Some additional notes

Diagnostic criteria

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) Classification of Obsessive-Compulsive Disorder (DSM-IV Code 300.3)

A. **Either obsessions or compulsions:**

Obsessions as defined by (1), (2), (3) and (4): (1) recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress. (2) the thoughts, impulses, or images are not simply excessive worries about real-life problems. (3) the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralise them with some other thought or action. (4) the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion).

Compulsions as defined by (1) and (2): (1) repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly (2) the behaviours or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviours or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive .

B. At some point during the course of the disorder, the person has recognised that the obsessions or compulsions are excessive or unreasonable. Note: This does not apply to children.

C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.

D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the

presence of an Eating Disorders; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder). **E.** The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

The International Classification of Diseases (ICD-10) Classification of Obsessive-Compulsive Disorder (ICD-10 Code F42)

The essential feature of this disorder is recurrent obsessional thoughts or compulsive acts

- Obsessional thoughts are ideas, images or impulses that enter the individual's mind again and again in a stereotyped form. They are almost invariably distressing (because they are violent or obscene, or simply because they are perceived as senseless) and the sufferer often tries, unsuccessfully, to resist them.
- Compulsive acts or rituals are stereotyped behaviours that are repeated again and again. They are not inherently enjoyable, nor do they result in the completion of inherently useful tasks. The individual often views them as preventing some objectively unlikely event, often involving harm to or caused by himself or herself.

Diagnostic Guidelines

For a definite diagnosis, obsessional symptoms or compulsive acts, or both, must be present on most days for at least 2 successive weeks and be a source of distress or interference with activities. The obsessional symptoms should have the following characteristics: (a) they must be recognized as the individual's own thoughts or impulses: (b) there must be at least one thought or act that is still resisted unsuccessfully, even though others may be present which the sufferer no longer resists; (c) the thought of carrying out the act must not in itself be pleasurable (simple relief of tension or anxiety is not regarded as pleasure in this sense); (d) the thoughts, images, or impulses must be unpleasantly repetitive.

The APA (American Psychiatric Association) (1994) also provides a diagnostic index of OCD subtypes; the categories included are: ‘Cleaners’, ‘Repeaters’, ‘Completers’, ‘Checkers’, ‘Overly Meticulous’, ‘Compulsive Avoider's’, ‘Hoarders’, and ‘Slowness’.

There are Five Distinct OCD Types

Research and clinical experience has suggested five major OCD types:

- **Contamination obsessions with washing/cleaning compulsions**: If you are affected by this symptom subtype you will usually focus on feelings of discomfort associated with contamination and wash or clean excessively to reduce these feelings of distress. For example, you might feel that your hands are dirty or contaminated after touching a door knob or worry that you will contaminate others with your germs. To get rid of these feelings, you might wash your hands repeatedly, for hours at a time.

  Examples of contamination fears:

  - Using public toilets (fear of contracting germs from other people).
  - Coming into contact with chemicals (fear of contamination).
  - Shaking hands (fear of contracting germs from other people).
  - Touching door knobs/handles (fear of contracting germs from other people).
  - Using public telephones (fear of contracting germs from other people).
  - Waiting in a GP’s surgery (fear of contracting germs from other people).
  - Visiting hospitals (fear of contracting germs from other people).
  - Eating in a cafe/restaurant (fear of contracting germs from other people).
  - Washing clothes in a launderette (fear of contracting germs from other people).
  - Touching bannisters on staircases (fear of contracting germs from other people).
  - Touching poles (fear of contracting germs from other people).
  - Being in a crowd (fear of contracting germs from other people).
  - Avoiding red objects and stains (fear of contracting HIV/AIDS from blood like stains).

- Clothes (having to shake clothes to remove dead skin cells, fear of contamination).
- Excessive Tooth Brushing (fear of leaving minute remains of mouth disease).
- Cleaning of Kitchen and Bathroom (fear of germs being spread to family).

- **Harm obsessions with checking compulsions**: If you experience this symptom subtype you will often have intense thoughts related to possible harm to yourself or others and use checking rituals to relieve your distress. For example, you might imagine your house burning down and then continually drive by your house to make sure that there is no fire. In addition, you may feel that by simply thinking about a disastrous event, you are increasing the likelihood of such an event actually happening.

Common checking includes:

- Gas or electric stove knobs (fear of causing explosion and therefore the house to burn down).
- Water taps (fear of flooding property and damaging irreplaceable treasured items).
- Door locks (fear of allowing a burglar to break in and steal or cause harm).
- House alarm (fear of allowing a burglar to break in and steal or cause harm).
- Windows (fear of allowing a burglar to break in and steal or cause harm).
- Appliances (fear of causing the house to burn down).
- House lights (fear of causing the house to burn down).
- Car doors (fear of car being stolen).
- Re-reading postal letters and greetings cards before sealing / mailing (fear of writing something inappropriate or offensive).
- Candles (fear of causing the house to burn down).
- Route after driving (fear of causing an accident).
- Wallet or purse (fear of losing important bank cards or documents).
- Illnesses and symptoms online (fear of developing an illness, constant checking of symptoms).
- People – Calling and Texting (fear of harm happening to a loved one).
- Reassurance (fear of saying or doing something to offend or upset a loved one).
- Re-reading words or lines in a book over and over again (fear of not quite taking in the information or missing something important from the text).

- Schizophrenia Symptoms – (fear that OCD is a precursor to Schizophrenia which will cause them to lose control).

- **Obsessions without visible compulsions or so-called "pure obsessions"**: This symptom subtype often relates to unwanted obsessions surrounding sexual, religious or aggressive themes. For example, you could experience intrusive thoughts about being a rapist or that you will attack someone. You may often use mental rituals such as reciting particular words, counting in your head or praying to relieve the anxiety you experience when you have these involuntary thoughts. Triggers related to obsessions are usually avoided at all costs.

- **Symmetry obsessions with ordering, arranging and counting compulsions**: When experiencing this subtype, you feel a strong need to arrange and rearrange objects until they are "just right". For example, you might feel the need to constantly arrange your shirts so that they are ordered precisely by colour. This symptom subtype can also involve thinking or saying sentences or words over and over again until the task is accomplished perfectly. Sometimes these ordering, arranging and counting compulsions are carried out to ward off potential danger ("If I arrange my desk perfectly my husband won't die in a car accident"); however, this is not always the case.

  Examples:

- Having everything neat and in its place at all times.
- Having pictures hanging aligned and straight.
- Having canned food items all facing the same way, usually forward.
- Having clothes on the rail all hanging perfectly and facing the same way.
- Having everything spotless, with no marks or smudges on windows and surfaces.
- Having books lined up perfectly in a row on a bookshelf.

- **Hoarding**

Hoarding involves the collection of items that are judged to be of limited value by others such as old magazines, clothes, receipts, junk mail, notes or containers. Often your living space becomes so consumed with clutter that it becomes impossible to live in. Hoarding is often accompanied by obsessional fears of losing items or possessions which may be needed one day and excessive emotional attachment to objects. People affected by the hoarding

symptom subtype will tend to experience higher anxiety and depression than people with other subtypes and are often unable to maintain steady employment. Importantly, compulsive hoarding can occur independent of OCD.

Is it Possible to Have Overlapping OCD Types?

Although the experience of a particular symptom types appears to be relatively stable over time, it is possible to experience a change in the nature and focus of your symptoms over time. In addition, although the majority of your symptoms might be consistent with a particular symptom subtype, it is possible to experience symptoms of other types at the same time.

Additional epidemiological facts about the disorder:

- 1.2% of the population will have OCD, which equates to 12 out of every 1000 people, and based on the current estimates for the UK population, these statistics mean that potentially, approximately 741,504 people are living with OCD at any one time

- The ratio of men to women suffering with the disorder is 1:1, although, more specifically, the disorder's onset is reported to occur earlier in men than women.

- Studies have demonstrated that at least a third of all adult sufferers have reported its onset as occurring during childhood or adolescence.

- There are often prominent anankastic features in the underlying personality.

- The course is variable and more likely to be chronic in the absence of significant depressive symptoms.

Comorbid conditions

- Pre-occupation with appearance - Body Dysmorphic Disorder (perhaps closest linked)
- Compulsive Skin Picking,
- Tourette Syndrome
- Trichotillomania
- Pre-occupation with food – anorexia
- Pre-occupation with drugs – substance use disorders
- Pre-occupation with serious illness – hyperchondriasis (health anxiety/somatoform disorder)
- Pre-occupation with sexual urges/fantasies (paraphillia)
- Guilty ruminations – major depressive disorder

Anxiety and depression

Autonomic anxiety symptoms are often present, but distressing feelings of internal or psychic tension without obvious autonomic arousal are also common. There is a close relationship between obsessional symptoms, particularly obsessional thoughts, and depression. Individuals with obsessive-compulsive disorder often have depressive symptoms, and patients suffering from recurrent depressive disorder may develop obsessional thoughts during their episodes of depression.

Differential Diagnosis

A differential diagnosis is a systematic diagnostic method used to identify the presence of an entity where multiple alternatives are possible.

Some ordinary behaviours (such as “checking”) are common in the general population but do not reach the level of impairment or distress required for obsessive-compulsive disorder.

Differentiating between obsessive-compulsive disorder and a depressive disorder may be difficult because these two types of symptoms so frequently occur together. In an acute episode of disorder, precedence should be given to the symptoms that developed first; when both types are present but neither

predominates, it is usually best to regard the depression as primary. In chronic disorders the symptoms that most frequently persist in the absence of the other should be given priority.
Occasional panic attacks or mild phobic symptoms are no bar to the diagnosis. However, obsessional symptoms developing in the presence of schizophrenia, Tourette's syndrome, or organic mental disorder should be regarded as part of these conditions.
Although obsessional thoughts and compulsive acts commonly coexist, it is useful to be able to specify one set of symptoms as predominant in some individuals, since they may respond to different treatments.

Predominantly Obsessional Thoughts or Ruminations These may take the form of ideas, mental images, or impulses to act. They are very variable in content but nearly always distressing to the individual. A woman may be tormented, for example, by a fear that she might eventually be unable to resist an impulse to kill the child she loves, or by the obscene or blasphemous and ego-alien quality of a recurrent mental image. Sometimes the ideas are merely futile, involving an endless and quasi-philosophical consideration of imponderable alternatives. This indecisive consideration of alternatives is an important element in many other obsessional ruminations and is often associated with an inability to make trivial but necessary decisions in day-to-day living.
The relationship between obsessional ruminations and depression is particularly close: a diagnosis of obsessive-compulsive disorder should be preferred only if ruminations arise or persist in the absence of a depressive disorder.

Predominantly Compulsive Acts (Obsessional Rituals) The majority of compulsive acts are concerned with cleaning (particularly hand-washing), repeated checking to ensure that a potentially dangerous situation has not been allowed to develop, or orderliness and tidiness. Underlying the overt behaviour is a fear, usually of danger either to or caused by the patient, and the ritual act is an ineffectual or symbolic attempt to avert that danger. Compulsive ritual acts may occupy many hours every day and are sometimes associated with marked indecisiveness and slowness. Overall, they are equally common in the two sexes but hand-washing rituals are more common in women and slowness without repetition is more common in men. Compulsive ritual acts are less closely associated with depression than obsessional thoughts and are more readily amenable to behavioural therapies.

OCDP

Obsessive-compulsive disorder is quite distinct from obsessive-compulsive personality disorder, which is not characterised by obsessions or compulsions and involves a pervasive and lifelong character style rather than a set of symptoms

With OCPD, a person may be generally preoccupied with orderliness, perfectionism and control in virtually every part of his or her life. But rather than be anxious about this, they have no interest in changing—in actual fact they see their behaviour and thoughts as desirable traits.

Some key features of OCD:

Intrusive thoughts/ excessive obsessional ruminations

- May take form of ideas, image or impulse to act
- Variable in content but nearly always distressing
- Sometimes the ideas are merely futile, involving an endless and quasi-philosophical consideration of imponderable alternatives.

Examples include:

- Violent intrusive thoughts

- Religious intrusive thoughts

- Sexual

- Relationship

- Magical thinking

Doubtfulness. Doubt is really at the heart of most OCD.

One of the principle symptoms of OCD is persistent and malignant doubt. (APA 2000)

People with OC tendencies have lost the ‘experience of conviction’ (Shapiro 1965)

There are some sufferers who cannot be sure whether or not they have actually acted in certain ways or performed certain behaviours. In order to be certain, they do things extra slowly so that they can observe themselves. They may also have to perform the same behaviour several times, or break down activities into a series of steps that must be performed the same way each time. There are some who count as they perform an activity, believing that if they finish by the time they reach a particular number, the activity must have been completed. These are all really forms of double-checking, which is the usual response to severe OC doubts. Another aspect of doubtfulness that leads to slowness is the attempt to reach certainty by having to always make "perfect" decisions. This, of course, only leads to further questioning, then to indecision, and so on. The final result looks like a kind of mental paralysis, where the sufferer just stands there, unable to act for long periods of time as they agonizingly go back and forth over.

Pervasive doubts come from deficient ‘feeling of knowing’ Lazarov et al 2010. Furthermore, they suggest that people with OC tendencies have a general deficiency in subjective conviction which leads to seeking and reliance on external proxies to compensate for that behaviour. Their biofeedback relaxation study illustrated that individuals with high OC tendencies performed better on relaxation tasks because of biofeedback monitor acting as external proxy & in study 2 requested monitor.

To use a metaphor by Shapiro, OC individuals can be likened to pilots flying at night, who must rely on flight instruments instead of their own vision. When asked whether they like someone, believe in something or prefer one thing to another; most people usually feel that they ‘know’ the answer. In contrast, OC individuals according to Shapiro, must deduce their answers from external indicators or base them on general rules of norms (Lazarov et al 2010).

Looming vulnerability

Some studies suggest that obsessional thoughts such as a fear of contamination are associated with a cognitive style factor called the *sense of looming vulnerability.* This means that individuals have a tendency to construe dangers as rapidly evolving and advancing

- Threats that seem to be rapidly evolving or advancing towards their dreaded climaxes produce more fear and anxiety than threats that advancing slowly or have a lower growth rate (Riskind et al 1996)

- The nervous system is geared towards detecting changes in things rather than static things (Gibson 1979)

- Riskind et al (1996) study examines the hypothesis that 'freezing' (using mental imagery) or slowing down the rate at which threats can advance therefore blocks this sense of looming vulnerability and can reduce fear and avoidant behaviour in OCD sufferers. In their study, they found that 'Freeze' imagination reduced fear in obsessional individuals however sensitised non- obsessional individuals to possibility of contamination that they had not previously considered.....

The **"just right"** feeling. This is where No one but the sufferer can actually say what this feeling is, and they even usually find it hard to describe, but claim to know it when they experience it. If it just doesn't feel right as they do something, it may have to be repeated over and over again from the beginning until it does. If this feeling must be there in order to begin an activity, the sufferer may have to wait long periods of time before even starting. Clearly either of these can take up a lot of time, making the sufferer very inefficient, and causing everyday activities to drag on for long periods. This is something also commonly seen in those who suffer from Tourette's Syndrome.

- Wahl et al (2008) found that the decision-making process of when to stop compulsion (ie stop washing hands) is down to the use of elevated evidence requirements in OC individuals. These criteria also depend on the perceived personal significance of the situation.

Perfectionism. Perfectionistic behaviour can be caused by a number of different things and is a common time waster in OCD. One symptom that can lead to perfectionism is magical thinking. Some sufferers believe superstitiously that if they do not do certain things in a perfect manner, something bad will happen to themselves or to others. The behaviours that they have to carry out are known as rituals. As they frequently become nervous and doubtful about performing their ritual perfectly, they inevitably make mistakes (or worry that they may have done so), and then they have to do it again. This can lead to many repetitions. If the rituals are mental, the sufferer may look as though they are moving very slowly, even though they are going through a rapid-fire series of repetitive activities in their heads.

- If this 'just right' feeling is not achieved sufferers often feel driven to perform an action/ritual until this uncomfortable sensation is reduced

- Rasmussen & Eisen (1992 p.756) describe their ocd patients as having an 'inner drive that is connected with wish to have things perfect, absolutely certain, or completely under control'

- If this perfection isn't achieved it leads to 'just not right experiences'. Coles et al 2003

Another form of perfectionism involves the **need for closure**. If a sufferer with this problem starts something, they must stay with it or wait around until it is absolutely and completely finished. This can apply to both mental and physical activities. They cannot start or do anything else in the meantime, as this would cause them considerable distraction and discomfort.

Magical thinking

Refers to beliefs that defy culturally accepted laws of causality.

Magical thinking implies that certain thoughts or behaviours exert a causal influence over outcomes, the fear is that even thinking about something bad

will make it more likely to happen - sometimes also called 'thought-action fusion'

- has been argued to be a central feature of OCD (Einstein & Menzies 2004)

Examples include:

- A certain colour or number has good or bad luck associated with it.
- Certain days have good or bad luck associated with them.
- A loved one's death can be predicted.
- One's thoughts can cause disasters to occur.
- Stepping on cracks in the pavement can make bad things happen.
- Whatever comes to mind can come true.
- Breaking chain letters will actually bring bad luck.
- Attending a funeral will bring death.
- One can inadvertently cause harm to others with thoughts or carelessness.
- Hearing the word 'death' will mean repeating the word 'life' to prevent death

Overvalued ideas

'Some OCD sufferers exhibit what is known as overvalued ideas. In such cases, the person with OCD will truly be uncertain whether the fears that cause them to perform their compulsions are irrational or not. After some discussion, it is possible to convince the individual that their fears may be unfounded. It may be more difficult to do ERP therapy on such patients, because they may be, at least initially, unwilling to cooperate. For this reason OCD has often been likened to a disease of pathological doubt, in which the sufferer, while not usually delusional, is often unable to realise fully what sorts of dreaded events are reasonably possible and which are not. There are severe cases when the sufferer has an unshakeable belief within the context of OCD which is difficult to differentiate from psychosis.'

Extract taken from O'Dwyer, Anne-Marie Carter, Obsessive–compulsive disorder and delusions revisited, The British Journal of Psychiatry (2000) 176: 281-284

Insight

Insight is the ability of the individual to accurately understand their own internal world, to objectively view their own behaviour or recognise their own illness and to appropriately speculate about the thoughts and actions of others.

Sadock & Sadock (2000) provide 5 levels of insight.

1. Complete denial of illness
2. Slight awareness of illness and need for help but denial of illness
3. Awareness of illness but blaming others/illness/external factors
4. Intellectual insight (awareness of illness and acknowledgement that symptoms are a result of irrational feelings or thoughts, however this knowledge is not a catalyst for change.
5. True emotional insight (awareness of emotions and underlying meaning of symptoms, as well as readiness for change and welcoming of new ideas and concepts about the self).

Etiology

- **The Brain**

There is a lot of research into which brain region may be activated in OCD sufferers. The amygdala – hippocampus region appears in quite few journal papers however there is no consensus as to whether these regions are definitely part of the cause of the disorder. There is however more general consensus that the following brain regions are involved.

Neuroimaging studies show:

3 brain areas hyperactive at rest relative to healthy control, become increasingly active with symptom provocation & no longer exhibits hyperactivity following SSRIs/CBT (Whiteside et al 2004)

Orbitofrontal cortex

Thalamus

Head of caudate nucleus

The Orbitofrontal cortex is the part of the brain that notices when something is wrong. For example, when the OFC registers that there is dirt nearby, it sends a 'worry' signal to the thalamus (sensory perception & regulation of motor functions).

When the thalamus receives a 'worry' signal, it becomes excited and sends strong signals back through the loop to the OFC, which interprets them. Normally, the head of the caudate nucleus acts like the brake pedal on a car, suppressing the original 'worry' signals sent by the OFC to the thalamus. This prevents the thalamus from becoming hyperactive.

If this occurs, the thalamus sends strong signals back to the OFC, which responds by increasing compulsive behaviour and anxiety. This could explain the repetitive and seemingly senseless rituals performed by obsessive-compulsives.

However, researchers point out that the difference in brain function between ocd and non-ocd subjects does not necessarily mean abnormal functioning, perhaps this could just indicate normal variations. Similarly, what is currently unknown is whether these changes in brain activity are a cause or effect of ocd. For example, these brain changes could be caused by symptoms of ocd such as worry more than the ocd itself.

- **Genetics**

According to the research OCD appears to possess a genetic component however specific genetic mechanisms have not yet been clarified.

Family studies have shown 3-12% of first degree relatives share the diagnosis (Polimeni et al 2005)

However, the theory that OCD is inherited genetically is not conclusive - for example, identical twins will not necessarily both have OCD. So, although the genetics may play a part, they aren't the whole story and learned or environment factors may play a part.

- **Environmental factors**

Parenting styles

- There is widespread acceptance of the idea that aspects of parenting such as overprotectiveness and perfectionism contribute to the pathogenesis of obsessive-compulsive disorder (Aycicegi et al (2002)

- However a controlling parenting style was not associated with onset of OC symptoms but was associated with depressive and anxiety symptoms.

Another paper examining 40 ocd patients v normal controls found OCD patients perceived higher levels of rejection from their fathers

- No diff in group with perceived levels of overprotection

- Hoarding was linked low parental emotional warmth

They suggest parenting style in conjunction with genetic & bio factors may contribute to OCD (Alonso et al 2004)

- Another paper examining 40 ocd patients v normal controls found OCD patients perceived higher levels of rejection from their fathers

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- **Evolution**

OCD can also be seen as portraying a set of adaptive traits that may have been useful to primitive man.

(Polimeni et al 2005)

- OCD could have been advantageous to ancient hunter gathering tribes

- Symptoms such as checking, hoarding or adhering to excessive hygiene could have benefited the entire tribe (to avoid being attacked, starving or contracting diseases)

- The content of most obsessional thoughts, ideas or actions revolves around security or safety of the self or others

- You don't need all the members of the tribe to have these traits

Serotonin

- Researchers have found that two genes (hSERT & SLC1A1) that can affect the transport and reuptake of serotonin between neurons may play a role

- If there are mutations in these two genes then it can result in a lower amount of serotonin available and resulting in more severe symptoms

- Treatment with SSRIs is effective in 40-60% of patients (Abundy et al 2011)

SSRIs

Fluvoxamine (Luvox CR)

Fluoxetine (Prozac)

Paroxetine (Paxil, Pexeva)

Sertraline (Zoloft)

If these are unsuccessful then the following SRI can be used:

Clomipramine (Anafranil) (Tricyclic anti-depressant)

It may produce more side effects as it works on other neurotransmitters as well as serotonin.

Psychological factors

OCD symptoms can be seen as a result of a person developing learned negative thoughts and behaviour patterns, towards previously neutral situations which can result from life experiences.

Many cognitive theorists believe that individuals with OCD have faulty beliefs, and that it is their misinterpretation of intrusive thoughts that leads to OCD.

According to the cognitive model of OCD, everyone experiences intrusive thoughts from time-to-time. However, people with OCD often have an inflated sense of responsibility and misinterpret these thoughts as being very important and significant which could lead to catastrophic consequences.

The repeated misinterpretation of intrusive thoughts leads to the development of the obsessions and because the thoughts are so distressing, the individual engages in compulsive behaviour to try to resist, block, or neutralise the obsessive thoughts.

CBT

CBT aims to help an individual explore and understand alternative ways of thinking and to challenge their beliefs through behavioural exercises.

The central technique for this approach is Exposure and Response Prevention (EX/RP)

- This approach requires the patient to expose him/herself to situations that increase his anxiety (exposure), which as a consequence increases

the urge to compulsively ritualise. He is then asked to refrain from ritualising

- Graded exposure is also used where the sufferer exposes himself in a gradual way

Effectiveness

75% to 85% treated with ERP benefited, only 50% maintained long term functioning at a level consistent with that of non-ocd population. Perreault & O'Connor (2014)

Limitations:

According to (Perreault & O'Connor 2014) approx. 25% of individuals with OCD refused ERP

Furthermore 20% abandoned treatment because it was too anxiety provoking. They also suggest that individuals with certain subtypes (compulsive hoarding, excessive rumination, sexual and religious rumination) respond less well to ERP

Interestingly many NHS trusts limit Psychological therapies to 6-10 sessions, many patients with OCD require 30-40 or more sessions of CBT... (Gournay et al 2006)

Brain Lock Approach

Another cognitive approach is offered by Jeffrey Swartz.

He suggests that in ocd brain gets locked in a loop of perceiving danger and acting accordingly. Through cognitive therapy and SSRIs, the individual can form a new groove in the brain.

He suggests that a four-step approach can be used to treat ocd.

1/ Relabel – recognise that the intrusive obsessive thoughts and urges are the result of OCD

2/ Reattribute – Realise that the intensity and intrusiveness of the thought or urge is CAUSED by OCD; it is probably related to a biochemical imbalance in the brain

3/ Refocus – work around the OCD thoughts by focusing your attention on something else, or at least for a few minutes: DO ANOTHER BEHAVIOUR

4/ Revalue – Do not take the OCD thought at face value. It is not significant in itself.

Solution focused hypnotherapy SFH

From our understanding of SFH we can see it can be enormously helpful for clients with ocd. It can:

- To understand personality and features of ocd

- Help to examine unhelpful thinking and give control back to person

- If as a result of depression or cause of, can help alleviate

- Reducing anxiety will reduce amygdala activity and emotional brain involvement

- To imagine a preferred future, help to facilitate a life beyond ocd

- Miracle question – systematically find solutions in life as well as to reduce symptoms

Initial consultation – to be conducted in the usual way but can include questions related to ocd if you think this may be applicable such as:

- Are you a checker? What do you check? And if you didn't?

- Do you ever experience intrusive thoughts? What sort? When, what do you do?

- Are you over tidy? What would it feel like if you left the washing up for example?

- Do you feel the need for symmetry? E.g. lining things up, when? How often etc.?

- Do you have anxiety over hygiene? What places? What do you need to do? How often etc.

- Anything else?

Explanation of the mind

(See Relating it to the client doc)

- Primitive man

Usual anger, anxiety, depression explanation but to include survival behaviours such as checking, hoarding and hygiene.

Emotional mind features – black and white thinking/ catastrophising etc.

- OCD – key features

Persistent doubt, looming vulnerability, avoidance, intrusive thoughts, magical thinking, just right feeling, perfectionism

Brain chemistry

- Evidence that increasing serotonin decreases ocd symptoms

Other sessions

Not unusual for number of sessions to be in the region of 15-20+

Dual approach

1/To reduce anxiety generally & increase 3 p's as severity and frequency of obsessions/rituals can decrease

2/ Introduce *notion* of ERP to aid in understanding and offer a strategic approach (also graded exposure/hierarchy)

Scaling – happiness

Miracle question – concept of ERP can come out in MQ

Couch – keep it general, perhaps only in latter session make visualisation more specific if need be. Imaginal exposure can have positive benefits but best to focus on a preferred future, a life beyond ocd more than reducing symptoms.