OBSESSIVE-COMPULSIVE DISORDER

05. Dez. 2013  Verena Kerschensteiner & Sonia Rogachev
A Typical day of an OCD patient

Chad’s OCD
1. Definition
“Obsessive compulsive disorder (OCD) is an anxiety disorder characterized by irresistible thoughts or images (obsessions) and/or rigid rituals/behaviors that may be driven by obsessions (compulsions).”
ICD 10 (I) (Worlds Health Organization ICD-10, 1992)

- **Obsessional thoughts** are ideas, images or impulses that enter the individual’s mind again and again in a stereotyped form.

- **Compulsive acts or rituals** are stereotyped behaviors that are repeated again and again for preventing some objectively unlike events, often involving harm to or caused by himself or herself.
Compulsive acts are almost invariably distressing.

The compulsion is, however, recognized as the individuals' own thought (even though they are involuntary and often repugnant).

Repeated attempts are made to resist it.

The behavior is recognized by the individual as pointless or ineffectual.
F 42 Obsessive-Compulsive Disorder

F 42.0 Predominantly Obsessional Thought Or Ruminations

F 42.1 Predominantly Compulsive Acts (Obsessional Rituals)

F 42.2 mixed obsessional thoughts and acts

F 42.8 other obsessive-compulsive disorders

F 42.9 Obsessive-compulsive disorder unspecified
the presence of obsessions or compulsions that produce significant distress and cause noticeable interference with functioning in domains such as work and school, social and leisure activities, and family settings.

- **Obsessions**: intrusive thoughts, ideas, images, impulses, or doubts that the person experienced in some way as senseless and that evoke affective distress.

- **Compulsions**: behavioral rituals or mental rituals that are senseless, excessive, and often conforming to strict idiosyncratic rules imposed by the individual.
DSM-IV 300.3 – criterion definition clusters

Cluster A
Either obsessions or compulsions

**Obsessions:**
Cluster Obsessions: A1. recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress

Cluster Obsessions: A2. the thoughts, impulses, or images are not simply excessive worries about real-life problems

Cluster Obsessions: A3. the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action

Cluster Obsessions: A4. the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

Cluster B
**Compulsions**

Cluster Compulsions: B1. repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly

Cluster Compulsions: B2. the behaviors or mental acts are aimed at preventing or reducing 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

Cluster C
Cluster C. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. Note: This does not apply to children

With Poor Insight. if, for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable

ICD-DCR-10 F 42. criterion definition clusters

**Obsessions/Compulsions**

Obsessions (thoughts, ideas or images) and compulsions (acts) share the following features, all of which must be present:

Cluster 1. they are acknowledged as originating in the mind of the patient, and are not imposed by outside persons or influences

Cluster 2. they are repetitive and unpleasant, and at least one obsession or compulsion that is acknowledged as excessive or unreasonable must be present;

Cluster 3. the patient tries to resist them (but resistance to very long-standing obsessions or compulsions may be minimal). At least one obsession or compulsion that is unsuccessfully resisted must be present;

Cluster 4. Experiencing the obsessive thought or carrying out the compulsive act is not pleasurable. (This should be distinguished from the temporary relief of tension or anxiety.)
2. Symptoms
<table>
<thead>
<tr>
<th>Obsessional thoughts</th>
<th>Compulsive Acts and rituals</th>
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<tbody>
<tr>
<td>Aggressive thoughts</td>
<td>Washing/Cleaning</td>
</tr>
<tr>
<td>Contamination</td>
<td>Checking</td>
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<tr>
<td>Sexual thought</td>
<td>Repeating</td>
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<tr>
<td>Religious thoughts</td>
<td>Counting</td>
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<tr>
<td>Collecting &amp; Hoarding</td>
<td>Ordering</td>
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<tr>
<td>Symmetry &amp; Arranging</td>
<td>Collecting &amp; Hoarding</td>
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Table 1.1  Percentage of obsessions and compulsions in OCD adult samples reported in various studies.

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Numbers in brackets refer to the relevant reference.
Differentiation!

OCD ≠ OCPD

Behavior ≠ Habbit
Case Study

- Mark was a 28-year-old single male who, at the time he entered treatment, suffered from a severe obsessive thoughts and images about causing harm to others such as running over pedestrians while he was driving. He also had severe obsessions that he would commit a crime such as robbing a store or poisoning family members or friends.

- Mark’s obsessions began in his early twenties. As the obsessions got worse, the checking ritual and avoidance of all places where such crimes would occur eventually led him to give up his career and move back to his parents.

- He virtually confined himself to his room and left it only if he had a tape recorder to record his crimes. Also, he couldn’t speak on the phone or write emails in fear of confessing some crime he had (or had not) do.
3. Prevalence, Age of onset and Gender differences
Prevalence

- OCD is more prevalent than it was once thought to be, although it is still considerably less prevalent than other anxiety disorders.

- **More than one quarter** of people experience obsessions and/or compulsions at some time. Of course, not all of them have OCD.

- The lifetime prevalence is about **2-2.5%**

- The annual prevalence is: **1-2%** of the amount of the general population.
- Obsessions and compulsions are independent phenomena
- 96% of OCD patients exhibited both of them.
- Only 2.1% evidenced obsessions in the absence of compulsive rituals.
- 1.7% compulsion without obsession.
Age and Gender Differences

- Studies show little or no gender differences in adults.

- Childhood or early adolescent onset is more common in boys than in girls and is often associated with greater severity.

- The average age of onset of OCD is 19 years of age, and it usually begins until 30 years of age.

- OCD is independent from the culture area
4. Comorbidity
Comorbidity (Murphy, 2012)

OCD and related disorders

- Hypochondriasis
- ADHD
- Trichotillomania and grooming disorders
- OC personality disorder
- Generalized anxiety disorder
- Panic/agoraphobia

OCD (with possible symptom subtypes, eg, checking, hoarding)

- Body dysmorphic disorder
- Tourette syndrome
- Chronic tic disorder
- Eating disorders
- Major depression

Other modulatory factors:
- Gender
- Age of OCD onset
- Familiality
- Insight

Others sometimes included on OCD spectrum:
- Pathological gambling
- Nonparaphilic sexual compulsions
- Kleptomania
- Internet addiction

*Schizophrenia (atypical neuroleptics?)
*Parkinson's disease
*Autism spectrum disorders
## Comorbidity (Murphy, 2012)

<table>
<thead>
<tr>
<th>Population</th>
<th>OCD (N = 334)</th>
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<th>OCD (N = 80)</th>
<th>OCD (N = 630)</th>
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**Table II.** Disorders occurring together with OCD in five clinical investigations and one epidemiologic investigation of adult OCD (modified from refs 60,71,77 compared with the incidence of these disorders in the general US population). (Percent of total N of individuals with OCD or in the general population).
5. Causes
1. **OCD as learned behavior:**

   - Mowrer’s two-process theory of avoidance learning.
   - The model predicts that exposure to feared objects or situations should be useful in treating OCD if the exposure is followed by prevention of the ritual.
   - However, this theory doesn’t explain why people with OCD develop the obsessions and/or compulsion in the first place.
2. **OCD and Preparedness** – The evolutionary context.

3. **Cognitive Casual Factors**
   a. The Effects of Attempting to Suppress Obsessive Thoughts.
   b. Appraisals of Responsibility for Intrusive Thoughts: “Thought-action fusion”.
   c. Cognitive Biases and Distortions.

4. **Potential Contributions from Traumatic Life Events**
Biological Casual Factors

1. Genetic Factors:
   - Family and twin-studies
   - The tic-related OCD
   - Genetic Polymorphism

2. OCD and the Brain.

3. Neurotransmitter Abnormalities
6. Treatments
1. **Exposure and Response prevention:**

   50-70% of reduction in symptoms.
   - The most affective approach.
   - Clients are asked to expose themselves to their obsession provoking stimuli, gradually without engaging in the rituals that the ordinary would engage in.

2. **Family treatments**
Medications

Medications that affect the neurotransmitter Serotonin:

- 40%-60% from the clients show at last a 25-35 percent reduction in symptoms.

The disadvantage:

- When the medication is discontinued, relapse rates are generally high.
Other Procedures

- Gamma knife radiosurgery

- Repetitive transcranial magnetic stimulation (rTMS).

- Deep Brain Stimulation

- Surgery:
  - Anterior cingulotomy
  - Anterior capsulotomy
Case study

- Mark was initially treated with medication and with exposure and response prevention.

- He found the side effects of the medication intolerable and gave it up within a few weeks.

- For the behavioral treatment, he was given a set of exercises in which he exposed himself to feared situations. Checking rituals were prevented. Although the initial round of treatment was not especially helpful, he did eventually make a commitment to more intensive treatment and showed a big progress.
What happens if OCD is not treated?

- Sufferer's life can become consumed, inhibiting their ability to attend school, keep a job, and/or maintain important relationships.

- Many people with OCD have thoughts of killing themselves, and about 1% complete suicide.
How is OCD prevented?

- Early recognition and treatment.

- Specifically, recognizing warning signs that a child may be at risk for developing OCD can be a place to start.

- Excessive complaints (hypersensitivity) by the child (certain clothes or food textures are intolerable, child engages in rigid patterns of behavior)
did you see that tv program on OCD the other night?

see it? I taped it and replayed it 367 times!


Thank you for your attention!