Evidence-based Treatment for OCD

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Workshop Outline

- What is OCD?
- What causes OCD?
- What treats OCD and how well?
- How do you do CBT for OCD?

What is Obsessive-Compulsive Disorder?

Phenomenology and Epidemiology

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)

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

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

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"

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 GMC

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

OCD Specifiers

- *Good or fair insight*: Recognizes that OCD beliefs are definitely or probably not true, or that they may or may not be true
- *Poor insight*: Thinks OCD beliefs are probably true
- *Absent insight/delusional beliefs*: Completely convinced OCD beliefs are true
- *Tic-related OCD*: The individual has a lifetime history of a chronic tic disorder

OCD Symptom Dimensions

- Hoarding
- Contamination/ cleaning
- Symmetry/ordering
- Forbidden thoughts
- Over-responsibility

	% of OCD Cases Reporting each Symptom
Checking	79.3
Hoarding	62.3
Ordering	57.0
Moral	43.0
Sexual/religious	30.2
Contamination	25.7
Harming	24.2
Illness	14.3
Other	19.0

OCD Prevalence

- Around 1% in pediatric population
- Between 2-3% in the adult population
  - 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
- Chronic, unremitting course if untreated
- Symptoms can change across time, but will rarely disappear

Abramowitz et al. (2009);

Gender Differences

- Many more male youth are diagnosed, but no sex differences in adults

- Among men, hoarding associated with GAD and tic disorders, but in women with SAD, PTSD, BDD, nail biting, and skin picking

Vesaga-Lopez et al. (2008)

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

Lack et al. (2009)

Impact of OCD

- Almost *all* people with OCD report obsessions causing significant distress
- Pervasive decrease in QoL compared to controls
- Youth show problematic peer relations, academic difficulties, and participate in fewer recreational activities

Lack et al. (2009); Fontenelle et al. (2010)

Impact of OCD

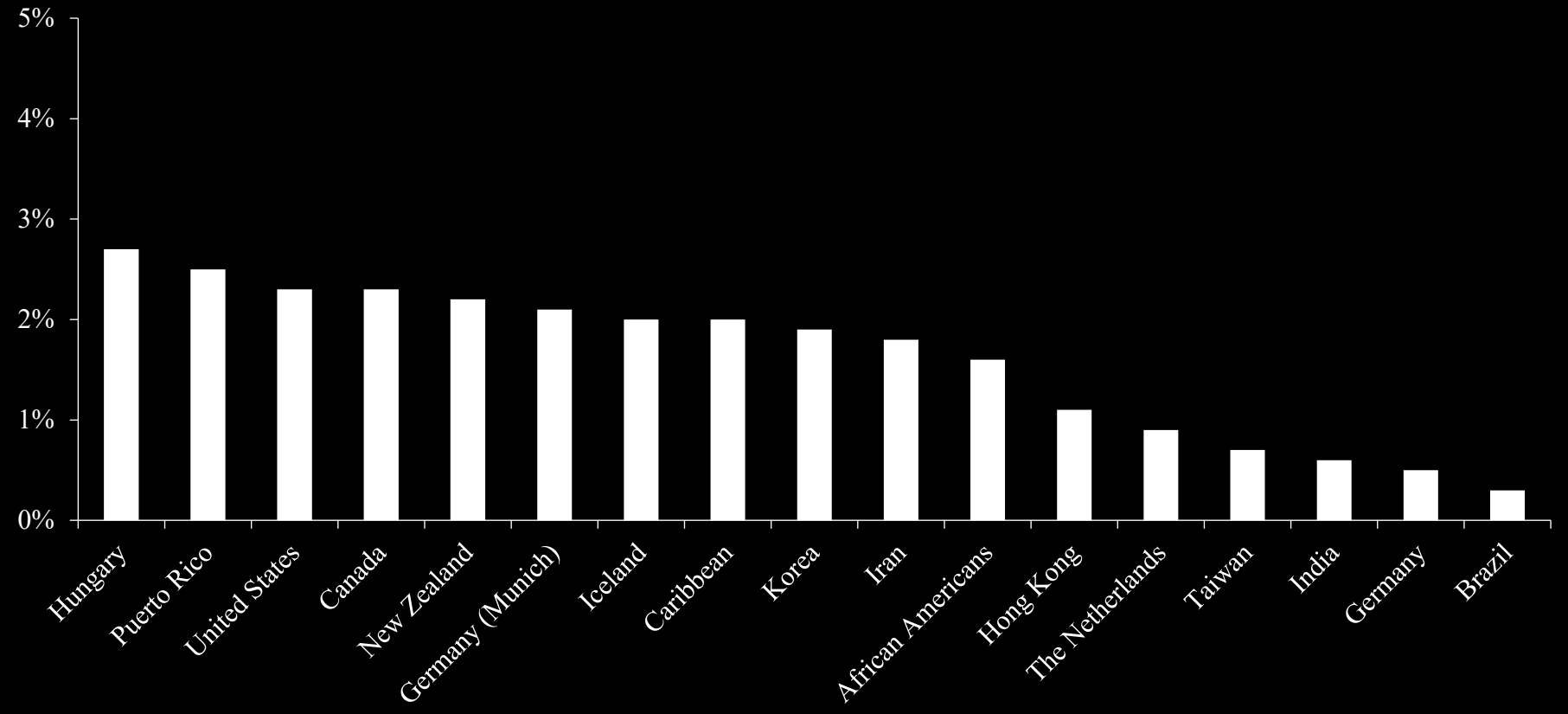
- Lower QoL in pediatric females

- Compared to other anxiety/unipolar mood:
  - Less likely to be married
  - More likely to be unemployed
  - More likely to report impaired social and occupational functioning

Lack et al. (2009); Abramowitz et al. (2009)

Cultural Aspects of OCD

- Similar epidemiological rates cross-culturally



Cultural Aspects of OCD

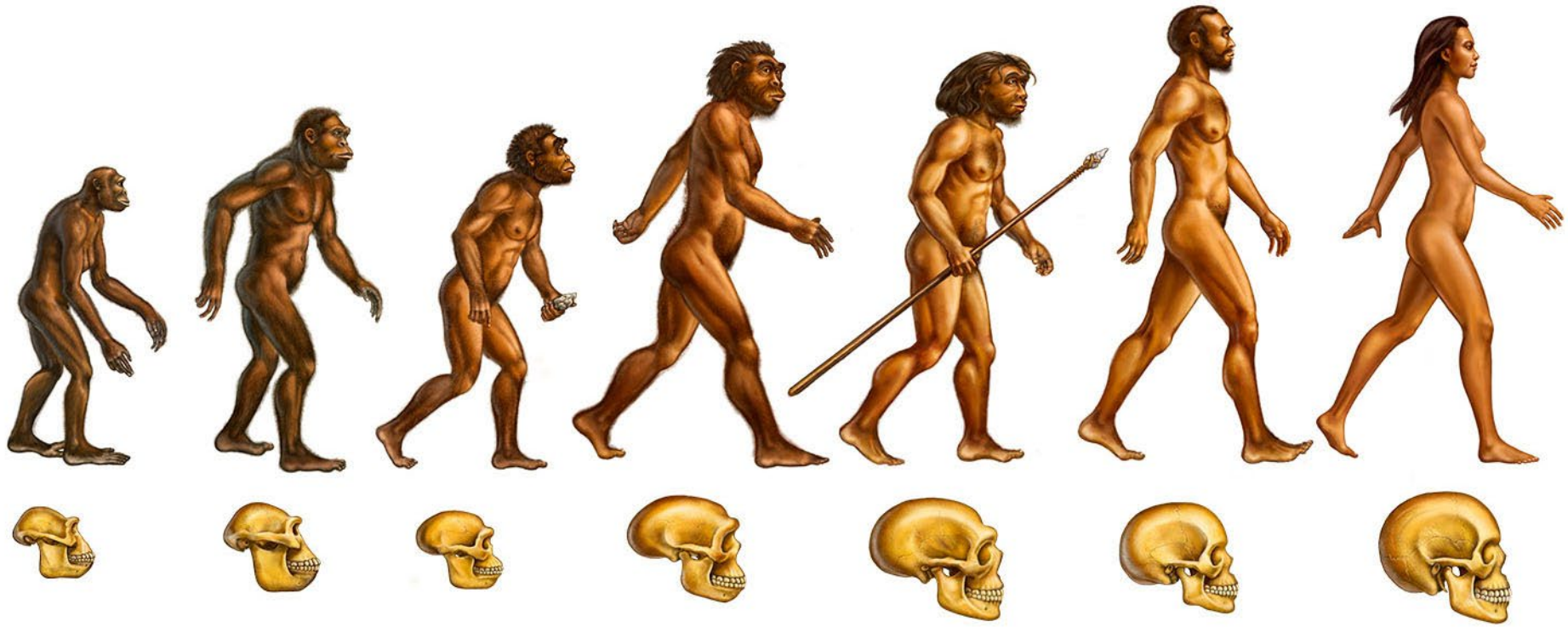
- Types of symptoms reported in various cultures varies little, but prevalence does
  - US Blacks more likely to show contamination issues, especially concerning animals
  - More religious Christians and Muslims place more importance on controlling their thoughts
  - High levels of scrupulosity in Jewish populations

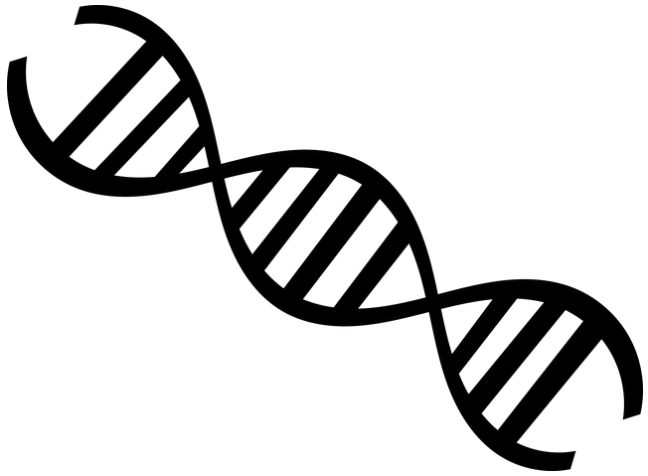
What Causes OCD?

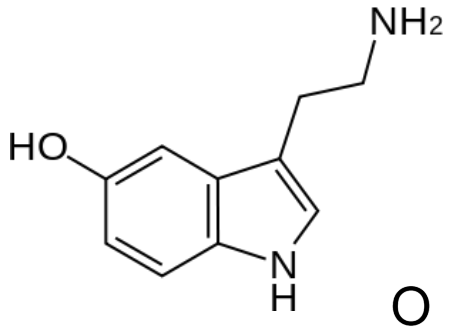
An Evolutionarily Informed Biopsychosocial Model

A Comprehensive Etiological Model

- Considering normative, adaptive behaviors and what they would look like when disrupted helps to understand ultimate roots of OCD
- Understanding biological aspects gives insight into a particular person's vulnerability to developing OCD
- Knowing the psychological underpinnings of OCD helps to provide both explanatory power at higher levels and informs interventions
- Let's meet Mark…



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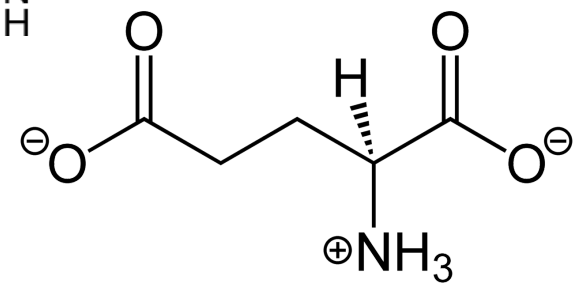
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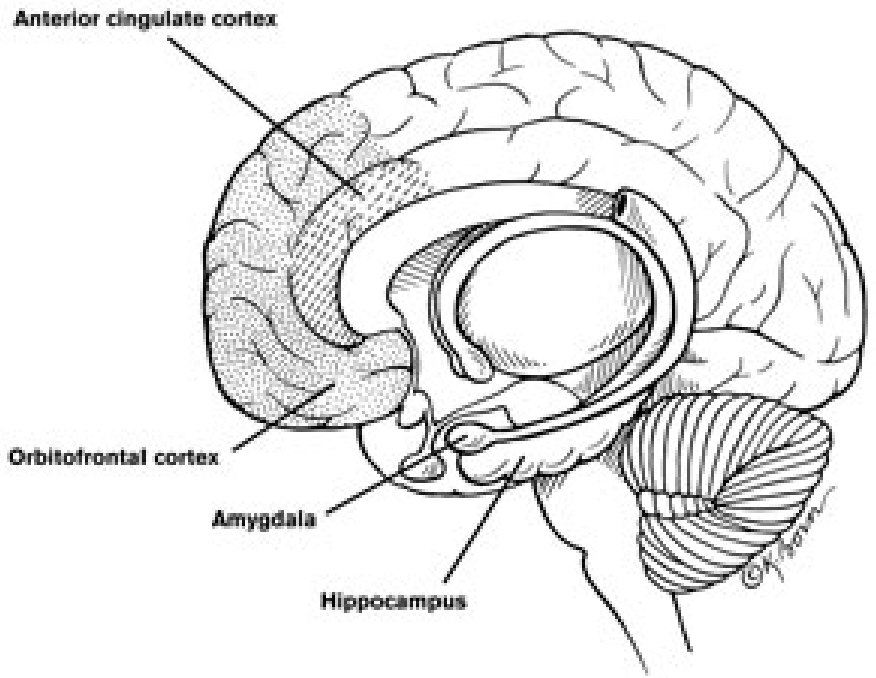
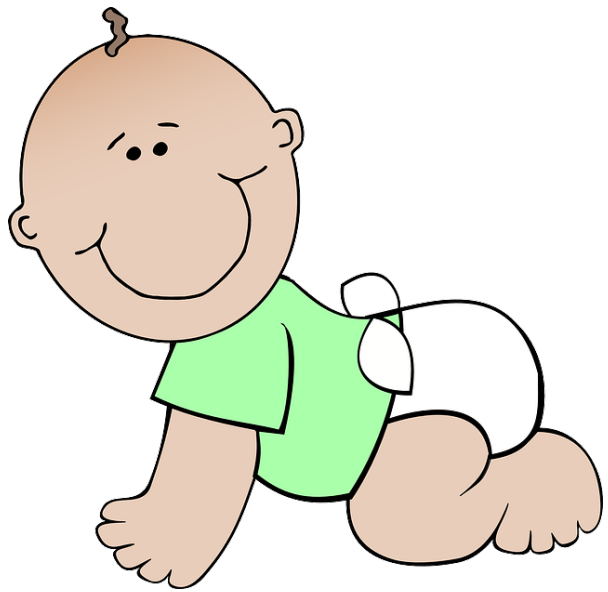
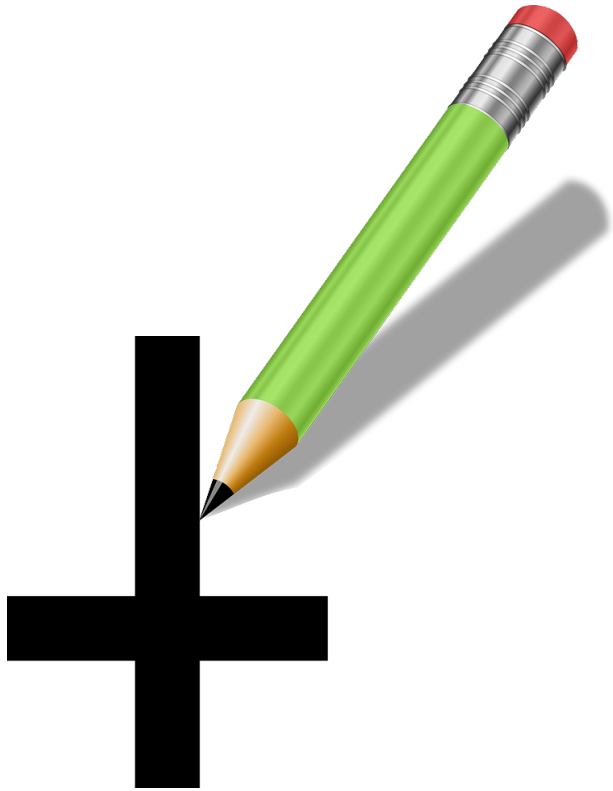
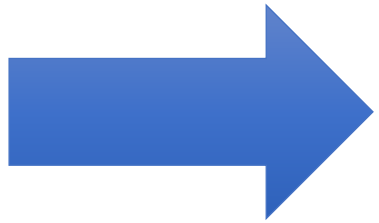
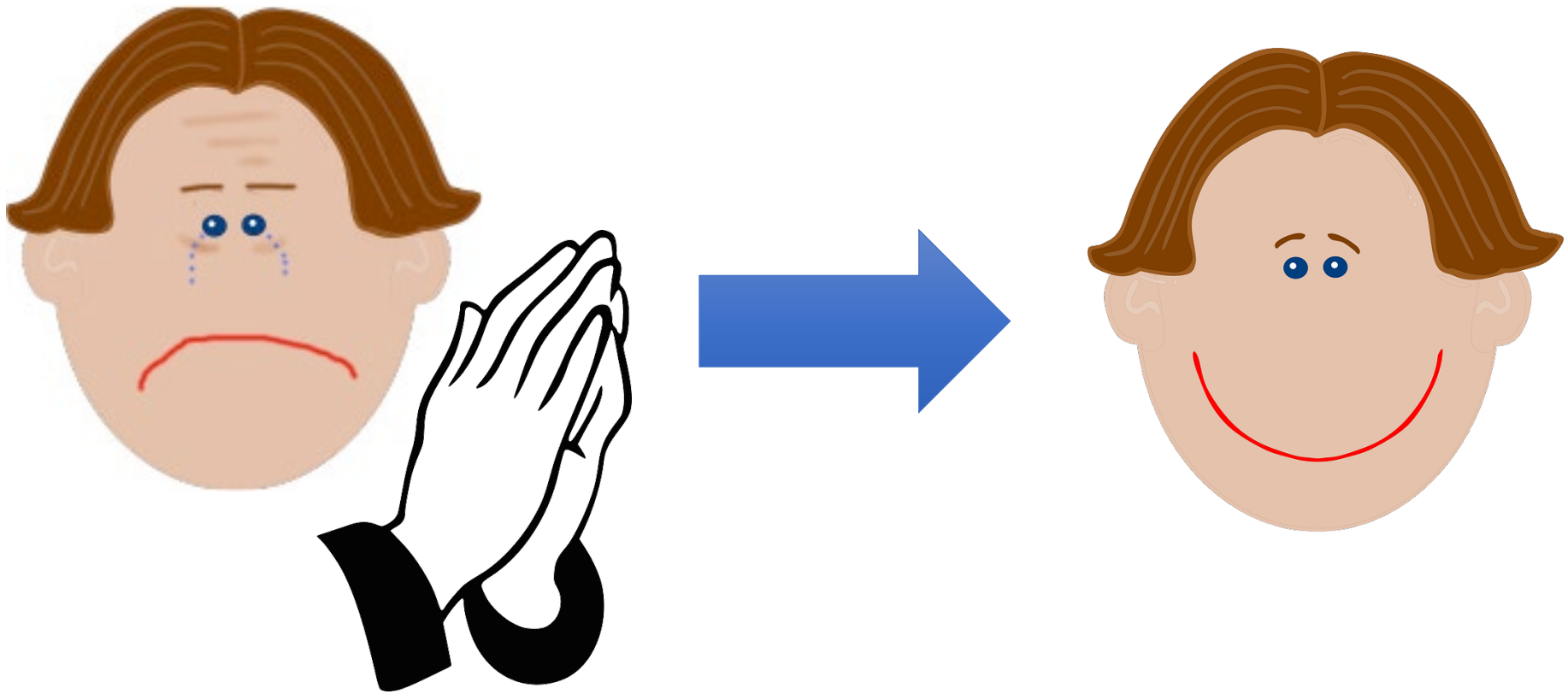
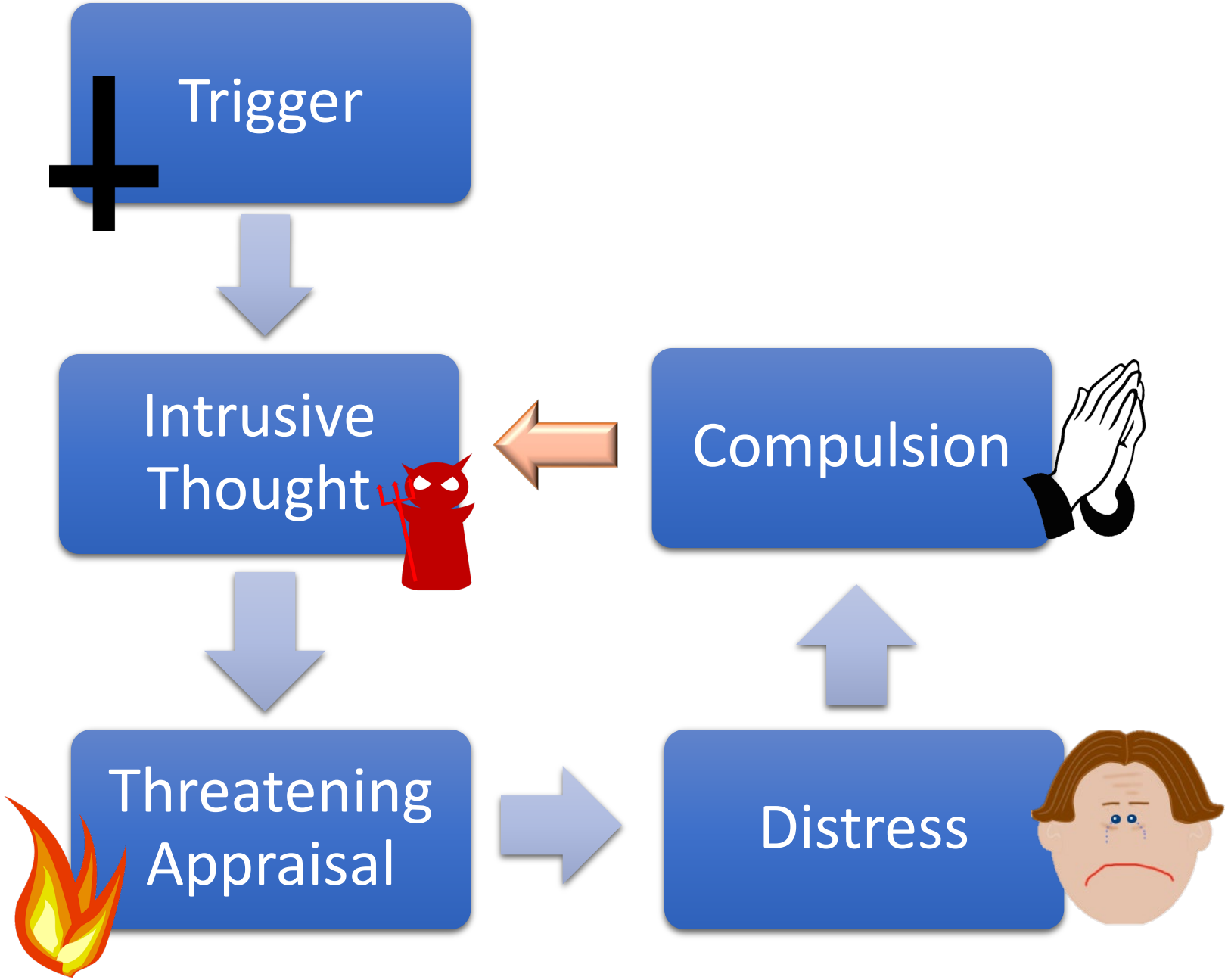

Anterior cingulate cortex
Orbitofrontal cortex
Amygdala
Hippocampus










Trigger
Intrusive Thought
Compulsion
Threatening Appraisal
Distress

What Treats OCD and How Well?

Evidence-based interventions

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)

Pharmacology for OCD

- SRIs can be adjuncted with antipsychotics, but only 1/3 will respond
- Presence of tics appears to decrease SSRI effects in children, unclear in adults
- OCD w/ tics responds better to neuroleptics than OCD w/o tics

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

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

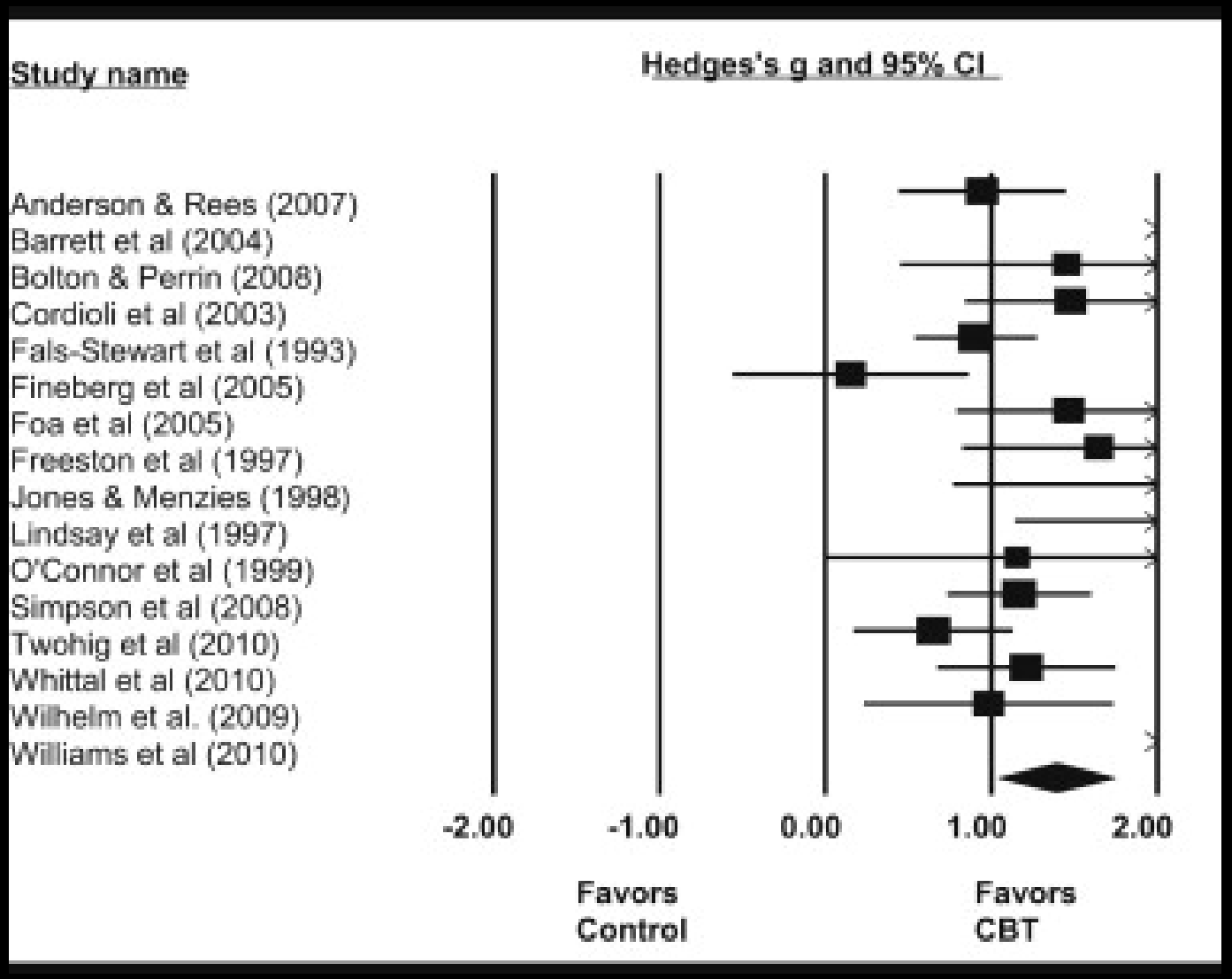
Deep Transcranial Magnetic Stimulation

- Relatively recent option, FDA approved since late 2018
- Used with treatment-resistant clients, 40% of patients see a response in as little as 6 weeks
- Small number of dTMS providers currently (only 1 in Oklahoma)

CBT 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 compared to placebo)
- Low (12%) relapse rate, but up to 25% will drop out prior to completion of treatment

CBT Outcomes



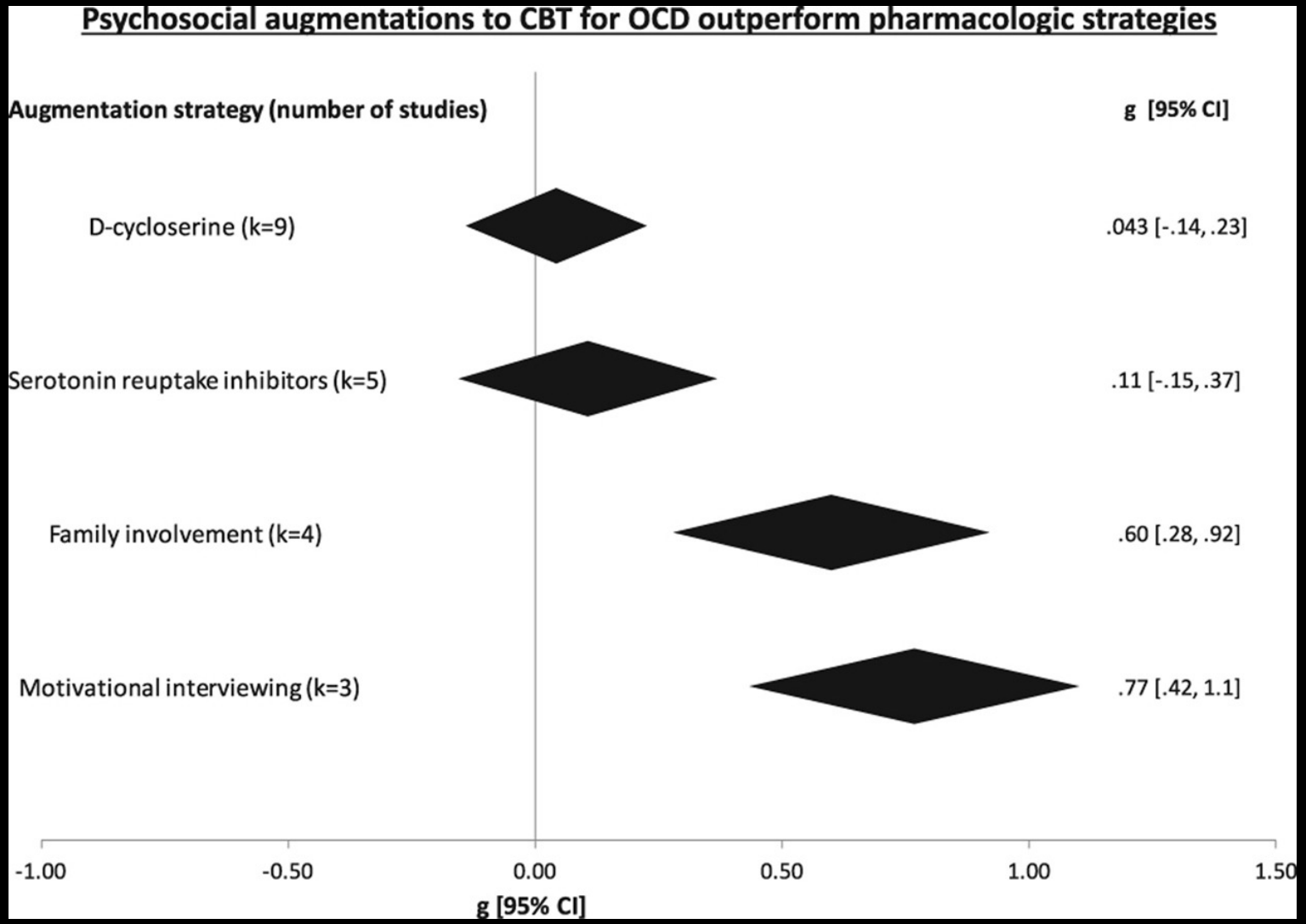
(Olatunji et al., 2013)

CBT Outcomes

- Those with hoarding symptoms appear to respond less well to treatment
- May need to add motivational enhancement techniques for those who are reluctant to engage in exposures
- Group therapy is as effective as individual

Abramowitz et al. (2009)

CBT Augmentation



(Guzick et al., 2018)

CBT Outcomes

- Those with comorbidity present higher severity, but respond equally well to ERP

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

Storch et al. (2010)

How do you do CBT for OCD?

Key Interventions and Structure

Children vs. Adults

- The overall treatment (course, methods used, etc.) is highly similar
- Children do tend to require more support and scaffolding from parents
- Nonetheless, both youth and adults need to have a strong support system in place to assist with therapy and homework

Outline of CBT Treatment

- Typically between 10-16 sessions
- For youth, includes parent and child in all aspects of treatment
  - May need to include other family/support persons for adults too
- Three primary components
  - Psychoeducation, development of a fear hierarchy, ERP with cognitive strategies

Psychoeducation

- Provide OCD information
- Correct misattributions
- Differentiate between OCD and non-OCD
- Describe treatment program

Parent/Support Tools

- Differential attention
- Modeling
- Scaffolding

Patient Tools

- Learn to externalize OCD
- Learn how to rate anxiety levels

Considerations

- Keep information and activities developmentally appropriate
  - For young children (under 8), they may not need/benefit from the education portion
  - Older children and adolescents, however, should be included

- Deliver treatment “with the client” and not “to the client”

Session Sequence

- An initial assessment should be conducted prior to therapy starting
- Complete a clinical interview and symptom measures
- Helps determine differential or comorbid diagnoses and impact of OCD symptoms on functioning

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
- Quick self-report of symptoms for screening purposes can use C-FOCI, LOI-C, or OCI-R

Session 1

- Results of assessment
- Provide education on
  - Etiology and course of OCD
  - Cormorbidity
  - OCD vs non-OCD behaviors
- Give overview of treatment program
- Homework – daily record of OCD symptoms

Instructions: Please keep a *daily* record of **TWO** of your child's OCD symptoms. In the space provided below (feel free to use additional space if necessary) record the date, the specific symptom, the amount of time your child spent engaging in that symptom, how much disturbance it causes in the family, and how the parents are involved in the symptom.

Date	OCD symptom	Time spent	Family disturbance	Parent's involvement
T 3/17	At dinner, looked at roll for mold	5 min	Made us run late for basketball	Answered many questions
W 3/18	Refused to eat muffin for breakfast	10 min	Fought on way to school	Yelled at her
W 3/18	Asked if she would get sick from Lysol	1 min	None	Told her not to worry (2x)
Th 3/19	Looked at bagel for mold	4 min	None	Answered many questions
F 3/20	Asked about bottle of Windex	1 min	None	Told her not to worry (2x)
Sa 3/21	Looked at dinner roll for mold	1 min	She cried	Answered many questions
Su 3/22	Asked if she would get sick from Windex	1 min	None	Told her not to worry
M 3/23	Refused to eat toast	5 min	Late to school b/c made eggs	Answered many questions

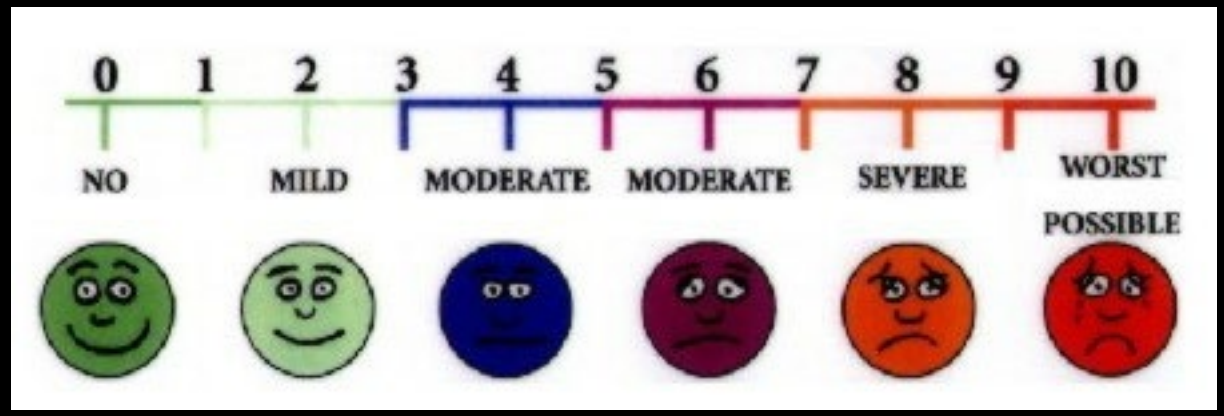
Session 2

- Review past session
- Start development of hierarchy
- Give overview of client and support tools
- Introduce differential attention and reward plan
- Homework – Track two O/C symptoms, prepare rewards and rewards chart

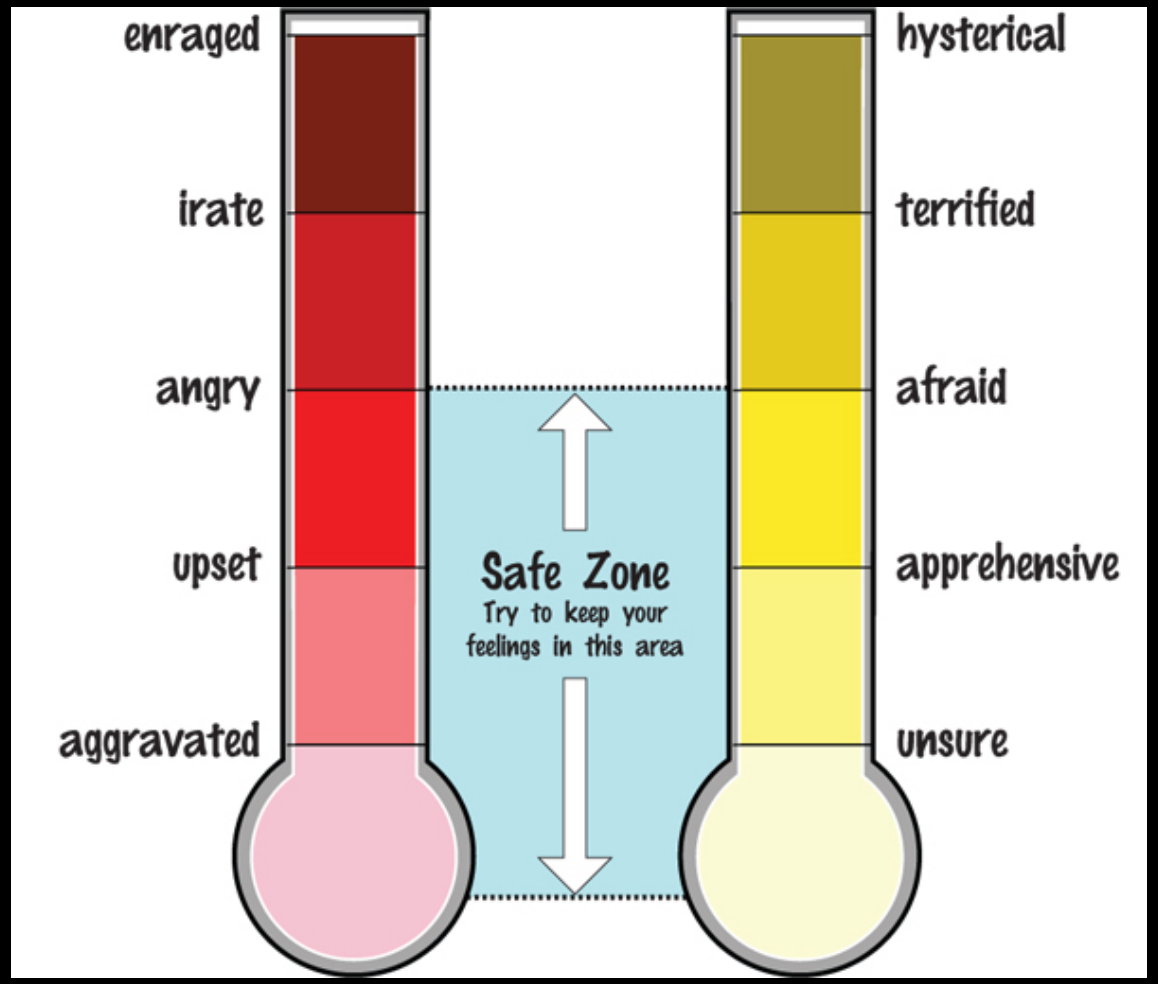
Ranking	Description of Symptom	Label (O, C, ?)	Notes
1.	Worries about household cleaners	O	
2.	Avoiding eating off recently cleaned surfaces	C	
3.	Questioning parents about use of household cleaners	C	
4.	Worries about mold on food	O	
5.	Examination of food for mold	C	
6.	Worries about whether she had swallowed objects (e.g., paper clip)	O	
7.	Avoiding eating certain foods	?	Need more info

Session 3

- Review last week
- Introduce child to reward program / implement adult reward program
- Review OCD symptoms with client/family
- Introduce feeling thermometer/SUDS and symptom tracking


0 1 2 3 4 5 6 7 8 9 10
NO
MILD
MODERATE
MODERATE
SEVERE
WORST POSSIBLE

SUDs


enraged
irate
angry
upset
aggravated
Safe Zone
Try to keep your feelings in this area
hysterical
terrified
afraid
apprehensive
unsure

Session 3

- Discuss praise & encouragement
- Review level of family involvement in and accommodation of OCD symptoms
- Homework – Monitor symptoms, start reward chart for doing so
- New hierarchy (by therapist between sessions)

Exposure Techniques

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

Rosqvist (2005)

Exposure Techniques

- Begin by constructing a fear hierarchy
  1. Generate specific feared situations
  2. Rate them using Subjective Units of Distress

- Continue by actually doing the exposures, working from lower to higher SUDS situations

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

Exercise!

- You will now create your own fear hierarchies
- Should include a wide range of fears and/or situations that are distressing
- Use SUDs rating to distinguish and order the hierarchy

Trigger	Obsession	Compulsion	Rating
Smelling cleaner, seeing the bottle, or seeing shiny or wet surfaces in the kitchen	Worries about being poisoned by household cleaners	Avoiding eating off recently cleaned surfaces	
Smelling cleaner, seeing the bottle, or seeing shiny or wet surfaces in the kitchen	Worries about being poisoned by household cleaners	Repeated questioning parents about use of cleaners (verbal checking)	
	Worries about mold on food	Examination of food for mold (self)	
	Worries about mold on food	Asking family member to examine food for mold	
	Worries about mold on food	Avoiding eating food that is likely to be moldy (e.g., bread, muffins)	
	Worries about whether he had swallowed objects (e.g., paper clip)		
	Worries about touching dirt on the floor		

Session 4

- Review last week
- Problem solve homework or reward program
- Continue hierarchy development
- Introduce arguing with OCD
- Conduct in-session exposure

Exposure Types

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

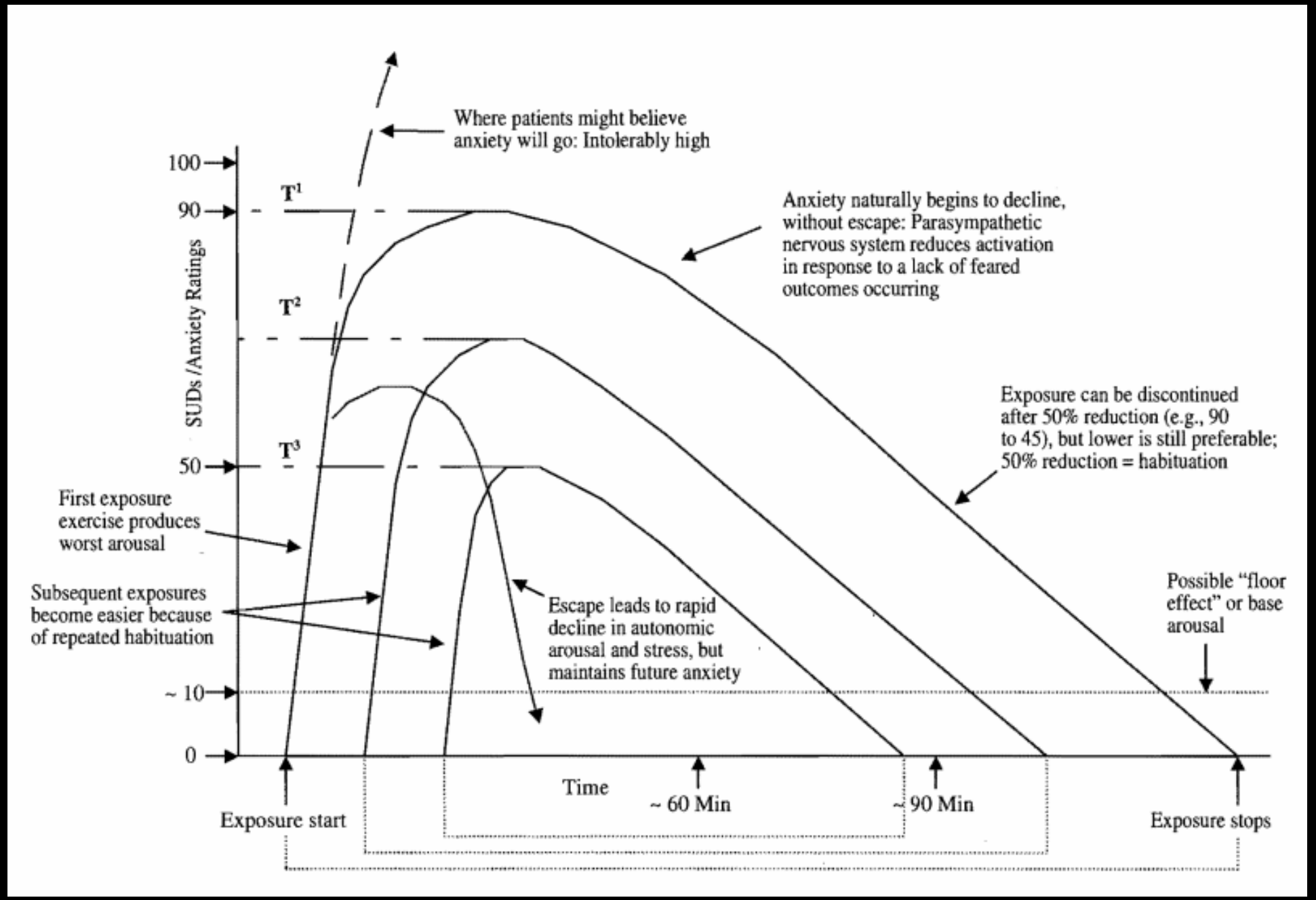
- In vivo exposure tasks
  - Often follow imaginal exposures, use a “live and in person” version of the feared situation

Exposures

- Exposure occur both in and out of session
- Requires cooperation of parents to facilitate successful homework exposures
- Should be similar to what is being done in session, using a hierarchy and SUDS ratings
- Internal and external rewards for successful exposure completion should be discussed beforehand

Exposures

- Ideal exposures are prolonged, repeated, and prevent the use of distraction behaviors
- SUDS decrease of at least 50%, with more being better
- May require shaping up to the more difficult situations, in terms of both time and use of distractors


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

Daily Practice Record

Task Description:

Reminder of Specific Strategies to Use:

Thermometer Ratings

Date	What was attempted	Pre-task	1 min	2 min	5 min	10 min	15 min	20 min

Reward (describe what can be earned and what are the criteria for earning it):

Therapist Tasks

- Realize long-term benefits outweigh short- term distress, and communicate this effective to the family
- Work collaboratively with the child and family to plan and execute the exposures
- Maintain rapport during exposures by building upon pre-established rapport

Therapist Tasks

- Do not allow avoidance or distracter behaviors during the exposure
- Modeling how to conduct exposures for the parents, so that they can perform them at home
- Be flexible and creative when dealing with less than optimal exposures and resistance

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

Demonstration of ERP!

Session 4

- Discuss differential attention again – especially ignoring
- Review family involvement in OCD symptoms
- Problem solve homework compliance obstacles
- Homework – ERP task completion, parents use positive attention and ignoring

Session 5

- Review last week
- Problem solve homework tasks
- Revise hierarchy of symptoms
- Review arguing with OCD
- Conduct in-session exposure

Session 5

- Discuss modeling

- Homework
  - Parental modeling, use of differential attention
  - Child completes ERP task(s) each day

Session 6

- Review last week
- Problem solve homework tasks
- Review disengagement efforts
- Revise hierarchy of symptoms & arguing
- Introduce scaffolding/coaching

Scaffolding

- Step 1 – Find out how child feels and empathize with the child
- Step 2 – Brainstorm with child how to approach the situation
- Step 3 – Choose option from Step 2 and act on it
- Step 4 – Evaluate and reward

Session 6

- Conduct in-session exposure
- Review scaffolding/coaching steps
- Homework
  - Parents use modeling, DA, scaffolding, continue disengagement, reward task completion
  - Child completes ERP task(s) each day

Session 7

- Review past week
- Problem solve homework
- Review disengagement
- Revise hierarchy of symptoms & check arguing
- Conduct in-session exposure to check parental scaffolding

Session 7

- Expand use of scaffolding outside of ERP practice tasks

- Homework
  - Encourage use of all parental tools
  - Have parents apply scaffolding outside planned practice times
  - Child complete ERP task(s) each day

Sessions 8-10

- Review past week
- Problem solve homework
- Review disengagement
- Revise hierarchy of symptoms & arguing
- Conduct in-session exposures
- Homework assignments

Further Sessions

- Take place two weeks after previous sessions
- Similar to sessions 8-10
- Focus on how to handle OCD future problems
  - Relapse prevention strategies
  - Dealing with symptom reappearance

Ending Therapy

- Sessions should be spaced further apart
- Some families may need more booster sessions than others
- Plan on having long-term follow-up visits to check progress and troubleshoot

Questions?

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