Seth Gillihan, Ph.D. Presented on
"Overcoming barriers to OCD treatment"

by Rachel Strohl, Psy.D.

On Monday September 11, 2017, Seth Gillihan, Ph.D. presented at the quarterly meeting of OCDNJ at the Cherry Hill library. Dr. Gillihan is a New Jersey Licensed Psychologist. He is a Clinical Assistant Professor of Psychology in the Psychiatry Department at the University of Pennsylvania. Dr. Gillihan has written and lectured nationally and internationally on cognitive behavioral therapy (CBT) and the role of the brain in psychiatric conditions. He wrote Overcoming OCD: A Journey to Recovery with Janet Singer as well as Retrain Your Brain: Cognitive Behavioral Therapy in 7 Weeks, a workbook for managing depression and anxiety. Dr. Gillihan has a clinical practice in Haverford, PA, where he specializes in CBT and mindfulness-based interventions for OCD, anxiety, depression, and related conditions.

Dr. Gillihan provided an overview to overcoming barriers in OCD treatment in his talk. He explained OCD recovery is a journey, and it does not start or end in the therapist's office. He carefully outlined the following steps to OCD treatment:

A) **Recognize the problem**: 1) People have reported they did not know what OCD was, 2) OCD did not affect them enough, 3) they assumed it would go away, 4) they did not know any different, and 5) they did not want to accept it.

B) **Decide to seek help**: Studies have shown that there is often a long delay in seeking treatment. Pinto et al. (2006) found it can take up to 17 years on average for a person to seek help. Three out of five people had not sought help. When exploring why there is a delay, some cited lack of information. They were not sure "where to turn" or "if I could afford therapy," and thought "I can handle it," "what would people think," or "treatment will not help me."

Dr. Gillihan discussed the role of stigma in delaying seeking treatment for OCD. People with OCD may not want to tell people or their doctors. They may have concerns if the doctor will know what OCD is, how will the doctor react, and will treatment help? They may have a fear of having OCD on their medical record. It is possible they want to "shield their family" from the diagnosis, or the family does not want to acknowledge the OCD.

He outlined that the following encourages seeking help: 1) being supported to seek help, 2) reaching a crisis point, 3) information from the media, e.g., blogs, YouTube, 4) confidence in a general practitioner or mental health professional, 5) the nature of obsessive thoughts, e.g., involving harming children, and 6) not accommodating OCD in the family.

C**) Receive the correct diagnosis**: OCD is characterized by pathological doubt, but the disorder can "look" like other psychiatric disorders. For example, bizarre symptoms look like psychosis, harming children looks like pedophilia, obsessive focus looks like autism spectrum disorder, and distractibility looks like ADHD (attention deficit hyperactive disorder), to name a few. If we do not have the correct diagnosis, "then we do not know what we are dealing with, and then we cannot treat it." Glazier et al. (2015) found that half of primary care doctors (n=208) misdiagnosed OCD from vignettes they were presented in the study. To improve diagnosis, there must be education of professionals and an increase in public awareness.

D) **Find the right therapist**: According to the research for OCD, ERP (exposure and response prevention) and cognitive therapy have "strong research support." ACT (acceptance and commitment therapy) has "modest research support." Dr. Gillihan said that ERP is CBT for OCD. ERP is doing the opposite of what the OCD demands. Exposure is "systematically approaching OCD triggers," such as using shaking hands without ritualized washing and using public bathrooms. Foa et al. (2005) found that 86% get a lot of benefit from effective ERP. The following does not help OCD: anxiety management, benzodiazepines (e.g., Xanax, Klonopin), and reassurance.

E) **Afford the treatment**: 1) Outpatient therapy - may be hard to find in network providers who offer ERP. According to Dr. Gillihan, the average cost is $6,000 for 30 hours of treatment. 2) Inpatient therapy - could be tens of thousands of dollars, and may not be covered by insurance. Access to treatment can be increased with telehealth (e.g., VSee is a HIPPA compliant communication program), alternate models (e.g., self help with minimal therapist contact), computer assisted ERP, and group ERP (e.g., led by a trainee, who is an advanced doctoral student).

DVDs of this presentation are available through the OCDNJ website.

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