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Assessing & Treating OCD and Anxiety Disorders: A Look Across the Life Span

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What is OCD?

- OCD is a neurobiological disorder that is characterized by:
- **Recurrent**, unwanted, intrusive, and unpleasant thoughts or images (obsessions)
- **Repetitive**, ritualistic behaviors/mental acts that a person feels driven to perform (compulsions)



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DSM-5 DIAGNOSTIC CRITERIA

A. "Presence of obsessions, compulsions, or both

Compulsions are defined by 1 and 2;

1. Repetitive behaviors (e.g. hand washing, counting, etc.) or mental acts (e.g., praying, counting in head, etc.) that the individual 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/distress or preventing some dreaded event/situation.

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013.

DSM-5 DIAGNOSTIC CRITERIA

B. "The obsessions or compulsions are time-consuming (more than one hour per day) or cause clinically significant distress or impairment in social, occupational or other important areas of functioning

C. The obsessive-compulsive symptoms are not attributable to the physiological effect of substance (drug use or medication) or another medical condition

D. The disturbance is not better explained by the symptoms of another mental disorder (worries- GAD, appearance- BDD, hoarding, trichotillomania, etc.)

Specify if:

- With good or fair insight: The individual recognizes that OCD beliefs are definitely or probably not true or that they may or may not be true
- With poor insight: The individual thinks the OCD beliefs are probably true
- With absent insight/ delusional beliefs: The individual is completely convinced that the OCD beliefs are true

Specify if:

- Tic-related: the individual has a current or past history of a tic disorder



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American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013.

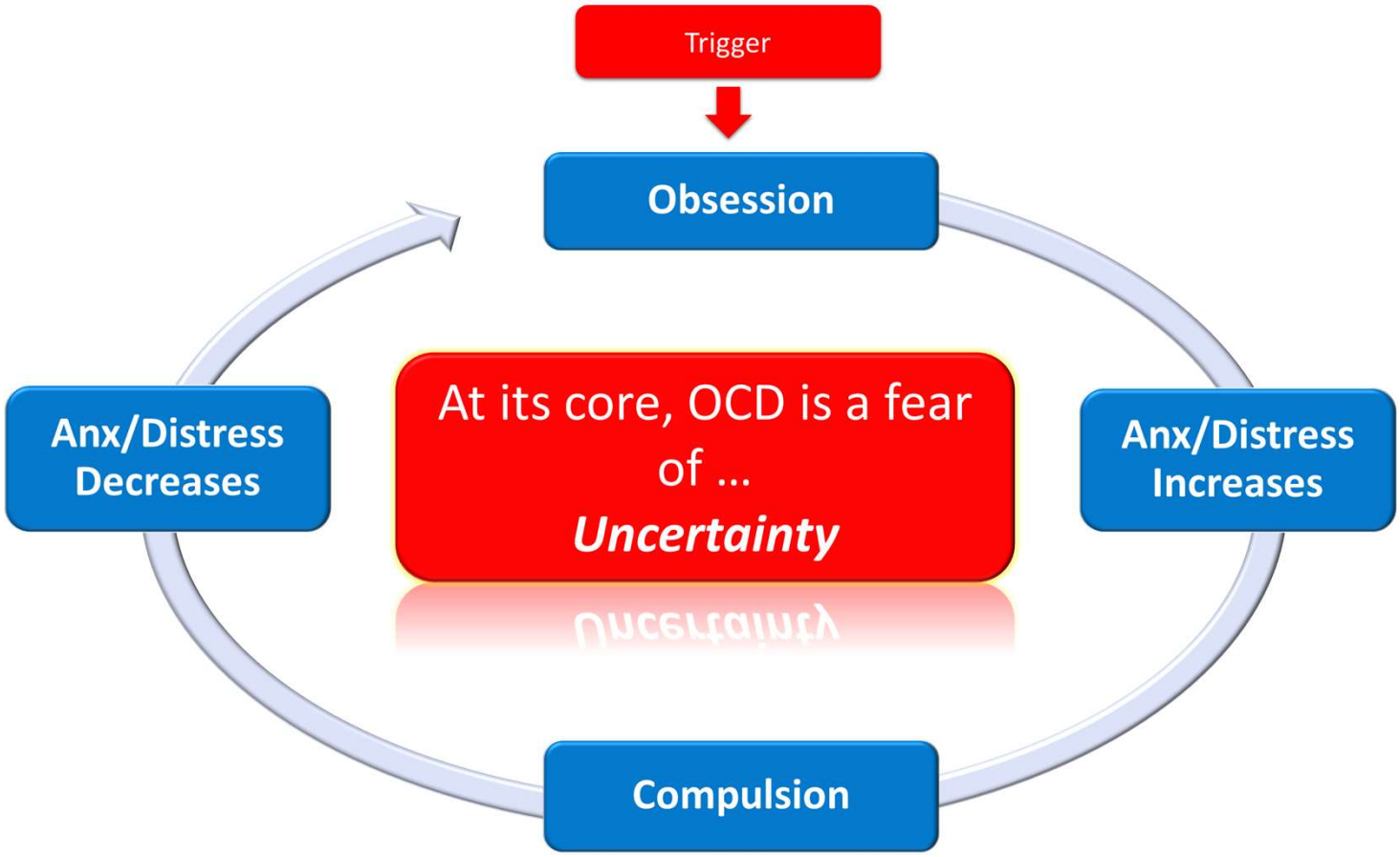
STATS

General Population	2-3%
Disabling Outcomes	~10%
Appropriate Care	17 yrs.
ERP + Meds	Best



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OCD Cycle



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Adapted from Van Kirk, N. (2021). *A roadmap for OCD treatment options: outpatient, intensive, and residential.*. Presentation conducted for the Anxiety & Depression Association of America Webinar series.

Common Obsessions

- *Fear of scary/ harmful things happening*
- *Thoughts of losing control or becoming aggressive*
  - Sleep, napping, zoning out
- *Persistent or unwanted sexual thoughts or images*
- *Unwanted blasphemous thoughts*
- *Fixation on numbers/ letters*
- *Need for symmetry/ order*
- *Concern that one's actions might endanger the health/ safety of another*
- *Worries about germs, getting sick*
- *Worries about doing something wrong*

Common Compulsions

- *Checking and rechecking*
- *Washing/ cleaning rituals*
- *Counting rituals*
- *Touching/ tapping/ rubbing*
- *Going in and out of a doorway*
- *Confessing/ reassurance seeking*
- *Re-reading and re-writing*
- *Excessive prayer*
- *Mental rituals*

A Comment on Intrusive Thoughts

- Unwanted intrusive thoughts are common in over 80-90% of the population *(Rachman, 1978).*

- The content of OCD thoughts are the same as non-OCD thoughts *(Rachman & deSilva, 1978; Morillo et al. 2007).*



Adapted from Van Kirk, N. (2022). *OCD Fundamentals in an Inpatient Setting.* Presentation conducted at McLean Hospital, Belmont, MA, United States.

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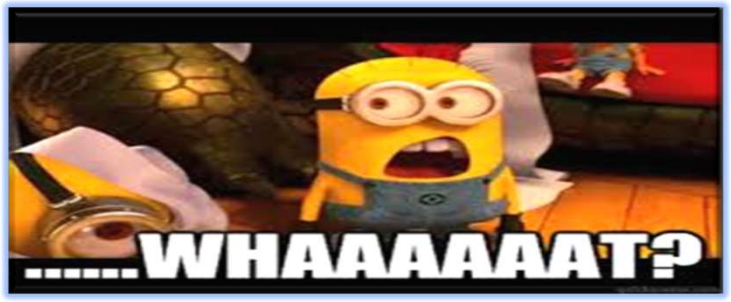
Other Noticeable Symptoms

- *Excessive Reassurance Seeking*
- *Frequent requests to use bathroom*
- *Staying in bathroom for long time*
- *Excessive hand washing resulting in chapped hands*
- *Rearranging items until it feels "just right"*
- *Need to start over if interrupted*
- *Difficulty changing tasks or fixating on one task*
- *Repetition of actions, sounds, words, or music*
- *Inability to finish work*

Diagnostic Challenges

- OCD symptoms are misidentified 38.9% of the time.

- Taboo Thoughts:
  - obsessions about sexuality (77.0%)
  - sexual obsessions about children (42.9%)
  - aggressive obsessions (31.5%)
  - Religious/moral obsessions (28.8%)



- Common Misdiagnoses:
  - GAD
  - Psychotic Disorder/Schizophrenia
  - Delusional Disorder
  - PTSD
  - Autism Spectrum Disorder

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Slide from Van Kirk, N. (2022). *OCD Fundamentals: Identifying & understanding OCD.* Presentation to the Social Work Department at McLean Hospital, Belmont, MA, United States.

(Glazier et al., 2013)

Assessment & Differential Diagnosis



Y-BOCS I + YBOCS II

Yale-Brown Obsessive Compulsive Scale

DOCS

Dimensional Obsessive-Compulsive Scale

CY-BOCS

Child Yale-Brown Obsessive Compulsive Scale

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	PTSD	GAD	OCD
Thought Content	Focused on a memories of specific past event	Focused on fear of catastrophic reactions to daily concerns	Future focused…what if?; span more domains
Repetitive Behavior	Preventing trauma from re-occurring; Feel safe/ in control	Worry ("Problem Solving") Checking (20%) Re-assurance Seeking	More rigid set of rules; focused on the 'how"; growing complexity; not tied to specific experience
Avoidance	Past memories of trauma; triggers; painful emotions	Making a mistake Acting without thorough preparation	uncertainty
Task Completion	"Doing it right" to maintain safety/control	Fully planned perfection	"Doing it perfect"
Relationship to Thoughts	To be avoided	To be analyzed "Thinking about thinking"	Must be controlled, neutralized, prevented from coming true
Underlying Feature	Avoiding emotional pain & re-experiencing trauma	Preparing for "inevitable" negative outcomes	Preventing possible feared consequences; intolerance of uncertainty

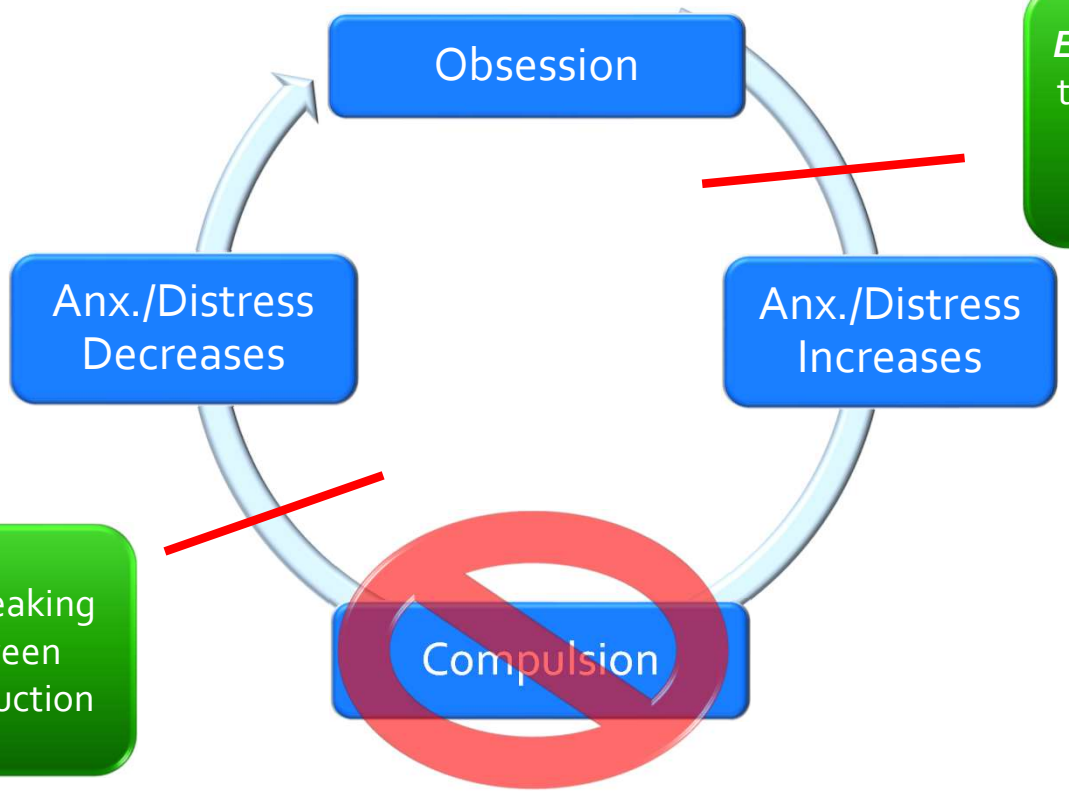
Slide from Van Kirk (2015). When fears become real: Post-traumatic OCD. Symposium presentation at the 22nd annual International Obsessive Compulsive Disorder Foundation conference, Boston, MA.

Treatment for OCD

- Pharmacology- SSRI's, TCA & SNRI

  Luvox®, Zoloft®, Celexa®, Lexapro®, Prozac®, Paxil®, Anafranil® (Clomipramine HCl), Effexor® (SNRI) (*http://iocdf.org/about-ocd/treatment/meds/*)

- Front line treatment is **Exposure with Response Prevention** (ERP; Foa, Yadin & Lichner, 2012) with a meta-analytic effect size of 1.41 (Abramowitz, 1996).
- CBT (based on foundations of ERP) demonstrates a similar effect size (*d* = 1.39; Eddy et al., 2004).
- ACT augmented ERP found to be equally as effective as ERP (Twohig et al., 2018)



Extinction: Reduction in the conditioned anxiety response associated with obsessions

Ritual Prevention: Breaking the association between rituals and anxiety reduction

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Slide from Van Kirk, N. (2017). *OCD & the spectrum disorders: What is it really?.* Presentation to the Behavioral Health Partial Program Practicum Series at McLean Hospital, Belmont, MA, United States.

(Abramowitz, 2013; Kozak & Foa, 1997)

Translating Theory into Practice

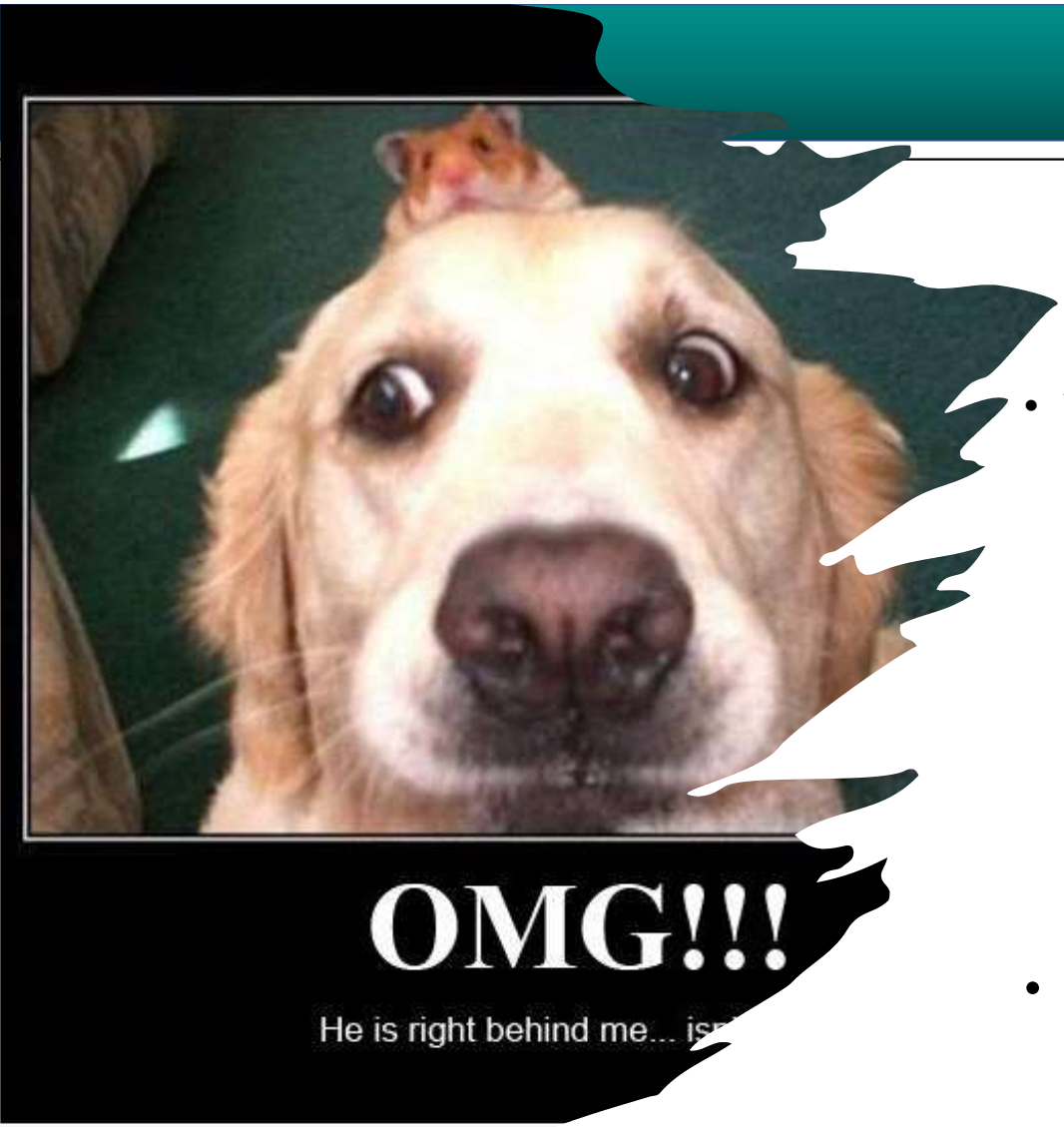
Exposure

- Goal:
  - Teach clients that anxiety is fleeting
  - Build confidence in client's ability to face their fears
- Practical Notes
  - Repeated & Prolonged
  - In vivo & imaginal
  - Systematic & gradual

Response Prevention

- Goal:
  - Teach clients more effective ways of managing distress
- Practical Notes
  - Forced blocking of rituals reduces effectiveness
  - Impact of subtle rituals & mental rituals

Slide from Van Kirk, N. (2017). *OCD & the spectrum disorders: What is it really?.* Presentation to the Behavioral Health Partial Program Practicum Series at McLean Hospital, Belmont, MA, United States.



Therapeutic Considerations

- You are not proving something is safe through ERP, instead you are helping clients tolerate uncertainty more effectively
  - While you don't want to create objectively dangerous situations, be careful about statements like "I won't have you do anything dangerous" - it can serve as re-assurance
    - Look out for questions like "are you sure this is safe?", "is this really ok to do?", "you would tell me if it becomes dangerous right?"

- Inhibitory learning (Craske et al., 2008 & 2014) has provided an additional avenue for understanding of how to enhance outcomes.

Slide adapted from Van Kirk, N. (2022). *OCD Fundamentals in an Inpatient Setting.* Presentation conducted at McLean Hospital, Belmont, MA, United States.

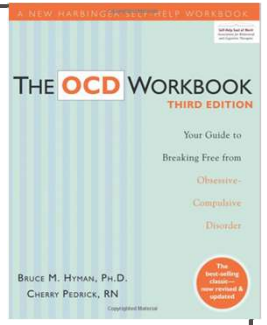


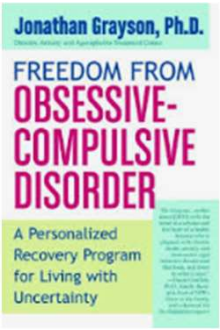
Identifying & Addressing Accommodation

TREATMENT FOR OCD

Inpatient/ Residential Services, Outpatient/ Intensive Outpatient







OCD CHALLENGE

Self-help

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Support Groups

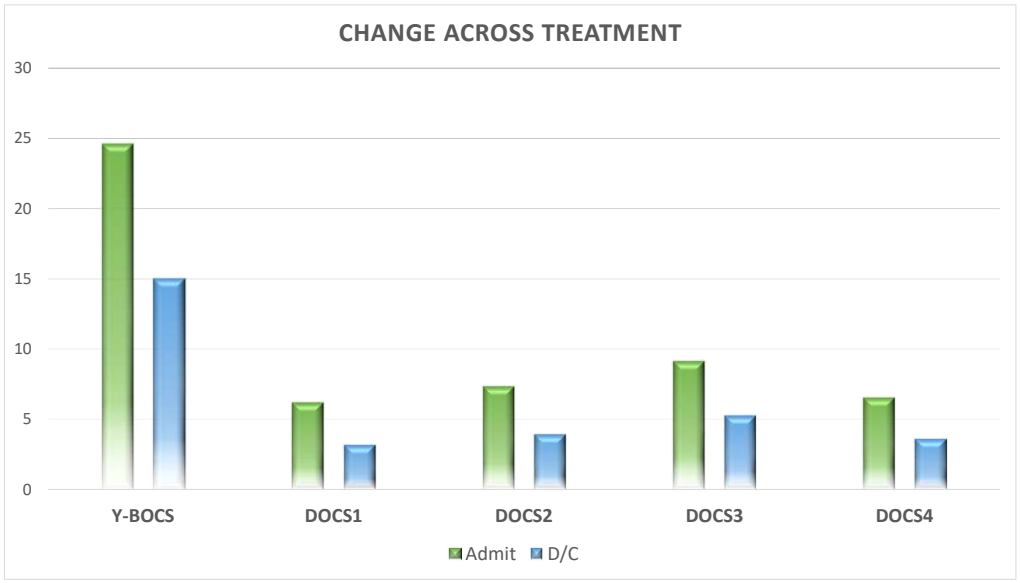


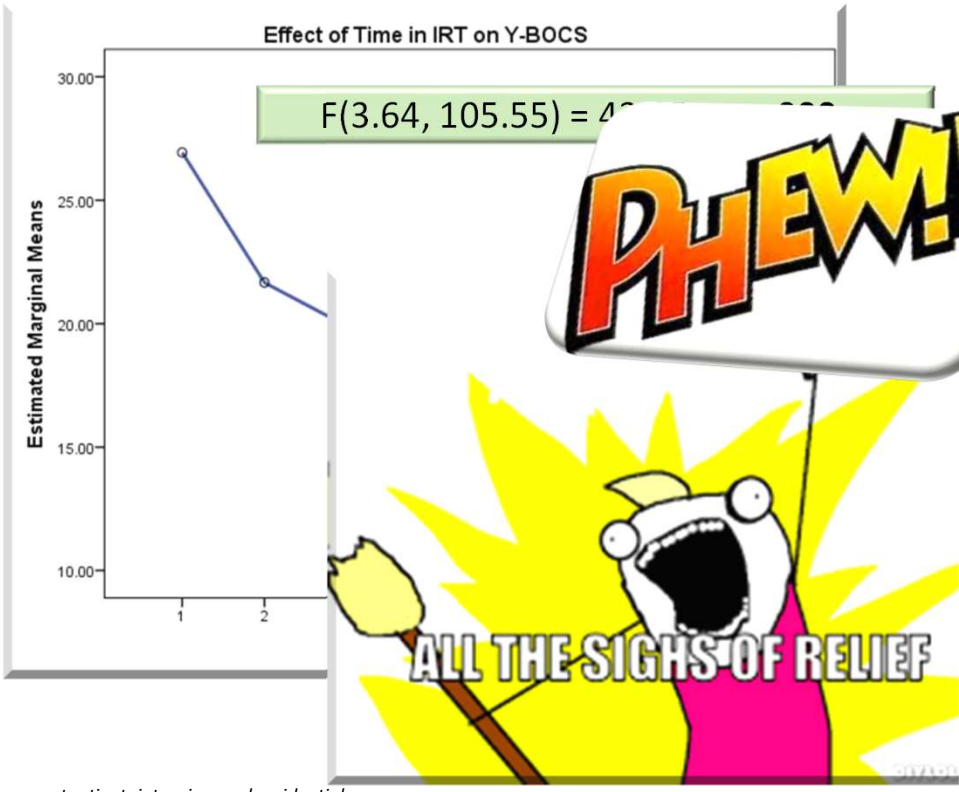
When should a higher level of care be considered?

- When stepping away from day to day life would allow for greater focus on treatment.
- If OCD symptoms are interfering with ability to do daily self-care tasks.
- Struggling to engage with independent exposure practices.
- Require more support due to severity or complex presentations.
- Lack of local services to meet an individual's need.
- Desire to maximize treatment gains in short amount of time to get back to daily life.

Slide from Van Kirk, N. (2021). *A roadmap for OCD treatment options: outpatient, intensive, and residential.*. Presentation conducted for the Anxiety & Depression Association of America Webinar series.

Impact of I/RT on OCD Symptoms





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International OCD Foundation

www.iocdf.org

Info@iocdf.org

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If you or anyone you know is ever feeling unsafe please call 911, go to your local ER or call the suicide prevention line at:

800-273-8255

McLean OCD Institute

- Residential Support
- Intensive Outpatient Treatment
- Outpatient Treatment

Mcleanhospital.org

www.mcleanhouston.org

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