Part III. Mental Disorders – Block 2

Module 9:

Obsessive-Compulsive and Related Disorders

Module 9: Obsessive-Compulsive and Related Disorders

Module Overview

In Module 9, we will discuss matters related to obsessive-compulsive and related disorders to include their clinical presentation, epidemiology, comorbidity, etiology, and treatment options. Our discussion will include obsessive compulsive disorder (OCD), body dysmorphic disorder (BDD), and hoarding. Be sure you refer Modules 1-3 for explanations of key terms (Module 1), an overview of the various models to explain psychopathology (Module 2), and descriptions of the therapies (Module 3).

Module Outline

- 9.1. Clinical Presentation
- 9.2. Epidemiology
- 9.3. Comorbidity
- 9.4. Etiology
- 9.5. Treatment

Module Learning Outcomes

- Describe how obsessive-compulsive disorders present.
- Describe the epidemiology of obsessive-compulsive disorders.
- Describe comorbidity in relation to obsessive-compulsive disorders.
- Describe the etiology of obsessive-compulsive disorders.
- Describe treatment options for obsessive-compulsive disorders.

9.1. Clinical Presentation

Section Learning Objectives

- Describe how obsessive compulsive disorder presents.
- Describe how body dysmorphic disorder presents.
- Describe how hoarding disorder presents.

9.1.1. Obsessive-Compulsive Disorder

Obsessive-compulsive disorder, more commonly known as OCD, requires the presence of obsessions, compulsions, or both**. Obsessions** are defined as repetitive and persistent thoughts, urges, or images. These obsessions are intrusive, time-consuming (i.e., take more than an hour a day), and unwanted, often causing significant distress or impairment in an individual's daily functioning. Common obsessions are contamination (dirt on self or objects), errors of uncertainty regarding daily behaviors (locking the door, turning off appliances), thoughts of physical harm or violence, and orderliness, to name a few (Cisler, Adams, et al., 2011; Yadin & Foa, 2009). Often the individual will try to ignore these thoughts, urges, or images. When they are unable to ignore them, the individual will engage in compulsory behaviors to gain temporary relief from the distress or anxiety.

Compulsions are time-consuming, repetitive behaviors or mental acts that an individual performs in response to an obsession. Common examples of compulsions are checking (e.g., repeatedly checking if the stove is turned off even though the first four-times they checked it was), counting (e.g., flicking the lights off and on exactly five times), hand washing, symmetry,

fears of harm to self or others, or repeating specific words (APA, 2022). These compulsive behaviors essentially alleviate the anxiety associated with the obsessive thoughts. For example, an individual may feel as though their hands are dirty after using utensils at a restaurant. They may obsess over this thought for some time, impacting their ability to interact with others or complete a specific task. This obsession will ultimately lead to the individual performing a compulsion where they will wash their hands with extremely hot water to rid all the germs, or even wash their hands a specified number of times if they also have a counting compulsion. At this point, the individual's anxiety should be temporarily relieved.

These obsessions and compulsions are more excessive than the typical "cleanliness" as they consume a large part of the individual's day. Additionally, they cause significant impairment in one's daily functioning. Given the example above, an individual with a fear of contamination may refuse to eat at restaurants, or they may bring their utensils from home. The frequency and severity of the obsessions and compulsions varies by patient, with some having mild to moderate symptoms and only spending 1-3 hours a day obsessing or engaging in compulsive behaviors, while other patients present with severe symptoms and have nearly constant intrusive thoughts or compulsions that can become incapacitating (APA, 2022).

9.1.2. Body Dysmorphic Disorder

Body dysmorphic disorder is another obsessive disorder; however, the focus of the obsessions is with perceived defects or flaws in one's physical appearance. A key feature of these obsessions is that they are *not* observable or appear slight to others. An individual who has a congenital facial defect or a burn victim who is concerned about their scars are ***not*** examples of an individual with body dysmorphic disorder. The obsessions related to one's appearance can run

the spectrum from feeling "unattractive" to "looking hideous." While any part of the body can be a concern for an individual with body dysmorphic disorder, the most commonly reported areas are skin (acne, wrinkles, skin color), hair (particularly thinning or excessive body hair), and nose (size or shape; APA, 2022). Interestingly, the disorder can occur *by proxy* meaning the individual is not concerned with their own defects but those of another person, often a spouse or partner but at times, a parent, child, sibling, or stranger.

Due to the distressing nature of the obsessions regarding one's body, individuals with body dysmorphic disorder also engage in compulsive behaviors that take up a considerable amount of time in their day. For example, they may repeatedly compare their body to other people's bodies in the general public; frequently look at themselves in the mirror; engage in excessive grooming, which includes using make-up to modify their appearance. Some individuals with body dysmorphic disorder will go as far as having numerous plastic surgeries in attempts to obtain their "perfect" appearance.

While most of us are guilty of engaging in some of these behaviors, to meet criteria for body dysmorphic disorder, one must spend a considerable amount of time preoccupied with their appearance (i.e., on average 3-8 hours a day), as well as display significant impairment in social, occupational, or other areas of functioning. Some individuals excessively tan, change their clothes repeatedly, or compulsively shop such as for beauty products. Camouflaging perceived defects is a common behavior and could involve applying makeup, adjusting a hat or one's clothes, or covering the forehead or eyes with one's hair, all to hide or cover the perceived defect or problem area (APA, 2022).

As the DSM-5-TR notes, body dysmorphic disorder has been associated with, "abnormalities in emotion recognition, attention, and executive function, as well as information-

processing biases and inaccuracies in interpretation of information and social situations" (APA, 2022, pg. 273). These individuals tend to express a bias for negative and threatening interpretations of facial expressions and situations that would be classified as ambiguous, for instance.

9.1.2.1. Muscle dysmorphia. While muscle dysmorphia is not a formal diagnosis, it is a common type of BDD, particularly within the male population. Muscle dysmorphia refers to the belief that one's body is too small or lacks the appropriate amount of muscle definition (Ahmed, Cook, Genen & Schwartz, 2014). While the severity of BDD between individuals with and without muscle dysmorphia appears to be the same, some studies have found higher use of substance abuse (i.e., steroid use), poorer quality of life, and increased reports of suicide attempts in those with muscle dysmorphia (Pope, Pope, Menard, Fay Olivardia, & Philips, 2005). The DSM-5-TR instructs clinicians to specify if body dysmorphic disorder occurs with muscle dysmorphia.

9.1.2.2. Insight specifiers. Those diagnosed with body dysmorphic disorder vary in the degree of insight they have about the accuracy of their body dysmorphic disorder beliefs, ranging from good to absent/delusional. On average, insight is poor and at least one-third of those diagnosed with the disorder display absent/delusional insight. Mental health professionals would indicate the degree of insight regarding body dysmorphic disorder beliefs using *with good or fair insight*, *with poor insight*, or *with absent insight/delusional beliefs*. See page 272 of the DSM-5-TR for more information. Note that the insight specifier is used with OCD and hoarding disorders as well.

9.1.3. Hoarding Disorder

In hoarding disorder, the key feature is the *persistent* over-accumulation of possessions (APA, 2022). While we all obtain items throughout life, individuals with hoarding disorder continue to accumulate items without discarding possessions, regardless of their value or sentiment. This lack of discarding occurs over a long period and is not explained by a recent significant stressor (e.g., lost house in fire, so now keeps everything). For example, last week's newspaper would likely have no relevance to you or possibly any historical value, but those with hoarding disorder would keep this newspaper despite the lack of value or sentiment.

The most commonly hoarded items are newspapers, magazines, clothes, bags, books, mail, and paperwork (APA, 2022). While these items may be stored in attics and garages, individuals with a hoarding disorder also have these items cluttering their living space, sometimes to the extent that they are unable to utilize their furniture because it is covered in stuff. Cognitive factors contributing to the need to hold onto these non-sentimental items are fear of losing valuable information and fear of being wasteful. When asked to "clean out" their house or get rid of these items, individuals with hoarding disorder experience significant distress. Individuals with hoarding disorder display indecisiveness, avoidance, procrastination, perfectionism, difficulty planning and organizing tasks, and are easily distractible.

One's hoarding behaviors also impacts their daily functioning and causes impairment in social and occupational functioning. It can lead to low quality of life and in extreme cases, place the individual at risk for figure, falling, poor sanitation, and other health risks. Family relationships are often strained and conflict with neighbors and local authorities is common (APA, 2022).

You should have learned the following in this section:

- As part of OCD, obsessions are repetitive and persistent thoughts, urges, or images while compulsions are repetitive behaviors or mental acts that an individual performs in response to an obsession.
- Body dysmorphic disorder is characterized by obsessions over perceived defects or flaws in one's physical appearance.
- Muscle dysmorphia refers to the belief that one's body is too small or lacks the appropriate amount of muscle definition and is a type of body dysmorphic disorder common to men.
- Hoarding disorder is characterized by accumulating items without discarding possessions, regardless of their value or sentiment.

Section 9.1 Review Questions

1. Define obsessions and compulsions. Provide a list of examples of each thought/behavior.
2. What is body dysmorphic disorder? Give examples of characteristics that would *not* be consistent with a body dysmorphic disorder diagnosis.
3. Many of us save items throughout our lifetime that remind us of specific events. How is this different from hoarding?

9.2. Epidemiology

Section Learning Objectives

- Describe the epidemiology of OCD.
- Describe the epidemiology of body dysmorphic disorder.
- Describe the epidemiology of hoarding disorder.

9.2.1. OCD

The prevalence rate for OCD is approximately 1.2% both in the U.S. and worldwide (APA, 2022). Women are diagnosed with OCD more often than males; however, in childhood, boys are diagnosed more frequently than girls (APA, 2022). With respect to gender and symptoms, females are more likely to be diagnosed with cleaning related obsessions and compulsions. In contrast, males are more likely to display symptoms related to forbidden thoughts and symmetry (APA, 2022). The DSM-5-TR reports that the mean age of onset of OCD is 19.5 years with a quarter of cases starting by 14 years of age. Additionally, males have an earlier age of onset (5-15 yrs.) compared to females (20-24 yrs.; Rasmussen & Eisen, 1990).

9.2.2. Body Dysmorphic Disorder

The point prevalence rate for body dysmorphic disorder among U.S. adults is 2.4% while outside the U.S., the point prevalence is 1.7% to 2.9%. Gender-based prevalence rates indicate that women are more likely to be diagnosed with body dysmorphic disorder than men, though muscle dysmorphia is diagnosed more frequently in men. Additionally, women are more likely

to be preoccupied with weight, breasts, buttocks, legs, hips, and excessive body or facial hair while men have preoccupations with their genitals, body build, and thinning hair (APA, 2022).

9.2.3. Hoarding Disorder

While national studies on the prevalence rate of hoarding within the U.S. and internationally are not available, community surveys estimate clinically significant hoarding as occurring in 1.5% to 6.0% of the population (APA, 2022; Gilliam & Tolin, 2010). Clinical samples are more highly represented by females than males and older individuals (over the age of 65 years) are three times more likely to be diagnosed with hoarding disorder than younger adults.

You should have learned the following in this section:

- The prevalence rate for OCD is about 1.2% while body dysmorphic disorder is 2.4% and hoarding is estimated at 1.5% to 6%.
- In terms of gender, females are more likely to be diagnosed with the three disorders, though in terms of body dysmorphic disorder, males receive the muscle dysmorphia specifier more than females.
- Gender differences are also present for symptom presentation in OCD and the area of the body focused on in body dysmorphic disorder.

Section 9.2 Review Questions

1. What are the key gender differences related to OCD and body dysmorphic disorder?
2. How do the prevalence rate of the three disorders compare?

9.3. Comorbidity

Section Learning Objectives

- Describe the comorbidity of OCD.
- Describe the comorbidity of body dysmorphic disorder.
- Describe the comorbidity of hoarding disorder.

9.3.1. OCD

There is a high comorbidity between OCD and other anxiety disorders. Nearly 76% of individuals with OCD will be diagnosed with another anxiety disorder, most commonly panic disorder, social anxiety disorder, generalized anxiety disorder, or a specific phobia. Additionally, due to the nature of OCD and its symptoms, nearly 41% of those with OCD will also be diagnosed with a depressive or bipolar disorder (APA, 2022).

There is a high comorbidity between OCD and tic disorder, particularly in males with an onset of OCD in childhood. Children presenting with early-onset OCD typically have a different presentation of symptoms than traditional OCD. Research has also indicated a strong triad of OCD, tic disorder, and ADHD in children. Due to this psychological disorder triad, it is believed there is a neurobiological mechanism at fault for the development and maintenance of the disorders.

It should be noted that there are several disorders—schizophrenia, bipolar disorder, eating disorders, body dysmorphic disorder, and Tourette's disorder – that OCD is much more common in. Therefore, clinicians who have a patient diagnosed with one of the disorders should also routinely assess patients for OCD (APA, 2022).

Finally, OCD has a mean rate of lifetime suicide attempts of 14.2%, a mean rate of lifetime suicidal ideation of 44.1%, and a mean rate of current suicidal ideation of 25.9%. Severity of OCD, the symptom dimension of unacceptable thoughts, a history of suicidality, and severity of comorbid depressive and anxiety symptoms are predictors of greater suicide risk (APA, 2022).

9.3.2. Body Dysmorphic Disorder

Major depressive disorder is the most common comorbid psychological disorder with body dysmorphic disorder and typically occurs after the onset of body dysmorphic disorder. Additionally, there are some reports of social anxiety disorder, OCD, and substance-related disorders (likely related to muscle enhancement; APA, 2022). Those with body dysmorphic disorder are four times more likely to have experienced suicidal thoughts and 2.6 times more likely to have made suicide attempts compared to healthy control subjects and those diagnosed with eating disorders, OCD, or any anxiety disorder.

9.3.3. Hoarding Disorder

Of those diagnosed with hoarding disorder, about 75% have a comorbid mood or anxiety disorder with major depressive disorder, social anxiety disorder, and generalized anxiety disorder being the most common comorbid conditions. Additionally, nearly 20% also meet the criteria for OCD (APA, 2022).

You should have learned the following in this section:

- OCD is shown to have a high comorbidity with anxiety and depressive disorders as well as tic disorder and ADHD in children.
- Body dysmorphic disorder has a high comorbidity with major depressive disorder.
- Hoarding disorder has a high comorbidity with mood and anxiety disorders.

Section 9.3 Review Questions

1. What are the most common comorbidities for OCD? Be specific.
2. This section discussed the OCD triad in children. What two other disorders complete this triad?
3. Which disorder is body dysmorphic disorder most comorbid with?
4. What can we say about comorbidities with hoarding disorder?

9.4. Etiology

Section Learning Objectives

- Describe the biological causes of obsessive-compulsive disorders.
- Describe the cognitive causes of obsessive-compulsive disorders.
- Describe the behavioral causes of obsessive-compulsive disorders.

9.4.1. Biological

There are a few biological explanations for obsessive-compulsive related disorders, including hereditary transmission, neurotransmitter deficits, and abnormal functioning in brain structures.

9.4.1.1. Hereditary transmission. With regards to heritability studies, twin studies routinely support the role of genetics in the development of obsessive-compulsive behaviors, as monozygotic twins have a substantially greater concordance rate (80-87%) than dizygotic twins (47-50%; Carey & Gottesman, 1981; van Grootheest, Cath, Beekman, & Boomsma, 2005). Additionally, first degree relatives of patients diagnosed with OCD are at a 5-fold increase to develop OCD at some point throughout their lifespan (Nestadt, et al., 2000).

Interestingly, a study conducted by Nestadt and colleagues (2000) exploring the familial role in the development of obsessive-compulsive disorder found that family members of individuals with OCD had higher rates of both obsessions and compulsions than control families; however, the familial relationship with regards to obsessions were stronger than that of compulsions suggesting that there is a stronger heritability association for obsessions than compulsions.

This study also found a relationship between age of onset of OCD symptoms and family heritability. Individuals who experienced an earlier age of onset, particularly before age 17, were found to have more first-degree relatives diagnosed with OCD. In fact, after the age of 17, there was no relationship between family diagnoses, suggesting those who develop OCD at an older age may have a different diagnostic origin (Nestadt, et al., 2000).

Initial studies exploring genetic factors for BDD and hoarding also indicate a hereditary influence; however, environmental factors appear to play a more significant role in the development of these disorders than that of OCD (Ahmed, et al., 2014; Lervolino et al., 2009).

9.4.1.2. Neurotransmitters. Neurotransmitters, particularly serotonin, have been identified as a contributing factor to obsessive and compulsive behaviors. This discovery was made accidentally, when individuals with depression and comorbid OCD were given antidepressant medications clomipramine and fluoxetine—both of which increase levels of serotonin—to mediate symptoms of depression. Not only did these patients report a significant reduction in their depressive symptoms, but also a substantial improvement in their OCD symptoms (Bokor & Anderson, 2014). Antidepressant medications that do not affect serotonin levels are *not* effective in managing obsessive and compulsive symptoms, thus offering additional support for deficits of serotonin levels as an explanation of obsessive and compulsive behaviors (Sinopoli, Burton, Kronenberg, & Arnold, 2017; Bokor & Anderson, 2014). More recently, there has been some research implicating the involvement of additional neurotransmitters—glutamate, GABA, and dopamine—in the development and maintenance of OCD, although future studies are still needed to draw definitive conclusions (Marinova, Chuang, & Fineberg, 2017).

9.4.1.3. Brain structures. Seeing as neurotransmitters have direct involvement in the development of obsessive-compulsive behaviors, it's only logical that brain structures that house these neurotransmitters also likely play a role in symptom development. Neuroimaging studies implicate the brain structures and circuits in the frontal lobe, more specifically, the orbitofrontal cortex, which is located just above each eye (Marsh et al., 2014). This brain region is responsible for mediating strong emotional responses and converts them into behavioral responses. Once the orbitofrontal cortex receives sensory/emotional information via sensory inputs, it transmits this information through impulses. These impulses are then passed on to the caudate nuclei, which filters through the many impulses received, passing along only the strongest impulses to the thalamus. Once the impulses reach the thalamus, the individual essentially reassesses the emotional response and decides whether to act (Beucke et al., 2013). It is believed that individuals with obsessive compulsive behaviors experience overactivity of the orbitofrontal cortex and a lack of filtering in the caudate nuclei, thus causing too many impulses to transfer to the thalamus (Endrass et al., 2011). Further support for this theory has been shown when individuals with OCD experience brain damage to the orbitofrontal cortex or caudate nuclei and experience remission of OCD symptoms (Hofer et al., 2013).

9.4.2. Cognitive

Cognitive theorists believe that OCD behaviors occur due to an individual's distorted thinking and negative cognitive biases. More specifically, individuals with OCD are more likely to overestimate the probability of harm, loss of control, or uncertainty in their life, thus leading them to over-interpret potential negative outcomes of events. Additionally, some research has indicated that those with OCD also experience disconfirmation bias, which causes the individual

to seek out evidence of their failure to perform the ritual or compensatory behavior correctly (Sue, Sue, Sue, & Sue, 2017). Finally, individuals with OCD often report the inability to trust themselves and their instincts, and therefore, feel the need to repeat the compulsive behavior multiple times to ensure it is done correctly. These cognitive biases are supported throughout research studies that repeatedly find individuals with OCD experience more intrusive thoughts than those without OCD (Jacob, Larson, & Storch, 2014).

We have shown that individuals with OCD experience cognitive biases and that these biases contribute to the obsessive and compulsive behaviors, but why do these cognitive biases occur so often? Everyone has times when they have repetitive or intrusive thoughts such as: "Did I shut the oven off after cooking dinner?" or "Did I remember to lock the door before I left home?" Fortunately, most individuals are able to either concede to their thoughts once, or even forgo acknowledging their thoughts after they confidently talk themselves through their actions, ensuring that the behavior in question was or was not completed. Unfortunately, individuals with OCD are unable to neutralize these thoughts without performing a ritual as a way to put themselves at ease. As you will see in more detail in the behavioral section below, the behaviors (compulsions) used to neutralize the thoughts (obsessions) provide temporary relief to the individual. As the individual is continually exposed to the obsession and repeatedly engages in the compulsive behaviors to neutralize their anxiety, the behavior is repeatedly reinforced, thus becoming a compulsion. This theory is supported by studies where individuals with OCD report using more neutralizing strategies and report significant reductions in anxiety after employing these neutralizing techniques (Jacob, Larson, & Storch, 2014; Salkovskis et al., 2003).

9.4.3. Behavioral

The behavioral explanation of obsessive compulsive-related disorders focuses on compulsions rather than obsessions. Behaviorists believe that these compulsions begin with and are maintained through **operant conditioning**. How so? Well, an individual with OCD may experience negative thoughts or anxieties related to an unpleasant event (obsession; the event is a stimulus). These thoughts/anxieties cause significant distress to the individual, and therefore, they seek out some behavior (compulsion; the response) to alleviate these threats (i.e., escape behavior associated with negative reinforcement). This provides temporary relief to the individual, thus reinforcing the compulsive behaviors used to lessen the threat. Over time, the compulsive behaviors are reinforced due to the repeated exposure of the obsession and the temporary relief that comes with engaging in these compulsive behaviors (escape behavior).

Strong support for this theory is the fact that the behavioral treatment option for OCD-exposure and response prevention, is among the most effective treatments for these disorders. As you will read below, this treatment essentially breaks the patient's operant conditioning associated with the obsessions and compulsions by preventing the individual from engaging in the compulsive behavior until anxiety is reduced.

You should have learned the following in this section:

- Biological causes of obsessive-compulsive disorders include hereditary transmission, neurotransmitter deficits particularly in relation to serotonin, and abnormal functioning in brain structures.
- Cognitive causes of obsessive-compulsive disorders include distorted thinking such as overestimating the probability of harm, loss of control, or uncertainty in their life, and negative cognitive biases such as disconfirmation bias.
- Behavioral causes of obsessive-compulsive disorders include operant conditioning.

Section 9.4 Review Questions

1. What are the biological implications regarding the etiology of OCD and related disorders? What brain structures have been linked to these disorders?
2. Discuss identified cognitive biases that are related to the development and maintenance of OCD and related disorders?
3. The behavioral model discusses how respondent conditioning may explain the development and maintenance of these disorders. What type of reinforcement is at work and how?

9.5. Treatment

Section Learning Objectives

- Describe treatment options for OCD.
- Describe treatment options for body dysmorphic disorder.
- Describe treatment options for hoarding disorder.

9.5.1. OCD

9.5.1.1. Exposure and Response Prevention (ERP). Treatment of OCD has come a long way in recent years. Among the most effective treatment options is exposure and response prevention (March, Frances, Kahn, & Carpenter, 1997). First developed by psychiatrist Victor Meyer (1966), as you might infer from the name, individuals are repeatedly exposed to their obsession, thus causing anxiety/fears, while simultaneously prevented from engaging in their compulsive behaviors. Exposure sessions are often done *in vivo* (in real life), via videos, or even imaginary, depending on the type of obsession. For example, a fear that one's house would burn down if their compulsion was not carried out would obviously be done via imaginary exposure, as it would not be ethical to have a person burn their house down.

Prior to beginning the exposure and response prevention exercises, the clinician must teach the patient relaxation techniques for them to engage in during the distress of being exposed to the obsession. Once relaxation techniques are taught, the clinician and patient will develop a hierarchy of obsessions. Treatment will start at those with the lowest amount of distress to ensure the patient has success with treatment, as well as preventing withdrawal of treatment.

Within the hierarchy of obsessions, the individual is also gradually exposed to their obsession. For example, an individual obsessed with germs, may first watch a person sneeze on the computer in session. Once anxiety is managed and compulsions refrain at this level of exposure, the individual would move on to being present in the same room as a sick individual, to eventually shaking hands with someone obviously sick, each time preventing them from engaging in their compulsive behavior. Once this level of their hierarchy was managed, they would move on to the next obsession and so forth until the entire list was complete.

Treatment outcome for exposure and response prevention is very effective in treating individuals with OCD. In fact, some studies suggest up to an 86% response rate when treatment is completed (Foa et al., 2005). Combination treatments such as ERP with family counseling (utilizing CBT techniques) may increase this response rate even higher (Bolleau, 2011; Krebs & Heyman, 2015). Like most OCD related treatments, the largest barrier to treatment is getting patients to commit to treatment, as the repeated exposures and prevention of compulsive behaviors can be extremely distressing to patients.

9.5.1.2. Psychopharmacology. There has been minimal support for the treatment of OCD with medication alone. This is likely due to the temporary resolution of symptoms during medication use. Among the most effective medications are those that inhibit the reuptake of serotonin, clomipramine and SSRIs. Reportedly, up to 60% of patients show improvement in symptoms while taking these medications; however, symptoms are quick to return when medications are discontinued (Dougherty, Rauch, & Jenike, 2002). While there has been some promise in a combined treatment option of exposure and response prevention and SSRIs, these findings were not superior to exposure and response prevention alone, suggesting that the inclusion of medication in treatment does not provide an added benefit (Foa et al., 2005).

9.5.2. Body Dysmorphic Disorder

Seeing as though there are strong similarities between OCD and body dysmorphic disorder, it should not come as a surprise that the only two effective treatments for body dysmorphic disorder are those that are effective in OCD. Exposure and response prevention has been successful in treating symptoms of body dysmorphic disorder, as patients are repeatedly exposed to their body imperfections/obsessions and prevented from engaging in compulsions used to reduce their anxiety. (Veale, Gournay, et al., 1996; Wilhelm, Otto, Lohr, & Deckersbach, 1999). The other treatment option, psychopharmacology, has also been shown to reduce symptoms in patients with body dysmorphic disorder. Similar to OCD, medications such as clomipramine and SSRIs are generally prescribed. While these are effective in reducing body dysmorphic disorder symptoms, once medication is discontinued, symptoms resume nearly immediately suggesting this is not an effective long-term treatment option for those with body dysmorphic disorder.

Treatment of body dysmorphic disorder appears to be difficult, with one study finding that only 9% of participants had full remission at a 1-year follow-up, and 21% reported partial remission (Phillips, Pagano, Menard & Stout, 2006). A more recent finding reported more promising findings, with 76% of participants reporting full remission over 8 years (Bjornsson, Dyck, et al., 2011).

9.5.2.1. Plastic surgery and medical treatments. Many individuals with body dysmorphic disorder seek out plastic surgery to attempt to correct their deficits. Phillips and colleagues (2001) evaluated treatments of patients with body dysmorphic disorder and found that 76.4% of the patients reported some form of plastic surgery or medical treatment, with dermatology treatment the most reported (45%) followed by plastic surgery (23%). The problem

with this type of treatment is that the individual is rarely satisfied with the outcome of the procedure, thus leading them to seek out additional surgeries on the same defect (Phillips et al., 2001). Therefore, it is important that medical professionals thoroughly screen patients for psychological distress before completing any medical treatment.

9.5.3. Hoarding Disorder

Recent research has concluded that unlike OCD, many individuals with hoarding disorder do not experience intrusive thoughts, nor do they experience urges to perform rituals. Because of this difference, treatment for hoarding disorder has moved away from exposure and response prevention, and more toward a traditional cognitive-behavioral approach.

Frost and Hartl (1996) believed that individuals with hoarding disorder engage in complex decision-making processes, overanalyzing the value and worth of possessions, thus leading to hoarding the object as opposed to discarding it. Therefore, in addition to having the individual engage in exposure treatment, an added component of cognitive restructuring and motivational interviewing are added to address the complex-decision making that is involved in maintaining unnecessary possessions. By discussing motives for keeping items, as well as fears that may be associated with discarding items, clinicians can assist patients in their cognitive processes to ultimately determine the item's actual worth (Williams & Viscusi, 2016). Unfortunately, due to the distressing nature of having to discard their possessions, many individuals in treatment for hoarding disorder prematurely end treatment, thus never reaching remission of symptoms (Mancebo, Eisen, Sibrava, Dyck, & Rasmussen, 2011).

You should have learned the following in this section:

- Treatment options for OCD include exposure and response prevention, as well as SSRIs though the drug does not provide an added benefit in treatment.
- Treatment options for body dysmorphic disorder include exposure and response prevention and drugs clomipramine and SSRIs.
- Treatment options for hoarding disorder include exposure treatment, cognitive restructuring, and motivational interviewing.

Section 9.5 Review Questions

1. Discuss the various types of treatments for OCD. Which treatment option has the best outcome?
2. What are the different components of Exposure and Response Prevention? How do they work together to reduce OCD symptoms?
3. What are the most effective treatment approaches for body dysmorphic disorder?
4. According to Frost and Hartl (1996) what are the main components that contribute to the maintenance of hoarding disorder?

Module Recap

As in all modules past, we have discussed the clinical presentation, epidemiology, comorbidity, etiology, and treatment options for a specific class of disorders – obsessive compulsive and related disorders.