Intensive Treatment for Intractable Obsessive-Compulsive Disorder: What, When, Where, Who, How?

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What is OCD?

- A multifaceted Anxiety Disorder characterized by symptoms of:
  - ✓ obsessive thoughts, images, feelings, impulses, or objects
  - ✓ compulsive behaviors, rituals, avoidances
- Obsessions are intrusive, uncontrollable, and trigger anxiety, discomfort, or distress.
- Compulsions are performed to reduce/neutralize the discomfort.
  - ✓ However, each compulsive behavior only serves to reinforce and strengthen the bond between the initial obsession and resulting compulsion.

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Epidemiology

- OCD has one-month prevalence of 1.2%
- OCD has a lifetime prevalence of 2.3%
- Six million adult Americans have OCD
- Factors contributing to underestimation of OCD prevalence
  - Patients resist disclosing ‘crazy’ symptoms
  - Failure to screen for OCD during Mental Status Exam
  - Difficulties in differential diagnosis

Ruscio, A. M., Stein, D. J., Chiu, W. T., & Kessler, R. C. (2010).

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Five specific assumptions characteristic of OCD:

1. Thinking a thought is equivalent to actually doing the action
2. Failing to prevent (or failing to try to prevent) harm to self or others is morally equivalent to causing the harm
3. Responsibility for harm is not diminished by extenuating circumstances
4. Failing to ritualize in response to an idea about harm constitutes an intention to harm
5. One can and should exercise control over one's thoughts

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High Rates of Comorbidity between OCD and other Disorders

- In Panic Disorder patients, 15%
- In PTSD patients, 10.1%
- In Social Phobia patients, 20%
- In ADHD patients,10%-33%
- In Tourettes patients, 36%-52%
- In Depression patients, 30%
- In BDD patients, 37%
- In Substance Abuse patients, 30%-33%, especially in PTSD
- In Eating Disorder patients, 10%

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Treatment-resistant OCD

- "**Treatment resistance**" refers to lack of sufficient improvement despite multiple adequate and appropriate treatment trials.
  - In Anxiety Disorders, minimal restoration of functioning after several treatment exposures.
- Research indicates that prolonged ERP is more effective for habituation to fears than short-duration ERP.

Khalsa, S.S., Schiffman, J.E., & Bystritsky, A. (2011).

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Effectiveness of Exposure with Response Prevention (ERP)

- Victor Meyer developed the first modern exposure and response prevention (ERP) treatment in 1966

- Research shows that when correctly used, ERP can produce a 76% symptom reduction in patients for 3 months to 6 years following termination of treatment

- **This rate increases for those sufferers of severe OCD when participating in an intensive treatment program**

Foa& Kozak, 1996

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Intensive Treatment through Exposure with Response Prevention

- In Vivo hierarchies must be carefully designed due to the extreme distress that the patient may experience from revisiting their triggers to anxiety

1. **Assess and identify behavioral patterns in the patient that have changed or have become distressing following triggers**
   - i.e., What does the patient avoid; what triggers maladaptive compulsive behaviors?

2. **Address areas of avoidance**
   - Repeat in vivo exposures

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Intensive Treatment Program

- Why Intensive?
  - Complicated comorbid diagnosis – not just OCD
  - Intractable – Previous treatments elsewhere unsuccessful to restore functioning
- When traditional weekly treatments offer limited benefits, the intensive treatment can be viewed as a last resort program for those individuals with severe OCD.
- An intensive treatment approach typically involves several continuous hours (> 90mins) on consecutive days/weeks of repeated and prolonged exposures to external and internal triggers of OCD.

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OC Spectrum Disorders

Impulsivity vs Compulsivity

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Impulsivity vs. Compulsivity: Continuum

Impulsivity

Ego-syntonic: fewer moral concerns (guilt, remorse), more pleasure-seeking behavior and risk-taking

Normal behavior,

'Vacillating' disorders

Compulsivity

Ego-dystonic: excessive morality (guilt, remorse), overthinking, anxiety reduction, compartmentalization

Treatment: repeated and prolonged exposures

'More impulsive' disorders require: NO initial exposures, then a 'stop-start.' (Eg. BDD, bulimia nervosa)

E.g. pyromania, antisocial personality disorder

E.g. 'pure' obsessive-compulsive disorder

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Impulsivity vs. Compulsivity Continuum: Disorders On The Spectrum

- Trichotillomania
- Skin-picking

- Sexual over activity
- Compulsive gambling
- Pyromania

Hoarding

- Antisocial Personality Disorder

- Body Dysmorphic Disorder
- Bulimia Nervosa
- Binge-eating

- Obsessive Compulsive Disorder
- Anorexia Nervosa

IMPULSIVITY

COMPULSIVITY

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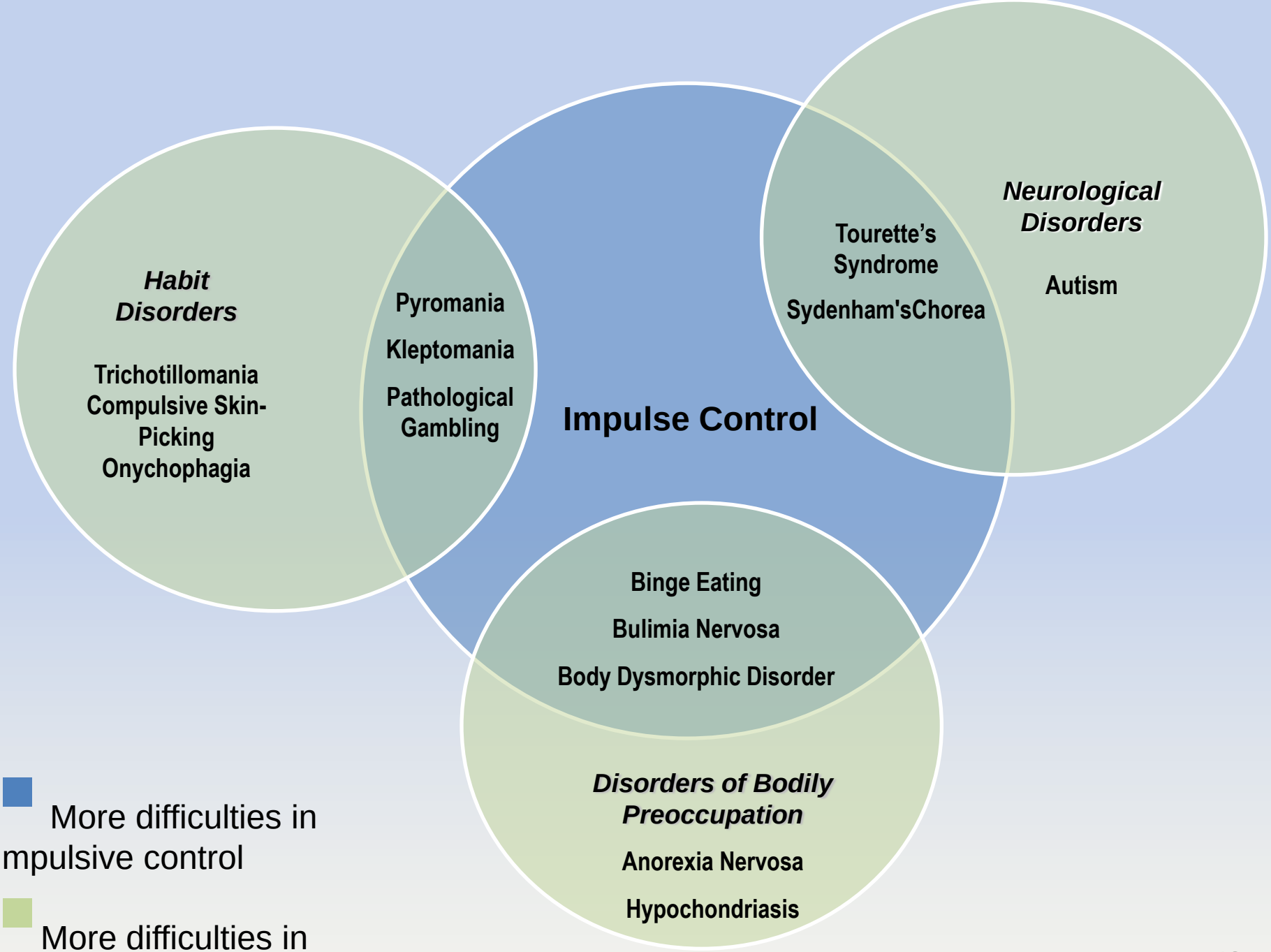

More difficulties in impulsive control

More difficulties in compulsive control

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6 Case Studies Illustrating OCD with Complex CoMorbidities

- **What** (proper assessment of diagnosis)
- **When** (duration of treatment)
- **Where** (inpatient vs. outpatient)
- **Who** (multidisciplinary team consisting of psychotherapist, psychiatrist, other paraprofessionals)
- **How** (which disorders to treat first)

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OCD and PTSD

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Case Study #1

- S.B., 31 year-old, male
- Presenting concerns:
  - Perfectionalistic concerns
  - Issue of tension
  - Posttraumatic stress (childhood sexual abuse)
  - Unwelcome homosexual thoughts
  - Intrusive sexual thoughts
  - Aggression
  - Inability to make decisions
  - History of drug and alcohol abuse

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S.B.

- Pre-tx assessment scores
  - YBOCS: 32
  - HAM-A: 9
- Post-tx assessment scores
  - YBOCS: 13
  - HAM-A: 7

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PTSD Symptoms

- 1st category: RE-EXPERIENCING symptoms
- 2nd class of symptoms: AVOIDANCE
- 3rd class of symptoms: INCREASED AROUSAL

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Typical PTSD Treatment

- CBT
  - Cognitive-Behavioral treatment can be divided into:
  - Exposure procedures
  - Anxiety management procedures
- Prolonged Exposure Procedures
  - A set of techniques custom-designed to help patients confront their feared objects, situations, memories, and images

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PTSD Treatment

- Exposure Therapy
  - Education about common reactions to trauma
  - Breathing retraining
  - Prolonged, repeated exposure to the trauma memory (reliving)
  - Repeated in vivo exposure to situations the client is avoiding because of assault-related fear

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Diagnosis

- 300.3 Obsessive-Compulsive Disorder
- 300.23 Social Phobia
- 309.81 Posttraumatic Stress Disorder
- 300.02 Generalized Anxiety Disorder
- 305.00 Alcohol Abuse

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Exposures

- **Sleep / Wake Cycle**
- **Writing / Mindfulness Awareness Training**
- **Psychoeducation**
- **Functional Analysis**
- **Structure Hierarchies**
- **Treat OCD**
  - Go to gym
  - Pick locker next to men
  - Watch men put body lotion on themselves
  - Spend time in the sauna
  - Walk around naked in locker room
  - Hang out with girlfriend
  - Go to West Hollywood gay bar
  - Initiate conversation with at least 5 people
  - Buy/Get pants that show off your “package”
  - Walk on sidewalk while holding male therapist’s hands
  - Perfectionism
  - Start/Stop exercise
  - Switch tasks frequently

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Exposures

- **Treat PTSD**
  - Keep inducing all the time.
  - Induce obsessive thoughts continuously
  - Induce feelings of anxiety
  - Attend Yoga
  - Listen to audio tape loop
  - Enjoy time in the car, traffic is not bothersome for the most part
- **Treat Social Phobia**
  - Always imagine the worst possible outcome is possible and probable.
  - Shake hands with people
  - Look into people's eyes
  - Make list of all avoidances – thoughts, situations, people and activities
  - Don't filter social comments - intentionally say most thoughts that come to mind during conversation
  - Complete your conversational contributions - Finish all stories and jokes that you start during conversation
  - Write several narratives about social interactions, doing things imperfectly and receiving criticism from peers, parents, and others

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Conclusion

- Generalized Anxiety Disorder
  - Top down
- Did not treat Alcohol Abuse
  - Previous treatments

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When Body Image Dissatisfaction Becomes a Disorder

The Elusive Remedy
or
The Sign of a Disease

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Video Clip #1

FOX News: “Trapped”

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Definition of the Ideal Body

- Changes over Time
  - ✓ In the eighteenth century full figured women were considered attractive.
  - ✓ Today, a slim, long legged figure is the acknowledged mark of beauty.
- Changes across Cultures
  - ✓ In America, hipless sports figures are considered attractive.
  - ✓ In France, women with small chest and buttocks are a symbol of attractiveness.
  - ✓ In Russia, women with big buttocks and big chest are the mold of an attractive woman.

Targeting Specific Symptoms

- BDD patients lack knowledge and insight.
- Their primary motivation for accepting referral is the unbearable level of distress and anxiety, which results in alcohol abuse in 48.9% of subjects (Grant, Menard, et al., 2005).
- BDD patients need to first accept re-orientation to be educated about the nature and course of BDD.

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- “Resizing” the defect = not giving in to the feeling that gives patients a wrong signal.

  - ✓ Deeply rooted self-esteem issues of body image that are present and work against the development of proper insight and correct perspective.

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- By its nature, BDD is highly comorbid with other psychopathologies.
  - ✓OCD and/or OC Spectrum Disorders
  - ✓Major Depression
  - ✓Social Phobia
- Substance abuse, which may have begun as a way of dulling the perceived social rejection, often becomes a major separate issue.

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Video Clip #2

OCD and BDD

Skin picking

Trichotillomania

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Case Study #2

- G.E., 18 year old female
- Presenting concerns
  - Depressive symptoms
  - Suicidal ideation**** (decided not to hospitalize)
  - Perfectionalistic concerns (i.e., fear of failure)
  - Mental checking
  - Comparing self to others
  - Performing socially or publicly causes great distress (i.e., fear of judgment/rejection)
  - Skin picking

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Diagnosis

- 300.3 Obsessive-Compulsive Disorder
- 296.3 Major Depressive Episode, Recurrent
- 300.7 Body Dysmorphic Disorder
- R/O 312.39 Trichotillomania

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G.E.

- Pre-tx assessment scores
  - YBOCS: 28
  - HAM-A: 10
  - BDD-YBOCS: 29

- Post-tx assessment scores
  - YBOCS: 13
  - HAM-A: 5
  - BDD-YBOCS: 17

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Exposures

- **Sleep/Wake Cycle**
- **Writing/ Mindfulness training**
  - Avoidances
  - Write narratives about anxiety and obsessions
- **Psychoeducation**
- **Functional Analysis**
- **Structure hierarchies**
- **Treat OCD**
  - Make and follow daily schedule
  - “Facing the feelings”
  - Compare self to others in community during community exposure exercises
  - Cover all mirrors in living environment for first week of treatment
  - Complete tasks imperfectly
  - Audit 2 college level courses and refrain from taking notes
  - Attend at least 3 yoga and/or dance classes per week, perform imperfectly
  - Write an imperfect essay
  - Ask for reassurance only once

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Exposures

- **Treat Trichotillomania**
  - Tactile
  - Visual
  - Cover hands with gloves for three days and not touch or skin pick
  - Use exaggerated mirror to look at skin imperfection

- **Treat BDD**
  - Compare self to others in the community during community exposure exercises
  - Cover all mirrors in living environment for the first week of treatment
  - Run fingers over skin imperfections on body for 3-minute increments at least twice daily. Resist compulsion to pick.
  - Inspect the ends of hair and resist the compulsion to pick.
  - Wear padding under tight clothes

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Case Study #3

- R.J., 24 year-old male
- Presenting concerns
  - Excessive anxiety about physical appearance
  - Obsessions over facial symmetry
  - Checking and comparing compulsions
  - Compulsive gambling
  - Spend over 8+ hours a day on the Internet
  - OCD first
  - Then BDD
  - Only 6 months later, recognized Bipolar Disorder, which tainted treatment
  - No hospitalization

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Diagnoses

- 300.3 Obsessive-Compulsive Disorder
- 300.7 Body Dysmorphic Disorder
- 296.25 Major Depressive Disorder, In Partial Remission
- R/O 296.89 Bipolar II Disorder

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R.J.

- Pre-tx assessment scores
  - Y-BOCS: 31
  - HAM-A: 10
  - BDD-YBOCS: 35

- Post-tx assessment scores
  - Y-BOCS: 16
  - HAM-A: 9
  - BDD-YBOCS: 17

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Exposures

- **Sleep/Wake Cycle**
- **Writing/ Mindfulness training**
  - Record all compulsive behaviors and avoidant behaviors in writing
- **Psychoeducation**
- **Functional Analysis**
- **Structure hierarchies**
  - Make a list of all avoidances and organize hierarchically by level of anxiety that the item provokes
- **Treat OCD**
  - No computer usage for the first 3 days of treatment
  - Ask for reassurance only once
  - Intentionally feel “wrong” all the time without giving into compulsions
  - Participation in a UCLA Extension class
  - Participation in an exercise class
- **Treat BDD**
  - Exaggerate perceived imperfections through pen sketching your own face in a caricature
  - Participate in Dr. Gorbis’ “Crooked Mirror Externalization Therapy”
  - Download distorted mirror application on phone and look at reflection for 15 minutes three times per day
  - Go out to street and ask women out for a date
  - Go to Trader Joes and approach and initiate conversation with attractive women

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Case Study #4

- A.J., 15 year old male
- Presenting Problems
  - intrusive obsessions interfered with thought processing & impaired functioning so severely that he has withdrawn from school
  - obsessions centered on themes of blasphemy and sexuality
  - fears that he may impulsively hurt himself due to obsession with knives and sharp objects

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Diagnosis

- 300.3 Obsessive Compulsive Disorder

- 296.25 Major Depressive Disorder, Single Episode, In Partial Remission

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A.J.

- Pre-tx assessment scores
  - Y-BOCS: 38
  - HAM-A: 17
  - BDD-YBOCS: 28

- Post-tx assessment scores
  - Y-BOCS: 10
  - HAM-A: 4
  - BDD-YBOCS: N/A

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Exposures

- Sleep/Wake Cycle
- Writing/ Mindfulness training
  - Avoidances
- Psychoeducation
- Functional Analysis
- Structure hierarchies
- Treat OCD
  - Make and listen to recorded narratives; imagine the “worst case scenario”
  - Refrain from asking questions
  - Say a white lie
  - Take a break with doing nothing
  - Sit with kitchen knife during in-vivo exposure
  - Do opposite of what OCD tells you
  - Be deliberately late by two minutes
  - Complete tasks imperfectly
  - “Embrace the doubt” and “shake hands with the devil”

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Exposures

- Walk around Westwood Village
- Read Bible narrative and inserting bad word
- Writing various scenarios of doubt
- Generalizing writings in different settings
- Tape post-its of OCD lies
- Writing various scenarios of doubt
- Generalizing writings in different settings
- Pick birthday card in aisle at Ralphs that also has baby wipes
- Attend dinner and wear diaper on head
- Take multiple 2-minute showers
- Carry baby wipes in pocket
- Listen to taped narrative
- Write obsessions while listening to narrative
- Recite obsessions out-loud
- Recite obsessions out-loud in hallway
- Crawl on floor reenacting baby behaviors
- Generalize doubts in various settings (UCLA campus)
- Use baby wipes
- Use baby wipes on private parts
- Crawl like a baby
- Say the word “baby”
- Watch Benjamin Button clip
- Write word “baby” on inside of hand
- Picture of girlfriend
- Put diaper on hands
- Walk on cracks
- Wear diaper on head and crawl like a baby

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Case Study #4

- P.A., 21 year-old, Caucasian female
- Presenting Concerns:
  - Severe anxiety
  - Intrusive irrational obsessions
  - Impulsive behaviors
  - Feelings of hopelessness
  - Withdrew from school, living at home with parents
  - Didn’t leave house
  - Panic attacks (once/twice a day)
  - In bed all day
  - Constant worry – perfectionism, failure, guilt, illness
  - Frustrated because no answer to what was causing her “illness”
  - Suicidal thoughts
  - Previous partial hospitalization

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Diagnosis

- 300.3 Obsessive-Compulsive Disorder
- 296.23 Major Depressive Disorder, Single Episode, Severe Without Psychotic Features
- 327.02 Insomnia Related to Obsessive-Compulsive Disorder
- 309.81 Posttraumatic Stress Disorder (provisional)
- R/O 300.7 Body Dysmorphic Disorder
- R/O 300.21 Panic Disorder With Agoraphobia
- R/O 312.39 Trichotillomania

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P.A.

- Pre-tx assessment scores
  - Y-BOCS: 34
  - HAM-A: 31
  - BDD-YBOCS: N/A

- Post-tx assessment scores
  - Y-BOCS: 7
  - HAM-A: 4
  - BDD-YBOCS: 14

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Exposures

- Sleep/Wake Cycle
- Writing/ Mindfulness training
  - Avoidances
- Psychoeducation
- Functional Analysis
- Structure hierarchies
- Imagery exposures during hospitalization
  - Tapes focusing on imperfections
  - Cover mirrors
- UCLA janitor's rally
  - Go outside and induce social criticism of self
- Treat OCD
  - Paint fingernails different colors
  - Mismatched clothes; bright colored clothes
  - Writing essays
  - Criticism from others
- Imagery exposures with regular mirrors
  - Writing and looking into mirrors
  - Increasing time
  - No make-up
  - Not doing hair
  - Cover the mirrors for three days

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Exposures Continued

- Wear bright colors
- Wear no makeup daily
- Mismatch outfits
- Wear hair imperfectly everyday
- Ask salesman a question about merchandise (Talk with strangers on the spot)
- Ask salesman a question about merchandise and keep the conversation going after they answer question about product
- Attend a book signing and ask a question on an unfamiliar topic
- Walk and jump in The Society of Janitors protest against the flow of traffic
- Write worst case scenarios about failing
- Repeatedly listen to a recording about failing
- Repeatedly listen to a recording about being titled the “ugliest girl in America” by the Society of Janitors

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So How Far Do You Go?

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How Far Do You Go?

- Need to make the determination based on ethical boundary.
  - ✓ "Primum non nocere" – First do no harm.
  - ✓ Which "harm" is greater: The exposure or suffering from OCD?

- Feared Consequences:
  - ✓ Criticisms
  - ✓ Rejections
  - ✓ Harm to Self / Others
  - ✓ Diseases
  - ✓ Death
  - ✓ Sexual Misbehaviors
  - ✓ Scrupulosity/Religiosity

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Factors Impeding Efficacy of ERP

- Severe depression or fear / anxiety
- Overvalued ideation (poor insight)
- Non-compliance with exposure or response prevention
- Severe personality disorders (i.e., Schizotypal)

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