Obsessive-Compulsive Disorder: Assessment, diagnosis and treatment

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HOME FOR BALANCE
PSYCHOTHERAPY GROUP LLC

Learning Objectives

Describe	Describe the clinical presentation of Obsessive Compulsive Disorder (OCD), prevalence and symptoms.
Explain	Explain the appropriate steps to complete a clinical evaluation of OCD utilizing proper assessment tools.
Recognize	Recognize evidence-based treatment for OCD, including Cognitive Behavioral Therapy and ERP.

Obsessive-Compulsive disorder (OCD)

- Statistics and prevalence
  - 2.3% of US population
  - 1/40 adults
  - 1/100 Children
  - One of the top 20 causes of illness related disability worldwide (btwn. ages 15 and 44)
  - Prevalence is higher in females, although males have an earlier age at onset than females
  - OCD does not discriminate on age, sex, culture, ethnicity, religion or SES.
  - Regional and culture factors may affect symptom expression

Obsessive-Compulsive disorder (OCD)

- Neurobiological Condition
  - Course is usually chronic, with waxing and waning symptoms
  - Onset in childhood and adolescence can lead to lifelong OCD, with 40% of this population experiencing remission by adulthood
  - First-degree relatives of someone with OCD, are twice as likely to also have OCD than first-degree relatives of those without OCD.

OCD: overview

- “The doubting disease”
- Primary Symptoms:
  - Obsessions, Compulsions
  - Symptoms are time consuming (present for > 1 hour a day), and cause clinically significant distress or impairment in social, occupational or other important areas of functioning.
- Suffering in silence – appropriate treatment is not received for up to 14 years on average from the onset of symptoms. (used to be 17!)
  - Children less likely to identify and verbalize obsessions
- Onset typically: some in childhood (10 years old), others in young adulthood (early 20s), rarely above 35 years of age.
- Associated Symptoms:
  - Anxiety (Fear), Depression, Perfectionism, Magical Thinking, Indecisiveness, “Slowness”

OCD: overview continued

- Obsession: An intrusive, repetitive thought, image, or sensation
  - Its presence brings about distress, disgust, discomfort, fear, guilt etc. (even headaches!) Not just anxiety!

- Compulsion: A physical or mental behavior (ritual) that “neutralizes,” suppresses, or otherwise mitigates an obsession, temporarily
  - Ex: Highly Excessive Cleaning, Washing, Checking, Ordering and Arranging, Asking Questions

DSM 5

- **DSM-5 Categorisation**
  Obsessive-Compulsive Disorder sits under its own category of ***Obsessive-Compulsive and Related Disorders*** and within that the following subcategories were placed:
- Obsessive Compulsive Disorder (OCD)
- Body Dysmorphic Disorder (BDD)
- Hoarding Disorder
- Trichotillomania
- Excoriation (Skin Picking) Disorder
- Substance/Medication-induced Obsessive-Compulsive and related Disorder
- Obsessive-Compulsive and Related Disorder due to another medical condition
- Other specified Obsessive-Compulsive and Related Disorder
- Unspecified Obsessive-Compulsive and Related Disorder

DSM 5 Diagnosis

- **A.** Presence of obsessions, compulsions, or both:
- Obsessions are defined by **(1)** and **(2)**:
  - 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.
  - The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize hem with some other thought or action (i.e., by performing a compulsion).
- Compulsions are defined by **(1)** and **(2)**:
  - Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
  - 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 are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

DSM 5 Diagnosis continued

- **B.** The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- **C.** The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- **D.** The disturbance is not better explained by the symptoms of another mental disorder

Examples of Obsessive Compulsive Disorder

- An individual has intrusive thoughts that they will get a deadly disease and will also cause others to get the disease therefore they will wash their hands in such a way to prevent this when they touch the floor.
- An individual has an intrusive thought that their children may not be safe unless they say a certain phrase throughout the day.
- An individual has an intrusive thought that they might offend God unless they read the bible “enough” times throughout the day.
- An individual has a body sensation of indigestion and they are trying to make it ”just right” by pushing on their stomach

Myths of Obsessive Compulsive Disorder

- People with OCD love doing compulsions
  - There is much distress associated with these behaviors
- People with OCD are very organized
  - “Oh I am so OCD”
- If you do something enough you would get OCD
  - You are either wired for it or you are not
- OCD will go away if you don’t do anything about it
- People with OCD can’t function in the world
  - Pandemic studies showed people with OCD who **had been in treatment** were very resilient
  - They knew what is was like to deal with uncertainty, and feel the fear and do it anyways

Co-Morbidities to be aware of

- Anxiety disorders: 76%
- Eating and Feeding disorders: 41% of individuals with eating disorders have OCD
- Autism Spectrum Disorders: 17% of people with ASD also have OCD
- Obsessive Compulsive Personality Disoder: 23-32%
- Tic Disorders: 30%
- Mood Disorder: 63%
  - Suicide attempts are reported in up to ¼ of individuals with OCD
  - Comorbid MDD (41%) increases the risk of suicide attempts.

Key Components of Treatment

- Proper diagnosis (YBOCS, CYBOCS)
- Cognitive Behavioral Therapy (CBT) – Exposure and Response Prevention (Gold Standard.)
- SSRI Medication
- Identify comorbid conditions
- Compulsions, avoidances, reassurances all **reinforce OCD**
  - How to validate yet not reassure your patients
- Explore and diminish family accommodation
- Consistency and accountability
- Family therapy
  - Behavioral interventions and contingency management

Goals of treatment

- Increase tolerance for uncertainty
- Increase ability to function
- Decrease reassurance seeking
- Develop more values driven behaviors
- Improve psychosocial functioning
- Not about proving something as more or less likely.

Individuals with OCD

- Experience guilt, shame, embarrassment; low self-worth
- Suffer in their psychosocial functioning
- Isolate, avoid and seek reassurance
- Experience excessive doubt
- Ask others to do things for them
- Engage others in their symptoms
- Focus on small or irrelevant details
- Are often late, or procrastinate, also get “stuck”

Providing Reassurance

- Reassurance is a compulsion done in hopes of reducing anxiety and distress
- OCD demands constant reassurance from others
- Providing reassurance creates short term relief, but in the long term it is harmful for the individual because the reassurance received is never enough
- OCD is insatiable and there is always “what if” that comes up following being reassured
- OCD is like a never ending marathon; you keep running to get to an end point that never happens and exhausts you in the process

Validating without Reassuring

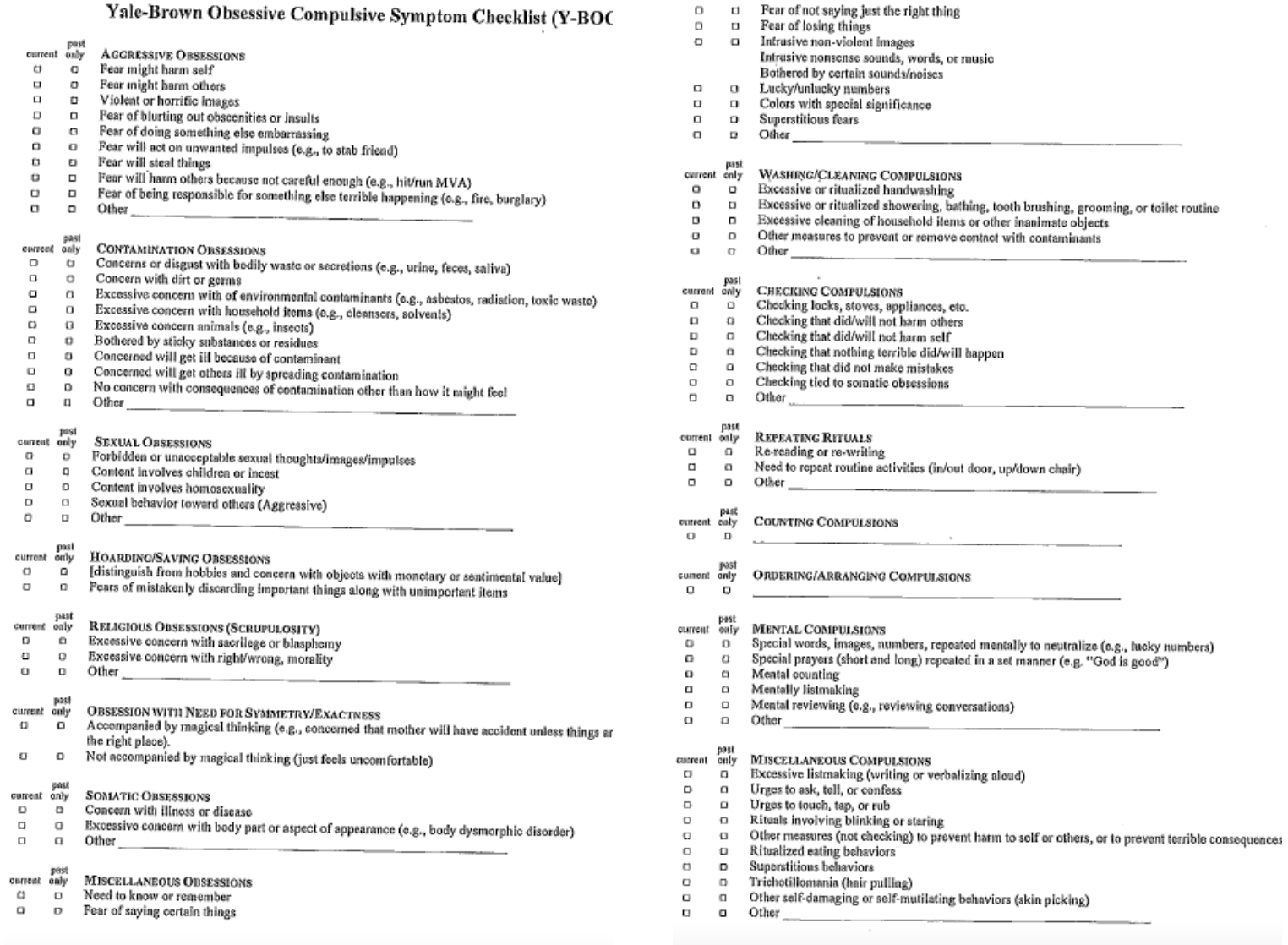
- Let them know you understand this work is hard
- Let your client know you see their strengths in tolerating uncertainty
- Exposure work is going to feel distressing
- “I hear you that this experience is overwhelming.”
- “I understand it feels very distressing for you.”
- “You are being resilient in facing your fears.”

- The keys is not to fall into stating what might reinforce their need to engage in compulsions, such as “everything will be alright”

Moving on to Assessment …

- YBOCS : Yale Brown Obsessive Compulsive Symptom Checklist
- CYBOCS: For Children under 18.
- The Family Accommodation Scale (FAS) Measures accommodation of OCD symptoms by family members. It is a **13-item, five-point Likert scale** that assesses the degree to which family members accommodate the patient's rituals over the preceding month. It has two core dimensions: 'participation' in rituals and 'modification' of daily routines (items 1–9).

Assessment: (YBOCS)



Yale-Brown Obsessive Compulsive Symptom Checklist (Y-BOC

current	past only	
		AGGRESSIVE OBSESSIONS
☐	☐	Fear might harm self
☐	☐	Fear might harm others
☐	☐	Violent or horrific images
☐	☐	Fear of blurting out obscenities or insults
☐	☐	Fear of doing something else embarrassing
☐	☐	Fear will act on unwanted impulses (e.g., to stab friend)
☐	☐	Fear will steal things
☐	☐	Fear will harm others because not careful enough (e.g., hit/run MVA)
☐	☐	Fear of being responsible for something else terrible happening (e.g., fire, burglary)
☐	☐	Other _____

current	past only	
		CONTAMINATION OBSESSIONS
☐	☐	Concerns or disgust with bodily waste or secretions (e.g., urine, feces, saliva)
☐	☐	Concern with dirt or germs
☐	☐	Excessive concern with of environmental contaminants (e.g., asbestos, radiation, toxic waste)
☐	☐	Excessive concern with household items (e.g., cleansers, solvents)
☐	☐	Excessive concern animals (e.g., insects)
☐	☐	Bothered by sticky substances or residues
☐	☐	Concerned will get ill because of contaminant
☐	☐	Concerned will get others ill by spreading contamination
☐	☐	No concern with consequences of contamination other than how it might feel
☐	☐	Other _____

current	past only	
		SEXUAL OBSESSIONS
☐	☐	Forbidden or unacceptable sexual thoughts/images/impulses
☐	☐	Content involves children or incest
☐	☐	Content involves homosexuality
☐	☐	Sexual behavior toward others (Aggressive)
☐	☐	Other _____

current	past only	
		HOARDING/SAVING OBSESSIONS
☐	☐	[distinguish from hobbies and concern with objects with monetary or sentimental value]
☐	☐	Fears of mistakenly discarding important things along with unimportant items

current	past only	
		RELIGIOUS OBSESSIONS (SCRUPULOSITY)
☐	☐	Excessive concern with sacrilege or blasphemy
☐	☐	Excessive concern with right/wrong, morality
☐	☐	Other _____

current	past only	
		OBSESSION WITH NEED FOR SYMMETRY/EXACTNESS
☐	☐	Accompanied by magical thinking (e.g., concerned that mother will have accident unless things ar the right place).
☐	☐	Not accompanied by magical thinking (just feels uncomfortable)

current	past only	
		SOMATIC OBSESSIONS
☐	☐	Concern with illness or disease
☐	☐	Excessive concern with body part or aspect of appearance (e.g., body dysmorphic disorder)
☐	☐	Other _____

current	past only	
		MISCELLANEOUS OBSESSIONS
☐	☐	Need to know or remember
☐	☐	Fear of saying certain things
☐	☐	Fear of not saying just the right thing
☐	☐	Fear of losing things
☐	☐	Intrusive non-violent images
		Intrusive nonsense sounds, words, or music
		Bothered by certain sounds/noises
☐	☐	Lucky/unlucky numbers
☐	☐	Colors with special significance
☐	☐	Superstitious fears
☐	☐	Other _____

current	past only	
		WASHING/CLEANING COMPULSIONS
☐	☐	Excessive or ritualized handwashing
☐	☐	Excessive or ritualized showering, bathing, tooth brushing, grooming, or toilet routine
☐	☐	Excessive cleaning of household items or other inanimate objects
☐	☐	Other measures to prevent or remove contact with contaminants
☐	☐	Other _____

current	past only	
		CHECKING COMPULSIONS
☐	☐	Checking locks, stoves, appliances, etc.
☐	☐	Checking that did/will not harm others
☐	☐	Checking that did/will not harm self
☐	☐	Checking that nothing terrible did/will happen
☐	☐	Checking that did not make mistakes
☐	☐	Checking tied to somatic obsessions
☐	☐	Other _____

current	past only	
		REPEATING RITUALS
☐	☐	Re-reading or re-writing
☐	☐	Need to repeat routine activities (in/out door, up/down chair)
☐	☐	Other _____

current	past only	
		COUNTING COMPULSIONS
☐	☐	_____

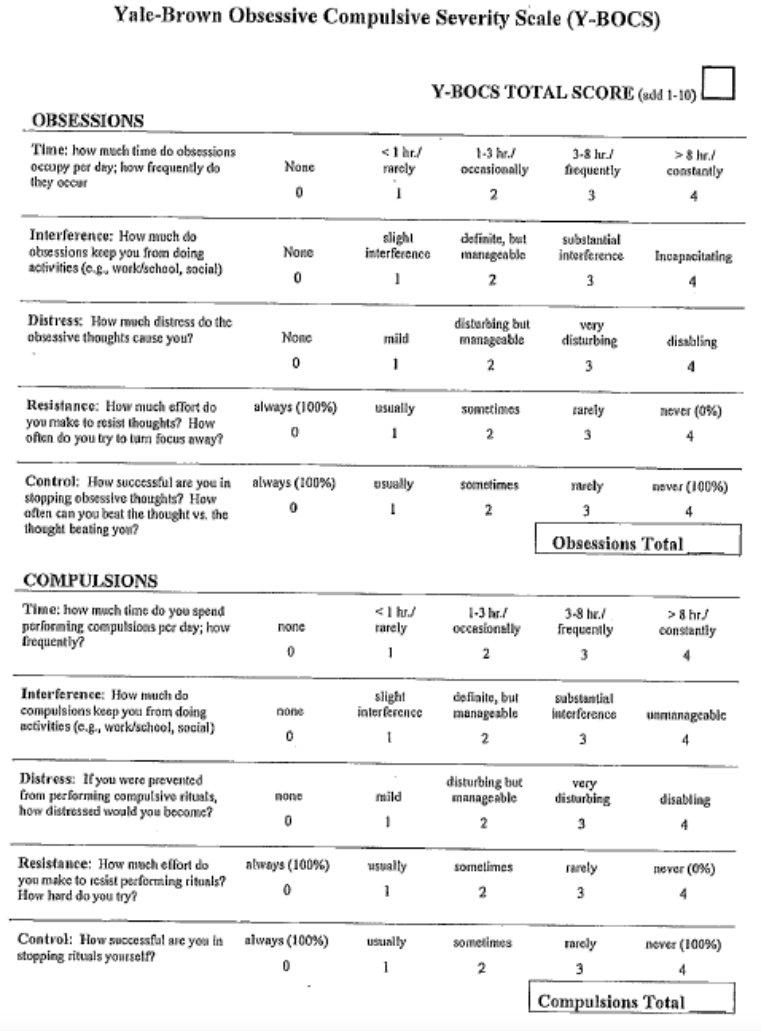
current	past only	
		ORDERING/ARRANGING COMPULSIONS
☐	☐	_____

current	past only	
		MENTAL COMPULSIONS
☐	☐	Special words, images, numbers, repeated mentally to neutralize (e.g., lucky numbers)
☐	☐	Special prayers (short and long) repeated in a set manner (e.g. "God is good")
☐	☐	Mental counting
☐	☐	Mentally listmaking
☐	☐	Mental reviewing (e.g., reviewing conversations)
☐	☐	Other _____

current	past only	
		MISCELLANEOUS COMPULSIONS
☐	☐	Excessive listmaking (writing or verbalizing aloud)
☐	☐	Urges to ask, tell, or confess
☐	☐	Urges to touch, tap, or rub
☐	☐	Rituals involving blinking or staring
☐	☐	Other measures (not checking) to prevent harm to self or others, or to prevent terrible consequences
☐	☐	Ritualized eating behaviors
☐	☐	Superstitious behaviors
☐	☐	Trichotillomania (hair pulling)
☐	☐	Other self-damaging or self-mutilating behaviors (skin picking)
☐	☐	Other _____

YBOCS: Continued

- **8-15 = Mild OCD**
- **16-23 = Moderate OCD**
- **24-31= Severe OCD**
- **32-40 = Extreme OCD**



Yale-Brown Obsessive Compulsive Severity Scale (Y-BOCS)

Y-BOCS TOTAL SCORE (add 1-10) ☐

OBSESSIONS

Time: how much time do obsessions occupy per day; how frequently do they occur	None 0	< 1 hr./ rarely 1	1-3 hr./ occasionally 2	3-8 hr./ frequently 3	> 8 hr./ constantly 4
Interference: How much do obsessions keep you from doing activities (e.g., work/school, social)	None 0	slight interference 1	definite, but manageable 2	substantial interference 3	Incapacitating 4
Distress: How much distress do the obsessive thoughts cause you?	None 0	mild 1	disturbing but manageable 2	very disturbing 3	disabling 4
Resistance: How much effort do you make to resist thoughts? How often do you try to turn focus away?	always (100%) 0	usually 1	sometimes 2	rarely 3	never (0%) 4
Control: How successful are you in stopping obsessive thoughts? How often can you beat the thought vs. the thought beating you?	always (100%) 0	usually 1	sometimes 2	rarely 3	never (100%) 4

Obsessions Total ☐

COMPULSIONS

Time: how much time do you spend performing compulsions per day; how frequently?	none 0	< 1 hr./ rarely 1	1-3 hr./ occasionally 2	3-8 hr./ frequently 3	> 8 hr./ constantly 4
Interference: How much do compulsions keep you from doing activities (e.g., work/school, social)	none 0	slight interference 1	definite, but manageable 2	substantial interference 3	unmanageable 4
Distress: If you were prevented from performing compulsive rituals, how distressed would you become?	none 0	mild 1	disturbing but manageable 2	very disturbing 3	disabling 4
Resistance: How much effort do you make to resist performing rituals? How hard do you try?	always (100%) 0	usually 1	sometimes 2	rarely 3	never (0%) 4
Control: How successful are you in stopping rituals yourself?	always (100%) 0	usually 1	sometimes 2	rarely 3	never (100%) 4

Compulsions Total ☐

Common themes in OCD

✓ No two presentations are the same (heterogeneity)

- Harm
- Contamination
- Sexual
- Scrupulosity
- “Just right”
- Need for symmetry and/or exactness
- Somatic – concerns for illness or disease,
- Relationship

What is the theme?

- Case study 1:

Tom is a 21 year old male. His family is Christian and he enjoys going to spiritual groups. Tom worries about sinning and that he might have caused hard to others. He explained that in his body he feels he is not connected to God during these times and he needs to make it right. Tom will pace for hours praying in such a way to feel in his body that he is right with God once again.

What is the theme?

- Case study 2:

Claire is a 30 year old woman, teacher at a public school. She is very careful about where she keeps her supplies and avoids touching anything that fell on the floor. She keeps her shoes at her doorstep at home. Claire also avoids eating meats, more specifically chicken.

What is the theme?

- Case study 3:

Brian is a 40 year old man, project manager at a local theater. Brian has begun taking his temperature multiple times a day, and has visited the urgent care 3 times last week. Brian is convinced that there is something wrong with him and even worries he might have a psychotic break. He constantly visits WebMD and asks his wife if it is normal when his stomach hurts.

Functional Analysis: Identifying the core fear

- The A – B – C in OCD
  - Antecedent (intrusive thought, sensation etc.)
  - Behavior (Compulsion, ritual etc.)
  - Consequence (Avoidance, relief etc.)

- Helps determine what the purpose of the behavior is

- Ex: Washing to relieve contamination vs. Washing until it feels just right vs. Washing because if it's dirty they are immoral vs. Washing because their mom otherwise would die…..etc.

Cognitive Errors In OCD: A framework

- **Intolerance of Uncertainty:** Need of absolute certainty; Any hint of doubt or ambiguity is intolerable. **This is the core distortion of OCD**.
- **Overestimation of Threat/Underestimation of Ability to Cope:** "Everything is dangerous and I won't be able to handle it."
- **Overestimation of Responsibility:** Feel 100% responsible for harmful consequences because of thinking about them; Failure to prevent (or failure to try to prevent) harm equals causing harm.

Cognitive Errors In OCD: A framework cont.

- **Significance of Thoughts:** Believing negative obsessional thoughts are **overly important** or very meaningful.
- **Thought-Action Fusion (TAF):** Thinking about an action becomes equivalent to actually carrying out that action.
  - **Moral Thought-Action Fusion:** You believe that your unwanted thoughts are morally equivalent to performing a terrible action.
  - **Likelihood Thought-Action Fusion:** You believe that thinking certain thoughts increases the chance that something terrible will happen.
  - Some people worry they will act on their unwanted thoughts unless the thoughts are suppressed

Cognitive Errors In OCD: A framework cont.

- **Need to Control Thoughts**: Beliefs about the significance of thoughts lead you to feel the need to control your obsessional thoughts (and actions). You worry that if you don't control (or try to control) unwanted thoughts, something terrible could happen that you could have prevented. Some people worry they will act on their unwanted thoughts unless the thoughts are suppressed.
- **Intolerance of Anxiety:** You feel that anxiety or discomfort will persist forever unless you do something to escape. Sometimes the fear is that the anxiety or emotional discomfort will spiral out of control or lead to "going crazy," losing control, or other harmful consequences.

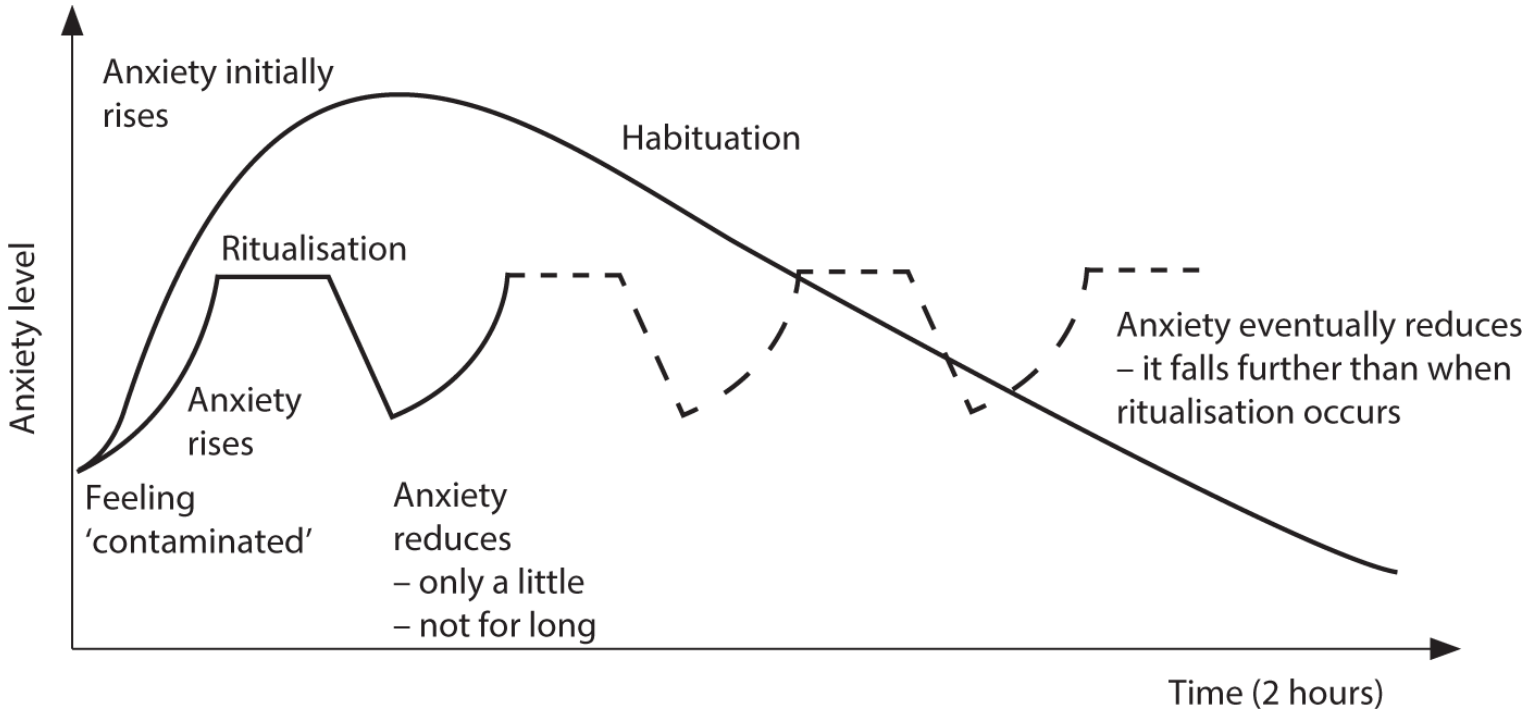
Cognitive Errors In OCD: A framework cont.

- **The “Just Right” Error (Perfectionism):** You feel that things must be “just right” or perfect in order to be comfortable. A related belief is the feeling that things need to be “evened out” or symmetrical or else you will always feel uncomfortable.
- **Emotional reasoning:** You assume that danger is present based simply on the fact that you are feeling anxious.

Treatment Philosophies: Habituation

Habituation:

The diminishing of a physiological or emotional response to a frequently repeated stimulus.



Habituation Model

- Like jumping into a cold swimming pool !
- Getting used to the otherwise avoided stimuli, eventually anxiety and distress are lower
- Goal is anxiety reduction and the body getting used to the stimuli

Challenges of this model:

- Hyper-focus on the reduction of anxiety
- Not always happens
    - Disgust response

Treatment Philosophies: Inhibitory Learning

- Research has shown is that ERP does not cause an obsessional fear to be “unlearned” or “erased.”
- Instead successful exposure a feared stimuli has both the original obsessional fear response and a new more adaptable meaning. (Car is dangerous; Car is generally safe)
- New adaptable meaning is strong enough to **INHIBIT** the previous obsessional meaning

Using inhibitory learning in treatment

- Focusing on anxiety **tolerance** versus diminishing anxiety
  - Not something we need to get rid of
  - Changing the meaning – not dangerous

- Disconfirming expectations
  - What actually happened? Vs. What did they expect will happen?
    - Actual outcome vs. Feared outcome
    - Unable to experience it (anxiety, uncertainty, body sensations) vs. being able to experience them
  - Teaches them they can live through this experience **without** the need of avoidance, reassurance, checking or other compulsions

The therapeutic relationship: An art form

- Collaborative
- Certain level of trust
- Willingness – look at your own resistance
- Ability to adapt
- Creativity – think outside the therapy office
- Placing the right pressure
- Practice and skill

Building a Hierarchy

Exposure Hierarchy

Create a list of anxiety-producing situations, beginning with the *most* distressing, and ending with the *least* distressing. Rank how distressing each item is on a scale of 1 to 10.

Anxiety, Obsession, or Compulsion Trigger	Distress Level (1 – 10)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Building a Hierarchy

Ask about a “1”	What is something that you didn’t think you could do, but you were able to do?
Ask about a “10”	What is something that you don’t think you would ever want to do/ be able to do?
Ask about a “5”	What would be something that could be challenging but you would be willing to try?

Considerations for Exposure Practice

- Gradual
  - SUDS (starting with lower items on the scale, meeting them where they are at)
- Prolonged
  - Not rushing them, or ending them early
- Frequency – and consistency
  - Scheduled or spontaneous
- For the person to initiate or create their own
  - Exposures should not be passive
  - The client must have an active role
- Variety
  - Practicing around different settings, circumstances, interpersonal contexts

Assign Exposure Homework

Exposure Homework Form

Situation to practice: _____

_____

Record Keeping
Record how difficult it was to complete the exercise each day of the week.

1 2 3 4 5 6 7 8 9 10
Very Easy — Moderate — Very Difficult

Mon.	Tue.	Wed.	Thu.	Fri.	Sat.	Sun.

Notes
Record any challenges that you encounter, or any comments about the process.

_____

_____

_____

_____

Challenges in ERP Practice

- “I don’t want to do that”
  - “Are you willing to try?”
  - “Can you take a step towards this?”
  - Revisiting the difficulty levels
  - Check in with their values – “Why would you bother? Why do it? What are you missing out of, or giving up because of OCD?”
- When an exposure backfires
  - Maybe it was too difficult
  - Make sure we are never promising that nothing bad WILL happen- its about learning that they CAN tolerate thing even if there is a bad outcome
- Misunderstanding the core fear
  - Is superficial
  - Not relevant

Thank you so much!

Questions?

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