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and

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Royal College of Psychiatrists Wednesday 21st February, 2024

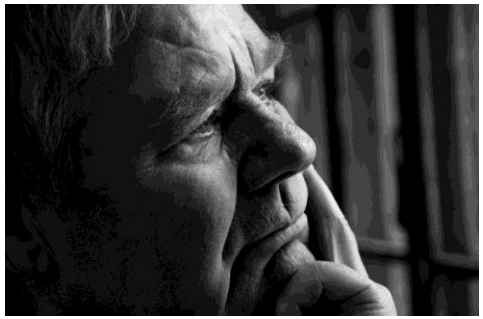
CBT for OCD and Related Disorders.

Plan of Today

- Description of OCD and why it is a serious disorder
- Why CMHTs and others need to know about OCD and what are the current issues with OCD treatment?
- Treatment of OCD
  - Psychopharmacology (brief overview as often used concurrently with CBT)
  - Psychological intervention (CBT; ERP and third wave treatment)
- How do you set about treating OCD with psychological treatments.? (detailed description)
- What can go wrong and how to tackle this.
- Conditions Comorbid with OCD
  - Depression
  - Autism and neorodevelpmental disorders
  - Schizophrenia
- Conditions Related to OCD
  - Tics
  - Trichotillomania
  - Skin Picking
  - Hoarding Disorder
  - Hypochondriasis and Health Anxiety

Obsessive Compulsive Disorder
Two Components:

Obsessions

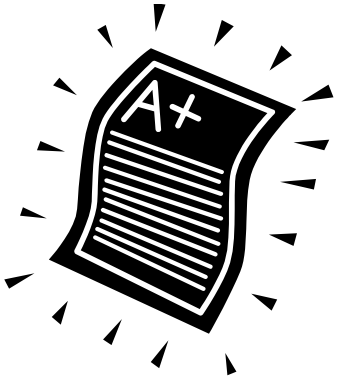


Compulsions

Obsessions

- Thoughts images or impulses that are extremely unpleasant, worrying and anxiety-producing

Obsessions Examples

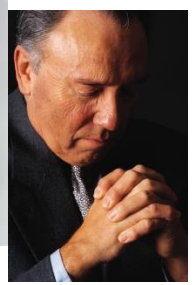
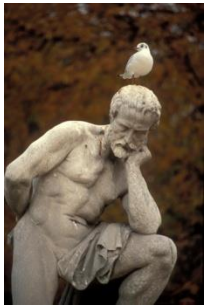


- Standing on a tube platform and feeling you may jump off
- Fear you may make yourself or others ill by "contamination"
- Fear of harm occurring to self or family due to an act of omission
- Fear that everything you do must be "perfect" or else you will fail spectacularly
- Thoughts of harm towards loved ones or strangers (violence; being a sex offender)
- Blasphemous thoughts

Compulsions

- Behaviours or thoughts that are designed to reduce or prevent the hard that is the theme of the Obsessive Thought

Compulsions Examples

- Excessive Handwashing and Cleaning
- Checking doors, electrical appliances et c.
- Counting rituals
- Praying to prevent harm
- "Reliving" past events to ensure actions were "correct"
- Repeating Actions
- Asking for REASSURANCE from others

Can anyone get OCD??

Who Gets OCD?

- Both Men and Women **(Mathes et al. Curr . Psychiatr Rep 2019 Apr 23;21(5):36.**
- Onset is generally (Brakoulias Compr Psychiatry 2017 76:79-86) :
  - Early adult life
  - Prepubertal (less common)
- Most common psychological disorder in children
- Runs in families and families with history of other psychiatric conditions eg schizophrenia (Devi et al, Compr Psychiatry 2015 Jan;56:141-8)

Does OCD matter??

Does OCD Matter?

- At the severe end of the spectrum it has been demonstrated that OCD causes more distress and social maladaption than conditions such as schizophrenia (Rosa et al J Psychiatr Res 2012 Oct;46(10):1286-92., Subramaniamnet el CNS Drugs2013 May;27(5):367-83.)
- OCD is ranked by WHO as one of the top 10 causes of disability wordwide (Fact Sheet No. 217: The 'Newly Defined' Burden of Mental health problems April 1999)
- "Silent" problem as rarely causes sensation
- Many sufferers living alone or with elderly parents
- I.5% of people with OCD die by suicide and 16 % engage in suicidal behaviour (Benatti et al. (2021) Prevalence and correlates of current suicide risk in an international sample of OCD adults: A report from the International College of Obsessive-Compulsive Spectrum Disorders (ICOCS) network and obsessive compulsive and related disorders network (OCRN) of the European College ofNeuropsychopharmacology. Journal of Psychiatric Research , 140: 357-363)
- Premature death and increase in chronic ill-health (Drummond et al, 2012 General Hospital Psychiatry, 34(6):618-25)

Physical effects of severe OCD

Drummond et al. Gen Hosp Psychiatry2012 Nov-Dec;34(6):618-25

- 20% had permanent kidney disease due to lack of drinking sufficient fluid
- More likely to have raised blood lipids than patients with other psychiatric diagnoses despite being on much lower dosages of drugs such as antipsychotic agents.
- Almost 50% were incontinent of urine or faeces

OCD: Misunderstandings

- I've had people describe profound OCD to me saying "these people are too ill to have OCD". OCD can present in a severe almost catatonic state

- I've had people claim someone with OCD is not sectionable as the "have Capacity and are not psychotic".
  - Psychosis is not a prerequisite for section
  - Almost all people with severe OCD lack capacity with respect to their obsessive fears.

This is The Reality

- Twitter:
  - Too ill for IAPT;
  - Too traumatised for CBT
  - Too OCD for trauma therapy
  - Too PD for OCD services
  - Not sufficiently severe for CMHT service….

The Scandal of People Being Left Untreated

MoS

22 October 2022

- https://www.dailymail.co.uk/health/article-11343553/Why-did-THREE-years-diagnose-one-mothers-OCD-Experts-warn-NHS-failing-THOUSANDS.html


12:22

Why did it take THREE years for doctors to diagnose one mother's OCD and offer help? Experts warn NHS is failing THOUSANDS of patients as cases soar to record highs

By Rosie Taylor For The Mail On Sunday
22:00 22 Oct 2022, updated 22:00 22 Oct 2022

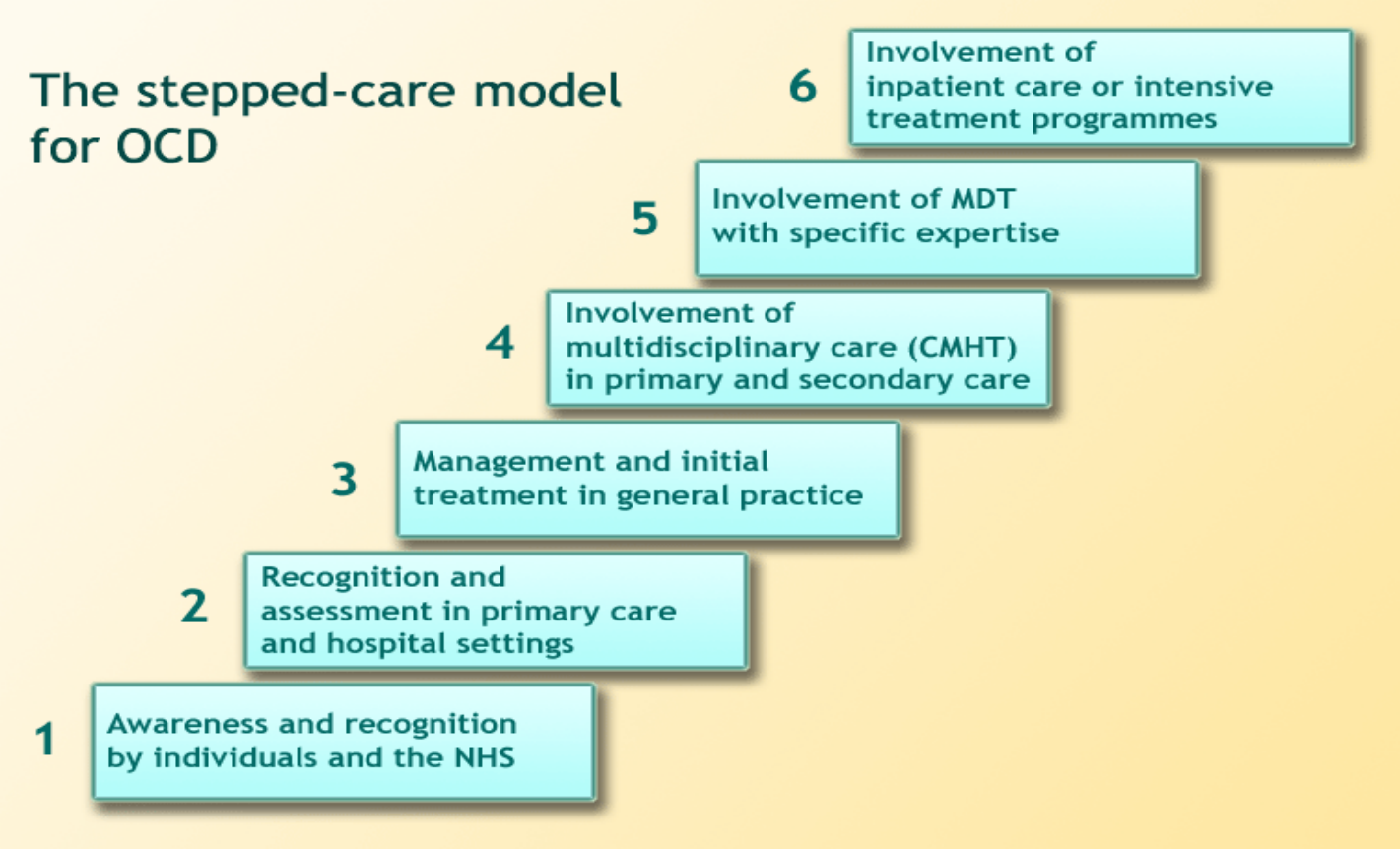
69 shares

2 comments

Mental health services are failing thousands of Britons who suffer with life

Search and register in a few clicks.

NICE Guidance 2005



Initial Diagnosis of OCD

- Initial Diagnosis of OCD
- Issues in IAPT (most have no psychiatrist and most do not use diagnoses)
- Gap between IAPT and CMHT
- Gap between CMHT and Specialist OCD Services

So with 1-3% of the population having clinical OCD where are the gaps in provision ?

- People with OCD are often reluctant to seek help initially
  - Stigma
  - Feeling silly
- They are not recognised as having OCD and/ or a serious problem
  - Told not to worry
- Many are diagnosed as having anxiety and/or depression

IAPT

- IAPT services vary what they offer people with OCD
  - Some offer generic “anxiety-management”
  - Most do not prescribe
  - Very few an offer home-based treatment .
- Difficult to know how many improve in IAPT
- Many disappear and are told they “are not suitable for CBT”

But is this really happening??

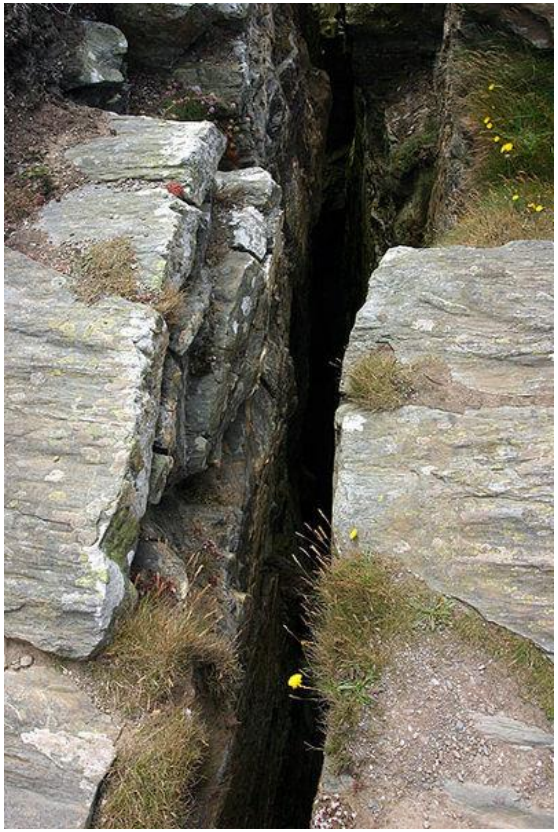
Sumeet Gupta and Gagandeep Singh

A tale of two mental health trusts – audits of management of OCD. Presentation at ACoMHS meeting, Royal College of Psychiatrists, 20th February 2019.

Singh and Gupta, 2009

- In North Yorkshire, the specific catchment population area was 602,086. It would this be anticipated that 6020 people with OCD would be in treatment. If, as in previous studies 60% improved with initial CBT then it would be anticipated that 3615 would be in treatment with the CMHT. In reality, over a 2.5 year period only 15 people were referred.
- In Cheshire and Wirral , with an active clinical CMHT case load of 5500, only 66 patients were diagnosed with OCD (0.012% of total caseload)

Chasm Between IAPT and CMHT



Number of Patients in England with Clinically significant OCD Needing Treatment

- OCD has a prevalence of between 1-3 % of the population.
- In England the adult population is approx. 67.1 million
- Therefore people with OCD (even at 1%) = 671K
- If 60% were to improve in IAPT (generous figure) then **268,400** people in England alone require treatment for OCD who have failed IAPT

From April 2007, National Highly Specialised Services of the DoH Commissioned the following:

- South-West London and St Georges
  - Inpatient Beds (10-14)
  - Home-based treatment services (including in-reach)
  - OP
- South London and Maudsley
  - OP
  - Hostel Services (up to 10)
  - Child and Adolescent
- Herts Partnership Trust
  - Inpatient (2)
  - OP
  - Home-based treatment services (including in-reach)
  - OP
- Priory
  - Inpatient Beds (2)

TOTALS = 28 inpatient beds plus limited Outpatient, Home-based and Inreach facilities. TOTAL treatment capacity = <300 patients per annum

THIS MEANS IT WOULD TAKE 894 YEARS FOR HIGHLY SPECIALIST SERVICES TO TREAT ALL THOSE DISCHARGED FROM IAPT

Drug Treatment for OCD

Drug Treatment of OCD - CLOMIPRAMINE

Drug	Dose	Major side effects	Any special features
Clomipramine	Up to 225mg at night (increase slowly as tolerated)	Seizures in a small number of patients and less likely if <250mg Sexual Dysfunction in 80 % Dry mouth; blurred vision drowsiness; weight gain and orthostatic hypotension	The first SRI to demonstrate effectiveness in reducing OCD symptoms It is a tricyclic

Drug Treatment of OCD - SSRIs

Drug	Dose	Major side effects	Any special features
Fluvoxamine (Faverin)	50 mg in evening initially and increased gradually to 300mg (divided doses for >150mg)	Gastro-intestinal upsets; anorexia and weight loss. Insomnia Hypersenstitivity reactions Sexual dysfunction in 30% Rare side-effects include movement disorders;galactorrhoea; urinary retention et c.	The first SSRI to be widely used for OCD May have more side-effects than others?

Drug Treatment of OCD - SSRIs

Fluoxetine (Prozac)	20mg (usually morning) and then if inadequate response after 2 weeks then increase up to maximum of 60mg	As above	Long-half life
Paroxetine (Seroxat)	10mg initially in the morning increasing to 40mg if required	As above	Maximal dose of paroxetine is 50mg
Sertraline (Lustral)	50mg (usually morning) increasing over several weeks to maximum of 200mg if required	As above	
Citalopram (Cipramil)	20mg increase over time to maximum of 60mg (morning or evening)	As above	Now cannot be recommended for new OCD sufferers
Escitalopram (Cipralex)	10mg increase over time to maximum of 20mg (morning or evening)	As above	The active enantiomer of citalopram **Evidence that Escitalopram prevents relapse in OCD[1]**

Studies on SRI Drugs

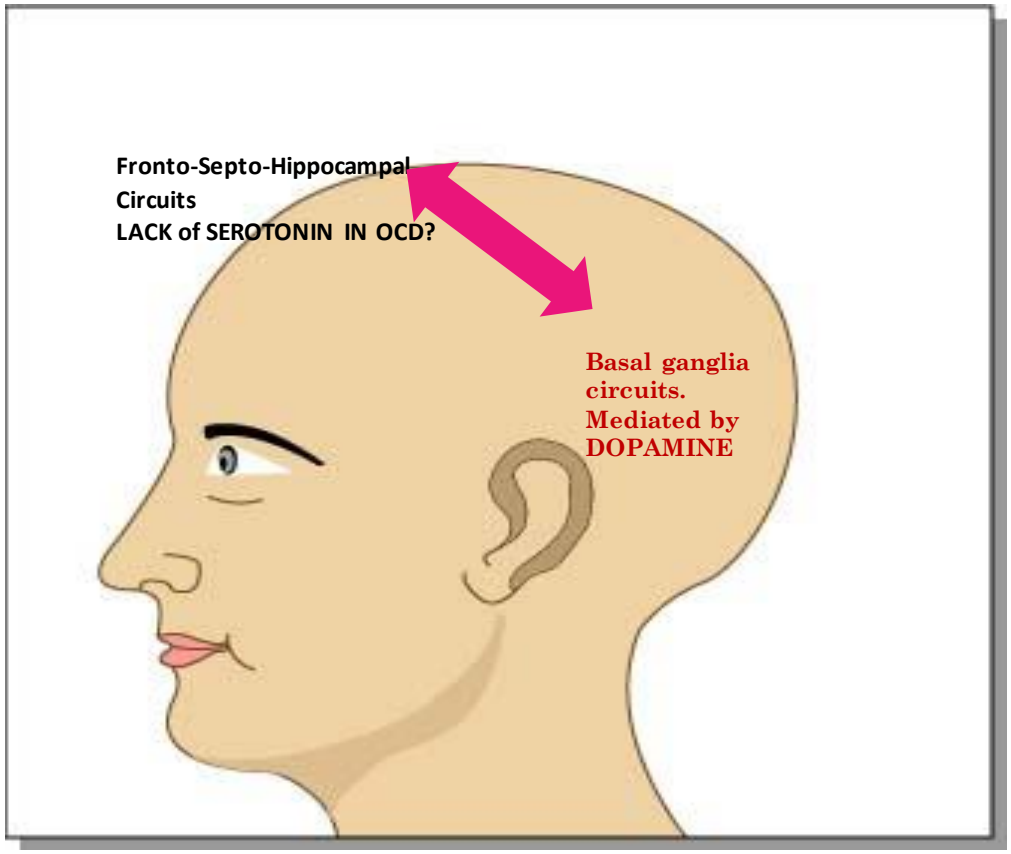
- Overall **c.50%** of patients will respond to an SRI (Goodman et al, 1992 International Clinical Psychopharmacology: 7:35-38 . Erzegovesi et al., 2001 J Clin Psychopharmacol:488-92.)
- Symptom reduction on standardised measures is c.35% (Dougherty et al., 2004)
- Response of **OCD** to **SRIs** is **SLOW and GRADUAL**
- Incremental improvement over weeks or months
- **40-45%** improvement at 10 weeks but **continued improvements up to 2 years** in large multicentre trial (DeVeaugh-Geiss, 1994 Advances in Pharmacology, 30, 35-52)

Psychopharmacological Approaches to SRI Refractory OCD

Psychopharmacological Treatment for Refractory OCD

- There are 2 main approaches to this and also some new ideas.
- **Dopamine Blockade**
  - **This is the most likely intervention outside of a specialist centre and is the most extensively researched**
  - **Doses of drug is normally considerably lower than that used for psychotic illness**
- **Supranormal doses of SSRI**
  - **Some patients are rapid metabolisers of SSRIs and thus higher doses are required**
  - **Blood levels should be checked and so this is best done at a specialist OCD clinic**

Adding Dopamine Blockade to SRIs



Psychopharmacological Treatment for Refractory OCD - Dopamine Blocking Agents

There are many side-effects with Dopamine Blocking agents e.g. tardive dyskinesias and Prolactin-related side-effects which are not specifically listed as they are less likely to occur with the low doses used in OCD

Psychopharmacological Treatment for Refractory OCD- Dopamine Blocking Agents

Drug	Dose	Major side effects	Any special features
Risperidone	Start at 500 micrograms and titrate according to response	Weight gain dizziness; postural hypotension and side effects for all atypical antipsychotics	PROBABLY MORE EVIDENCE at present than for others
Aripiprazole	Start on 2.5 mg and titrate up to maximum of 10mg	Weight gain dizziness; postural hypotension and side effects for all atypical antipsychotics	No controlled trials but case series seem very promising

Psychopharmacological Treatment for Refractory OCD - Dopamine Blocking Agents

Olanzepine	Start at 2.5mg and titrate according to response g	As other atypical antipsychotics	Weight gain can be a major problem. Only small studies which fail to show benefit
Amisulpiride	Start at 50mg and titrate according to response	As other atypical antipsychotics plus insomnia, agitation and GI symptoms	Only small studies which fail to show benefit
Quetiapine	Start at 25mg and titrate according to response	As other atypical antipsychotics plus insomnia, agitation and GI symptoms	Only small studies which fail to show benefit

Efficacy of augmentation for OCD with Dopamine Blockers

- Overall only 1/3of SRI refractory patients improve with addition of Dopamine Blockade

  (Pittenger and Bloch, 2014 , Psychiatric Clinics of North America, 37 (3) 375-391)

- Most of the studies are small but some better evidence for rispiridone than others. More recently encouraging results from aripiprazole

  (PAMPALONI,I., KHAN,M., TYAGI,H. and DRUMMOND L.M. (2017). Aripiprazole Augmentation in Profound, SRI-Refractory Obsessive-Compulsive Disorder. European Neuropsychopharmacology 27 (6): 616

- Overall c. 2/3rd people with OCD respond to psychopharmacology alone (Pittenger and Bloch, 2014 , Psychiatric Clinics of North America, 37 (3) 375-391)

HOWEVER!!!!

- Remember that adding CBT with ERP to the SRI is MORE EFFECTIVE than drug augmentation

- Cognitive-behavioral therapy vs rispiridone for augmenting SRIs in OCD: a randomised controlled trial. (Simpson HB et al. 2013 JAMA Psychiatry. Nov;70(11):1190-9.)

Psychological Approaches to OCD

Potential Psychological Treatment for OCD

- **Graded Exposure with Self-imposed Response Prevention = ERP**
  - This has the most evidence base
- Cognitive Behaviour Therapy = CBT
  - "Exposure " is still present but is framed as tests to challenge the negative automatic thoughts.
- Cognitive methods such as Danger Ideation Reduction Therapy = DIRT
- Habit Reversal
- Eye Movement Desensitisation and Reprocessing = EMDR
- Dialectical Behaviour Therapy
- Third Wave Therapies based on Mindfulness

Recent Review of Psychotherapies for OCD in Adults

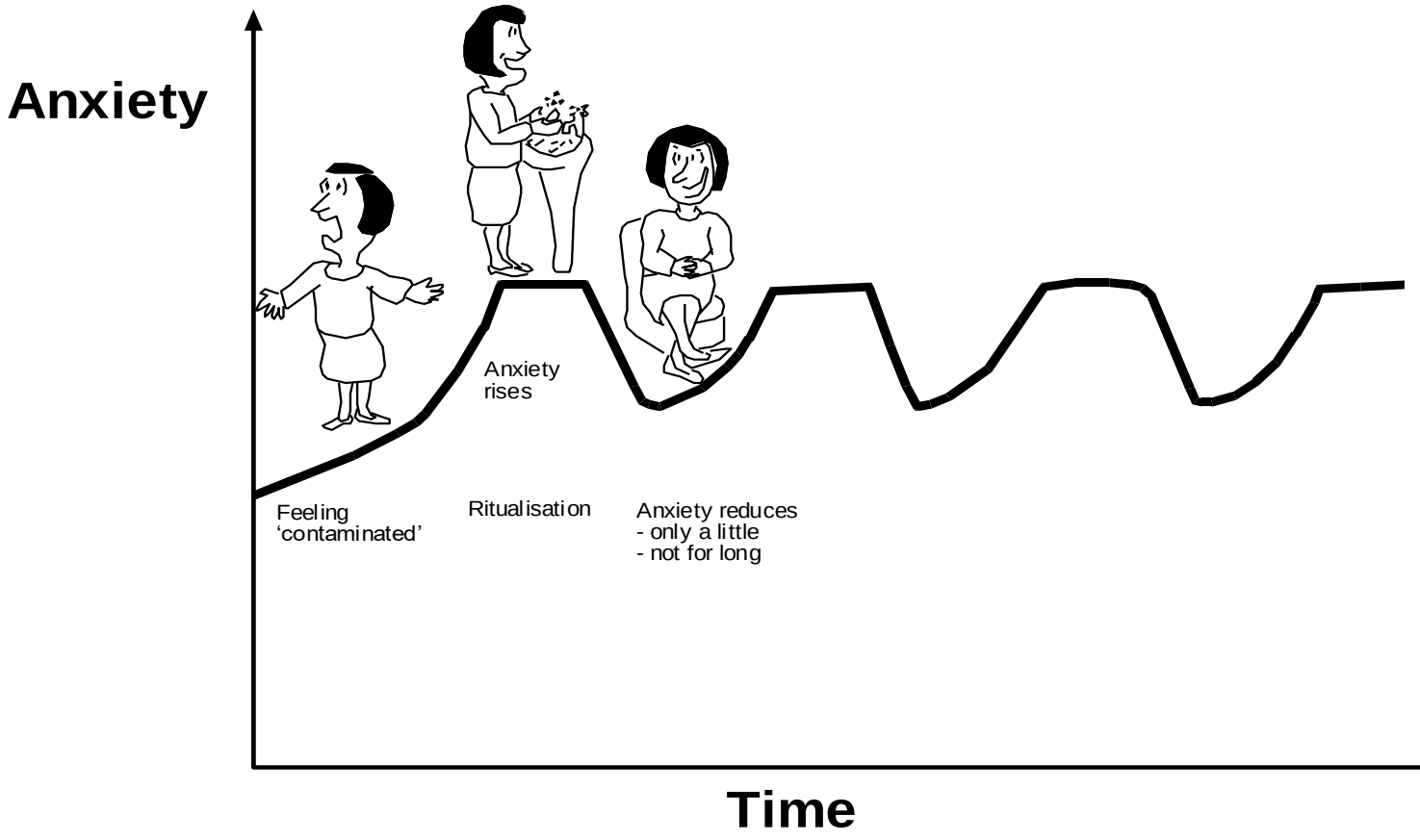
- Castle, D. Feusner,J., Laposa,J.M. Richter, P.M.A., Hossain, R, Lusicic,A and Drummond, L.M.) Psychotherapies and digital interventions for OCD in adults: What do we know, what do we need still to explore? Comprehensive Psychiatry ,doi.org./10.1016/j.comppsych.2022.15235

Psychological Treatment of OCD.

Gold Standard = **ERP**

- Prolonged graduated exposure in real life to the feared situation with self-imposed response prevention

Education about the role of Compulsions/ Reassurance/ Rituals (Adapted from Stern and Drummond, 1991)



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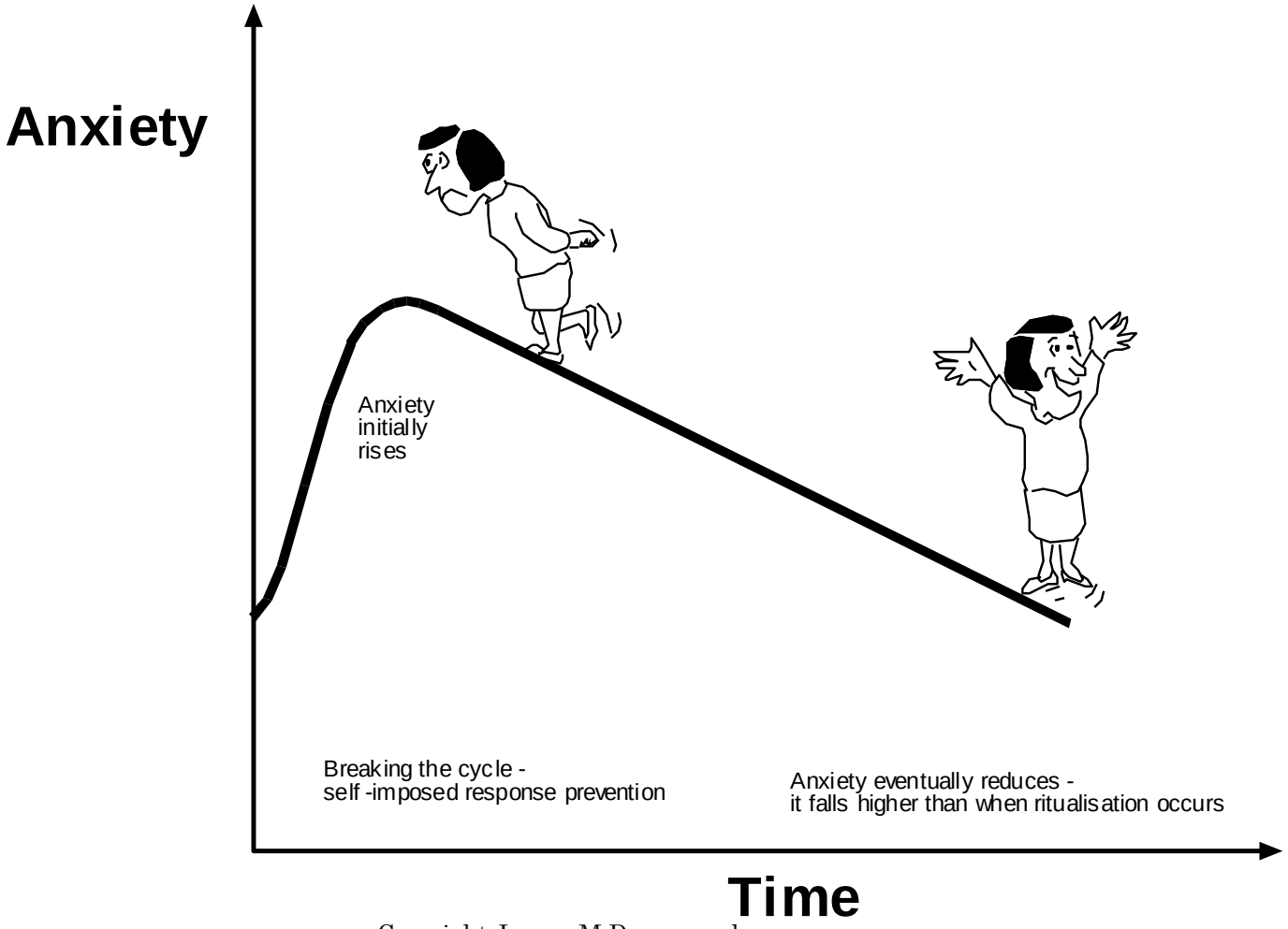


Cognitive Therapy versus ERP

Outcome of Exposure Treatment versus CBT

Researchers	Reference	Study	Outcome
Anholt et al.	Psychother Psychosom, 2008:77(1):38-42	ERP vs CT	EQUAL
Whittal, Thorarson and McLean	Behav Res Ther ,2005:43(12):1559-76	ERP vs CBT	EQUAL (CBT>ERP? no significant differences)
Cottraux et al.	Psychother Psychosom, 2001:70 (6): 288-97	ERP vs CBT	Equal (CBT>ERP for depressive symptoms)
McLean et al.	J Consult Clin Psychol, 2001:69(2):205-14	CBT vs ERP (Group Treatment)	ERP >CBT

Outcome of Exposure Treatment versus CBT Ougrin,D BMC Psychiatry 2011 Dec 20;11(1):200

- Randomised Controlled Trials with (n=1,308) directly comparing the efficacy of Cognitive Therapy and Exposure in anxiety disorders were included in the meta-analysis. No statistically significant difference in the relative efficacy of Cognitive Therapy and Exposure therapy was revealed in Obsessive Compulsive Disorder (OCD)

CBT with ERP versus other CBT treatment

- Cognitive behavioural therapy with exposure and response prevention in the treatment of obsessive-compulsive disorder: A systematic review and meta-analysis of randomised controlled trials

  Jemma E. Reid , Keith R. Laws , Lynne M. Drummond , Matteo Vismara , Benedetta Grancini , Davis Mpavaenda , Naomi A. Fineberg

  Comprehensive Psychiatry , 2021, (April) https://www.sciencedirect.com/science/article/pii/S0010440X21000018?via%3Dihub

Reid et Al, 2021

- CBT with ERP is widely accepted as the most beneficial treatment for OCD
- This systematic review and meta-analysis assessed randomised-controlled trials of CBT with ERP in patients of all ages with OCD. The study was preregistered in PROSPERO (CRD42019122311).
- The primary outcome was end-of-trial OCD symptom scores.
- The moderating effects of patient-related and study-related factors including type of control intervention and risk of bias were examined.
- Additional exploratory analyses assessed the effects of treatment fidelity and impact of researcher allegiance.

Reid et Al. 2021

- Thirty-six studies were included, involving 2020 patients (537 children/adolescents and 1483 adults) with 1005 assigned to CBT with ERP and 1015 to control conditions.
- When compared against all control conditions, a large pooled effect size (ES) emerged in favour of CBT with ERP
- While CBT with ERP was more effective than psychological placebo it was no more effective than other active forms of psychological therapy
- Similarly, whereas CBT with ERP was significantly superior when compared to all forms of pharmacological treatment, the effect became marginal when compared with adequate dosages of pharmacotherapy for OCD
- A minority of studies (were deemed to be at low risk of bias.
- 75% of studies demonstrated suspected researcher allegiance and these studies reported a large ES (g = 0.95: 95% CI 0.69 to 1.2), while those without suspected researcher allegiance indicated that CBT with ERP was not as efficacious

Reid et Al, 2021 -Conclusions

A large effect size was found for CBT with ERP in reducing the symptoms of OCD, but depends upon the choice of comparator control. This meta-analysis also highlights concerns about the methodological rigor and reporting of published studies of CBT with ERP in OCD. In particular, efficacy was strongly linked to researcher allegiance and this requires further future investigation.

ERP versus CBT

CBT	ERP
More expensive	Relatively cheap
Needs higher level of training/supervision	Easy to learn
Intellectually attractive	Can be easily used by the patient themselves

Maybe we should use Cognitive Therapy in a targeted way???

Steps in conducting ERP

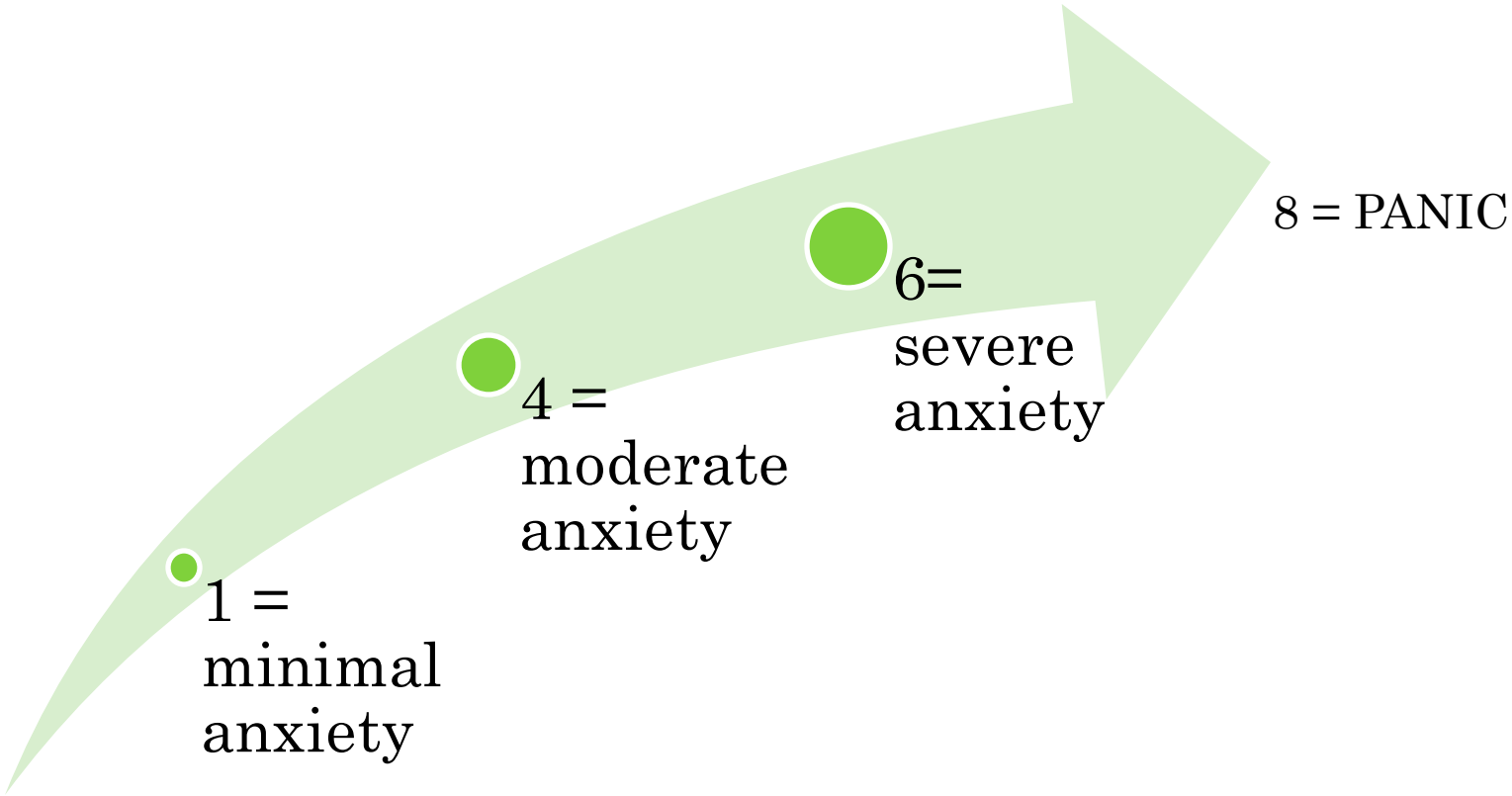
- Preparation and Groundwork
- Creation of Hierachy
- Structuring Treatment Sessions
- Follow-up

Preparation and Groundwork For ERP

- **Education**
  - Explain the physical, cognitive and behavioural symptoms of anxiety.
  - Anxiety is unpleasant but it does no harm.
  - Anxiety does eventually reduce.
  - The patient needs to agree and accept the 'risks' of inducing and tolerating anxiety without neutralising or engaging in compulsive behaviours
- **Concerns discussed**
- **Advantages and disadvantages**
- **Measurement**
  - Chose Measure to use (Yale-Brown Obsessive-Compulsive Scale YBOCS is the most widely used.
  - Simple scale to communicate with patient

EXPOSURE THERAPY -SIMPLESCALE

9-POINT ANXIETY SCALE



Structuring Treatment Programmes

- Usually we are talking about at least 20 hours exposure therapy per patient
- "Homework " exposure should be done between therapy sessions.
- Any Exposure therapy session needs to allow 2 hours to ensure habituation can occur
- Diary is useful.

Example of a Diary

Problem:		
Fear that I may have inadvertently sexually abused children.		
Final Goal:		
To take my nieces on a day out to a theme park without taking any "precautions" **To go on a field trip with my class at the end of term without taking any "precautions.**		
Hierarchy All of the items below to be performed without wrapping my penis in tissue paper.	**Anxiety Level (0-8)**	**Number of times per day to perform**
To record the statement "I am a paedophile on my mobile phone in my own voice and to listen to it on continuous play via headphones for an hour	4	3x/day

Second Page of Diary

To listen to the "I am a paedophile" tape for an hour whilst looking at photographs of school children (e.g., school prospectus brochures)	5	3x/day
To watch the film "Bugsy Malone"	6	Once a day
To watch the film "Bugsy Malone" whilst listening to the "I am a paedophile" on continuous play	6	
To walk around the streets near the local schools whilst listening to the "I am a paedophile" recording	7	Twice a day in the morning and evening. At weekends to walk in parks where children are 3 times a day
To visit my sister and play my usual rough and tumble games with my nieces.	7	Once a week.

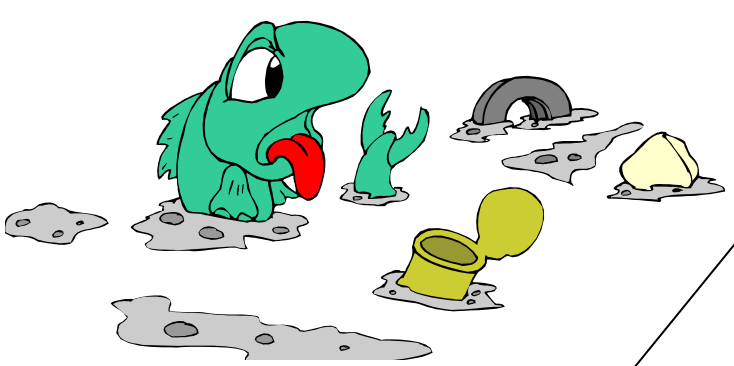
Third Page of Diary

To go into school and teach class	7	Next placement to discuss starting by teaching for 2 hours alone only daily (GP to write asking for a phased return to work and advising no more than 2 hours a day initially for 1 week and increasing thereafter).
To go out on a day trip with my sister and nieces and interact with them as normal	7	At the weekend
To take my nieces to a theme park on my own	8	Once
To take my class, along with other teachers on the end of term trip to the activity centre and stay overnight with the other teachers.	8	Once

Follow-up

- Essential to ensure patient continues to improve and doesn't just relapse and give up.
- Before the end of therapy it is important to work with the patient on a relapse prevention plan. This should be something the patient writes and examines:
  - The warning signs they may be relapsing
  - The strategies they need to take if these signs appear.

TREATMENT PENDULUM



SLOB

OB

"NORMAL"

But what if this treatment is not working??

Reassess the situation and confirm ……

- Has the OCD Sufferer understood the treatment?
- Does he/she agree with the treatment or is the treatment worse than the disorder at present
- Has exposure been done for long enough and without compulsive activity?
- Has the exposure been repeated often enough?
- If no issues with above, examine medication status

Other problems that may occur…

- Depression (Foa 1979 found SEVERELY depressed individuals did not habituate within sessions) (Foa 1979 Behav Res Ther. 17(3):169-76.
- Overvalued Ideation (Foa 1979 found these individuals did not habituate between sessions)
- Obsessive Ruminations
- Obsessive-Compulsive Slowness
- Autistic Spectrum Disorder. (Some studies suggest autistic traits predict poorer outcome eg Mito et al 2014 Murray et al. 2015 Psychiatry Res. 228(1):8-13. but we found in a refractory series it did not predict poorer outcome Ramos-Barbosa and Drummond, 2018)International Congress of Royal College of Psychiatrists, Birmingham and Internationa College of Obsessive Compulsive Specrum Disorders, Barcelona)

Depression and OCD

OCD and Depression

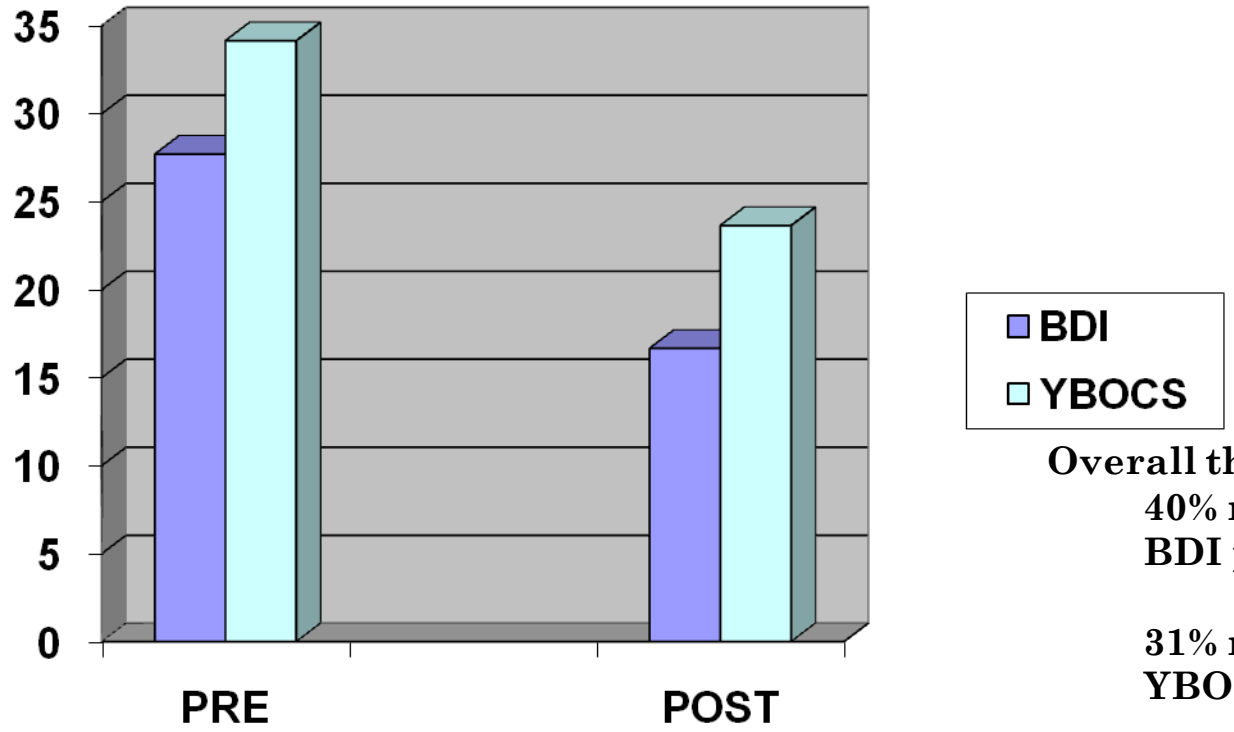
- Most people with OCD and depression can respond to ERP and both OCD and Depression Improve
- Some are too depressed and fail to respond (Foa et al., 1979).
- CBT may be preferable in these cases (Cottraux et al, 2001)
- SSRI may help both OCD and Depression

Outcome with 179 patients with Profound OCD Treated in an Outpatient Specialist Unit

Patel, R., Tyagi, H. And Drummond, L.M. (2012) Comorbid Depression in Treatment Refractory Obsessive Compulsive Disorder . Journal of Obsessive-Compulsive and Related 2(2):222-22 22Doi/10.13140/RG.2.2.25101.69606

179 patients of whom 165 scored moderately to severely depressed at the start of treatment using Beck Depression Inventory

61 SEVERE, REFRACTORY OCD PATIENTS OUTCOME WITH INPATIENT ADMISSION

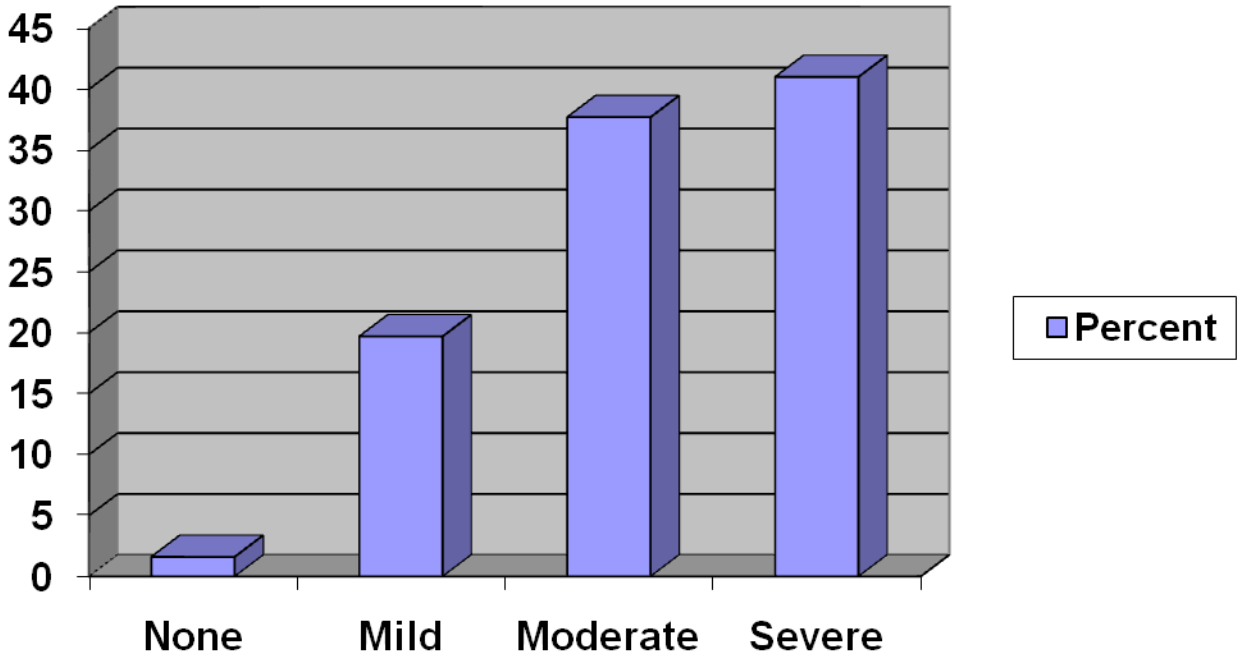


Overall this represents:

40% reduction on BDI p<0.001

31% reduction in YBOCS p<0.001

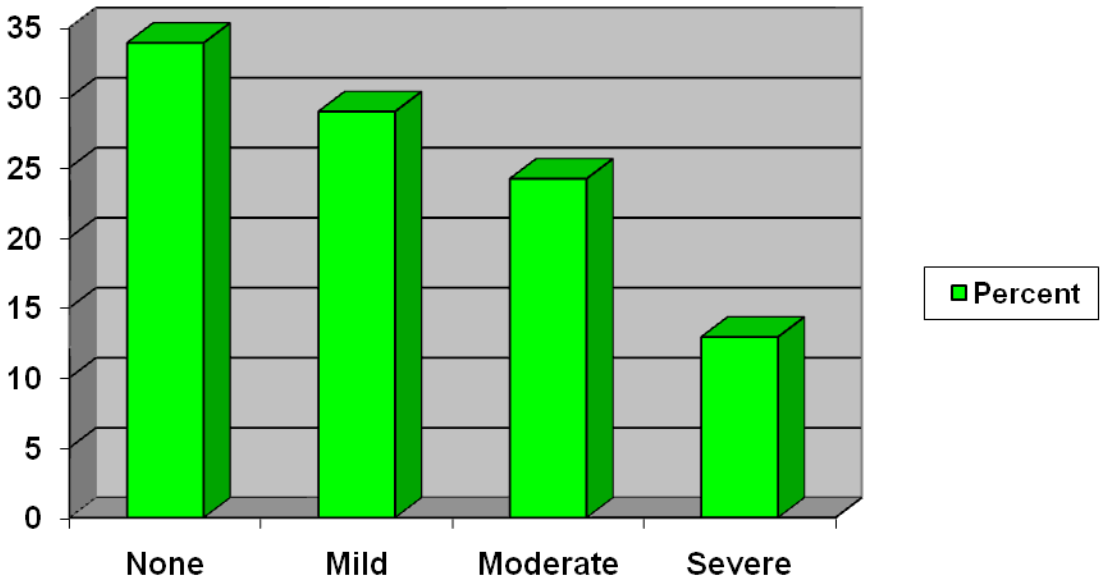
61 SEVERE, REFRACTORY OCD PATIENTS ON INPATIENT ADMISSION



Overall 79% had evidence of significant depression prior to treatment

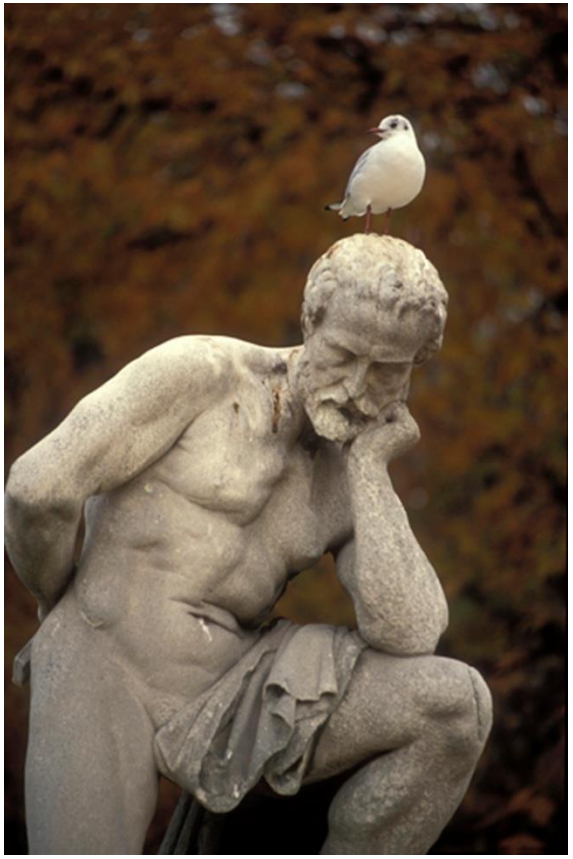
No significant differences in depression between men and women

61 SEVERE, REFRACTORY OCD PATIENTS ON INPATIENT DISCHARGE



Overall 45% had evidence of significant depression at discharge

Obsessive Ruminations



Obsessive Ruminations

- ANXIOGENIC obsessions
- ANXIOLYTIC compulsive thoughts
- EXPOSE to ANXIOGENIC
- PREVENT ANXIOLYTIC

Obsessive Ruminations – techniques to aid ERP

- Exposure using:
  - Deliberately provoking thoughts
  - Writing
  - Loop tape
  - Cue cards

Obsessive Compulsive Slowness

Obsessive Compulsive slowness

- Usually is due to PERFECTIONISM
  - " If a thing's worth doing it is worth doing absolutely completely correctly at all times and despite whatever else"

Causes of obsessional slowness

- Doubting actions
  - Self-observation
  - Repeating
  - Breaking down complex tasks
  - Counting
- The “just right” feeling _ this is often seen as an Autistic Trait

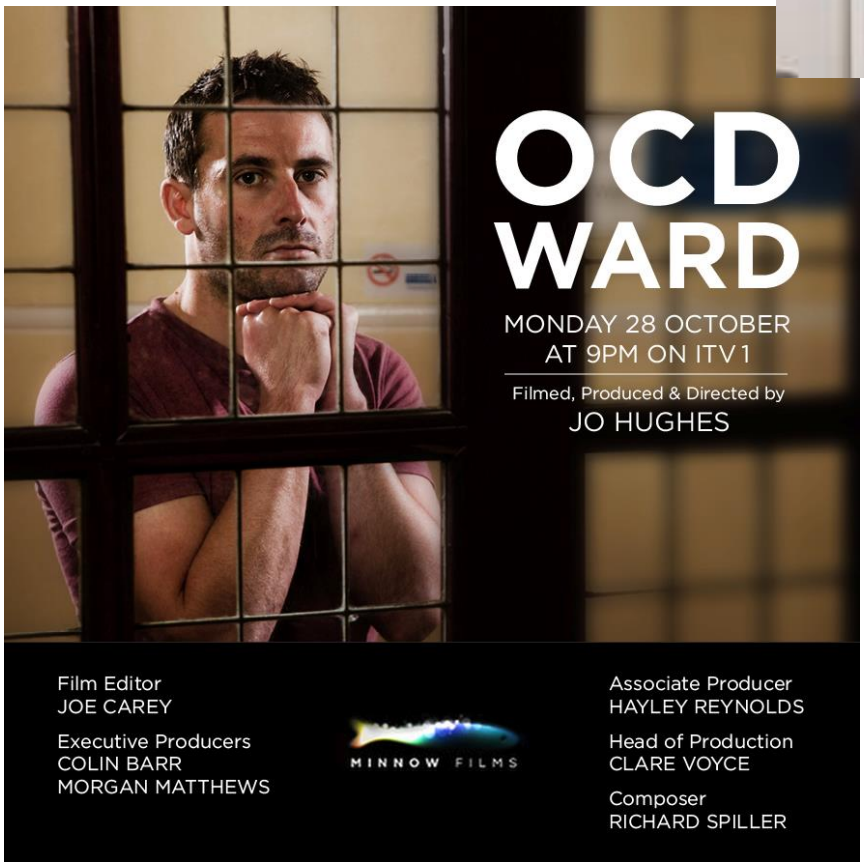
Interventions

- PERFECTIONISM
  - deliberately do things incorrectly

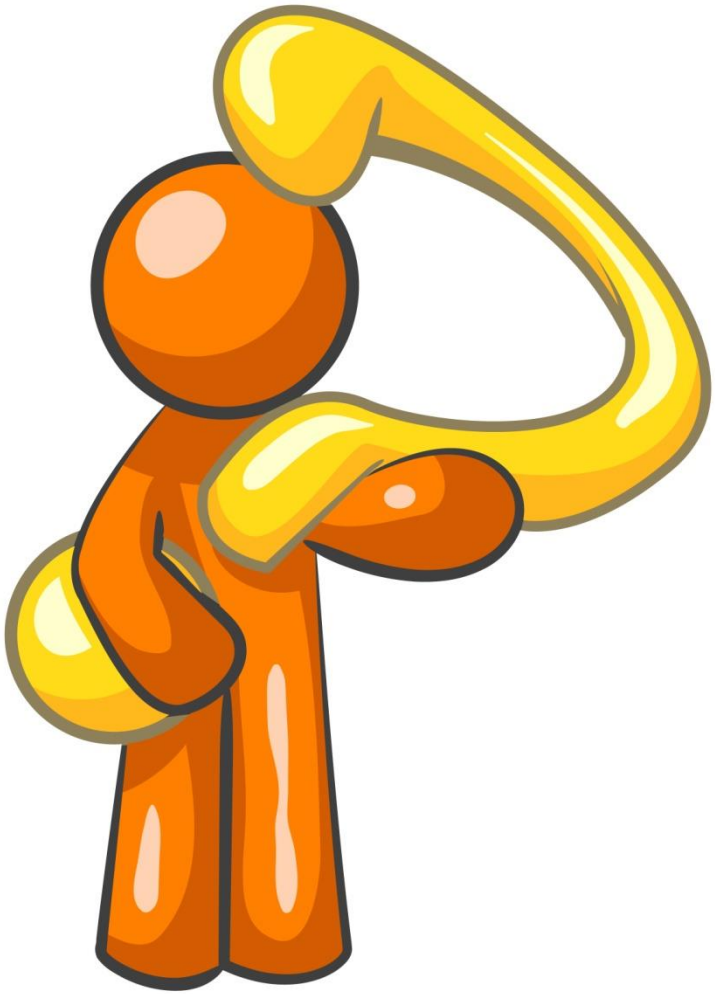
Discussion and Questions

Coffee/Tea/Comfort Break

Video



Any Questions or Discussion Points??



LUNCH!!!!

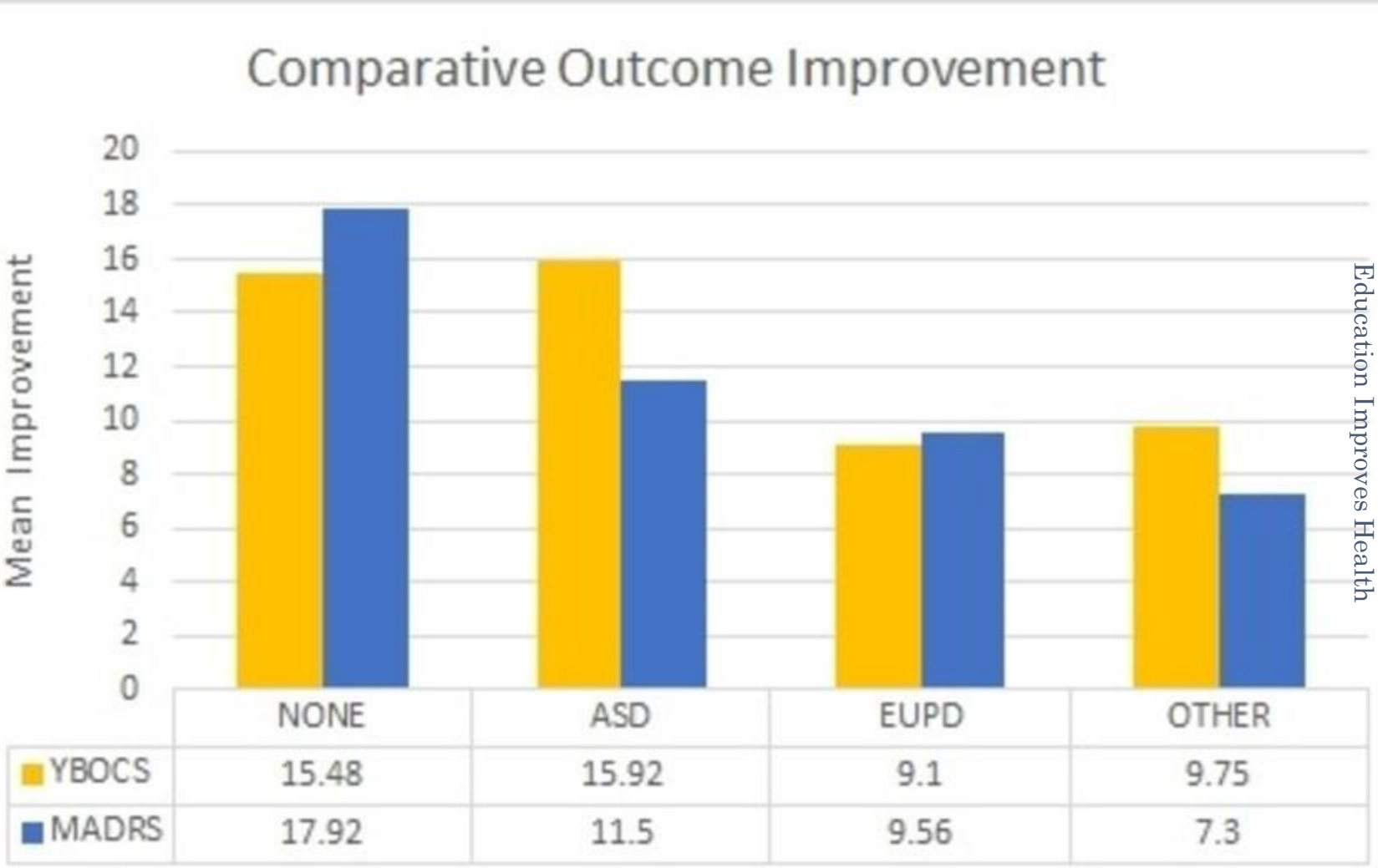
OCD Comorbidities and Related Conditions

- Conditions Comorbid with OCD
  - Depression
  - Autism and neorodevelpmental disorders
  - Schizophrenia
- Conditions Related to OCD
  - Tics
  - Trichotillomania
  - Skin Picking
  - Hoarding Disorder
  - Hypochondriasis and Health Anxiety

Autism and OCD

Examining The Relationship Between The Outcomes Of Patients With Profound, Refractory Obsessive-compulsive Disorder And A Diagnosis Of Autism Spectrum Disorder Or Personality Disorder Ramos_Barbosa, P. and Drummond, L.M. 2018 Presentation at RCPsych International Conference

- 81 patients (54 men and 27 women)
- Average age = 40 years (18-79; sd 14.2)
- 21% of sample diagnosed with ASD
- 12.4% had EUPD
- 18.5% OCPD



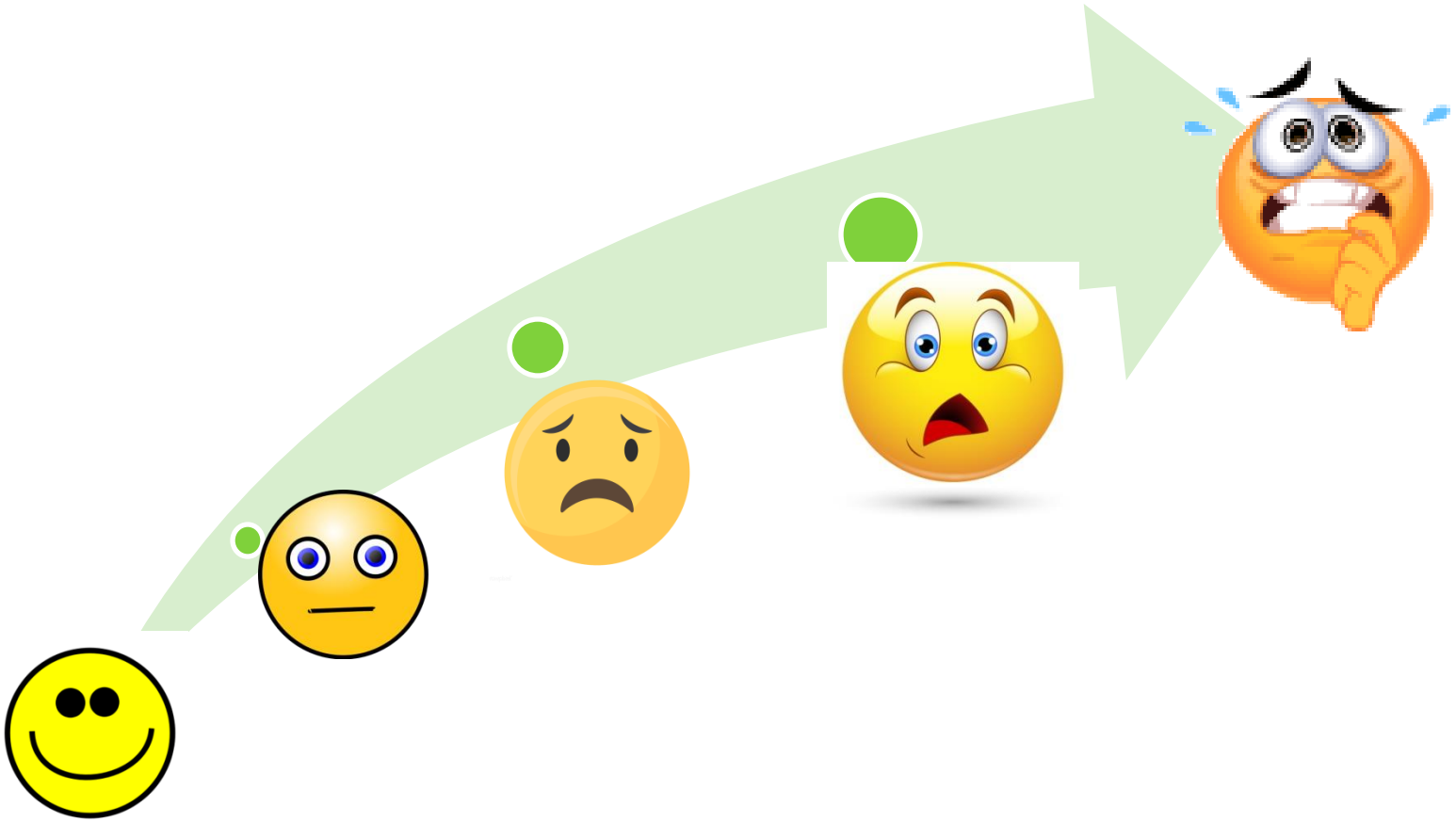
Ramos Barbosa and Drummond (2018)

- Overall ASD and OCPD did not appear to have a detrimental effect on outcome
- Poorer response for people with comorbid EUPD

Case History Example

- George 23 yo man with diagnosis of autism and acalculia
- Liked his daily patterns to be rigid and the same eg eating at same time of day, same "balance" of food on plate etc
- Presented with a fear of contamination by radiation from TV; computer screen , mobile phone etc.
- Full assessment of George (which took several sessions in order to gain his trust and obtain the story showed that it was this fear of radiation that he wanted to change)

Example of a Way to Communicate Distress with George.

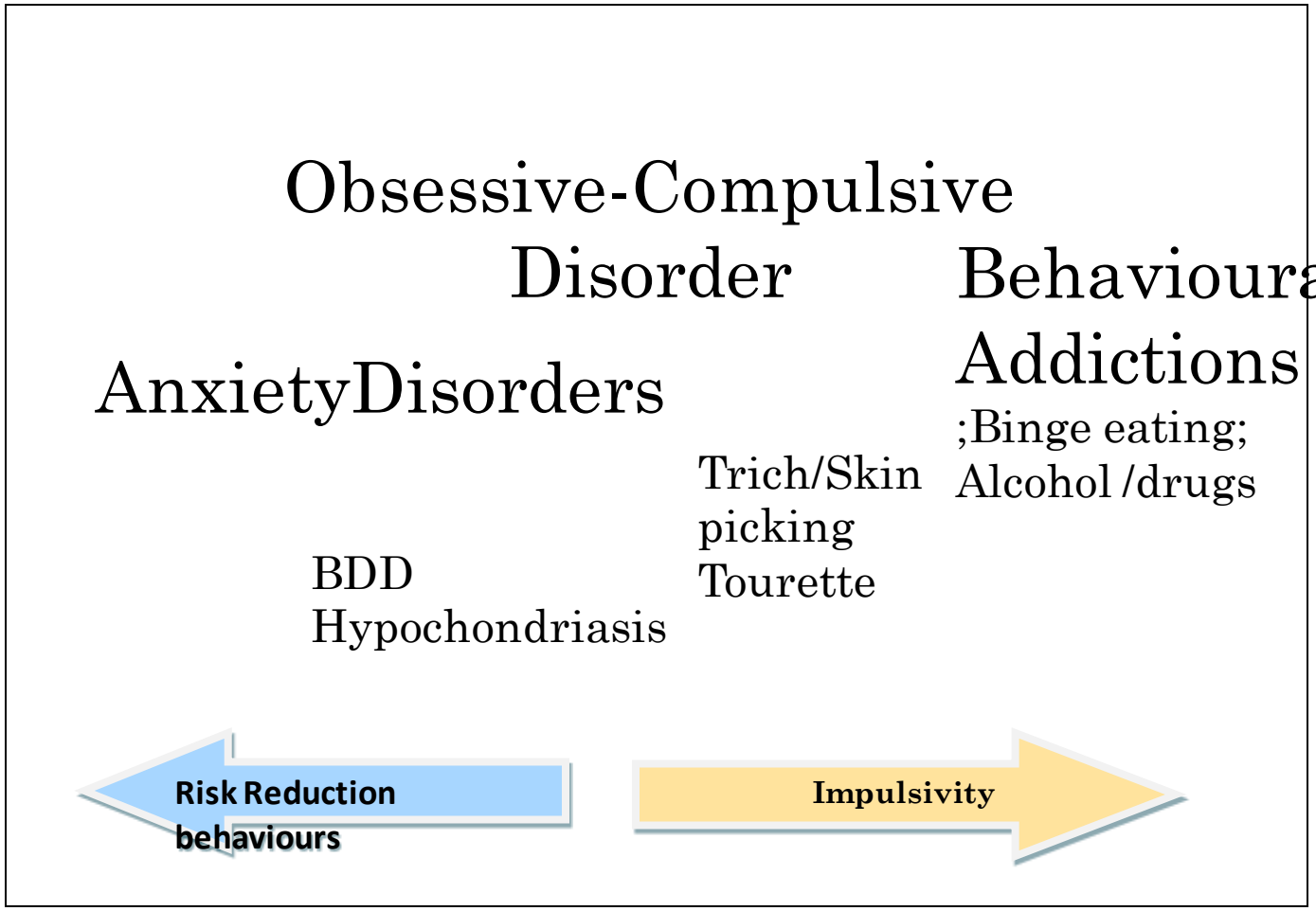


Addiction and OCD

Compulsivity vs Impulsivity Vs Habit

- Used to be think as opposites but now realised that both appear in the same syndromes.
- **Impulsivity** = tendency to Act on impulse for immediate gain/reward without considering longer term consequences of the action
- **Compulsivity** = performing a repetitive behaviour in order to reduce of prevent some negative experience/emotion.
- **Habit** = Stimulus leads to a stereotyped response. When we perform an action regularly the link between the triggers and the action become strengthened (Dickenson 1985) This results in HABIT FORMATION

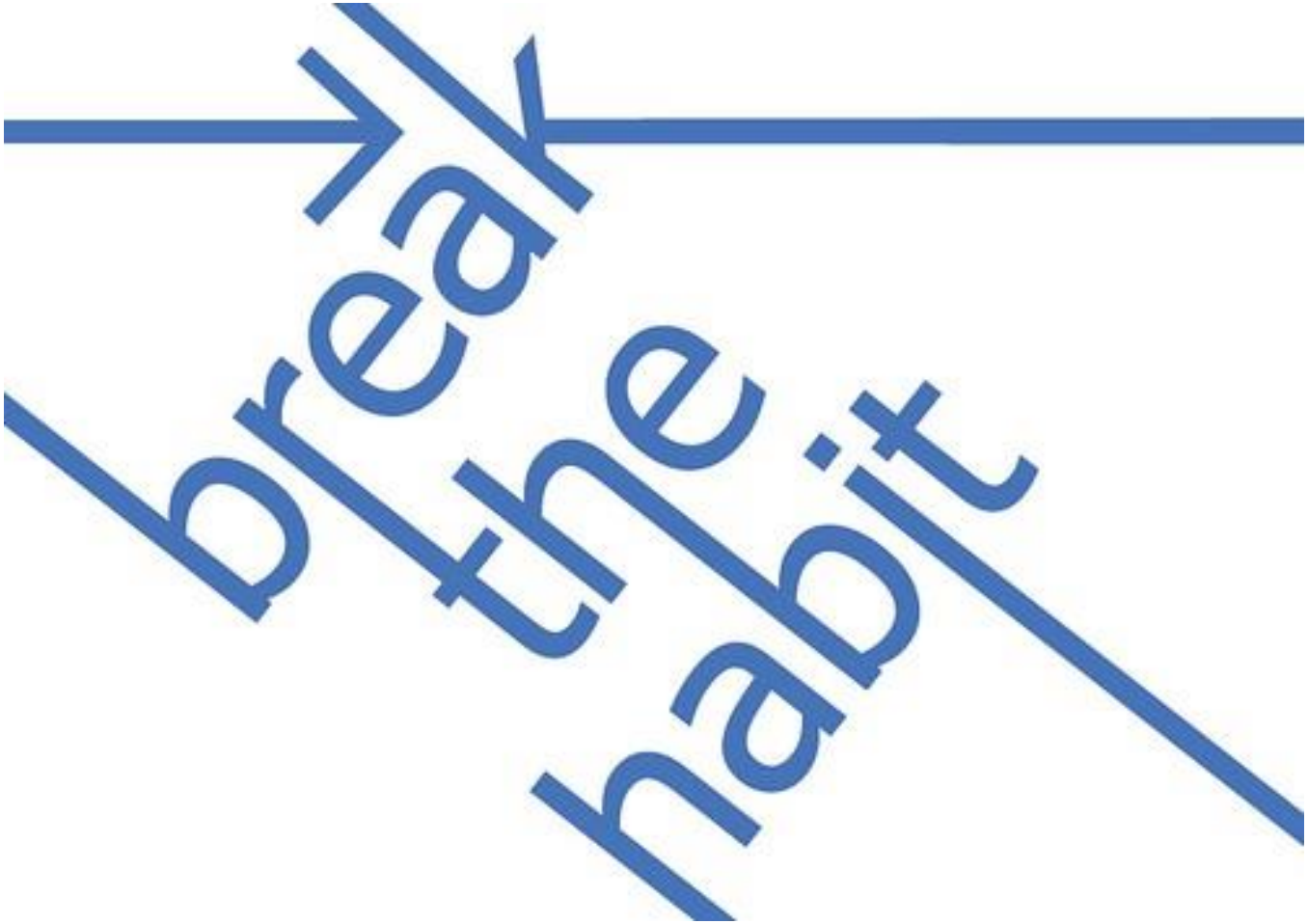
Impulsivity and Compulsivity



OCD and Substance Misuse/ Behavioural Addictions

- Vitanen, A et al. (2022) Association of Obsessive-Compulsive Disorder and Obsessive-Compulsive Symptoms With Substance Misuse in 2 Longitudinal Cohorts in Sweden JAMA Netw Open. 2022;5(6):e2214779. doi:10.1001/jamanetworkopen.2022.14779
- Swedish cohort study of 6 304 188 individuals from the general population and 9230 individuals in a separate twin cohort found that individuals with an OCD diagnosis had a **3.7-fold elevated risk of any substance misuse outcome**. The association of OCD and obsessive-compulsive symptoms with substance misuse was partially attributed to shared genetics.

OCD and Habit



Compulsivity vs Habit

- In OCD compulsions are initially performed to reduce or prevent the harm of the adversive obsessive thought. Over time, **in some patients** , they are performed in a more habitual way ie an automatic response to a particular stimulus
- Similar behaviour is seen with behavioural addiction whereby initially he behaviour eg binge-eating is in response to a negative emotion but over time, it may become habitual and in response to a stimulus.

Habit Reversal Used in the Following Conditions

- Trichotillomania (Grant JE, Chamberlain SR.Am J Psychiatry. 2016 Sep 1;173(9):868-74)
- Chronic Eczema (Tsakok et al, Br J Dermatol. 2017 Aug;177(2):554-556.)
- Skin Picking (Lochner C, Roos A, Stein DJ.Neuropsychiatr Dis Treat. 2017 Jul 14;13:1867-1872., (Kent and Drummond Clin Exp Dermatol1989 Mar;14(2):163-4).)
  - Habit reversal +/- acceptance-enhanced techniques; SSRIs or N-acetyl cysteine
- Tic Disorder and Tourette Syndrome (Davide and Pringsheim, Int Rev Neurobiol. 2017;134:1461-1490; Yu L, Li Y, Zhang J, Yan C, Wen F, Yan J, Wang F, Liu J, Cui Y.Expert Rev Neurother. 2020 Nov;20(11):1189-1196)

- ?????Many OCD patients describe their compulsions as habitual, that is, fixed 'stimulus-response 'acts that, through habit learning, occur automatically in response to a specific environmental trigger. In this case Habit Reversal has been suggested instead of or in conjunction with ERP. However little research at present (Lee MT, Mpavaenda DN, Fineberg NA. Habit reversal therapy in obsessive compulsive related disorders: a systematic review of the evidence and CONSORT evaluation of randomized controlled trials. Front Behav Neurosci. 2019a; 13:79.

Habit Reversal

- Awareness training
- Competing response training
- Habit control motivation
- Generalisation training

Case Example (From L.M.Drummond (2014) CBT for Adults Cambridge University Press/Royal College of Psychiatrists)

- **Treatment of facial tics using habit reversal**
-
- Sarah, an attractive and lively 24 year old games mistress was referred to the clinic with a 14 year history of unsightly and embarrassing facial tics. The onset had occurred at puberty, but was not related by Sarah to any particular life-event. Over the years she had received treatment with a variety of medication including haloperidol and benzodiazepine drugs with no effect. She had also received individual psychodynamic psychotherapy which had not helped.
-
- The tic could occur at any time but was more frequent if she was anxious or bored. Close observation of the movements revealed that it commenced with Sarah screwing up both eyes, followed by crinkling her nose, and then making a sharp downward movement of her chin opening her mouth.
-

Awareness Training

The first thing that Sarah was asked to do was to record the frequency of her tics over a few days. This **awareness training** is useful, as many people with habit disorders are oblivious of some of the times when they perform the undesirable behaviour. Obviously, Sarah had a busy life and so the records were made as simple as possible for her to keep.

Measuring the Problem

In addition, the therapist decided to use another assessment measure by recording an interview with Sarah for a 20 minute period. During this interview, the therapist asked a series of `neutral' questions about her job and hobbies and some more emotive questions about the effect of the tic on her life. The mean number of tics per minute during the `neutral' and `emotive' discussion was then calculated and this procedure was repeated at the end of treatment with the therapist asking identical questions. The baseline measures showed that Sarah performed the tic an average of 300 times a day or approximately 0.5 tics per minute.

Competing Response Practice and Habit Control Motivation

- At the second session the principle **of competing response practice** was explained to Sarah. The therapist said:-
- "One of the problems with a long-standing habit is that you have built up and strengthened the muscles of your face which are involved in the tic at the expense of the opposing muscles. What I will be asking you to do is to perform some exercises to strengthen these opposing muscles.
- The start of every tic begins with you screwing up both your eyes. As soon as you feel that you are going to tic, I want you to raise your eyebrows, wrinkling your forehead. You may find this easier to do if you place your thumb and index finger of one hand under each of your eyebrows. I then want you to hold this position to the count of 20 or until the urge to tic passes, whichever is the longer time. At the same time as doing this I would like you to clench you teeth together very tightly and likewise to maintain this position.'

- Following this description, the therapist asked Sarah to practice the competing response in the session. The therapist then asked Sarah to list all the deleterious effects of having a tic and the advantages of being tic-free. She was asked to write this list down and to read it through whenever she felt bored or disheartened by the treatment (**habit control motivation**).

Generalisation

Finally, ways in which Sarah could incorporate the competing response movements into her everyday life without looking conspicuous were discussed. Sarah suggested that if she were outside, she could place her hand under her eyebrows as if shielding her eyes from the sun. If she was inside and sitting at a desk or table, she could use her hand under her eyebrows to `support' her head (**generalisation training**).

Body Dysmorphic Disorder

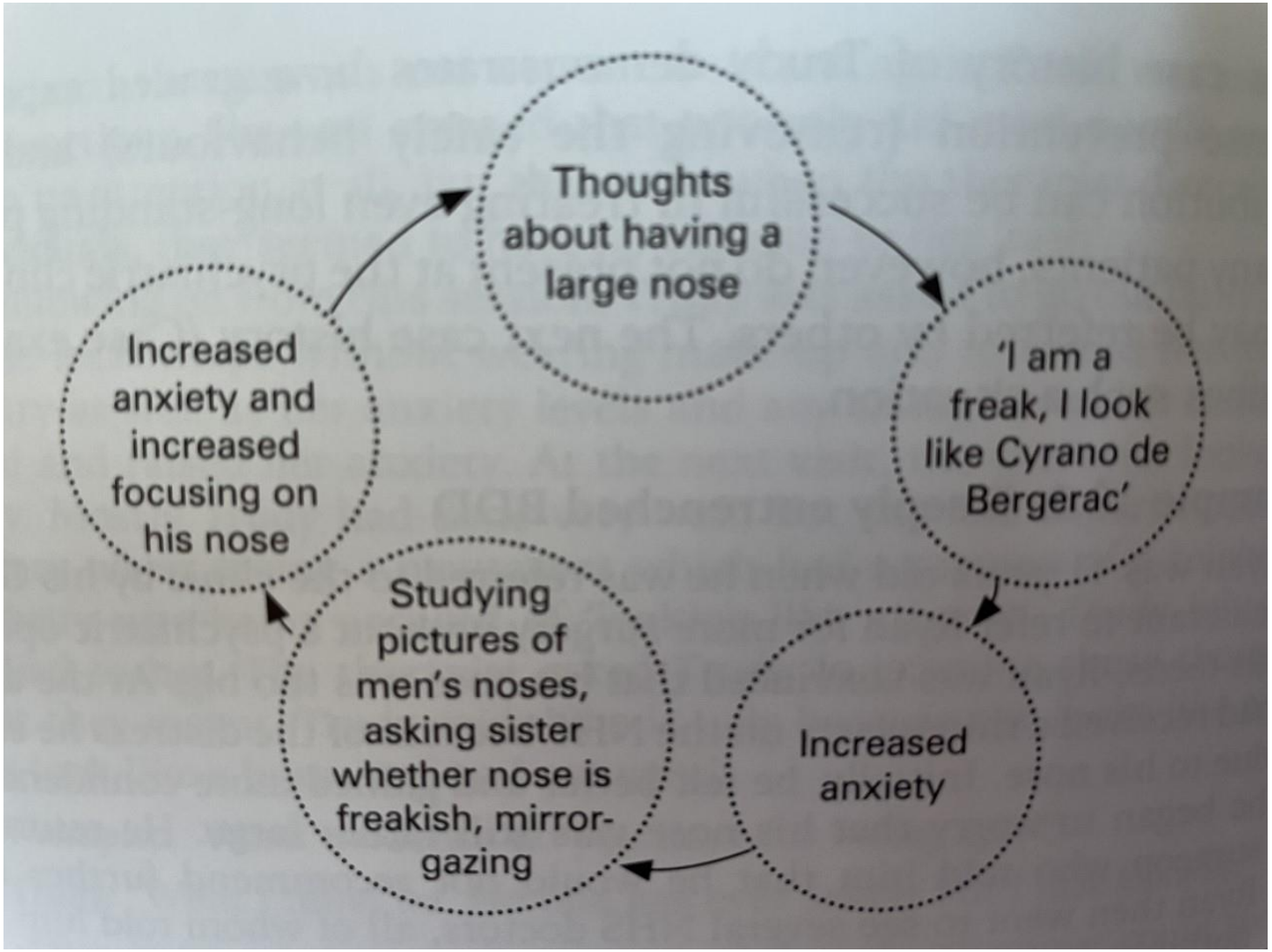
Body Dysmorphic Disorder

- Similar to OCD in many ways.
- Patients are less willing to engage with therapy.
- Need to use other methods to persuade them to undertake therapy eg Theory A and Theory B
- Many engage in mirror-gazing for prolonged periods of time and the more you examine yourself in the mirror , the more dissatisfied you will become with your appearance!
- Once you have them engaged and reduced their "safety behaviours" eg mirror gazing and reassurance seeking you can proceed with ERP type of therapy.

Case History

- 25 year old man, Ryan, who had been bullied at school and was convinced his nose was hideous and large .
- He had undergone 3 rhinoplasty procedures privately and was still dissatisfied but had already built up considerable debt.
- Reluctantly agreed to see a therapist and was brought along by his extremely anxious parents.

Case Formulation



Treatment

- The therapist suggested two possible explanations for the way he was feeling:
  - He had an extremely large nose which was ugly as he believed and was the cause of comment for everyone who saw him. The only way to rectify this situation would be for Ryan to have surgery.
  - It was the way Ryan felt about his nose which caused the problem, and this fed into a vicious cycle.
- He was reluctant to go along with this as he believed his nose was hideous but agreed to 5 sessions because he thought his GP would then agree to NHS surgery
- Ryan was asked to make a list of other men with large noses but who were successful and he considered attractive and bring it to the next session

Treatment

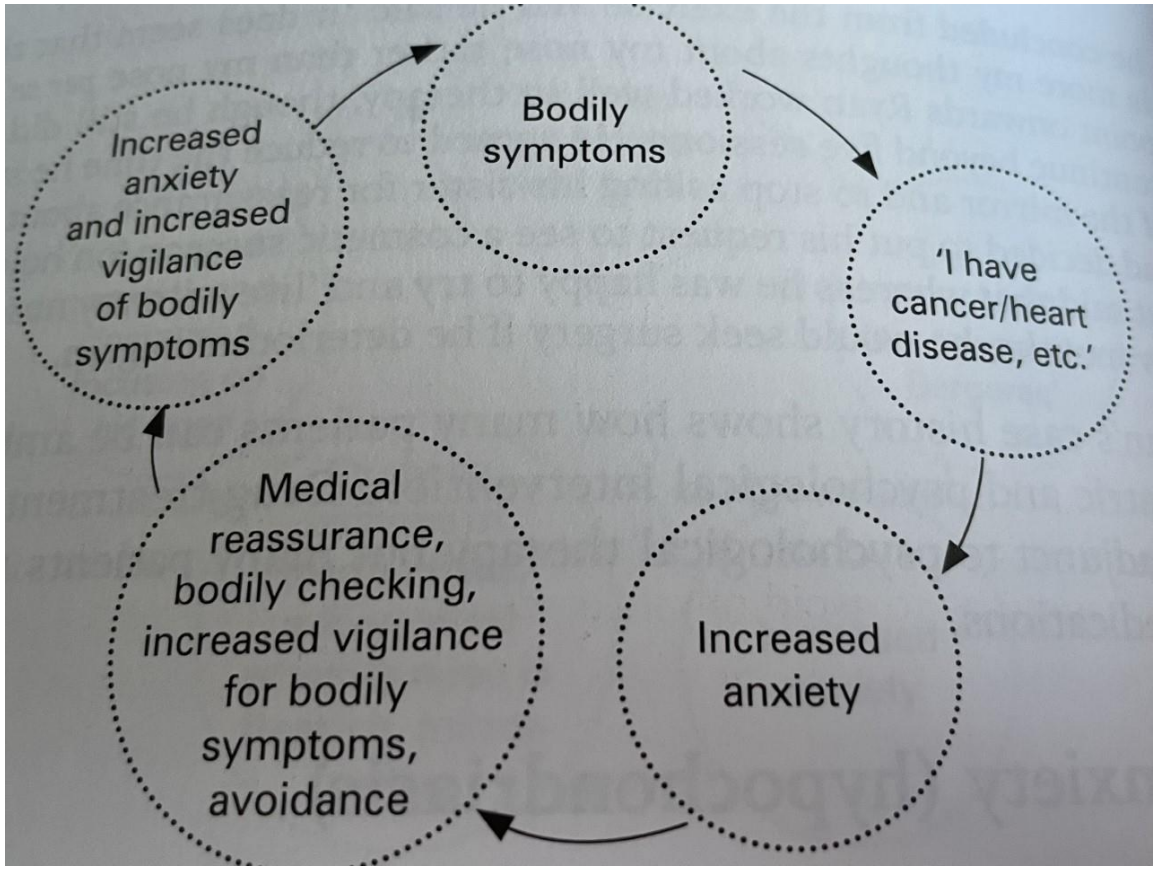
- During that session pictures of the people who were famous and successful and had big noses were found online and , using a ruler, Ryan was asked to measure the width and breadth of their faces and the width and breadth of their noses.
- He was then instructed to do the same with a picture of himself.
- Given instruction to not look in mirror apart from looking at his hair for a short period twice a day. Also asked not to phone sister for reassurance

Case History

- Ryan discovered he felt better when he didn't "mirror-gaze" or ask for reassurance.
- From then on a graded programme getting Ryan to go out and about was implemented.

Hypochondriasis

Formulation of Hypochondrias (Health Anxiety)



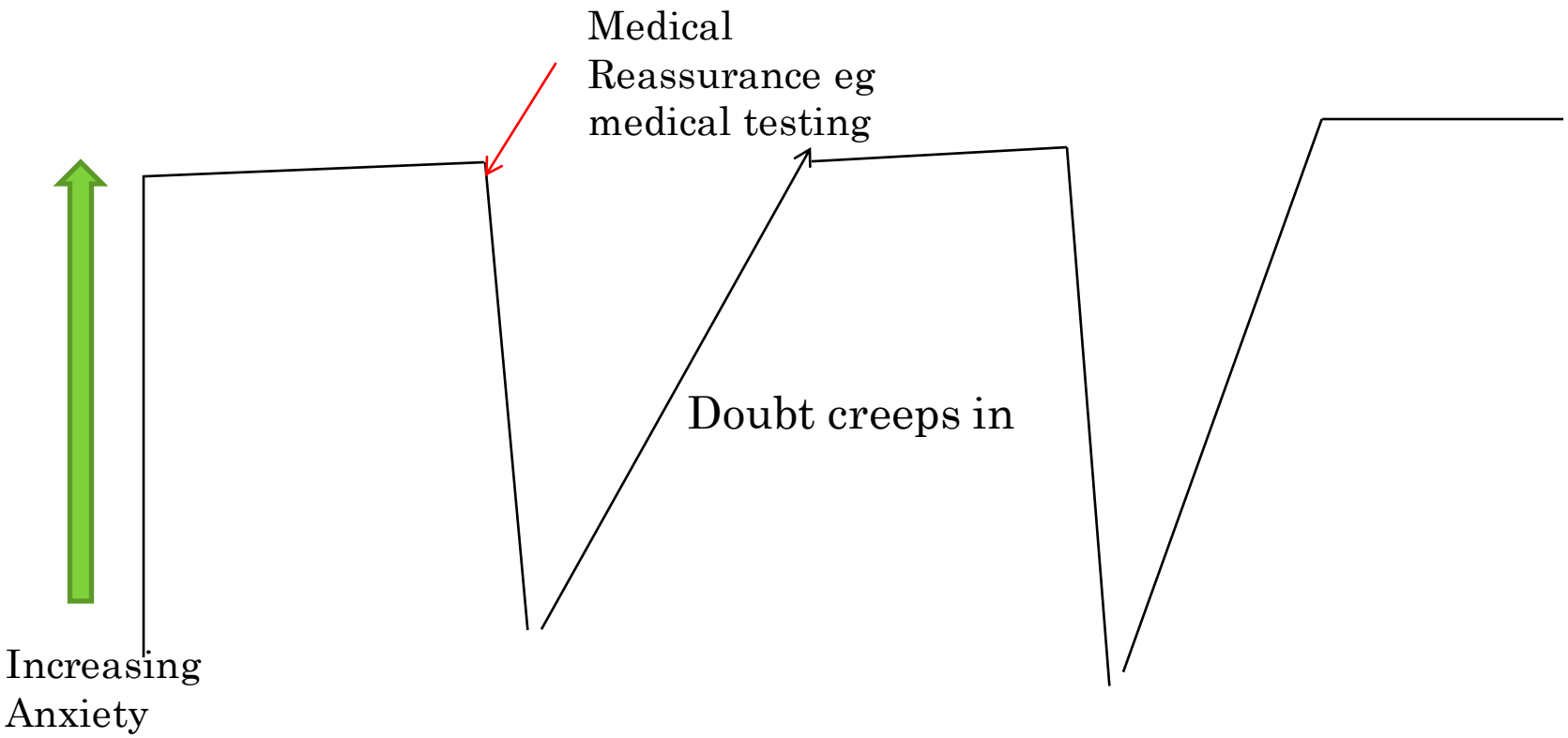
Case example

- Jenny a 50 year old lady with fear of developing breast cancer
- Spending hours in the shower twice a day checking for breast lumps
- Asking to be seen by GP on a daily basis
- Once restricted in attendance at GP then frequent presentations at A&E
- When placed on “blacklist” by A&E would cut her breasts so that she had to be seen due to wound.
- Psychiatry was the very last place she wanted to come!!

Jenny Case Example

- Theory A versus Theory B
  - Theory A .
    - "I may have breast cancer which will go undetected unless I check frequently. This will lead to me having a horrible uncontrollable painful lingering death"
  - Theory B.
    - "I am anxious about having breast cancer. This concern is taking over my life and restricting all that I do. Most people check their breasts at most on a weekly basis as breast cancer will be suddenly appear in a week"
- Restrictions of visits for medical reassurance
- Time-limited shower
- Cognitive Therapy examining her negative automatic thoughts about breast cancer.

Medical Reassurance



Hoarding Disorder

Hoarding Disorder

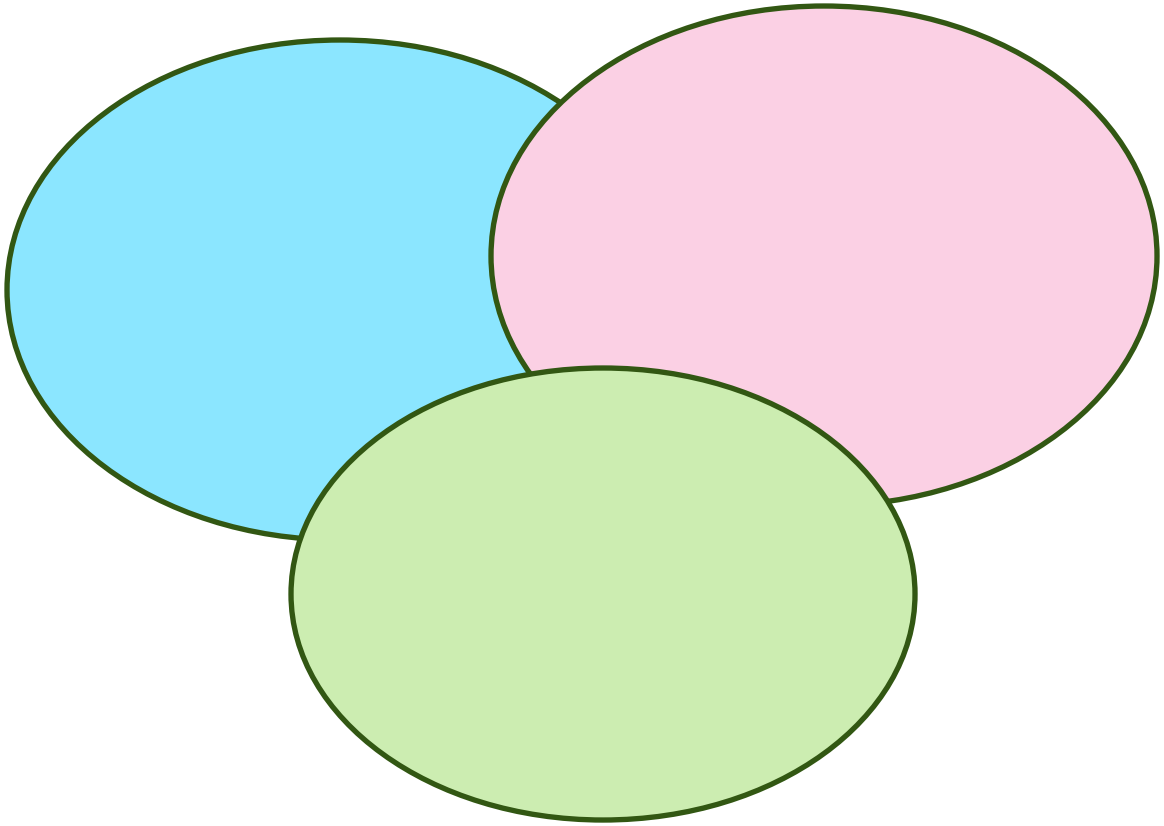
- Little research as did not officially exist until May 2013!

- Suggestion that it may be more common in certain types of individuals (some of this also true for hoarding found in OCD)

Hoarding Is A Symptom Rather Than Diagnosis

- Physical Causes of Hoarding e.g.
  - Stroke
  - Rheumatoud Arthritis
- Psychological/PsychiatricCauses of Hoarding e.g.
  - `Depression
  - Schizophrenia
  - Drug/Alcohol addiction
- Neurodevelopmental causes of Hoarding eg
  - ASD
- Cognitive Causes of Hoarding eg
  - Dementia
- Conditions related to OCaRDs causing Hoarding eg
  - OCPD
- **Hoarding Disorder**

Overlap Between ASD/OCPD and Hoarding Disorder.



Symptom	Autistic Spectrum Disorder	OCPD	Hoarding Disorder
Social and Communication issues which may lead to social isolation	Very frequent	Frequent	Frequent
Sensitivity to intensity of or specific tastes, smells, sounds, textures	Very frequent	Not usually	Not usually
Liking sameness and routine	Very frequent	Sometimes	Not usually
Fixated on a specific issue or hobby	Very frequent	Sometimes	Not usually

Miserliness	May occur due to lack of social awareness	Very frequent	Very frequent
Inability to delegate jobs to others	May occur due to lack of social awareness	Very frequent	Not usually
Inability to demonstrate affection	Very frequent	Very frequent	Not usually
Preoccupation with details	Very frequent	Very frequent	Not usually
Difficulty in sorting and classifying objects	Very frequent	Very frequent	Very frequent
Difficulty and extreme distress in discarding items	Very frequent and can be related to liking sameness	Very frequent	Very frequent
Living in a cluttered environment	Frequent if environment not controlled by others	Very frequent	Very frequent
Social Isolation	Very frequent	Very frequent	Very frequent
Loneliness	Very frequent	Very frequent	Very frequent
Anxiety	Very frequent	Very frequent	Very frequent
Depression	Very frequent	Very frequent	Very frequent

Hoarding Disorder

- May be more common in
- Older individuals (although histories often suggest it started in early life)
- Living alone
- History of emotionally deprived upbringing
- Maybe history of extreme poverty and lack of physical possessions
- Form huge emotional attachment to the hoarded objects

And even then.....

- Many patients will NOT want intervention – often huge shame and stigma
- In these cases, need to assess capacity of the individual
- Need a multi-agency approach (social services, mental health, fire brigade, housing association et c)

Hoarding and Capacity

- If they do NOT have capacity then take appropriate action to ensure their health and safety
- If they are deemed to have capacity then….are others at risk? What action needs to be taken to protect:
  - Children
  - Neighbours et c.

What distinguishes a collection and a hoard??

OR

Treatment of Hoarding Disorder

- Need to establish absolute trust which can take time. Indeed may take several hours.
- Need to know you are on "their side"
- They need to agree on a ban of bringing in more items during treatment.
- Start with then taking one area of one room.
  - Select items to keep or to discard/take to charity shop
- Keep time holding item to a minimum (the longer they hold it, the more attached they will feel to the item.
- Similarly a rule of only handling each item once to make decision and then no going back!
- Get rid of discarded items immediately

OCD and Schizophrenia

- Two things to consider
  - OCD triggered by medication to treat schizophrenia
  - Schizophrenia runs in families of those who have OCD.

OCD and Schizophrenia

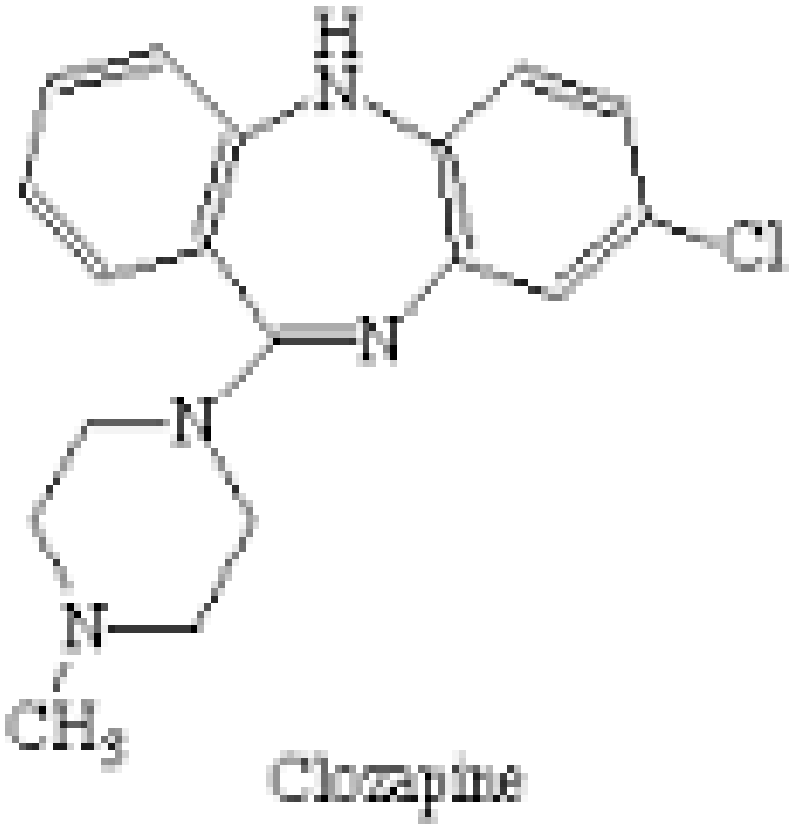
- 40% of patients develop OC symptoms before schizophrenia; 40% after the development of schizophrenia and 20% concurrently (Devi et al., 2015)
- OCD and Schizophrenia seem to be related and to run in the same families. Offspring of parents with OCD also had an increased risk of Schizophrenia
- Danish Study (Meier et al, 2014) examined 3 million people, of whom 30,556 developed schizophrenia or Schiz Spectrum Disorders. The prior diagnosis of OCD was associated with increase risk of developing schizophrenia

Drugs which have been demonstrated to possibly worsen or precipitate OC symptoms in people with schizophrenia

- CLOZAPINE
  - 20-28% of patients treated with clozapine developed OCS *de novo* and 10-18% exacerbation of existing OCS. (Fonseka , et al 2016)
- OLANZAPINE
  - 11 to 20% of patients treated for schizophrenia with Olanzepine will develop OCS (Fonseka et al, 2016)
- RISPIRIDONE (Fonseka et al, 2016)

- First generation antipsychotics have not generally been implicated (with the exception of a rare case report for Haloperidol) (Sa et al, 2009)

CLOZAPINE



Clozapine

Second Generation Anti-Psychotic drugs and OC Symptoms – a paradox!!

- Drugs such as Clozapine, Rispiridone and Olanzepine have been reported to precipitate OC Symptoms in patients with schizophrenia.
- All three agents (less so clozapine) have some evidence as beneficial when combined with an SRI in the treatment of refractory OCD
- But HIGH doses are used in treatment of schizophrenia whereas low doses are used as an adjunct to SRI treatment (eg 0.5mg to 2 my rispiridone)

How should we treat OC Symptoms in Schizophrenia?

- Stopping/reducing drugs thought to precipitate the symptoms?
  - Studies suggest that reducing or stopping clozapine reduces OC symptoms in c. half of affected patients (Grover et al. 2015, Zink 2014))
- Adding in other drugs?
  - Some evidence for reducing drugs such as clozapine and adding in others such as aripiprazole , amisulpiride or haloperidol (Zink 2014)
  - SSRIs can be useful , particularly escitalopram (Stryjer et al, 2013) but addition of fluvoxamine , (Poyurovsky et al, 1999) and clomipramine can worsen psychosis (Poyurovsky et al 2004)
  - SSRIs/Clomipramine can increase risk of seizures by altering blood levels of clozapine!!

How should we treat OC Symptoms in Schizophrenia?

- CBT
  - A review by Tundo and Necci (2016) reviewed studies of CBT for the treatment of OC symptoms in patients with schizophrenia. They found 8 case reports and 1 case series. Suggest:
    - CBT was safe and did not worsen psychotic symptoms
    - Similar effect and similar drop-out to patients with OCD but without psychosis
    - Worked in atypical antipsychotic drug- induced OC symptoms

- ERP can be performed effectively but :
  - Need to progress slowly and monitoring for any worsening of psychotic symptoms.
  - Hierarchy worked out carefully with patient to ensure that tackling issues they find problematic.

Comfort/Tea/ Coffee Whatever Break

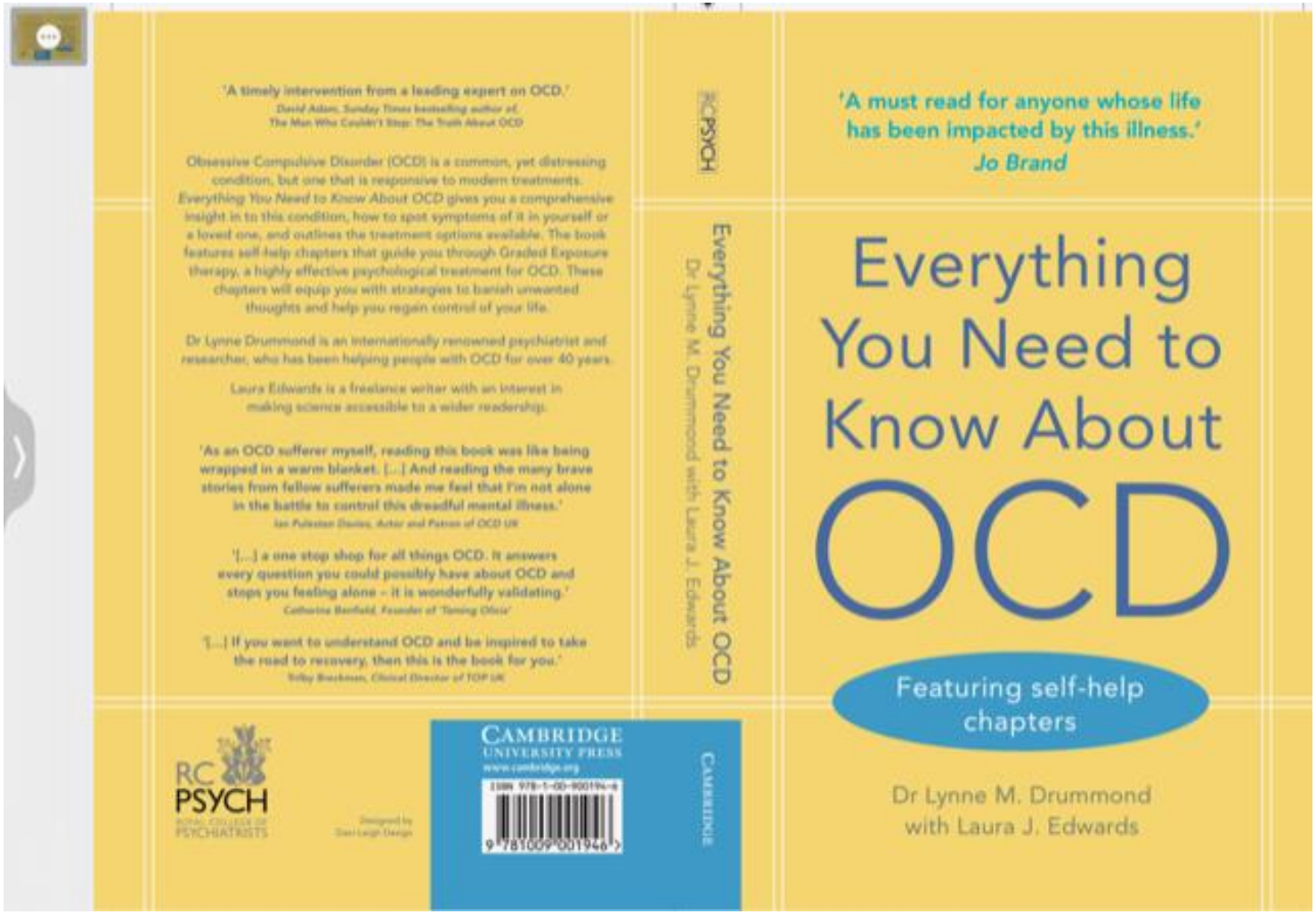
Video QED - 1987

0 items selected

Q.E.D., Jean - a Battle with Obsession

produced by Stephen Rose, 1949-2008, in Q.E.D. (London, England: BBC Worldwide, 1987), 41 mins

New book available on Amazon or at Cambridge.Org/EverythingOCD with 20% discount if you put EOCD20 at checkout



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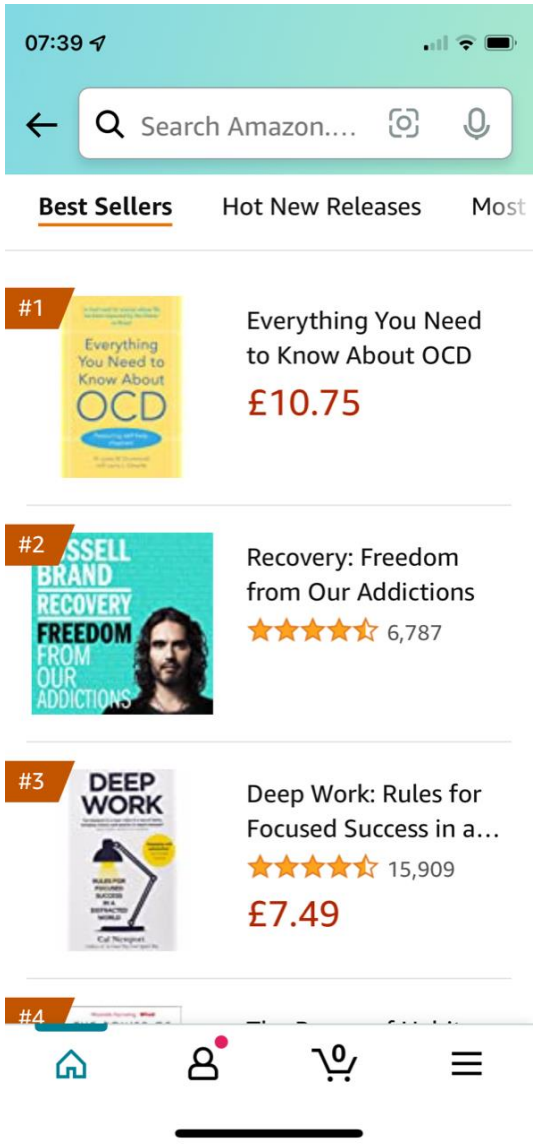

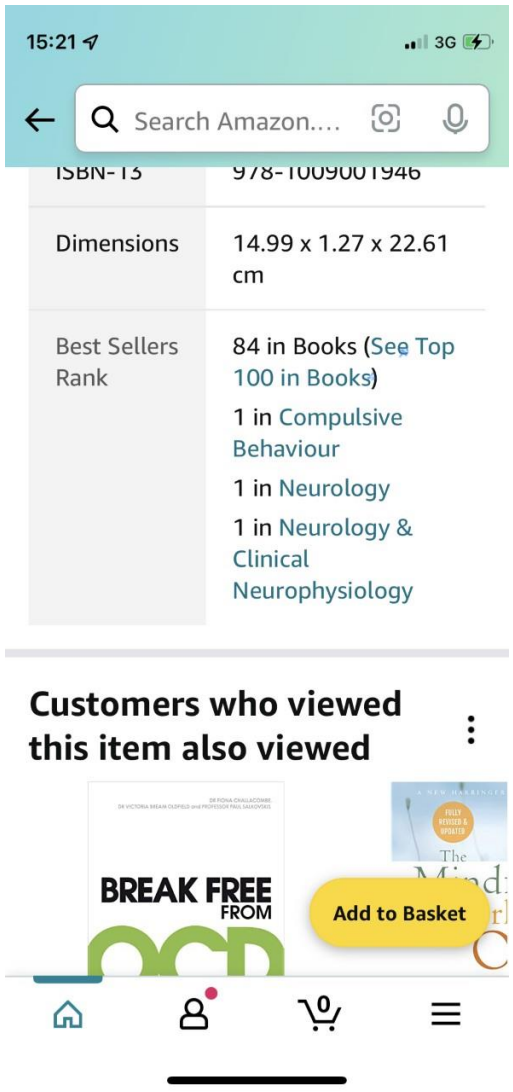

Any Questions/Comments?