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Highlights...

Our page 1 stories look at the importance of function, not content, when treating OCD; and helping minority youth achieve healthy, not risky, romantic relationships.

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Free Parent Handout...

- Preventing violence, encouraging positive experiences for children

Monthly reports on the problems of children and adolescents growing up

OCD

[Correction added on February 25, 2022, after first print and online publication: Original article headline has been corrected from "OCD: Focus on functional links, not content, of obsessions."]

Treating harm avoidance, incompleteness, and disgust in OCD

By Lauren Milgram, B.A., Jennifer Freeman, Ph.D., and Kristen Benito, Ph.D.

Obsessive compulsive disorder (OCD) is a heterogeneous mental health condition that encompasses a wide range of topographical symptoms. OCD is defined not by one specific set of symptoms, but broadly by the presence of obsessions (intrusive or unwanted thoughts) and compulsions (repetitive or ritualized behaviors; American Psychiatric Association, 2013). The hallmark of OCD is not the content of the obsessions, nor the appearance of the compulsions, but rather the functional links between the two.

For most youth and adults with OCD, there exists a link between an obsession and a compulsion such that the purpose of a compulsion is to "get rid of" or relieve distress associated with an obsession. Like the obsessions and compulsions themselves, these functional links are heterogenous. In other words, obsessions vary by individual, compulsions vary by individual, and so too does the explanation for how or why one compulsion alleviates one obsession. This implies that no two presentations of OCD are exactly alike. Two people may report the same obsession but perform a different compulsion in response, two people may perform the same compulsion in response to different obsessions, and even two people who exhibit the same obsession and same compulsion may perform the compulsion in

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Minorities

[Correction added on December 9, 2021, after first print and online publication: Original article headline has been corrected from "Romantic relationships among minority youth."]

Romantic Relationships Assets among Minoritized Youth: Lessons from Child Welfare and Juvenile Justice Involved Adolescents

By Charlene Collibee Ph.D. and Sneha Thamotharan Ph.D.

Healthy romantic relationships are a critical, but an undervalued, aspect of adolescent development. Consequently, providers, teachers, and caregivers often struggle with what defines a healthy romantic relationship. Oftentimes, a healthy romantic relationship is understood from a problem behavior perspective, in which healthy aspects of romantic experiences are those that are negatively associated with problem behaviors, such as delinquency. By doing so, caregivers and providers emphasize the absence of "risky" romantic relationship features, rather than the presence of romantic strengths or assets. This pitfall is especially noteworthy among minoritized youth, including those who are systems-involved through child protective services or juvenile justice.

Minoritized youth, including Black, Native, and Hispanic youth as well as sexual and gender minoritized adolescents, are targeted by racist and oppressive systems that result in their disproportionate representation in child welfare and juvenile justice systems. The unique romantic relationship features, especially assets, of these youth have received very little attention. Yet, we know that systems-involved youth begin romantic relationships earlier in development, rank these romantic relationships as a significant source of support, and communicate more frequently

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OCD

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a different way or under a different set of circumstances.

A topographical description of a patient's presenting symptoms (e.g., "they worry about getting sick," "they like symmetry and order") does not provide information about the functional links between a patient's presenting obsessions and compulsions and is often insufficient to inform treatment planning (Conelea et al., 2012).

Instead of focusing on topographical symptoms, it may be more informative to examine the fears or motivations that underly a range of symptoms for people with OCD. Research on the nature of OCD suggests that OCD symptoms are typically motivated by harm avoidance, incompleteness, disgust, or some combination of the three (Cervin et al., 2021; Summerfeldt et al., 2014). These "core motivations" provide insight into the functional links between a patient's presenting obsessions and compulsions and can inform the implementation and tailoring of exposure and response prevention, the leading treatment for OCD.

Specifically, as exposure and response prevention consists of planned contact with feared stimuli and the subsequent resistance of compulsive behaviors, knowledge of core motivations can inform the selection of exposure stimuli and expected exposure response.

Harm avoidance

Patients who present with a harm avoidance core motivation are those who report fear of a negative outcome (something "harmful" or bad) and perform a compulsive behavior in an effort to prevent such an outcome from occurring (or "avoid" it). Patients who present with harm avoidance often report fear of becoming contaminated or getting sick, fear that they will hurt themselves or others even though they do not want to, fear that harm will come to themselves or others, and/or fear of another unwanted consequence. Patients with harm avoidance core motivations often perform compulsions to avoid harm by way of avoiding objects or situations that are associated with harm fears (e.g., avoiding touching contaminated surfaces, avoiding holding knives), engage in checking behavior to ensure that harm did not occur (e.g., checking the locks on doors, checking their body for signs of injury), and seeking reassurance from others that harm has not occurred.

Exposures for harm avoidance core motivation should entail the presentation of a stimulus or situation in which, from the patient's perspective, a feared outcome may possibly occur. The closer that the potential feared outcome during exposure is to the real-world feared outcome, the harder (and likely more beneficial) the exposure will be for the patient. For example, if a patient fears they will hurt themselves, holding a toy knife may evoke some fear (and can be used as a titration of an exposure), but will probably not evoke as much fear as holding a real knife, because the patient knows that the possible harm from the real knife is greater. Alternatively, if a patient is certain that a feared outcome will not occur, the exposure will not likely be effective.

Before, during, and after an exposure, clinicians should refrain from using language that suggests that the feared outcome is unlikely to occur and should instead highlight the possibility that it could occur, or that it is uncertain whether or not it may occur. Patients should be discouraged from engaging in mental rituals such as self-reassuring that the feared outcome will not occur. Patients with harm avoidance core fears often report high distress before and during an exposure task, and often demonstrate a decrease in distress over the course of one exposure and across multiple exposure tasks. Repeated trials of exposure and response prevention will hopefully allow the patient to realize (naturally, for themselves) that they do not need to avoid situations or perform compulsions to avoid harm, that harm is unlikely to happen, and that even if some harm does happen, they are able to tolerate it.

Incompleteness

Patients who present with incompleteness core motivation may exhibit difficulty expressing this as their motivation, as incompleteness is difficult to explain and not widely understood by the public. Incompleteness core motivation includes the need for things to be perfect, symmetrical, even, or "just right," and a vague sense of discomfort or "not just right" feeling that may occur at random or after a specific trigger. Patients with incompleteness core motivations are often unable to cite a feared outcome other than the uncomfortable feeling itself. Patients with incompleteness core motivations also often cannot report what triggers these "not just right" feelings or why they feel that way. Some patients with incompleteness report feeling a greater or lesser sense of incompleteness depending on the situation, whereas others report that the feeling is either present or not present, with no in-between. Patients who describe incompleteness often engage in repetitive or ritualized behaviors until it feels "just right" (e.g., flipping a light switch multiple times, washing hands until it feels just right). Patients with incompleteness may also avoid situations that elicit "not just right" feelings.

Exposures for incompleteness core motivations should entail the presentation of a stimulus that elicits a "not just right" feeling for the patient. Patients should be encouraged to sit with the "not just right" feeling without engaging in compulsions to get rid of the feeling. Incompleteness exposures differ from harm avoidance exposures in that the sense of incompleteness or "not just right" feeling is the feared outcome, and the exposure itself confirms that the feared outcome does occur. If a patient does not report any discomfort or "not just right" feeling during an exposure, the exposure will likely be ineffective. If a patient reports experiencing a greater or lesser sense of incompleteness depending on the situation, exposures that induce a greater sense of incompleteness will likely be harder and more beneficial for the patient.

If a patient reports that the sense of incompleteness is either present or not present, exposures can be titrated instead using amount of time allotted for and focus during the exposure, wherein longer time and greater focus will likely increase the difficulty of the exposure. Clinicians should refrain from distracting a patient or encouraging a patient to distract themselves during an exposure. As the patient sits with the "not just right" feeling, they will habituate or learn to tolerate the feeling, which will likely lead to a decrease in patient-reported distress during subsequent exposure tasks. However, compared to patients with harm avoidance core motivation, patients with incompleteness core motivation may require more time either within one exposure task or

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across multiple exposure tasks to exhibit this decrease in distress.

Disgust

Patients who present with disgust core motivation often also present with harm avoidance, incompleteness, or both other core motivations. Patients who report disgust motivations often describe concerns related to germs, dirt, bodily fluids, or other contaminants. Patients with disgust core motivations often perform compulsions in the form of avoiding contact with disgust-provoking stimuli and measures to remove contamination when it occurs (e.g., cleaning rituals). Symptoms related to contamination appear similar to those that present for patients with harm avoidance core motivation.

The difference between harm avoidance and disgust is that patients with primarily harm avoidance motivations generally place emphasis on the outcome of contamination (e.g., contamination could lead to sickness, sickness could lead to death), whereas patients with only disgust core motivations are usually less concerned with a feared outcome and more disgusted by the contamination itself. Patients with disgust core motivation may also describe visceral discomfort when in contact with a disgust-provoking stimulus. The lack of a specific feared outcome and vague sense of discomfort mark ways in which disgust is similar to incompleteness. Disgust is also similar to incompleteness in that it represents an emotional process that is distinct from fear, and thus may respond differently than harm avoidance to exposure and response prevention.

As with exposures that target incompleteness, exposures that target disgust are self-confirming (i.e., the disgust feeling does occur). Exposures for disgust core motivation should entail the presentation of a stimulus that elicits a disgust reaction from the patient. Patients should not be encouraged to calm themselves down, reappraise, or change this reaction, but should instead be encouraged to feel the disgust feeling and sit with it without engaging in compulsions to get rid of it. Similar to patients with incompleteness core motivations, patients with primary disgust core motivations may require more time to habituate or exhibit a decrease in distress compared to patients with harm avoidance core motivation. Feelings of disgust are unlikely to completely remit with treatment, but instead, patients may learn to better tolerate feeling disgusted without engaging in compulsive behaviors to get rid of the feeling.

In summary, harm avoidance, incompleteness, and disgust represent three distinct (although often co-occurring) core motivations of OCD symptoms that mark different clinical presentations and warrant different treatment approaches, even within the context of exposure and response prevention. Knowledge of core motivations can provide insight to clinicians about which exposure stimuli to select and what response to expect from a given patient. Furthermore, using information about core motivations to inform treatment planning can potentially improve treatment response and outcome for patients with OCD.

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Jennifer Freeman is the Director of Research and Training at the Pediatric Anxiety Research Center (PARC), Associate Director of Research at Bradley Hospital, and Professor (Research) of Psychiatry and Human Behavior at the Warren Alpert Medical School of Brown University. Dr. Freeman provides clinical services to youth with anxiety, OCD, and related disorders. Dr. Freeman's current research is focused on health services-related questions about barriers to accessing CBT for youth with anxiety disorders.

Kristen Benito is an Associate Professor (Research) at the Warren Alpert Medical School of Brown University and a Staff Psychologist at Bradley Hospital. Dr. Benito is also the Principal Investigator on an NIMH-funded study testing the Exposure Guide as a practical measure of quality in exposure therapy. Dr. Benito's research interests are related to understanding treatment quality and mechanism of change in exposure-based treatments and using this knowledge to 1) disseminate efficacious treatments into community settings, 2) augment existing treatments, and 3) develop new treatments.

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with romantic partners via social media as compared to other interpersonal relationships. In essence, romantic relationships among systems-involved youth are known to be highly influential but are rarely seen beyond a problem behavior lens. Drawing on work conducted with systems-involved adolescents, we discuss three areas that may elucidate new ways of considering romantic relationship assets among minoritized youth: shared lived experiences (e.g., discrimination, systems involvement), romantic experiences as a developmental task, and a reconsideration of how we weigh risks and rewards of romantic experiences.

Systems-involved adolescents may have unique lived experiences with romantic partners, namely shared experiences with oppression. Unfortunately, providers, teachers, and researchers often have Eurocentric beliefs of adolescent romantic experiences. Especially concerning, factors not known to be beneficial among White youth may be overlooked. Among adults, there is greater awareness of culturally unique strengths among minoritized couples. For example, conversations about race and shared racial ideology have been linked to positive romantic relationship qualities among adult Black couples. Yet, similar processes have not been extended to minoritized adolescent couples. While minoritized youth who are systems-involved may have shared lived experiences with racism, discrimination, and oppression, there exists significant heterogeneity in how these lived experiences are shared