Assessment and Treatment of Obsessive Compulsive Disorder

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SAMHSA
Substance Abuse and Mental Health Services Administration

Mountain Plains (HHS Region 8)
MHTTC Mental Health Technology Transfer Center Network
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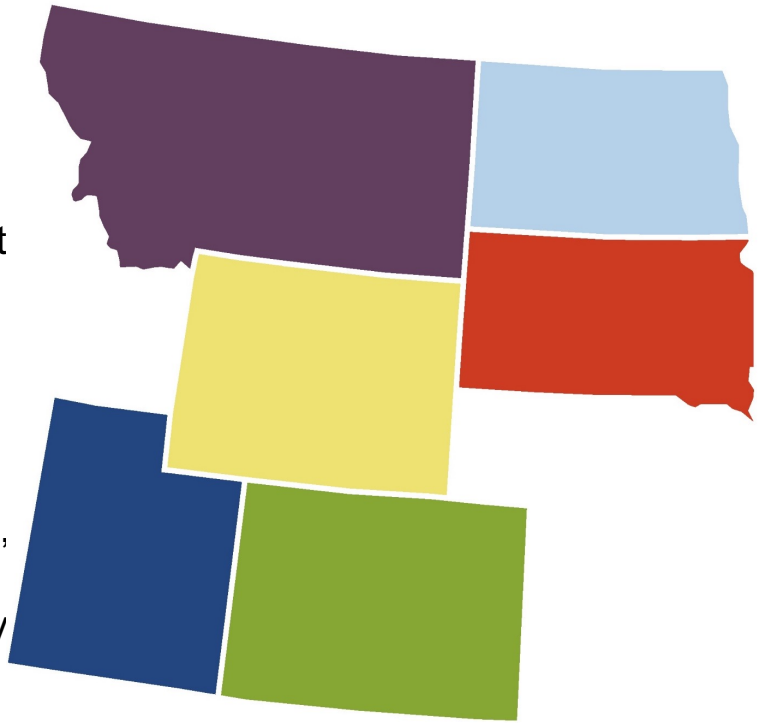
The Mountain Plains Mental Health Technology Transfer Center

The Mountain Plains Mental Health Technology Transfer Center (Mountain Plains MHTTC) provides training and technical assistance to individuals who serve persons with mental health concerns throughout Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming).

We belong to the Technology Transfer Center (TTC) Network, a national network of training and technical assistance centers serving the needs of mental health, substance use and prevention providers. The work of the TTC Network is under a cooperative agreement by the Substance Abuse and Mental Health Service Administration (SAMHSA).



Land Acknowledgement Statement

Today, the University of North Dakota rests on the ancestral lands of the Pembina and Red Lake Bands of Ojibwe and the Dakota Oyate - presently existing as composite parts of the Red Lake, Turtle Mountain, White Earth Bands, and the Dakota Tribes of Minnesota and North Dakota. We acknowledge the people who resided here for generations and recognize that the spirit of the Ojibwe and Oyate people permeates this land. As a university community, we will continue to build upon our relations with the First Nations of the State of North Dakota - the Mandan, Hidatsa, and Arikara Nation, Sisseton-Wahpeton Oyate Nation, Spirit Lake Nation, Standing Rock Sioux Tribe, and Turtle Mountain Band of Chippewa Indians.

The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- Strengths-based and hopeful
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Healing-centered and trauma-responsive
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

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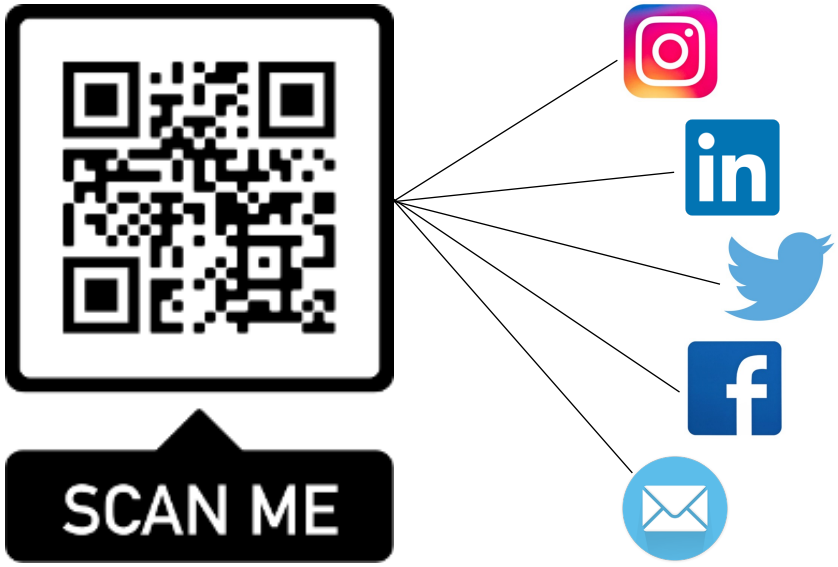

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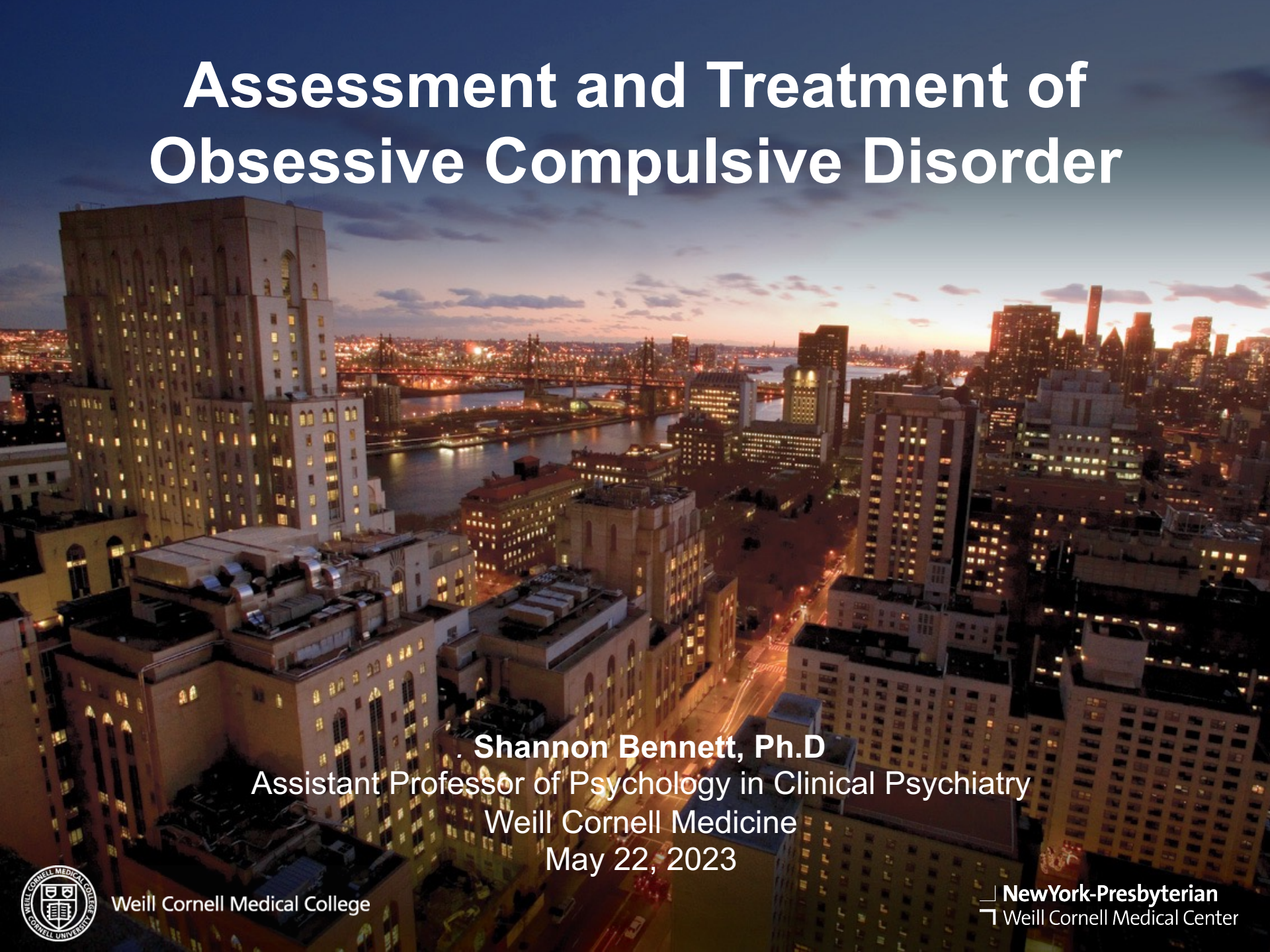

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Overview

- Phenomenology of OCD
- Clinical examples
- Behavioral Treatment Approach
- Empirical Support for Combined Treatment
- Pharmacological Approaches

Obsessions

- Recurrent and persistent thoughts, impulses, or images.
  - Intrusive and/or inappropriate
  - Cause **marked anxiety or distress**.
  - Attempts to ignore, suppress, or neutralize.
  - Recognized by patient as a product of his/her own mind

Compulsions

- Repetitive Behaviors or Mental Acts
  - Driven to perform.
    - Response to an obsession.
    - According to rigid rules aimed at:
      - Preventing or reducing distress.

        OR
      - Preventing some dreaded event or situation.
  - Not realistically linked to what they are designed to prevent OR are clearly excessive.

Subtypes of OCD

- Pure Obsessions
- Contamination
- Symmetry/Order
- Hoarding
- Aggressive/Sexual

Pediatric OCD Phenotype

- Independent of gender or age of onset
- Limited insight
- Compulsions without well-defined obsessions
- Waxing and waning pattern
- Multiple obsessions and compulsions
- Symptoms evolve over time/development
- Parental involvement in rituals

Epidemiology of OCD

- Incidence: 2 peaks [Geller, et al., 1998]
  - Preadolescent children.
  - Early adult life (mean age = 21).
- Prevalence: 1-2% (pediatric OCD)
- In adults, 12-month prevalence is 1.0% and lifetime prevalence is 1.6% [Kessler et al., 2005]

Assessment

- Yale Brown Obsessive Compulsive Scale (YBOCS; Goodman et al.)
- Child YBOCS (CYBOCS; Scahill et al.)
  - Interview for symptom screening & severity measures

- Self Report Questionnaires
  - Compulsive Activities Checklist (Grayson)
  - Obsessive Compulsive Inventory (Foa et al)
  - Childrens OCD Impact Scale (Piacentini et al)
  - Family Accommodation Scale (Pinto et al.)

CYBOCS/YBOCS Symptom Inventory

- Compulsions
  - Washing/cleaning
  - Checking
  - Repeating
  - Counting
  - Ordering/arranging
  - Hoarding
  - Superstitious behavior
  - Rituals involving others
- Obsessions
  - Contamination
  - Aggressive
  - Sexual
  - Hoarding
  - Magical
  - Somatic
  - Scrupulosity/religious

CY/YBOCS Severity Items

- Time Spent 1-5
- Interference 1-5
- Distress 1-5
- Resistance 1-5
- Control 1-5

Comorbidity in Adult OCD

- 90% of individuals with OCD meet criteria for another lifetime DSM-IV disorder
  - Anxiety Disorders: 75.8%
  - Mood Disorders: 63.3%
  - Impulse Control Disorders: 55.9%
  - Substance Use Disorders: 38.6%

Ruscio et al (2010). The Epidemiology of Obsessive Compulsive Disorder in the National Comorbidity Survey Replication. *Mol Psychiatry, 15*, 53-64.

Comorbidity in Pediatric OCD

- Comorbidity is the norm
  - Mood disorders: 31%.
  - Anxiety disorders: 31%.
  - Disruptive behavior disorders: 25%.
  - Tic disorders/Tourette's Disorder: 21%.
  - Speech/specific developmental disorders: 18%.
  - Enuresis: 17%.
  - Pervasive Developmental Disorder (PDD): 5%.

OCD Treatment Overview

- Mild to moderate cases: Cognitive Behavioral Therapy (CBT) is first-line treatment
- Consider using medication with:
  - Severe OCD
  - Concurrent psychopathology
  - Lack of family cohesion
  - Poor insight
  - Lack of skilled CBT practitioners
  - Any situation that could impede the successful delivery of CBT

Case Example

K was a 10 year old, Caucasian female with an intense fear of becoming sick and vomiting, which led to a number of compulsive rituals and extreme avoidance of touching anything that might put her at risk of contracting germs. In addition, she involved her parents, especially her mother in long cleaning rituals and became extremely upset if she touched anything that might be germy. She refused to leave the building after one session, spending 45 minutes screaming in the waiting room because she did not want her mother to touch the doorknob in order to leave the building.

Case Example

P was a 13 year old Filipino male who came to the United States for the summer to attend a math enrichment program and to participate in intensive CBT for OCD and Hoarding. He came to the US with two suitcases: one containing his clothing for the trip, and the other he brought empty to fill with the things he would collect or purchase on his trip. After two weeks it was filled with items that others would consider garbage, in addition to trinkets and souvenirs.

Case Example

R was a 16 year old, Indian male with a presenting for hospitalization because he had stopped speaking, walking, eating, toileting, and appeared catatonic. His mother reported a gradual deterioration in functioning that began with obsessional slowness. R had begun doing everything slowly due to an obsession that if he was not "careful" then something bad would happen. This progressed until he was not functional.

Case Example

- M was a 27 yo Pakistani male presenting with distressing thoughts about contamination, specifically being poisoned by certain cleaning products and taking on undesirable characteristics of certain others if he were to inhale their breath. As a result he engaged in excessive washing of his hands and face, difficulty maintaining conversations and would not eat in places where he did not know what cleaning products were used.

CBT for OCD

- Exposure and Response Prevention (ERP)
  - Relies on finding that one typically habituates to the experience of anxiety with sufficient duration of contact with a feared stimulus
  - Repeated exposure
    - Decreased anxiety across exposure trials
    - Improved distress tolerence
  - Adequate exposure depends on response prevention
    - Blocking the negative reinforcement effect of rituals or avoidance behavior.
  - Gradual exposure

ERP Principles

- Psychoeducation
  - Starting from the assessment
  - Negative reinforcement cycle
  - "It's only a false alarm"
  - Neurobiology of OCD
  - Externalize OCD
  - Normalize anxiety symptoms
  - Discuss role of family/partner
  - Describe ERP process and rationale

Cognitive Therapy Strategies

- Cognitive Reappraisal or "detective thinking" (kids)
- Evaluate evidence for or against fears
  - Probability, another persons perspective, facts, past experiences, What's the worst?
    - Kids and adults with limited insight may not believe the evidence
- Sometimes general is better
  - "this is just my OCD talking"

Exposure and Response Prevention

- Exposure and Response Prevention
  - Hieracrchy
    - Imaginal exposure
    - In office exposure
    - Real world exposure**
  - Start with mild problems to build confidence and teach skills

Exposure

- Exposures done in session should be repeated at home frequently
  - Tracking habituation curve if possible
- Repetition and variety in exposures will assist with generalization of gains
- Include reward system for kids
- Watch for how behavior change will be accepted in the family

Exposure examples

- In-office exposure practices
  - Internet
  - YouTube
  - Touching doorknobs, light switch, railings
  - Breaking “number” rituals/doing something the “wrong” number of times
  - Reading/Writing practices
  - Bathroom exposures
  - Talk with others around the office
  - ***Therapist Modeling***

Case Examples: Exposures

- Exposures for K (Zoloft 100mg, Risperidone 2mg)
  - Pictures/videos of vomit, touching doorknobs etc, mom touching things without washing, decrease the number of times K washed, being around other kids, vomit soup, water fountain, taking shoes off…
- Exposures for P (Prozac 60mg)
  - Leaving something from the suitcase over night, throwing things away, resisting acquiring new items, having money in his pocket and not spending it, discussing the meaning of the items and of loss…

Case Examples: Exposures

- Exposures for R (Zoloft 200mg+)
  - Listening to reading about OCD, hand over hand feeding, writing words, saying words, taking steps, walking, running, independent toileting and ADLs, school work, reading and writing....
- Exposures for M (Lexapro 30mg)
  - See Exposure Hierarchy

Exposure Hierarchy for M

Week	0	2	4	6	8	10	12
1. *Inhaling someone else's breath who I don't like*	10	10	9	8	8	6	4
2. *Eating off of plates, table, or silverware cleaned by unknown products*	9	8	8	7	7	4	3
3. *Conversation with someone I don't like without washing my face/hands*	9	9	8	8	5	6	5
4. *Shower for less than 30 minutes in the evening*	8	8	6	6	5	4	2
5. *Not washing my face/hands after a conversation with someone I like*	7	7	6	5	4	3	2
6. *Cleaning with non-organic cleaning products*	7	6	5	5	4	4	4
7. *Not washing my hands and feet after cleaning the shower*	5	5	5	4	2	2	1
8. *Not rinsing off the shower before getting into it*	5	6	5	4	2	0	0
9. *Eating at a new restaurant*	4	5	5	4	3	2	2
10. *Eating food in someone else's home*	4	4	3	3	2	1	0
11. *Shower for less than 30 minutes in the morning*	3	3	2	2	1	0	0

Function-based Interventions

- Assess and address antecedents and consequences of OCD symptoms
  - Provoking experiences
  - Social and psychological consequences
    - Positive reinforcement
      - Internally and externally rewarded
    - Negative reinforcement
      - Reduce internal distress and escape external demand

Types of Reinforcement

	Positive Reinforcement	**Negative Reinforcement**
Internally Reinforcing	Provides gratification	Relieves distress
Externally Reinforcing	Attention and support	Avoidance

Types of Reinforcement and Related Treatment Options

	Positive Reinforcement	Negative Reinforcement
Internally Reinforcing	Provides gratification (**Consequences, raise the cost**)	Relieves distress (**ERP**)
Externally Reinforcing	Attention and support **(Redirect parents and others)**	Avoidance **(Re-engage, not escape)**

Functional Assessment

- K - 10 year old girl vomiting
  - Gratification from symptom (Int +)
    - Perfectionism – academic and athletic
    - Highly valued – no insight
  - Attending to the symptom (Ext +)
    - Washing their own feet before coming in the house
    - Changes in cooking and cleaning
  - Escape functions (Ext -)
    - Not attending school
    - Worsening symptoms in the face of expectations
- P – 13 year old with hoarding
  - Gratification from symptom (Int +)
    - Collections had personal value
    - Some items had sentimental value
  - Attending to the symptom (Ext +)
    - Parents paid for things
    - Parents bought the suitcase
  - Escape function (Ext -)
    - Normal daily home functions

Functional Assessment

- R – 16 yr old with OCD slowing
  - Gratification from symptom (Int +)
    - Perfectionism
    - Highly valued – no insight
  - Attending to the symptom (Ext +)
    - Arguing, prodding, criticism
    - To Disengagement
  - Escape functions (Ext -)
    - Not attending school
    - Parents abandoned all expectations

- M – 27 yr old with contamination fear
  - Gratification from symptom (Int +)
    - Control over his environment
    - Extended adolescence
  - Attending to the symptom (Ext +)
    - Parents purchsing special cleaning products for him
    - Mom cleaning his apartment
  - Escape functions (Ext -)
    - Getting out of family gatherings he did not like
    - Avoidance of other social situations (restaurants)

OCD Combined Treatment

- For greatest efficacy, CBT and medication is the treatment of choice.
- Foa et al (2005) tested Clomipramine vs ERP vs Combination vs Placebo in adults
- Found Combination = ERP > Clomipramine > Placebo
- Treated and Completer Response Rates:
  - ERP: 62%, 86%
  - Clomipramine: 42%, 48%
  - Combination: 70%, 79%
  - Placebo: 8%, 10%

Pediatric OCD Treatment Study: POTS I

- Multi-site, RCT, enrolling 112 patients aged 7-17

- Combined Treatment was superior to CBT alone or Meds alone. All were better than placebo
  - Clinical Remission Rate for Combined TX: 54%, CBT alone: 39%, Sertraline alone: 21%, PBO: 3.6%

- Effect Size for Combined Treatment = 1.4
- Site Differences for CBT and Med conditions, but not for combined treatment

March et al., JAMA, 2004

POTS II

- Multi-Site, RCT included 124 pediatric outpatients ages 7-17 with primary OCD

- 3 Tx Conditions (7 sessions over 12 weeks)
  - Medication Management (30% responders)
  - Med Management + CBT Instruction (34%)
  - Med Management + Full CBT (69%)

- *Importance of in vivo exposure*

Questions?

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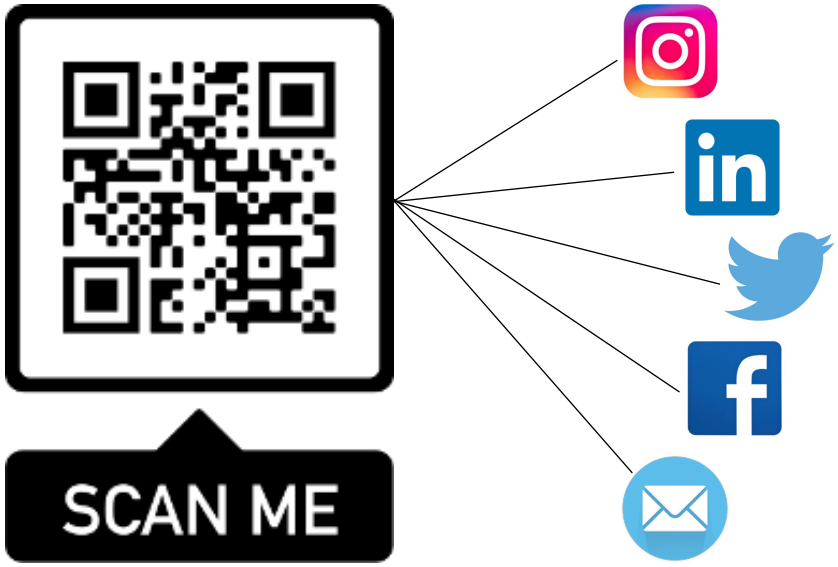

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