FEAR EXPOSURE TIME!	
• Get into groups of 3-4	
<ul> <li>Decide how each of you will do a low- to mid- level fear exposure over the next 3 hours</li> </ul>	
Be back at 1 pm, ready to discuss what you did	
and the results	
Obsessive-Compulsive Disorder	

# **Operational Definition**

- A. Either obsessions *or* compulsions:
- Obsessions as defined by (1) and (2):
  - Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted and that in most individuals cause marked anxiety or distress
  - 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)

#### **Common Obsessions**

- Unwanted thoughts of harming loved ones
- Persistent doubts that one has not locked doors or switched off electrical appliances
- Intrusive thoughts of being contaminated
- Morally or sexually repugnant thoughts

## **Operational Definition**

- Compulsions as defined by (1) and (2):
  - 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
  - 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**

- · Hand washing
- Ordering
- · Checking
- Praying
- Counting
- Thinking good thoughts to undo bad ones

-	

### **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: Completely convinced OCD beliefs are true
- *Tic-related OCD*: The individual has a lifetime history of a chronic tic disorder

## **OCD Subtypes**

- Tic-related OCD
  - May account for up to 40% of pediatric cases
  - Often male-dominated
  - High incidence of symmetry/exactness/ordering
  - Lower cleaning/contamination
  - High rates of trichotillomania and DBDs

Leckman et al. (2010)


### **OCD Subtypes**

- Early-onset OCD
  - Pre-pubertal onset of OC symptoms
  - Similar nature of OC symptoms
  - Dominated by males
  - Substantial portion will remit by adulthood
  - Increased risk of tics and trich
  - Confounded/overlapping with tic-related OCD

Leckman et al. (2010)

#### **PANDAS**

- Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcus
- Some individuals may develop OC or tics after strep infections and worse during infections
- Highly controversial and contentious area of research, with many for and against

Leckman et al. (2010)

## **OCD Symptom Dimensions**

- Some disagreement over how many dimensions are present
- Factor analytic and latent class analysis models have come up with different dimensions
- Dimensions appear to be temporally stable

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

4-factor	5-factor
Hoarding     Contamination/cleaning     Symmetry/ordering     Forbidden thoughts	<ul> <li>Hoarding</li> <li>Contamination/ cleaning</li> <li>Symmetry/ordering</li> <li>Forbidden thoughts</li> <li>Over-responsibility</li> </ul>
severity o	ctrum based on r number of symptoms

## **OCD** Prevalence

- Between 2-3% in the adult population

   Large number of "sub-clinical" cases (5%)
- Around 1% in pediatric population
- 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**

- No sex differences in adults, but many more male youth are diagnosed
- 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)

### **SES & Cultural Differences**

• Similar symptom categories across cultures, but can impact content of O/C

Abramowitz et al. (2009)

# 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)

### Comorbidity

- Different primary O/C are associated with certain patterns of comorbidity
  - Symmetry/ordering: Tics, bipolar, OCPD, panic, agoraphobia
  - Contamination/cleaning: Eating disorder
  - Hoarding: Personality disorders, especially Cluster C
- Most prevalent adult comorbids are SAD, MDD, alcohol abuse

Leckman et al. (2010)

## Impact of OCD

- Almost all adults and children 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)


## Etiology

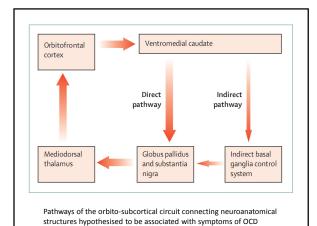
- Modestly heritable for adult onset (27-47%)
- Higher heritability for child onset (45-65%)
- Obviously, environment is still very important contributor to OCD

Abramowitz et al. (2009)

## Etiology

- Serotonin, glutamate, and dopamine dysfunctions all implicated
- Seems to be highly mediated by frontal cortico-striatal circuitry
- Overactivity of the direct pathway thought to be associated with OCD symptoms

Abramowitz et al. (2009)



## Etiology

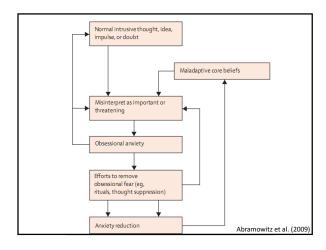
- CBT model proposes that O/C arise from dysfunctional beliefs
- The stronger the beliefs, the greater chance a person will develop OCD
- Basis is the finding that unwanted cognitive intrusions are experienced by most people, with similar contents to clinical obsessions

Abramowitz et al. (2009)

## Etiology

- Intrusions become obsession if appraised as
  - Personally important
  - Highly unacceptable or immoral
  - Posing a threat for which the individual is personally responsible
- One then attempts to alleviate distress this causes via compulsions

Abramowitz et al. (2009)



### 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

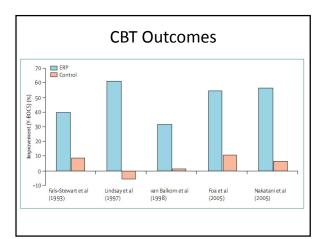
Abramowitz et al. (2009); Leckman et al. (2010)

#### **CBT for OCD**

- The treatment of choice, for both adult and child OCD; superior to meds alone
- Primarily focuses on EX/RP, which has shown effect sizes of 1.16-1.72
- Low (12%) relapse rate, but up to 25% will drop out prior to completion of treatment

## EX/RP in OCD

- Construction of fear hierarchy is key first step
- Different O/C symptoms are often interwoven in hierarchy
- Start with moderately difficult situations, as ones below will show decrease naturally



#### **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 Outcomes**

- Those with comorbidity present higher severity, but respond equally well to EX/RP
- Comorbid anxiety or depressive symptoms tend to show improvements as well, even if not specifically targeted

Storch et al. (2010)

