Understanding and Assessing OCD

Bespoke Mental Health Webinar

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What do you want from the day?

- What is OCD?
- What are the distinguishing symptoms of OCD?
- What sort of questions help to identify it as the primary disorder?
- How might outcome measures support our identification and ultimately treatment?
- Questions?

- Anything else that you feel would be helpful?

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So what do you know about OCD?

- Media?
- Literature?
- Taught at university?
- How many cases are treated at LI compared to HI as a figure of overall referrals for OCD?

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Obsessive Compulsive Disorder

- A presentation where obsessive thoughts and/or compulsive behaviour are the main presenting features.
- This disorder carries a large amount of stigma, however…
- In the UK it affects about 12 out of 1000 people (1.2%)(OCDUK)
- This is however likely to be an underestimate, some studies suggest 2-3%, Why might there be a difference?
- Unpicking some local data; just over 3% are in or waiting for LI treatment (out of total waiting or in GSH)
- Of confirmed cases around 50% will be in the severe category, less than 25% mild (OCDUK)
- 2019/20 IAPT National data coded 24,151 being assessed as OCD; 81.4% show some sign of recovery (47.6% recovered or reliable)

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Does it work at Low Intensity?

- IAPT national data for 2019/20 shows mean treatment appointments for PWP with OCD to be 2.2 for trainee and 3 for qualified
- A recent qualitative piece of research found that LI treatment for OCD did not demonstrate significant benefit.
- However, LI input led to significant reduction of HI uptake.
- Ultimately PWPs provided those with OCD with greater access, choice and flexibility (Gellatly et al 2017)
- Assessment and identification therefore vitally important for PWPs

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Obsessions

- Recurrent and unwanted intrusive thoughts.
- They cause marked anxiety and are distressing for the sufferer as they believe they have the power to do or stop 'harm'.
- The thoughts may also be images or even strong urges.
- These obsessions are usually at odds with the individuals value of who they should be.
- Comes from the latin obsidere - to besiege

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Compulsions

- These are responses to 'right' the obsessions and are developed to neutralise the obsession and can be actions or mental acts.
- They have 3 purposes:
  - Reduce the chance that what you are thinking will happen,
  - Reduce the anxiety,
  - And reassure yourself that if something bad does happen you have done everything to prevent it.
- They are often repetitive and may need to be done in a certain way, e.g. rituals.
- They can be overt or covert.

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Common obsessions and compulsions…

- Having intrusive thoughts is common to nearly all of us.
- Many of us have compulsive behaviours…
- On the Poll, identify the 3 most common compulsions you think are seen in OCD presentations

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Common obsessions and linked compulsions

Obsession	Compulsion
• Agression	• Reassurance seeking, checking
• Contamination	• Washing or cleaning
• Magical thoughts / superstitions	• Avoidance, repetitive rituals
• Religious	• Reassurance, praying, seeking forgiveness
• Sexual	• Avoidance, repetitive rituals
• Somatic	• Reassurance seeking
• Symmetry	• Ordering, balancing, arranging

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Well we all have some obsessions and compulsions…

- So what distinguishes us from those affected by OCD?
- We acknowledge that this disorder, like so many anxiety disorders is better represented as a continuum, however…
- There are particular features that make this more debilitating for our patients:
  - The meanings given to obsessions,
  - And the strategies used to control the obsessions, specifically the compulsions which end when the person 'feels right'.

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Unhelpful meanings given to obsessions

- Everyone has odd or unwanted obsessions/thoughts from time to time.
- 80-88% of people have obsessions, and the content of normal and abnormal obsessions are similar.
- However the meaning or interpretation that is given to them can seem very personally significant in those where the obsession becomes abnormal.
- This makes them more disturbing and therefore more likely to turn into an unhelpful obsession.
- For example I was catching a tube in London recently…
- What might be my interpretation of this thought?

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Strategies used to control obsessions

- The strategies used (e.g. checking, washing seeking reassurance, avoiding etc.) only reduce anxiety temporarily, and the next time there is a trigger, or obsession you carry out the strategy again, therefore never develop effective strategies.
- Remember the avoidance graph for exposure?
- There is no opportunity to see if the meaning given to the obsession is true and the anxiety decreases.
- This then increases the likelihood of the obsessions re-occurring.
- What do you think might have been a strategy/compulsion of mine in my recent example?

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OCD vicious cycle

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Thought-Action Fusion

- As we learnt earlier we are all on a continuum of anxiety and that those with OCD the thoughts contain some 'power' by the individual to stop or reduce the chance it might happen.
- This is known as thought-action fusion.
- TAF can occur in other anxiety disorders so cannot be assumed a diagnostic criteria, but it may form part of the larger picture.
- Thoughts are equated to actions.
- For example, my thought about pushing someone in front of the train means **I am going to push them in front of the train**.
- The patient therefore believes that intrusive thoughts reflect reality.
- Not true, right?

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Beliefs that are commonly associated with OCD

- Inflated sense of responsibility.
- Overestimating threat.
- Being intolerant of uncertainty.
- Being perfectionist.

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ICD-10 vs DSM-5

ICD-10

- Obsessions and compulsions present on most days over a 2 week period
- Obsessions and compulsions:
  - Recognised as patients own
  - Repetitive and unpleasant with at least one unreasonable or excessive
  - Effort made to resist the obsession/compulsion, but unsuccessful
- Obsessions and compulsions cause distress and interfere with activity
- Not diagnosed in the presence of schizophrenia or Tourette syndrome

DSM-5

- Presence of obsessions, compulsions or both
- The obsessions or compulsions are time consuming (e.g. take more than 1 hour a day) or cause clinically significant distress or impairment in social, occupational or other functioning
- The obsessive-compulsive symptoms are not attributable to physiological effects of a substance or another medical condition
- the disturbance is not better explained by the symptoms of another mental disorder

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IAPT screening prompts for OCD (see IAPT MDS appendices/IAPT Manual)

1. Depression is commonly co-morbid, however if questioning suggests that depression is secondary, or the PHQ-9 score is 'less' than GAD-7 then carry onto steps 2 onwards. If not then consider depression as the primary presenting problem.
2. Ask; Are there times when you are very frightened or anxious, and feel very uncomfortable?
3. If yes, then ask; Is it related to a specific situation(s)/object(s)?
4. If yes, then ask; In what situation(s) or with what objects does the intense anxiety arise?
5. If the fear is accompanied by recurrent thoughts, impulses or images (obsessions) or ritualistic behaviour (washing hands, switching off lights) or mental acts (counting, repeating words silently) (compulsions) then consider OCD.

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Jane and questioning exercise

- Meet Jane, Jane is a 20 year old student at a local University. She has come to you on recommendation from her GP. She lives in a shared house with 4 housemates.
- She tells you that she feels anxious and on edge most of the time. It is slightly easier for her when at home, but her anxiety peaks if she has to go out at short notice.
- She tells you that she worries about leaving her room and that it can take her a long time to get ready to leave.
- She finds it difficult to concentrate, particularly when she is out of the house.
- You suspect that she may have some OCD traits, what sort of questions could you ask based on our understanding of OCD from today?

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Okay, so we think it is OCD from what we have gathered

- Whilst our questioning skills and the format of a LI assessment helps to identify OCD we can use outcome measures to help support our decision making process, and as evidence in our supervision discussions.
- We have one OM that we have to use for anxiety; GAD-7
- Our phobia scales don't include OCD

- Can we rely on the GAD-7 as a reliable tool to measure OCD?
- If not why?

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Online CBT Resources

Obsessive Compulsive Inventory

Name/initials: Date:

The following statements refer to experiences which many people have in their everyday lives. Please check the box that best describes how much that experience has distressed or bothered you during the past month.	Not at all	A little	Moder-ately	A lot	Extre-mely
1. Unpleasant thoughts come into my mind against my will and I cannot get rid of them	0	1	2	3	4
2. I think contact with bodily secretions (perspiration, saliva, blood, urine, etc.) may contaminate my clothes or somehow harm me	0	1	2	3	4
3. I ask people to repeat things to me several times, even though I understood them the first time	0	1	2	3	4
4. I wash and clean obsessively	0	1	2	3	4
5. I have to review mentally past events, conversations and actions to make sure that I didn't do something wrong	0	1	2	3	4

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The OCI

- OCI is a recommended IAPT tool so can be freely used, however only if clinically indicated and not at every contact.
- 42 questions with a cut off score of 40 and can be separated into distinct behaviours:
- Washing: 2, 4, 8, 21, 22, 27, 38 and 42
- Checking: 3, 7, 9, 10, 19, 24, 31, 32 and 40
- Doubting: 26, 37 and 41
- Ordering: 14, 15, 23, 29 and 35
- Obsessing: 1, 12, 13, 17, 20, 28, 30 and 33
- Hoarding: 6, 11 and 34
- Mental neutralising behaviours: 5, 16, 18, 25, 36 and 39

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Supervision

- As we have heard OCD can be treated at low intensity
- We have however heard that LI doesn't always lead to recovery, but it does reduce referrals on to HI
- Broadly, HI would probably be indicated by the following;
  - Long standing difficulties around obsessional thoughts and compulsions, generally in excess of a couple of years.
  - Significant periods of time dedicated to the compulsions, generally in excess of 1-2 hours a day, quite possibly interfering significantly with work or home life.
  - An OCI score above 40.
  - Compulsions including or exclusively mental, for example counting, praying etc.
- A robust discussion in supervision can help determine whether HI or LI should be the first point of call. these should be supported with both your assessment information, and scores from outcome measures, including the OCI if clinically indicated

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LI Treatment

- LI treatment follows a very similar approach to HI, except single strand
- Exposure Response Prevention (ERP) is the accepted LI treatment
- Exposure - therapeutic confrontation to a feared stimulus until fear subsides through habituation
- Response Prevention - choosing to resit performing the compulsive behaviour
- At HI a multi strand approach may incorporate cognitive interventions such as behavioural experiments or cognitive restructuring alongside a behavioural approach (ERP)

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Any questions?

- Thank you for your time and participation.
- I hope you have found this training useful.

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