

# Medication Assisted Treatment - MAT

Medications are important tools in the treatment of OCD and SUD, with each specialty having its own prescribing protocols used during treatment. However, to date, we are lacking studies that directly address medication for co-occurring OCD-SUD.

# Medications

- Medications for OCD typically start with using serotonin reuptake inhibitors or SRIs, though for many with OCD, these medications have limited effectiveness.
- Medications for SUD are mostly substance specific and in many cases, individuals with SUD use more than one substance.
  - There are two FDA approved medications to assist with cravings for heroin/opioids, but have no effect on cocaine cravings. There are a handful of medications that will assist with alcohol use, but have no effect on marijuana use.

# Clarifying Expectations of Medications

Speaking with patients about expectations for medications is a necessary factor and is by no means outside the scope of practice for a non-medically trained therapist. You are not prescribing, but are clarifying the role of medication in treatment. It is important to balance expectations of medications and behavioral interventions: medications can assist, though rarely eliminate symptoms completely.

# Expectation of Meds Cont.

Far too often, this is the expectation of the individual in treatment. If this belief is not addressed head-on, it is likely the patient will not fully engage in the behavior therapy component of treatment. “Medication assisted treatment” options for either OCD or SUD require willingness of the patient to engage in behavioral treatment to enhance the potential for positive outcomes in the treatment of OCD-SUD.

# Treatment Protocols for OCD-SUD

- AMITA Health/Alexian Brothers in IL has OCD-SUD concurrent treatment
- Detox 1<sup>st</sup> if needed
- Center for Addiction Medicine (CAM) Partial
  - Screens for OCD
  - Cross track into groups for OCD – 1 hour a day/3 days a week
  - After 2 weeks switch primary tx focus to OCD program and cross track into groups to CAM
- This provides psycho-ed and tx for both disorders

# Outpatient Tx Protocol

- Weekly Session
  - Consider two sessions per week
    - One with a SUD TSF or CBT focus
    - One with an OCD – ERP focus – adjust ERP as needed
- Social Supports
  - Identify community resources to support SUD recovery
    - The ability to be honest about SUD symptoms is the key
    - Five people who could be called to support recovery on an index card

# Foglia Family Foundation Residential Treatment Center

- Can do similar to PHP and IOP
- Cross tracking between groups is essential to healing.
- Common amongst almost all of our SUD pts. is a report of a lack of treatment for their mental health needs while in any level of treatment.
- Now our Anxiety pts. are more likely to share their struggles with addiction.



# What Does My Practice Need to Move Forward with Treating OCD-SUD

- Identify internal resources
  - Do you have access to detox protocols inpt or outpt?
  - Do you have access to 12 step meetings on site or nearby?
  - Do you have a SUD specialist? Or can you obtain training
  - Can you prescribe medications for SUD?
- Identify community resources
  - Do you know where to find 12 step meeting lists?
  - Do you know of non-12 step support groups?
  - Do you know of community MAT programs for SUD?
- Distance resources for discharge plans from OCD residential who are providing OCD-SUD treatment

# Tools for Basic Education

## Easy to implement (example)

- Pleasure Unwoven: inexpensive DVD outlining historical and modern concepts of calling addiction a disease –good for staff and patients/families to view
  - Increases discussion on the realities why relapse happens despite honest desire for recovery
  - Increases understanding of the biological aspect of addiction and why someone may relapse while in treatment
- Chasing Heroin – Frontline DVD also inexpensive discusses national response to opioid epidemic, histories and new treatment approaches.  
**(NOT GOOD FOR PATIENT VIEWING)**
  - Increase understanding that Relapse Sensitive Care is part of a disease model of care for a chronic health condition

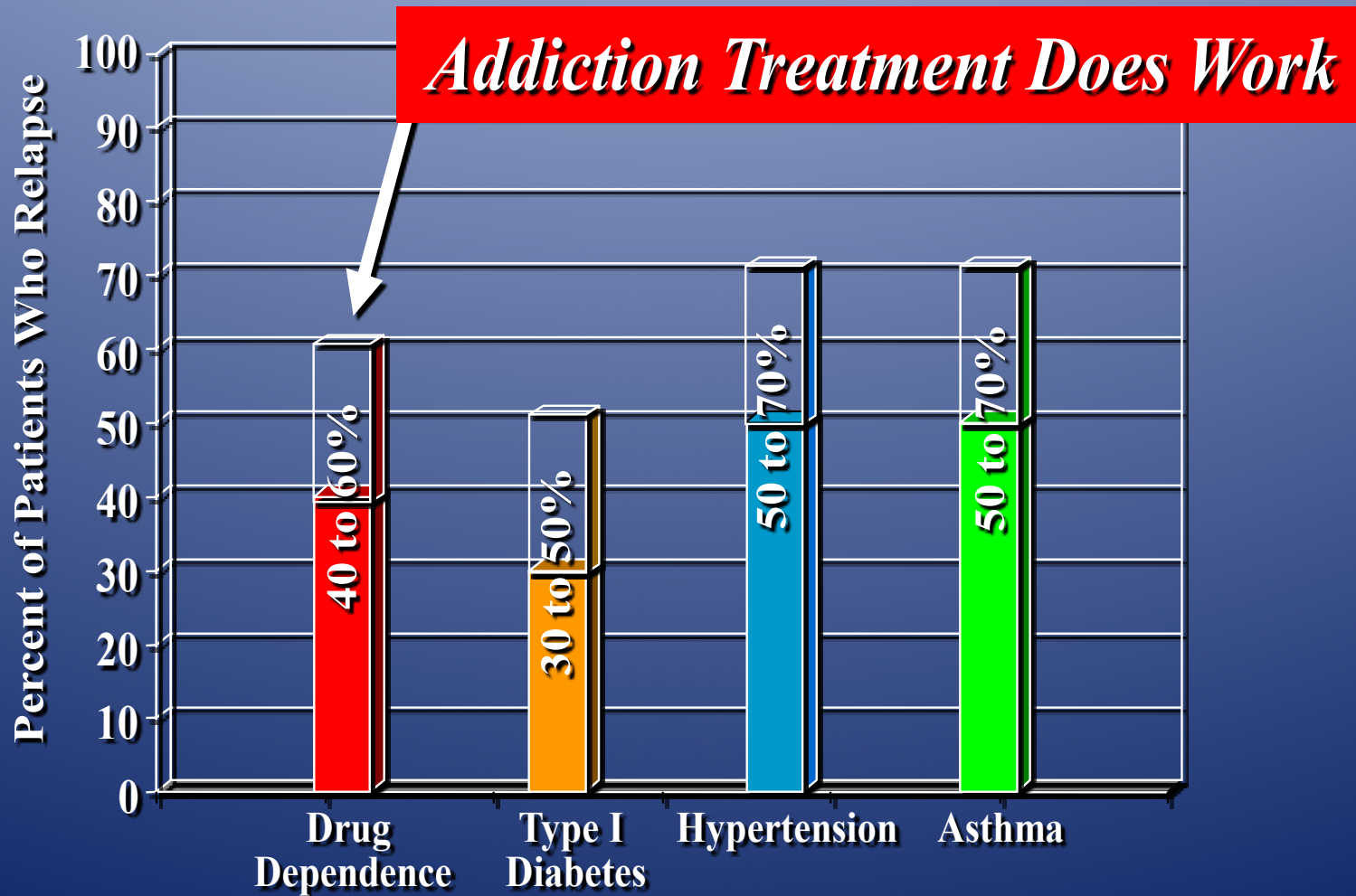
McCauley, Kevin (producer) (2009). Pleasure Unwoven: a personal journey about addiction. (DVD) Institute for Addiction Study.

WGBH (2016) Chasing Heroin: Investigating An American Crisis (DVD) PBS.org

# What About SUD Relapse During Treatment

- The potential for a lapse or relapse to substance use increases with a co-occurring disorder such as OCD. Thus, a strategy to address relapse needs to be part of a treatment plan.

# Relapse Rates Are Similar for Drug Dependence And Other Chronic Illnesses



Source: McLellan, A.T. et al., JAMA, Vol 284(13), October 4, 2000.

# Drug Related Cue Literature Review

These drug-related cues may be:

- **Visual** (seeing words, pictures or silent videos)
- **Auditory** (e.g., listening to imagery scripts)
- **Audiovisual** (combination of sights and sounds)
- **Tactile** or haptic (handling the corresponding paraphernalia)
- **Olfactory** or **gustatory** (smelling or tasting the substance)
- Increasingly often, **multi-sensory drug cues** are also employed (e.g., holding a cigarette while watching audio-videos of smoking)

Jasinska A.J., Stein E.A., Kaiser J., Naumer M.J., Yalachkov Y. (2014). Factors modulating neural reactivity to drug cues in addiction: A survey of human neuroimaging studies. *NeurosciBiobehavRev*

# Recovery Supports

- Addiction treatment and recovery support services have repeatedly been shown to be effective with many people achieving recovery. As with any chronic disease, however, discrete treatment episodes, supported by continuing recovery support services, are often needed to help people achieve and maintain recovery. Treatment for addictive disorders is not typically a “one-shot” type of intervention.

Kaplan, L., The Role of Recovery Support Services in Recovery-Oriented Systems of Care. DHHS Publication No. (SMA) 08-4315. Rockville, MD: Center for Substance Abuse Services, Substance Abuse and Mental Health Services Administration, 2008.

# Changing how Addiction is viewed...

- We would hope that the days are numbered in which the addictions field can argue that addiction is a **primary health care problem** while its clinicians continue to treat the **primary symptoms** of addiction as bad behavior subject to “disciplinary discharge.”

White, W.L., Scott, C. K., Dennis, M. L., and Boyle, M. G. (April 2006) “It’s time to stop kicking people out of treatment. Counselor.

# OCD and SUD

- Instead of considering relapses as markers to discontinue treatment, a relapse could be used as a point in time to allow for a reassessment of the recovery process. What might have been missing? What needs to be shored up? Or, is this in fact an indication of the patient's non-engagement in the treatment process? Rather than jump to the latter as the most likely conclusion, it is recommended that this be assessed further.



## Those in charge of treatment planning could consider the following factors before discharge:

- A review of the patient's overall engagement in treatment prior to the relapse.
- A consideration as to whether this was a one-time return to substance use or a full blown relapse to repetitive substance use.
- Consideration on the part of the therapist as to the pace of the patient's ERP. Were the expectations of the therapist too overwhelming for the patient, and should there be a change in treatment expectations instead?
- Was the patient receiving enough support and given access to all resources that might have circumvented the relapse?
- Would the addition of medications for either OCD or SUD provide additional support during the treatment process?

# Relapse Sensitive Care (RSC)

A systemic philosophy of care with the goal of maintaining an individual in **TREATMENT** to enhance the potential for sustained recovery.

This is true for OCD and SUD

# What is Recovery? OCD and/or SUD

SAMHSA has established a working definition of recovery that defines recovery as a process of change through which individuals improve their **health** and **wellness**, live **self-directed lives**, and strive to reach their **full potential**. Recovery is built on access to evidence-based clinical treatment and recovery support services for all populations.

SAMHSA's Working Definition of Recovery **Pub id:** PEP12-RECDEF,  
**Publication Date:** 2/2012, **Format:** Brochure  
[SAMHSA's Working Definition of Recovery — 2012.](#)

# Hiring Staff

OCD residential and day programs would greatly benefit from having at least one SUD specialist on staff who could develop concurrent treatment plans for OCD-SUD and provide professional consultation to treatment teams on SUD treatment needs.

# Additional Information

- Co-Occurring OCD and Substance Use Disorder: What the Research Tells Us. OCD Newsletter Fall 2015 Volume 24 Issue 4.
- Treating Co-occurring OCD and Substance Use Disorder: What Professionals Need to Know. OCD Newsletter Winter 2016 Volume 30 Issue 1.



**Thanks for your attendance today.**

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