Obsessive Compulsive Disorder

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Password to Access Handouts for SFH for OCD CPD

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What are your objectives?

Don't Reinvent

Perfect It

It’s only a problem…

Overview – Section 1

Section 1 – Diagnosis

- Definition DSM-IV
- Subtypes & manifestations
- Comorbid conditions
- Prevalence
- Key features

Overview – section 2

Section 2 – Etiology

- Brain regions/Genetics
- Adaptive mechanism/ Evolution
- Social/ parenting
- Pharmacological treatment options
- Cognitive model

Overview – Section 3

Section 3 – CBT

- CBT Interventions
- Cognitive model of OCD
- Exposure & response prevention
- Pros & Cons

Overview – section 4

Section 4 – SFH

- SFH & OCD
- SFH & CBT
- SFH, OCD & children
- Case studies

OCD - Definition

Discussion

a) What you think OCD is
b) Common manifestations
c) Impact on life
d) Comorbid conditions

Video from OCD UK

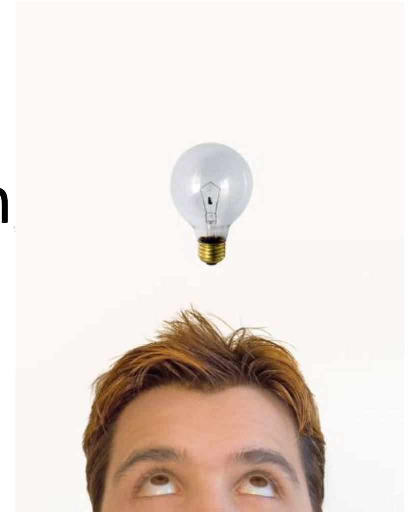
Section 1 – OCD classification

DSM - IV

- A. Either obsessions or compulsions
- B. Recognise excessive/unreasonable (not children)
- C. Cause marked distress, take more than 1 hour a day, significantly interfere with the person's normal routine.
- D. Not related to other disorder if present
- E. Not as a result of drugs/illness/medication

Subtypes

- **There are Five Distinct OCD Types**
- Contamination obsessions with washing/cleaning compulsions
- Harm obsessions with checking compulsions
- Obsessions without visible compulsions or so-called “pure obsessions”:
- Symmetry obsessions with ordering, arranging and countin compulsions
- Hoarding
- Can you think of any examples?



Additional facts:

- 1.2% UK OCD, approx. 741,504 people are living with OCD at any one time
- The ratio of men to women is 1:1, although, the disorder’s onset is reported to occur earlier in men than women.
- 1/3 of all adult sufferers have reported it's 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

Comorbid conditions and spectrum disorders

- **Body Dysmorphic Disorder** (perhaps closest linked)
- **Compulsive Skin Picking-**
- **Tourette Syndrome**
- **Trichotillomania**
- **Eating disorders**
- Pre-occupation with **drugs** – substance use disorders)
- **Hyperchondriasis** (health anxiety/somatoform disorder)
- **Paraphillia**)
- Guilty ruminations – major **depressive disorder**

Associated symptoms

- - Depression (3/4 people with OCD will have depression)
- - Anger
- - Anxiety
- - Panic attacks
- - Phobic avoidance of situations related to obsessions (ie dirt/contamination)

Types of thinking

Can you identify some unhelpful OCD thought patterns/ thinking styles?

Key features – unhelpful thought patterns

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.

Key features – unhelpful thought patterns

Doubtfulness

- One of the principle symptoms of OCD is persistant and malignant doubt. (APA 2000)
- Pervasive doubts come from deficient 'feeling of knowing' Lazarov et al 2010
- Lose the 'experience of conviction' Shapiro 1965 & lack confidence beyond general memory to include decision making and concentration abilities (Nedeljkovic & Kyrios 2007)
- OCD checking may be motivated by the wish to **reduce uncertainty**, but checking appears to be a counter-productive safety strategy. Rather than reducing doubt, checking fosters doubt and ironically increases meta-memory problems. (Van Den Hout 2003)
- - Lazarov et al 2010, people with OC tendencies have general deficiency in subjective conviction which leads to seeking and reliance on external proxies to compensate for that behaviour
- - Lazarov et al 2010 biofeedback relaxation study. High OC performed better on relaxation task because of biofeedback monitor acting as external proxy & in study 2 requested monitor.

Key features – unhelpful thought patterns

Looming vulnerability

- A tendency to construe dangers as rapidly evolving and advancing

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

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

- Riskind study. Freeze imagination reduced fear in obessesional individuals however sensitised non-obessional individuals to possibilty of contamination that they had not previously considered......!

Key features – unhelpful thought patterns

- **The ‘Just right feeling’**

- Sufferers experience anxiety and discomfort if a particular action, motion, or thought doesn't "feel" right in a certain way.
- Using multiple criteria is a general strategy
- 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. This criteria also depends on the perceived personal significance of the situation

Key features – unhelpful thought patterns

Perfectionism

- 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 a 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
- Intolerance of uncertainty linked to OCD & GAD – negative forecasting and compulsions in order to gain control or prevent bad things from happening
- Schienle et al 2010 - worry and IU correlates to amygdala activity in fmri study

Key features – unhelpful thought patterns

Magical thinking

- Refers to beliefs that defy culturally accepted laws of causality.
- 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)

Key features – unhelpful thought patterns

Avoidance

- Common compulsive behaviour, and this is where a person with OCD will go to great lengths to avoid the objects, places or person/people that that they feel triggers their OCD
- **Examples?**

Key features – unhelpful thought patterns

Overvalued ideas

Some Ocd sufferers exhibit ‘overvalued ideas’

- Unsure as to whether fears that cause them to perform compulsion are irrational or not
- May be more difficult to do ERP, may be unwilling to cooperate
- Linked to doubt, sufferer, while not usually delusional, is often unable to realise fully what sorts of dreaded events are reasonably possible and which are not
- Some severe cases more delusional and more closely linked to psychosis

Key features – unhelpful thought patterns

Insight

- Accurately understand own internal world, objectively view own behaviour & recognise own illness

5 levels

1. Complete denial
2. Slight awareness but denial
3. Awareness but blaming others/external factors
4. Intellectual insight but not catalyst for change
5. True emotional insight, readiness for change (Sadock & Sadock 2000)

Safety Behaviours

- Reassurance seeking
- Googling
- Checking
- Avoiding

Graph

Etiology - Brain

Neuroimaging studies show :

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

- Orbitofrontal cortex (area of pfc- cog processing of decision making- sends message when something wrong ie dirt nearby)
- Anterior cingulate cortex (decision making, impulse control)
- Head of caudate nucleus (top of brain stem, goal directed action, memory, learning)

However

- does not necessarily mean abnormal functioning, perhaps normal variations
- don’t know if cause or effect
- could be caused by symptoms of ocd ie worry more than ocd itself

The orbital-frontal cortex (OFC)

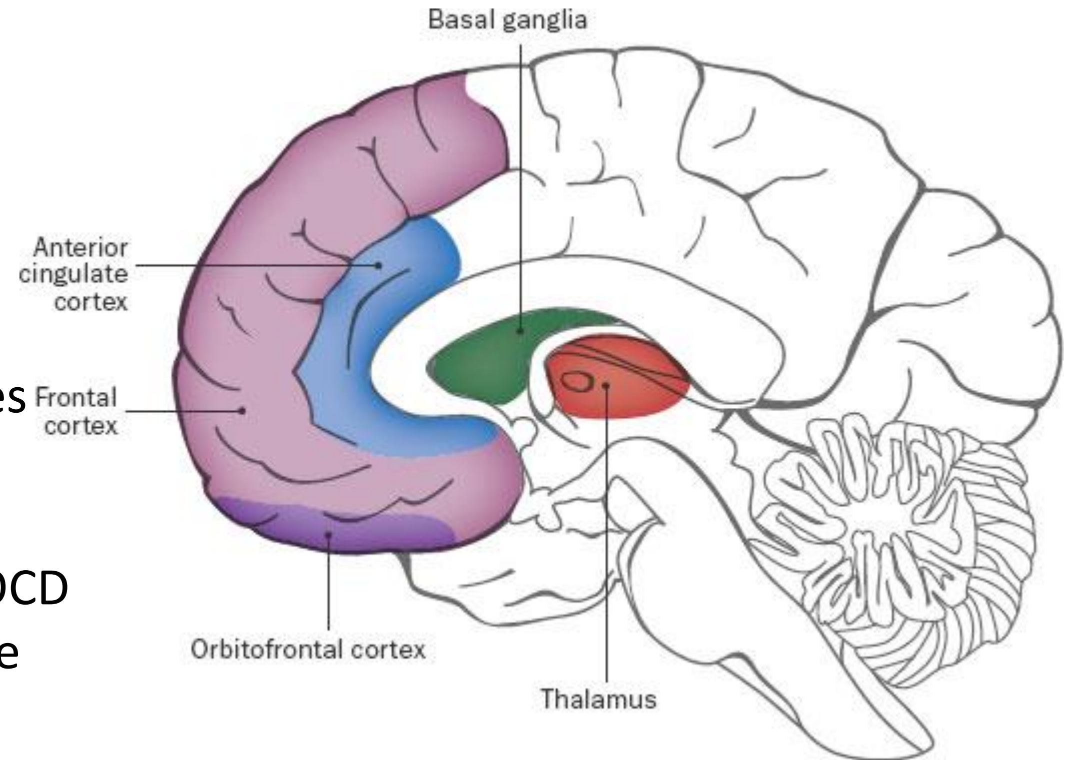
- part of the brain that notices when something is wrong (decision making & expectation)
- Sends a 'worry' signal to the thalamus (sensory perception & regulation of motor functions).

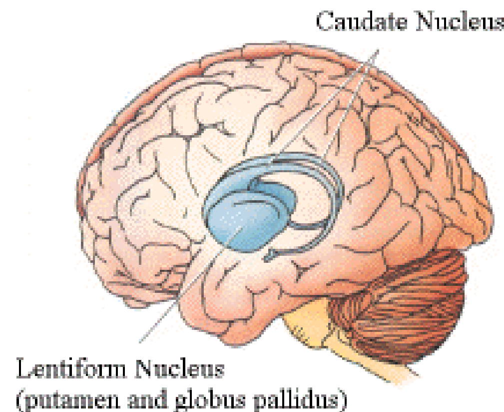
Thalamus

- When thalamus receives a ‘worry signal’ it becomes excited & send a signal back to OFC

Caudate Nucleus

- Normally acts like the brake pedal on a car but in OCD individual's may be faulty so it doesn’t suppress the response from the thalamus (allows thalamus to become over excited) back to the OFC





- 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.

Etiology - Genetics

- OCD appears to possess a genetic component (specific genetic mechanisms have not been clairified)
- 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.

Etiology - 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 syle in conjunction with genetic & bio factors may contribute to OCD (Alonso et al 2004)

Etiology - Evolution

(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 benefitted 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

Etiology - Serotonin

- Two genes (hSERT & SLC1A1) that can affect the transport and reuptake of stn 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)**

Etiology - Psychological factors

- 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 for OCD

A video guide to CBT

This CBT video guide was produced in 2009 by the British Medical Journal Group who have kindly given permission for OCD-UK to broadcast.

The video features Professor Paul Salkovskis, a clinical psychologist and the clinical director at the Centre for Anxiety Disorders and Trauma (CADAT) and Karen Robinson sharing her personal experiences of both OCD and CBT.

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CBT

- The central technique for this approach is Exposure and Response Prevention (EX/RP)
- Requires the patient to expose him/herself to situations that increase his anxiety (exposure) , which as a consquence increases the urge to compulsively ritualise. He is then asked to refrain from ritualising (anxiety graph)
- Graded exposure

Effectiveness

Perreault & O'Connor (2014)

- 75% to 85% treated with ERP benefited, only 50% maintained
- long term functioning at a level consistent with that of non-ocd

population

Limitations

- Approx. 25% individuals with OCD refused ERP
- 20% abandoned treatment because it was too anxiety provoking
- Individuals with certain subtypes (compulsive hoarding, excessive rumination, sexual and religious rumination respond less well to ERP

(Perreault & O’Connor 2014)

- 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)

SFH

Can help OCD sufferers in following ways:

- 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 faciliitate a life beyond ocd
- Miracle question – systematically find solutions in life as well as to reduce symptoms

SFH – Initial consultation

- *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 overtidy? What would it feel like if you left the washing up for example
- Do you feel the need for symmetry? Eg 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?

SFH – Other sessions

Revision part of session

Explain key thinking styles & that they reduce/can be challenged as we reduce anxiety

- Persistent doubt, looming vulnerability, avoidance, intrusive thoughts, magical thinking, just right feeling, perfectionism
- Safety behaviours/draw graph

Dual approach to treating OCD

- 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 (also graded exposure/hierarchy) but not prescriptive as client will do this naturally

Scaling/Miracle question/Couch

SFH

Common questions

Do you use rewind?

What does the client imagine on couch?

Miracle Q, just says “I wouldn’t be....”

Imaginal exposure

Any others?

SFH

Children:

Wizard of oz metaphor

- Everyone jumped to follow his orders, the alternative was simply too frightening consider
- BUT the wizard of OZ was a sham
- Brain sorter: instead of moving bad/useless thoughts into trashcan it goes into save pile
- Its just a glitch, you aren’t crazy/doomed its ocd
- Ocd likes to do magic tricks,eg optical illusions are things that make brain think it is seeing somethig tht isn’t really true

Some tricks are fun, some aren't !

Children cont...

Ocds 1st trick...

- Sound the alarm, your body springs into action

2nd trick...

- The maybe game; “maybe a sparrow flew in when no-one was looking...”
- “maybe a sparrow did a poo on the bathroom floor”
- “maybe i’ll step in it”
- Dad asks you to go and clean teeth, so you must check in bath, cabinet, toilet, check windows etc

3rd trick...

- The disappearing just right feeling
- Ocd makes that just right feeling disappear
- Lots of very clever people have ocd

Have you met your objectives?