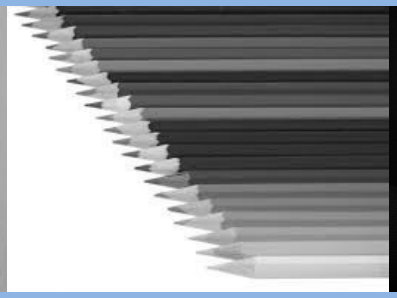


OBSESSIVE-COMPULSIVE DISORDER

05.Dez. 2013 Verena Kerschensteiner & Sonia Rogachev

A Typical day of an OCD patient

Chad´s OCD

1. Definition

OCD (Stöppler, 2012)

"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.

ICD 10 (II) (Ibid., 1992)

- 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**

Classification ICD 10 (Ibid. 1992)

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

OCD DSM-IV (McKay & Abramowitz, 2007)

- **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 he 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 arc 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

Obsessional thoughts	Compulsive Acts and rituals
Aggressive thoughts	Washing/Cleaning
Contamination	Checking
Sexual thought	Repeating
Religious thoughts	Counting
Collecting & Hoarding	Ordering
Symmetry & Arranging	Collecting & Hoarding

(Zohar, 2012)

Table 1.1 Percentage of obsessions and compulsions in OCD adult samples reported in various studies.

Study	[4] ($n = 560$)	[5] ($n = 354$)	[6] ($n = 180$)	[7] ($n = 293$)	[8] ($n = 485$)	[9] ($n = 343$)
Obsessions						
Aggressive	31	44	56	71	58	36
Contamination <--	50	35	60	58	59	48
Sexual	24	15	17	13	26	10
Hoarding		18	11	29	34	12
Religious		22	22	26	31	8
Symmetry	32	36	32	48	50	42
Somatic	33	23	26	26	40	12
Compulsions						
Washing/cleaning	50	35	59	60	59	47
Checking <--	61	43	72	69	73	47
Repeating rituals		42	58	56	52	31
Counting	36	29	16	26	34	14
Ordering	28	29	25	43	50	22
Hoarding	18	16	13	28	36	12

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.

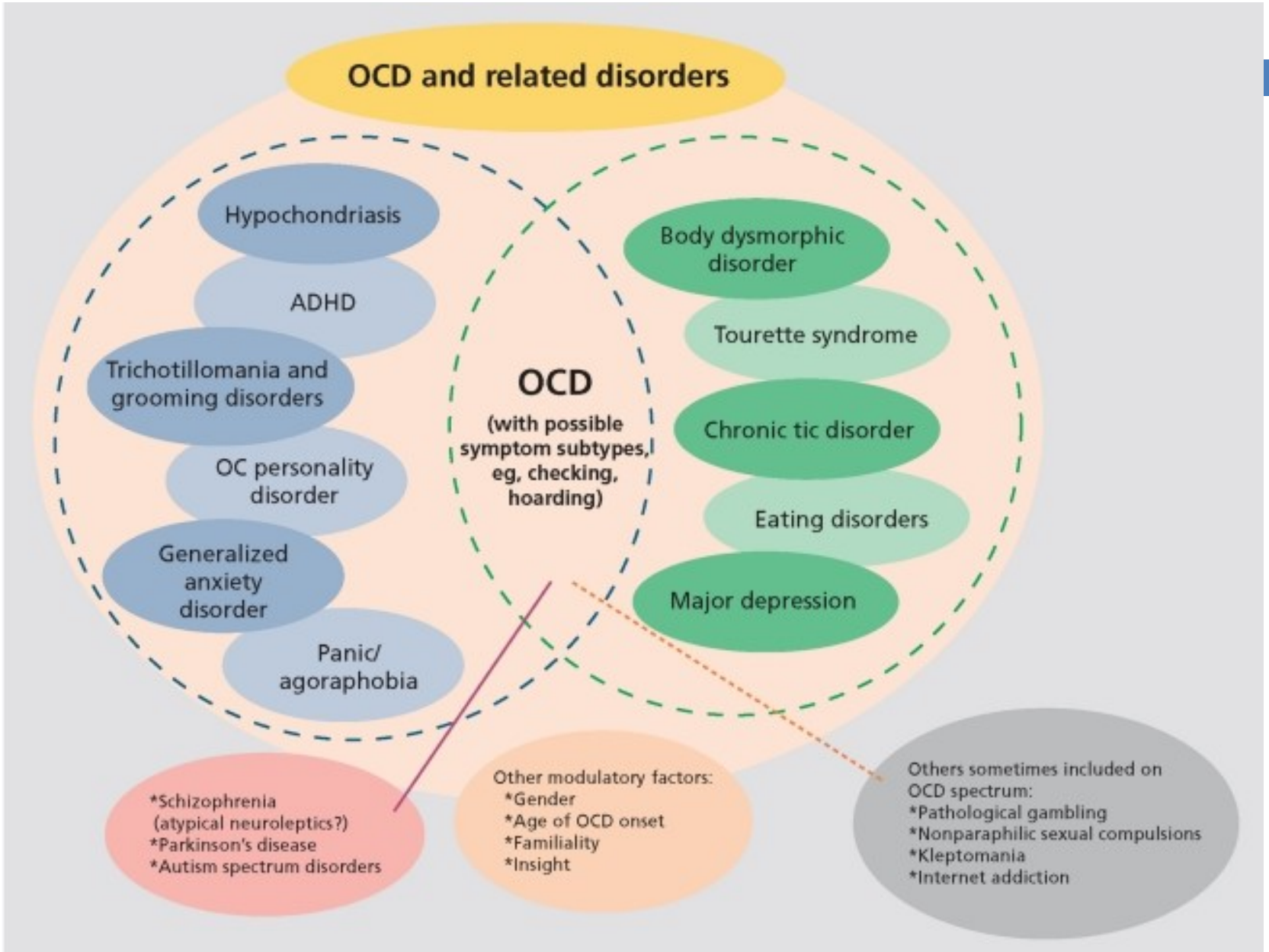
- **Obsessions and compulsions are independent phenomena**
- 96% of OCD patients exhibited both of them.
- Only 2,1% evidenced obsessions in the absence of compulsive rituals.
- 1.7% compulsion without obsession.

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)



Comorbidity (Murphy, 2012)

Population	OCD (N = 334)[71]	OCD (N = 206)[60]	OCD (N = 80)[77]	OCD (N = 630)[79]	OCD (N = 418)[57]	OCD (N = 2073)[72]	General US Population (N = 8098)[78]
Major Depressive Disorder	66	38	54	70	67	41	17.1
Dysthymia	24	---	8	11	14	13	6.4
Social Phobia	23	---	36	37	43	44	13.3
Panic Disorder	23	19	21	6	21	20	3.5
Alcohol Abuse/Dependence	23	---	15	8	16	39	23.5
Generalized Anxiety Disorder	18	43	13	35	46	8	5.1
Agoraphobia	18	---	17	6	16	8	5.3
Substance Abuse/Dependence	14	---	8	2	9	22	11.9
Specific Phobia	12	---	31	---	39	43	11.3
Trichotillomania	10	---	---	36	9	---	---
Bulimia Nervosa	10	---	---	3	5	---	---
Anorexia Nervosa	9	---	---	3	6	---	---
Post Traumatic Stress Disorder	8	---	---	16	10	19	---
Bipolar I/II Disorders	13	7	1	10	7	23	1.6
Body Dysmorphic Disorder	6	---	---	12	12	---	---
Tourette's Disorder	4	---	---	7	---	---	---
Autism Spectrum Disorders	3	---	---	---	---	---	---
Binge-Eating Disorder	1	---	---	---	1	---	---
No Comorbid Disorder	8	---	---	---	---	10	52.0

Table II. Disorders occurring together with OCD in five clinical investigations[57,60,71,77,79] and one epidemiologic[72] investigation of adult OCD (modified from refs 60,71,77 compared with the incidence of these disorders in the general US population[78]). (Percent of total N of individuals with OCD or in the general population).

5. Causes

Psychological Casual Factors (I)

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.

Psychological Casual Factors (II)

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

Behavioral 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 engage 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!

List of References

Butcher, M.N., Mineka, S., & Hooley, J.M. (2010). Abnormal Psychology , 14th Edition.

Cromer, k, Schmidt.N, Murphy, D. (2007). An investigation of traumatic life events and obsessive-compulsive disorder. *Behaviour Research and Therapy*, 45 (7), 1683-1691.

Dar. R, Rish. S, Hermesh. H, TaubM, Fux. M. (2000). Realism of confidence in obsessive-compulsive checkers. *Journal of Abnormal Psychology, 109 (4), 673-678.*

Grootheest.V, Catch.D, Beekman.A, Boomsma. D, (2007). Genetic and environmental influences on obsessive-compulsive symptoms in adults: a population-based twin-family study. *Psychological Medicine, 37, 1635-1644.*

Lindquist.C.(1995). Gamma knife Radiosurgery. *Seminars in Radiation Oncology,* 5(3), 197-202.

McKay, D. T., & Abramowitz, S. (2007). Obsessive-Compulsive Disorder : Subtypes and Spectrum Conditions. Jordan Hill, GBR : Elsevier Science & Technology .

Murphy, D. L. (2012, June). *Dialouges in Clinical Neuroscience.* Retrieved 12 03, 2013, from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181955/

List of References

Rachman. S, Hodgson.R. (1980). *Obsessions and compulsions.* Englewood Cliffs, N.J.: Prentice-Hall

Rachman,S, Shafran. R, Riskind, J. (2006). *Cognitive vulnerability to emotional disorders*, Lawrence Erlbaum Associates, Inc, London.

Purdon. C. (2004). Empirical investigations of thought suppression in OCD. Journal of Behavior Therapy and Experimental Psychiatry, 35 (2), 121-136.

Stöppler, M. C. (2012, 03 10). *medicinenet.com*. Retrieved 12 2013, 02, from http://www.medicinenet.com/obsessive_compulsive_disorder_ocd/article.htm

World Health Organization ICD-10. (1992). Retrieved 12 03, 2013, from http://www.mentalhealth.com/icd/p22-an05.html

Zohar, J. (2012). Obsessive Compulsive Disorder: Current Science and Clinical Practice. Hoboken, HJ, USA: John Wiley & Sons, Ltd.

Thank you for your attention!