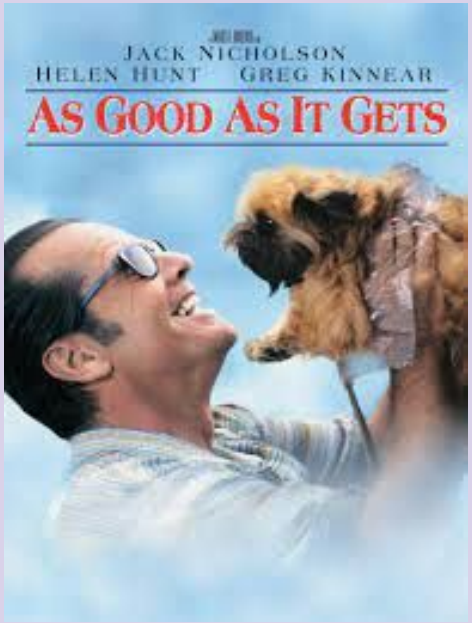
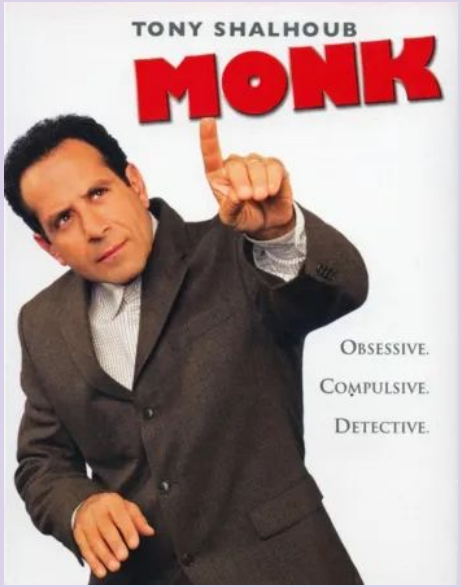
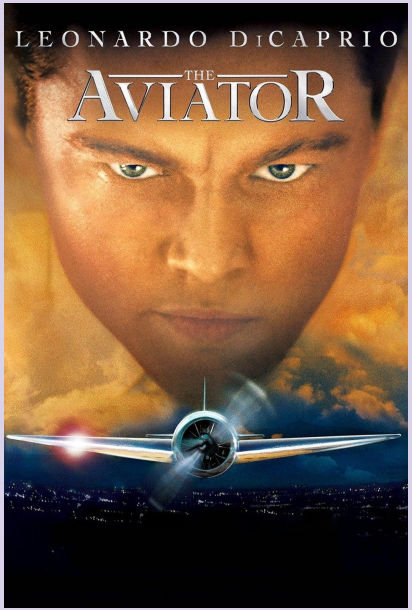
Obsessive-compulsive disorder (OCD)

Obsessive-compulsive disorder in movies







Introduction

Obsessive-Compulsive Disorder (OCD) involves obsessions (persistent, unwanted thoughts) and compulsions (repetitive behavioral or mental acts).

Obsessions are intrusive and uncontrollable, while compulsions are often carried out to neutralize negative thoughts

Common obsessions relate to the fear of:

♦ contamination ♦ aggression (harming oneself or others) ♦ religious, ethical mistakes

♦ losing loved ones ♦ unwanted sexual impulses

Compulsions:

- ❑ Physical- touching, tapping things in a certain way, reorganizing, washing hands...
- ❑ Mental - counting, repeating specific phrases

→ basically compulsions are a **response** to obsessions, attempts to prevent feared events to happen

→ compulsions can, but aren't necessarily linked to obsessions - e.g. counting cannot change the probability of feared accident

Diagnostic criteria (ICD -11)

Essential (Required) Features:

- Presence of persistent obsessions and compulsions.
- Obsessions and compulsions are time-consuming (e.g., take more than 1 hour per day) or result in significant impairment in important life areas. If functioning is maintained, it is only through significant additional effort.
- The symptoms or behaviours are not a manifestation of another medical condition and are not due to the effects of a substance or medication.

Specifier that can be added to diagnosis:

- Level of insight into the condition

no insight means patient is convinced that their obsessional thoughts are true and that their compulsions are necessary to control events in the world

Obsession	Compulsion
Contamination: A carer may be terrified of passing germs onto a client, for fear of them getting ill or even dying.	Cleaning: An employee may feel forced to clean floors and surfaces multiple times and wash their hands until they are sore.
Harm/safety: A parent may have obsessive thoughts about their children being involved in accidents, fires, floods, etc.	Checking: A parent may check they have locked all the doors and windows, or that they have turned off electric appliances multiple times.
Symmetry/order: A student may feel uncomfortable unless everything around them is perfectly aligned and in its 'right' place.	Counting, ordering and arranging of possessions: A student may spend hours organising items on their desk or in their room before starting schoolwork.
Forbidden thoughts/taboos: A person might have sexual thoughts.	Ritualistic physical and/or mental acts in an attempt to neutralise: The person may say prayers repeatedly or carry out ritualistic washing to 'purify' themselves.

Diagnostic criteria - case study of a 12-year-old boy (Rapoport)

- Started experiencing obsessions at 12, focused on stickiness
- Three-hour showers, avoidance of honey due to fear
- Symptoms affected daily routines, school attendance, and family dynamics
- Treatment included tricyclic antidepressant (clomipramine) - was a short-term relief
- 1 year after he relapsed: he developed a tolerance for this medication (body get used to it and medication is no longer effective)

Strengths and weaknesses both steam from this being a case study.

Measures - Maudsley Obsessive-Compulsive Inventory (MOCI)

- **Questionnaire** developed in order to create a typology of many different types of OCD
- first step in developing MOCI: 30 people with OCD were interviewed to develop a list of true and false statements relating to them
- second step: These statements were given to two groups of people: one with obsessional thinking, and other with anxiety, but without obsessions
- third step: 30 items that were best at differentiating people with and without obsession were chosen
- Major types that stood out: cleaning and checking; minor types: slowness and doubting.

<u>Evaluating MOCI</u>

- Strength: high test-retest reliability (89% consistency) *tested 1 month later again*
- Weakness: fixed-choice (only true- false option, no rating) - may limit validity

"I only use an average amount of soap" - **but what is the average amount ?!**

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

https://pandasnetwork.org/wp-content/uploads/2018/11/y-bocs-w-checklist.pdf

- **Semi-structured interview** with 5 items about obsessions and 5 items about compulsions
- Severity rated on a 0-4 scale; when thinking about events in the last week
- Total scores categorized as mild, moderate, severe and extreme
- Includes an additional checklist for interviewer to fill in (with 50+ types of obsessions and compulsions)
- Takes approximately 30 minutes

Evaluating Y-BOCS

- Weakness: Focus on the last week may not capture symptom variability
- Strength: Strong inter-rater reliability - meaning _____?

evidence: 40 people with OCD were assessed by four different interviewers - agreement between them was excellent

Explanations of OCD

- Biological

- Psychological

Biological explanations - Biochemical

Strength for this one can always be: understanding brain chemistry well will lead to creating better medications

1. Dopamine - high levels in OCD; evidence: Szechtman - rats with increased dopamine showed repetitive movements, like compulsions

2. Serotonin - lower levels in OCD, evidence: antidepressants that specifically target an increase in serotonin are more effective treatments for OCD than antidepressants that have less effect on serotonin

3. Oxytocin - " love hormone", it's involved in enhancing trust and attachment BUT can also increase mistrust and fear when facing threatening situations
- mixed evidence: Some studies showed higher levels of oxytocin in individuals with OCD, while some other studies did not find any link

* nasal drops with oxytocin given to people with autism did help decrease the repetitive behaviors (made the ocd researchers consider this connection in the 1st place)

Biological explanations - Genetic

Fact: **OCD is one of the most heritable of all mental disorders** - if one member of the family has OCD, then other biologically close family members have a higher probability of also having the disorder

Evidence 1: Classic **family studies** - Lewis (1936): 37% of people with OCD had at least one parent who also had the disorder, 22% had a sibling with OCD

Evidence 2: **Twin studies**: Carey and Gottesman (1981) found a concordance rate of 87% for monozygotic (MZ) twins but only 47 % for dizygotic (DZ) twins
→ both MZ and DZ share the exact environment, but MZ share more genes (100%) than DZ (50%). Thus this evidence highlights the effect of nature, not nurture.

*OCD is another example of a **polygenic disorder** ‘ polygenic? → When condition is caused by the combined effects of multiple genes, rather than being determined by a mutation in a single gene.*

Both biochemical and genetic explanations

Applications to everyday life - understanding of the role of serotonin and other neurotransmitters has led to the development of drug treatments

Which sides of the debates are favoured?

Individual - situational

Reductionism - holism

Nature - nurture

Determinism - free will

Psychological explanations: cognitive perspective

Thoughts:

- Average person has about 6000 thoughts daily.
- People with OCD struggle to ignore certain thoughts, believing all thoughts are meaningful
- Thinking errors, as well as the way we label and interpret the thoughts (not the content of the thoughts!!!) lead to obsessions

Thinking Errors in OCD:

- Overestimation of personal responsibility
- Thought-action fusion (TAF)
- Thought-event fusion (TEF)

Thinking errors explained:

Personal responsibility - people believing they alone are responsible for ensuring harm does not happen to others or indeed oneself. This can easily could turn into compulsive washing, cleaning and checking

Strength of this explanation: research evidence: one study showed that "checking type" OCD sufferers felt less urge to check are doors locked and is stove off **when they were told they don't held responsibility for any negative outcomes** (they were not in their own houses, but in some research space)

Thought-action fusion - people believing that imagining behaving a certain way increases the probability that they will actually behave this way

→ for example, imagining yourself deliberately smashing a classmate's new laptop means you believe that you may actually do this in real life

Thought-event fusion - people believing that imagining a certain event will make it more likely to happen

→ for example, imagining your friend dropping their laptop will make it more likely to happen

Behavioral perspective (operant conditioning):

Operant Conditioning and OCD:

- Compulsive behaviors develop to reduce negative emotions (anxiety, fear, guilt) that result from obsessions
- Behaviors that reduce negative emotions are (negatively) reinforced, becoming more likely → same mechanism as with phobias, impulse control disorder…

Similar to compulsive behaviors in OCD are rituals in non-clinical samples

https://www.youtube.com/watch?v=wYbCNfC0iuM

And then https://www.youtube.com/watch?v=Vr42G2P_mr :)

Psychodynamic perspective:

Freud's psychodynamic explanation:

- Mental health symptoms are form of defense mechanism that protect us from becoming aware of *unresolved conflicts (id vs superego) stored in unconscious mind*
- Id's unfulfilled desires - expressed through obsessions, while compulsions form from excessive guilt by the superego

Link to Anal Stage:

- OCD linked to unresolved conflict in the anal stage (ages 1-3)
- Potty training experiences crucial
- Fixation in the anal stage may lead to traits like cleanliness, orderliness, and perfectionism
- Anally retentive personality associated with OCD traits

Psychological explanations → Which debates are applicable?

Psychoanalytic explanations have to do a lot with **idiographic approach.**

Why? Case studies

Individual vs situational - all 3 can be both

- Cognitive focuses on individual faulty thinking, but can take into account the situational circumstances that act like triggers for this cognitions; also behavioral can take into account situations that especially provoke compulsions

- Psychoanalytic: id and superego unresolved conflict, and personality described as anally retentive - individualistic; but childhood negative experiences - situational

Deterministic versus free will - all 3 are somewhat deterministic, but cognitive and behavioral maybe less because we do possess the ability to, with self-work and therapy, change maladaptive thoughts and behaviors

- on the other hand, changing personality is harder, and changing childhood is impossible (psychoanalytic)

Treatments

- Biological
- Psychological

Biological treatment

To repeat general things about medication (basically same applies for depression treatment):

- SSRIs, tricyclics, and MAOIs are used to increase monoamine neurotransmitters
- Improvement may not be noticed initially; the time lag can be up to 12 weeks
- Long-term use (at least one year) is often needed to prevent relapse
- After the person got better, the maintenance doses may be needed
- And when it's time to stop with medication, it's never good idea to rapidly stop all at once
  → but gradual reduction! to minimize withdrawal symptoms

Antidepressants for OCD

Tricyclics:

- Increase serotonin and noradrenaline how? :)
- Effective for OCD and depression
- Charles, 12yo boy from the beginning - used one type of tricyclics (clomipramine) which helped for some time, but tolerance developed later

SSRIs:

- Increase serotonin by blocking presynaptic transporters
- Even though this neurotransmitter is immediately increased in synapse, improvement in symptoms may take time

MAOIs And what was that, exactly ? :))

- (monoamine oxidase inhibitors) inhibit enzyme known as monoamine oxidase

★ Sometimes, doctors will combine antidepressants with antipsychotics when treating OCD; one study showed effectiveness of combo SSRI + risperidone

Evaluation of biochemical treatment

You already know about effectiveness and side effectiveness of antidepressants

Debate> **individual - situational:**

treating only the internal, individual cause

Psychological treatment: Exposure and Response Prevention (ERP)

→ ERP is a another form of cognitive-behavioral therapy

Preparation part:

- Identifying obsessional thoughts and environmental triggers
- Using the Subjective Units of Distress Scale **(SUDS)** ratings
- Creating **trigger hierarchy** based on SUDS ratings for **gradual exposure**

Exposure part:

- Exposing them to triggers (from lowest to highest) e.g. - touching a door handle

Response prevention part:

- Therapist prevents maladaptive behaviors to teach that anxiety can reduce without compulsions
- Also they must abstain from safety behaviors (e.g. touching the door handle only with fingertips)

Important for ERP:

- How long 1 exposure is going to last? → need to last long enough for *habituation*, when the reduction in SUDS rating is at least 50% they can move to the next trigger
- Multiple exposures may be needed until a situation reaches a SUDS rating of 0
- No relaxation training is included; clients are discouraged from using anti-anxiety medication before sessions
- Clients are even encouraged to increase anxiety levels consciously for effective learning

Evaluation of ERP:

Strengths

- ERP is shown to be more effective than drug treatments like clomipramine in reducing OCD symptoms
- Practical applications include adapting ERP for diverse populations, such as children with autism spectrum disorder
- ERP can be delivered via telephone, making it more accessible and cost-effective

Weaknesses

- ERP can be challenging for inexperienced therapists to deliver effectively, limiting real-world applications
- Common pitfalls, like failure to involve relatives, may reduce efficacy
- Old compulsions may be replaced with new ones if the core underlying fear is not addressed

Example case study : again 12y boy, but with psychological treatment (Lehmkuhl et al.)

Participant : 12-year-old with both autism spectrum disorder (ASD) and OCD

- Diagnosed with ASD at age 2, developed OCD symptoms at 11
- Symptoms included sensory issues, repetitive language, and ritualistic behaviors
-

Treatment: modified (to fit boy's needs) CBT sessions over 16 weeks

- Exposure therapy included
- Involving parents and teachers in treatment process, very important

Results: Initial Y-BOCS score: 18 (moderate); reduced to 3 after therapy.

- Overcame exposure challenges; reduced avoidance
- Three-month follow-up: no signs of relapse

Strengths and weaknesses - **refer to *case study* for both!**

Conclusion:

- When modified according to developmental needs CBT is effective for ASD-OCD in children

Key study : Lovell et al. (2006) Telephone-Based Cognitive-Behavioral Therapy (CBT) vs. Face-to-Face CBT for OCD

Context (Background)

- Annual costs for OCD treatment in the USA alone are $8.4 million.
- Standard CBT involves weekly in-person sessions create challenges in time commitment and financial costs.
- Trials of new delivery modes, including online and telephone-based therapy, aim to address these limitations.

Main Theories and Explanations:

- Offering CBT over the phone can reduce waiting lists and make treatment more accessible.
- Telephone CBT is beneficial for those without transport, facing difficulties fitting in face-to-face sessions, and experiencing anxiety related to travel.
- Previous research shows telephone CBT can be as effective and less expensive than face-to-face CBT.

Aim:

- Compare the effectiveness of CBT delivered by telephone with face-to-face CBT in treating OCD

Design:

- **Randomized controlled trial (RCT)** comparing ERP face-to-face and ERP telephone sessions.
- Independent measure design, since two group are independent (no control group!)
- **Longitudinal design**

Sample:

- 72 participants aged 16-65 with OCD
- from UK, from 2 outpatient clinics, opportunity sample
- Exclusion criteria: comorbid substance misuse, suicidality, recent medication for depression or anxiety.

Procedure:

- Participants randomly allocated to face-to-face (n=36) or telephone treatment (n=36)
- Assessments of symptoms (OCD and depression severity, Y-BOCS, and BDI scale):

→ before treatment: **baseline levels were measured twice**, four weeks apart

→ immediately after treatment ended (they also added questionnaire for measuring client satisfaction)

→ 3 follow-up sessions (1, 3, 6 months post treatment)

researchers who assessed their symptoms were “blind” - unaware of the condition (face to face / telephone)

- Experienced therapists, one at each clinic, delivered both type of therapy

Results:

- At the beginning there was no significant difference in **OCD symptoms** severity between the groups. **Reduction of symptoms was the same** amount after the treatment, and during all follow-up assessments
- Slight difference in **depression scores**; the **telephone group had slightly higher scores initially**, but the reduction in scores was impressive.
- What was considered as clinically relevant improvement → if an individual's symptoms decreased by two standard deviations or more from the baseline mean
- With that criteria in mind: **77% of the telephone group** and **67% of the face-to-face** group showed **relevant improvement**
- Client satisfaction scores showed no significant difference.

▼ Table 6.19 Average Y-BOCS and BDI scores obtained at baseline and follow-up for the two modes of delivery

	Y-BOCS scores				BDI scores			
	The face-to-face group (n=36)		The telephone group (n=36)		The face-to-face group (n=36)		The telephone group (n=36)	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Baseline visit 1	25.5	5.5	25.9	4.9	15.7	8.5	20.2	10.4
Baseline visit 2	23.7	5.8	24.9	4.7	14.1	9.1	19.1	10.6
Immediately after treatment	13.4	7.7	14	6.9	9.3	8.5	11.2	8.0
One-month follow-up	13.7	8.5	14	7.3	10.3	8.4	12.7	10.1
Three-month follow-up	12.9	7.7	12.6	7.5	10.6	8.4	10.1	8.4
Six-month follow-up	13.3	8.6	14.2	7.8	11.1	9.1	11.5	9.5

Conclusion: Telephone-delivered CBT for OCD is as effective as face-to-face CBT

Implications for cost savings: telephone CBT is 50% shorter in duration, saving both time for therapists and patients; therapists can treat more patients

Evaluation

Strengths:

1. **taking baseline measures twice**

a) compensating for absence of control condition - ruled out the possibility of spontaneous recovery

b) reliability of diagnosis ! (test - retest)

2. RCT, random allocation to conditions, equal number of M/F in each

Weaknesses:

1. Blind raters - but **some participants revealed their conditions**
2. **Initial depressive scores -** higher for telephone group
3. **Attrition** (participants dropout) lowers generalizability, validity...

Evaluation

Ethics and risk management ✔

Applications to everyday life !

Nomothetic approach

Cultural differences!

UK being individualistic country, so this works. Maybe in more collectivist people would prefer face to face therapy