OCD 101

Presenter: Jessica Hood, MSW, LCSW
Clinical Director & Owner, Indy Child Therapist

Founder: Indy Private Practice Network

Jessica@Indychildtherapist.com

Obsessive-Compulsive Disorder

- Formerly in Anxiety Disorders

Body Dysmorphic Disorder

- Formerly in Somatoform Disorders

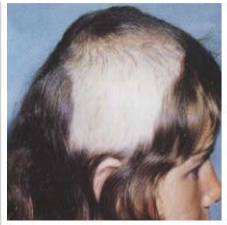
Hoarding Disorder

Excoriation (skin-picking)

- New disorders

Trichotillomania (Hair-pulling)

- Formerly in Impulse Control Disorders



DSM-5 Operational Definition

A. Presence of obsessions, compulsions, or both:

- Obsessions as defined by (1) and (2):
  1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted and that in most individuals cause marked anxiety or distress
  2. The person attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion)

DSM-5 Operational Definition

- Compulsions as defined by (1) and (2):
  1. Repetitive behaviors or mental acts that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly
  2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive

Operational Definition

B. The O/C are time consuming (for example, take more than 1 hour a day) or cause clinically significant distress or impairment in functioning.

C. The O/C symptoms are not due to the direct physiological effects of a substance or a medical concern

D. The content of the obsessions or compulsions is not restricted to the symptoms of another mental disorder

GAD vs OCD

- Many view GAD (and even Social Anxiety Disorder) along the same spectrum as OCD and often treat it with both ERP and ACT.
- "GAD obsessions are generally focused on common, everyday concerns, while OCD obsessions tend to be significantly more unrealistic. Also, while someone with GAD (or *anyone* for that matter) may experience unwanted thoughts similar to those experienced by people with OCD, they are generally able to quickly write those thoughts off as being unrealistic. They are unlikely to become consumed by these thoughts, and will usually revert back to obsessing about more mundane concerns."
  - https://ocdla.com/ocd-vs-gad-7071

Most Common Obsessions

Type of Obsession	Examples
Contamination	Bodily fluids, disease, germs, dirt, chemicals, environmental contaminants
Religious Obsessions	Blasphemy or offending God, high concern about morality and what is right and wrong.
Superstitious ideas	Lucky numbers, colors, words
Perfectionism	Evenness and exactness, "needing" to know or remember, fear of forgetting or losing something
Harm	Fear of hurting others through carelessness, fear of being responsible for something terrible happening
Losing Control	Fear of acting on an impulse to harm self or others, fear or unpleasant mental images, fear of saying offending things to others
Unwanted Sexual Thoughts	Forbidden or "perverse" sexual thoughts, images, or impulses; obsessive thoughts about homosexuality; obsessions involving children or incest; obsessions about aggressive sexual behavior

Common Compulsions

Type of Compulsion	Examples
Checking	Making sure that you did not (or will not) harm yourself or others, or that you did not make a mistake, or that nothing "terrible" happened
Repeating	Repeating things in multiples or a certain number of times, certain body movements, rereading or rewriting
Washing / Cleaning	Washing hands excessively, excessive showering or bathing, cleaning outside the norm
Mental compulsions	Cancelling out bad thoughts with good ones, counting while walking or performing some task, prayer to prevent something terrible from happening
Hoarding	Collecting items due to compulsions
Ordering and Arranging	Putting things in "proper" order or until it "feels right"

Sub-Types

- Just Right OCD
  - Something is just not right with this, I need to start this over to make it perfect, This just doesn't feel right
- Pure O: No physical/outward compulsions
  - What if I'm actually not a good person?, How do I know that life is even worth it?, What if I go over there and push that guy off this bridge?, If I don't clean my mess up well enough someone will get slip and get seriously hurt because of me
- Contamination OCD
  - Oh no, this time I've really gotten AIDS, I just gave my sister's baby a serious illness when I held him, This whole place is full of bad bacteria, I can just tell

https://www.treatmyocd.com/education/different-types-of-ocd/

Egodystonic vs Egosyntonic

- OCD vs other disorders
  - Ego Dystonic: referring to thoughts and behaviors (dreams, compulsions, desires, etc.) that are in conflict, or dissonant, with the needs and goals of the *ego*, or, further, in conflict with a person's ideal self-image.
  - Ego Syntonic: of or relating to aspects of one's behavior or attitudes viewed as acceptable and consistent with one's fundamental personality and beliefs

  - Pathological uncertainty & doubt
  - Distress & want to get rid of
  - Function of behavior

Sub-Types: The Harder Ones

- **HOCD:** Harm OCD
  - I could jump in front of the train right now, I could stab my husband with this knife, What if I drove into that person?, What if I killed my nephew and I just can't remember?
- **POCD:** Pedophilia OCD
  - What if I have sexual thoughts about the kid I'm babysitting? I just had a sexual thought when I was around my cousin's kid, am I attracted to them? What if I molested a kid and I just can't remember?
- **ROCD:** Relationship OCD
  - Is this the right person for me?, Couldn't there be someone better out there?, Are we meant for one another? What if we're not meant to be but we still end up stuck together?
- **SO-OCD:** Sexual Orientation OCD
  - I was attracted to that guy back there. This means I'm gay., Other people can detect that deep down I'm into women, Was I really into her when we dated? Or am I more into guys?

OCD Prevalence

- Around 1% in pediatric population (about same as diabetes)
- Between 2-3% in the adult population (about the population of Houston)
  - Large number of "sub-clinical" cases (5%)
- 96%+ of patients have both O and C

Abramowitz et al. (2009); Leckman et al. (2010)

OCD Course

- Usually gradual onset
  - A sudden onset in children could be PANDAS/PANS especially if they just had an infection, most commonly strep.
  - *Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal infections*
  - *Pediatric Acute-onset Neuropsychiatric Syndrome*
- Chronic, unremitting course if untreated
- Symptoms can change across time, but will rarely disappear

Abramowitz et al. (2009);

Comorbidity

- Up to 75% present with comorbid disorders
- Most common in pediatrics are ADHD, DBDs, depression, and other anxiety disorders
- Presence of comorbids predict QoL, more so than OCD severity
- No evidence to support that OCD is caused by trauma or other "deep rooted" issue, however, there is co-morbidity but as you will see less than other diagnoses.
  - Causal issues would include PAN/PANDAS or Post-Partum

Lack et al. (2009)

Comorbidity

- Different primary O/C are associated with certain patterns of comorbidity
  - Symmetry/ordering: Tics, bipolar, OCPD, panic, agoraphobia
  - Contamination/cleaning: Eating disorder
  - Hoarding: Personality disorders, especially Cluster C
- Most prevalent adult comorbids are SAD, MDD, alcohol abuse
  - Notice PTSD is NOT listed!

Leckman et al. (2010)

Evidence-based Treatments

Pharmacology for OCD

- Overall, pharmacology (SRIs) shows large effect sizes in adults (0.91), but…
  - Most treatment responders show residuals
  - Very high relapse rate (24-89%)

- Only moderate effect sizes in youth (0.46)

Abramowitz et al. (2009)

Strength of Evidence for Meds

Medication	Type	Adults	Children
Clomipramine (Anafranil)	TCA	A	B
Citalopram (Celexa)	SSRI	B	C
Escitalopram (Lexapro)	SSRI	B	D
Fluoxetine (Prozac)	SSRI	B	A
Fluvoxamine (Luvox)	SSRI	A	B
Paroxetine (Paxil)	SSRI	A	B
Sertraline (Zoloft)	SSRI	B	A

Cognitive-Behavioral Therapy for Obsessive-Compulsive Disorder

CBT for OCD
aka Exposure Response Prevention

- ERP is different than traditional CBT that we would use for say depression.
  - In fact many of the things we would do CBT-wise for depression are COUNTER-indicated for OCD!!
- The treatment of choice, for both adult and child OCD; superior to meds alone
- Primarily focuses on ERP, which has shown effect sizes of 1.16-1.72 (88-95% improve)
- Low (12%) relapse rate, but up to 25% will drop out prior to completion of treatment

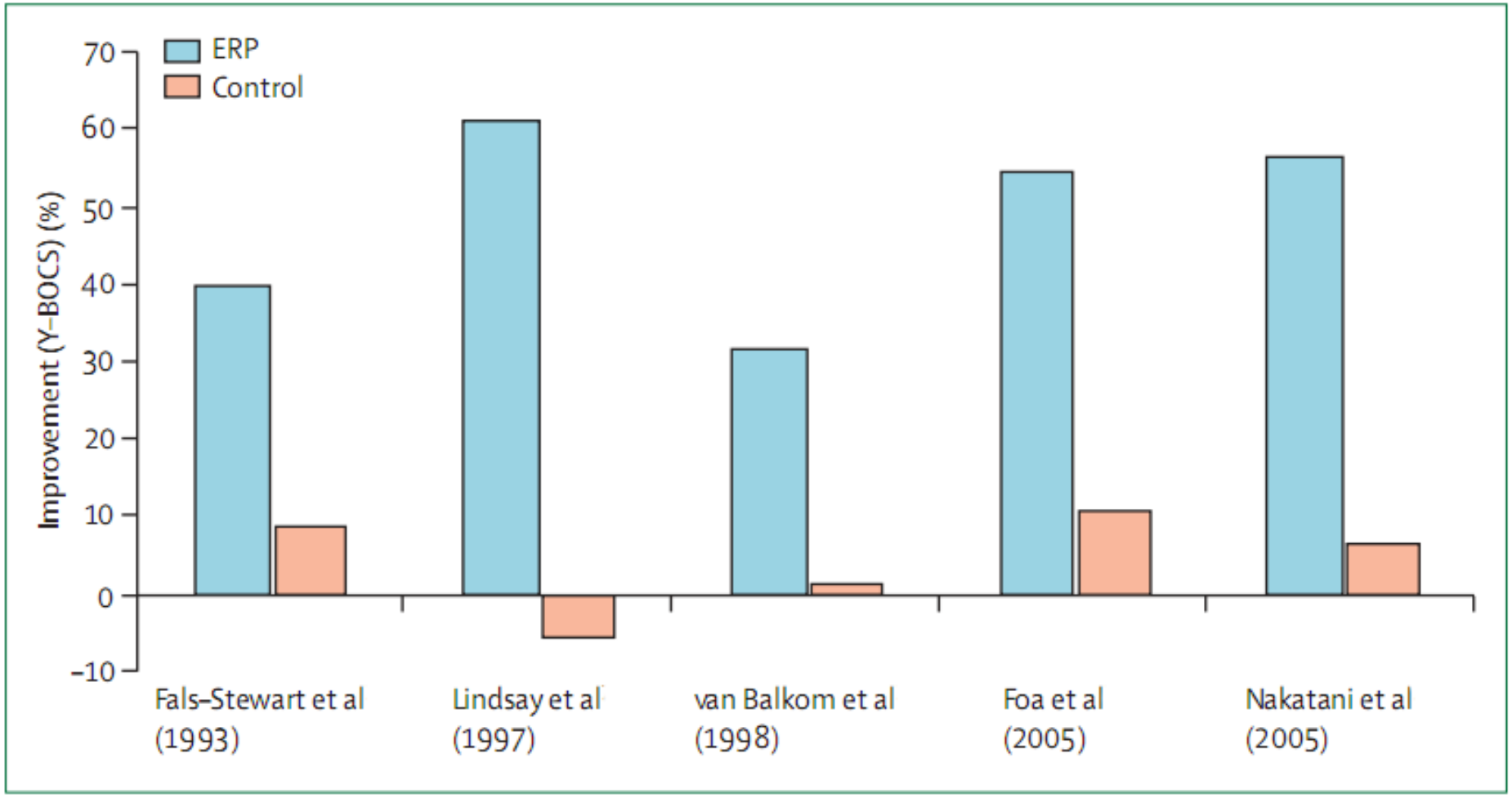
CBT Outcomes

- Those with comorbidity present higher severity, but respond equally well to EX/RP

- Comorbid anxiety or depressive symptoms tend to show improvements as well, even if not specifically targeted

Storch et al. (2010)

CBT Outcomes



Assessments

- Gold standard in assessments are clinician interviews like CY-BOCS & Y-BOCS
- Useful to assess impact of OCD and family accommodation with FAIS-C, COIS-R, FAS-SR
  - Family Accommodation and Impact Scale, Child OC Impact Scale, Family Accommodation Scale
- Quick self-report of symptoms for screening purposes can use C-FOCI, LOI-C, or OCI-R
  - Children's Florida OC Inventory, Leyton Obsessional Inventory, OC Inventory

Exposure

- The common thread in effective anxiety treatments is hierarchy-based exposure tasks
- Controversy over exactly *why* exposure therapy works so well for anxiety
- Does *not* require extensive preparation to be effective and long-lasting

Rosqvist (2005)

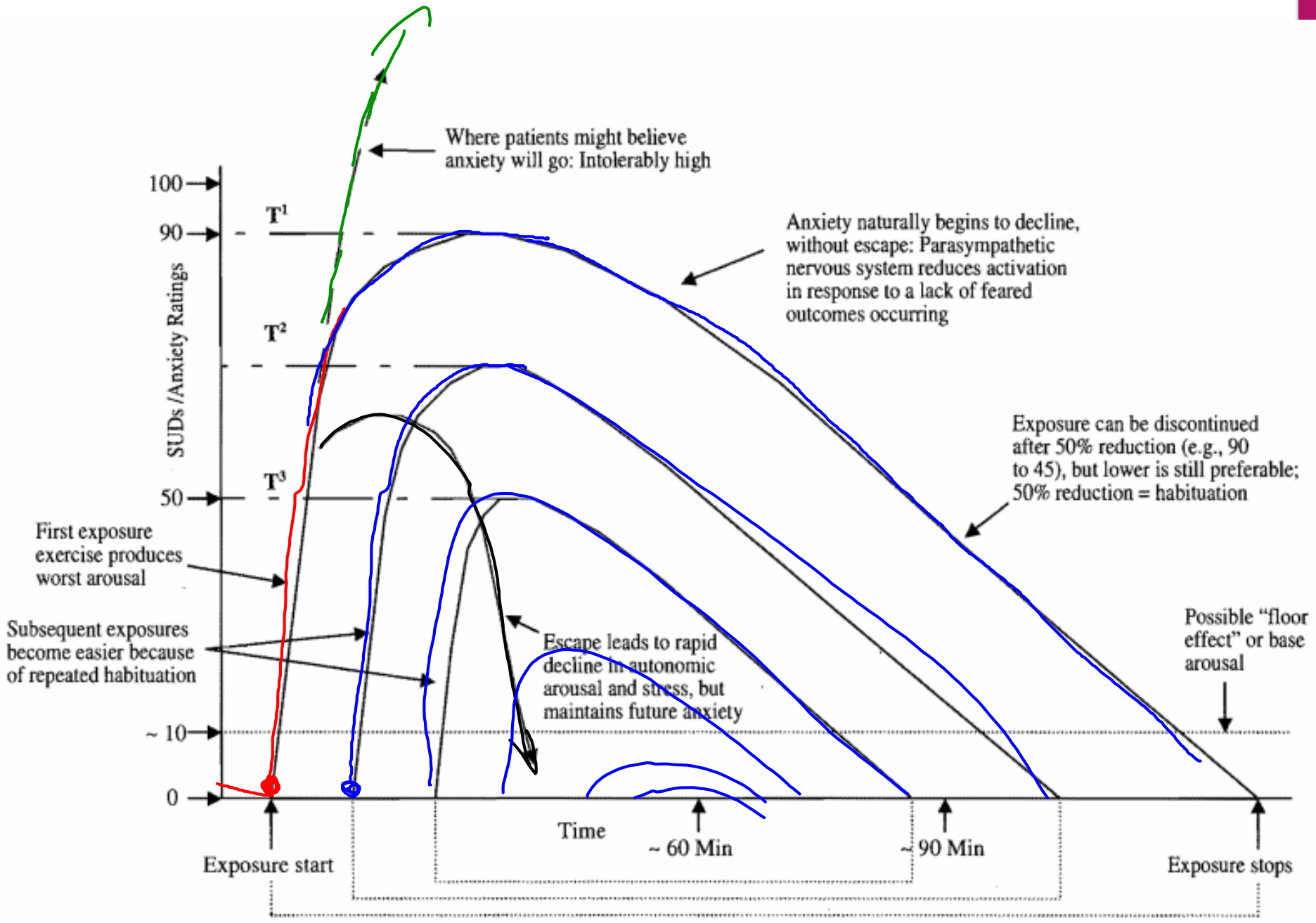
Sample Fear Hierarchy

Situation	*Fear Rating*
Driving over the Steel Bridge at rush hour	100
Driving on the highway at rush hour, at dusk, and in poor weather	90
Driving on the highway at rush hour, in good weather	80
Being a passenger on the highway during rush hour	75
Driving on the highway in the middle of the day, in good weather	65
Driving on a city street at midday, when it is raining	65
Driving on a city street at midday, when the sky is clear	50
Turning onto a city street during traffic hours	45
Driving in a busy parking lot during business hours	35
Driving in an empty parking lot during "off" hours	25

Exposure Types

- Imaginal exposure tasks
  - Often used in the beginning, or when the client has abstract worries / fears
  - Allows for practicing coping skills before confronting the real situation

- In vivo exposure tasks
  - Often follow imaginal exposures, use a "live and in person" version of the feared situation


Where patients might believe anxiety will go: Intolerably high
100
90
50
~ 10
0
SUDs /Anxiety Ratings
T1
T2
T3
Anxiety naturally begins to decline, without escape: Parasympathetic nervous system reduces activation in response to a lack of feared outcomes occurring
Exposure can be discontinued after 50% reduction (e.g., 90 to 45), but lower is still preferable; 50% reduction = habituation
First exposure exercise produces worst arousal
Subsequent exposures become easier because of repeated habituation
Escape leads to rapid decline in autonomic arousal and stress, but maintains future anxiety
Possible "floor effect" or base arousal
Time
Exposure start
~ 60 Min
~ 90 Min
Exposure stops

Obstacles for the Therapist

- I'm making my client more upset / anxious
- It's difficult to see people in distress
- Can be emotionally draining for some therapists
- May have to do exposures that you are not comfortable with

Giving Treatment a Boost

- CBT using EX/RP is the gold-standard, followed by a medication regimen
  - ACT is second tier standard
- But, some 20%+ of people with OCD may not respond fully to EX/RP
  - Number is much higher for meds
- This has led to augmentation efforts

Body Dsymorphic Disorder

Operational Definition

A. Preoccupation with one or more perceived defects or flaws appearance that are not observable or appear slight to others.

B. At some point during the course of the disorder, the individual has performed repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (e.g., comparing his or her appearance with that of others) in response to the appearance concerns.

Operational Definition

C. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The preoccupation is not better accounted for by another mental disorder(e.g., dissatisfaction with body shape and size in Anorexia Nervosa).

Body hate/ dissociation	Distorted body image	Body preoccupied/ obsessed	Body acceptance	Body ownership
I often feel separated and distant from my body—as if it belongs to someone else. I don't see anything positive or even neutral about my body shape and size. I don't believe others when they tell me I look OK. I hate the way I look in the mirror and often isolate myself from others.	I spend a significant amount of time exercising and dieting to change my body. My body shape and size keep me from dating or finding someone who will treat me the way I want to be treated. I have considered changing or have changed my body shape and size through surgical means so I can accept myself.	I spend a significant amount of time viewing my body in the mirror. I spend a significant amount of time comparing my body to others. I have days when I feel fat. I am preoccupied with my body. I accept society's ideal body shape and size as the best body shape and size.	I base my body image equally on social norms and my own self-concept. I pay attention to my body and my appearance because it is important to me, but it only occupies a small part of my day. I nourish my body so it has the strength and energy to achieve my physical goals.	My body is beautiful to me. My feelings about my body are not influenced by society's concept of an ideal body shape. I know that the significant others in my life will always find me attractive.

BDD risk

What are Body-Focused Repetitive Behaviors?

BFRBs

- Repetitive self-grooming behaviors in which pulling, picking, biting or scraping of the hair, skin or nails result in damage to the body

- Common BFRB behaviors include skin picking (of scabs, acne, or other skin imperfections, for example), cuticle or nail biting or picking, and lip or cheek biting

OC&R and BFRBs

- Two of the OC&R disorders are also BFRBs
  - Trichotillomania (hair-pulling disorder)
  - Excoriation (skin-picking disorder)

- Distinct from OCD and **not** the result of some "deeper" disorder or trauma

Symptoms of BFRBs

- Pulling/picking most often occur when sedentary
  - Lying in bed, reading, listening to a lecture or in class, riding in or driving a car, using the bathroom, talking on the phone, using the computer or sitting at a desk at work
- Can be planned or accidental

Symptoms of BFRBs

- Some have sensations that "pull" fingers to the sites, some do not
- Many report they are search for "wrong" hairs or skin in order to remove/fix the perceived problem
- For many, these searching behaviors are part of the process

Behavioral Therapy

- Several different therapeutic approaches have been used with BFRBs, all variations of CBT
- Habit Reversal Training, Comprehensive Behavioral Treatment, Acceptance & Commitment Therapy, and Dialectical Behavior Therapy have all been used
- HRT and ComB are more well studied, ACT and DBT are considered adjunctive

Habit Reversal Training

Most well-researched method to date

Three critical components

Awareness training	Competing response training	Social support