

**PENAL REFORM INTERNATIONAL
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Obsessive-Compulsive Disorders

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Definitions (from DSM-IV)

- **Obsessions**
 - Recurrent or persistent thoughts, images or impulses that are experienced as intrusive and inappropriate and cause marked anxiety or distress
 - They are not simply excessive worries about real-life problems
 - The person attempts to ignore or neutralize them
 - The person recognises they are a product of his or her own mind
- **Compulsions**
 - Repetitive behaviours or mental acts that the individual feels driven to perform in response to an obsession, or according to rules that must be applied rigidly
 - These actions are aimed at preventing some dreaded event or situation
 - They are not connected in a realistic way with what they are designed to prevent; or are clearly excessive

Symptom patterns include:

- **Repetitive rituals (compulsive acts) combined with obsessions**
- **Compulsive slowness and orderliness**
- **Obsessions without rituals (ruminations)**

Patterns of occurrence

- **More than half of sufferers are female**
- **Age of onset mainly from early adolescence to mid-20s; 74% before age 30**
- **Earlier average onset in males (13-15) than females (20-24)**
- **Average of 7 years from onset before seeking treatment**
- **Marital distress reported in 50% of cases**

OCD has parallels with:

- **Hypochondriasis**
 - **excessive preoccupation with illness symptoms**
 - **individual believes he/she has a disease**
- **Dysmorphophobia (Body Dysmorphic Disorder)**
 - **preoccupation with an imagined physical defect**
 - **may be linked to compulsive checking**

Data on prevalence

SOURCE STUDY OR LOCATION	6-MONTH PREVALENCE	LIFETIME PREVALENCE
Epidemiological Catchment Area studies (ECA)	1.5%	2.5%
Canada	1.5%	3.0%
New Zealand	1.6%	2.2%

Co-morbidity

ANXIETY PROBLEMS

- phobic disorders: 46%
- tic disorders: 36-52%
- social phobia: 20%
- panic disorder: 15%

OTHER DIFFICULTIES

- sleep disturbances: 40%
- major depressive disorder: 32%
- substance abuse problems: 24%
- eating disorders:
 - 10% of women with OCD had history of anorexia
 - 33% of bulimic patients had history of OCD

Continuum of normality-abnormality

(cf. Salkovskis, Forrester, Richards and Morrison 1998)

- **Studies have reported that 90% of the population experience intrusive thoughts that are indistinguishable from obsessional thoughts; they are not an abnormal phenomenon *per se*.**
- **Part of therapy may be to help the client accept that intrusive thoughts are likely to occur and do not need to be controlled:**
 - they can help in solving problems
 - attempts to suppress them might be counter-productive

Models of causation

BEHAVIOURAL

Mowrer's two-factor theory
(conditioned fear +
avoidance)

More support for avoidance as
maintenance factor

Anxiety decreases after
performance of a ritual

COGNITIVE

Focus in fears on issues related to
health, death, welfare of
others, sex, religion, etc.

Fundamental belief in need to be
competent

Perception of threat and use of
rituals as control

Assessment

(1) **Clinical interview: areas to be covered**

- external fear cues
- internal fear cues
- feared consequences
- strength of belief
- avoidance and rituals
- history of difficulties
- social functioning
- mood states

(2) **Self-monitoring**

(3) **Structured assessments, e.g.**

- Yale-Brown Obsessive Compulsive Scale
- Maudsley Obsessive Compulsive Inventory
- Compulsive Activity Checklist (Revised)

Therapeutic approaches

- **Behaviour therapy**
 - exposure
 - response prevention
- **Cognitive therapies**
 - A-B-C + replacement of dysfunctional thoughts
 - focused on underlying beliefs
- **Medication**
 - clomipramine
 - fluoxetine
- **Combined cognitive-behavioural and pharmacotherapy**

Implementing exposure + response prevention

- **Best effects obtained when two are combined**
- **Prolonged exposure sessions (45 min → 2 hrs) produce best effects**
- **Anxiety begins to dissipate after 30 min**
- **May be combined with graduated exposure (more acceptable)**
- **Recommended procedure: therapists develops hierarchy, client determines pace of intervention**
- **Clients are requested to enlist the aid of a support person**
- **Need to avoid giving reassurance**
- **Overt behavioural rituals more easily addressed than mental rituals**
- **Clients are more able to comply with strict RP instructions**

Implementing cognitive therapies

- 1 Assessment and development of (a) shared account, (b) alternative account**
- 2 Detailed identification and monitoring of thoughts, feelings, behaviours**
- 3 Discussion techniques for challenging basic assumptions**
- 4 Behavioural experiments to illustrate counter-productive effects of safety strategies**
- 5 Behavioural experiments to illustrate how avoidance and neutralization maintains problems**
- 6 Enabling client to identify and monitor underlying assumptions**

Outcome studies: 1

Meta-analysis by Christensen et al (1987)

**27 studies with pre-post data;
only 8 controlled trials**

**Gains made post-treatment for
Exposure were maintained at
82-week follow-up**

**For tricyclics, no follow-up data
available**

INTERVENTION: ES:

Exposure 1.22

Tricyclics 1.40

Non-specific 0.21

Compulsions 1.13

No compulsions 0.41

Outcome studies: 2

Meta-analysis by von Balkom et al (1994)

With self-ratings as outcome, BT > anti-depressants

86 studies conducted between 1970-1993

With observer ratings, no differences found amongst treatments

58 controlled trials

70-80% of individuals who

complied with treatments improved

Studies included:

Anti-depressants

Behaviour Therapy

CBT + pharmacotherapy combined

Cognitive Therapy (4 studies only)

Follow-up studies from 3 mo. to

3yr. showed gains maintained

Issues and complexities in therapy

- **Non-compliance with response prevention instructions**
- **Continued passive avoidance**
- **Arguments**
- **Emotional overload**
- **Non-anxious reactions to exposure**
- **Emergent fears and rituals**
- **Family reactions**
- **Functioning without symptoms**

Salkovskis (1985) model of OCD

1: Causal sequence

- 1 Intrusive obsessional thoughts**
- 2 Negative automatic thoughts**
- 3 Mood disturbance if contrary to belief system**
- 4 Central themes of responsibility and blame**
- 5 Feelings and thoughts must be neutralized**
- 6 Methods include behavioural or cognitive compulsions**
- 7 Fundamental assumptions concerning relation between thought and action**

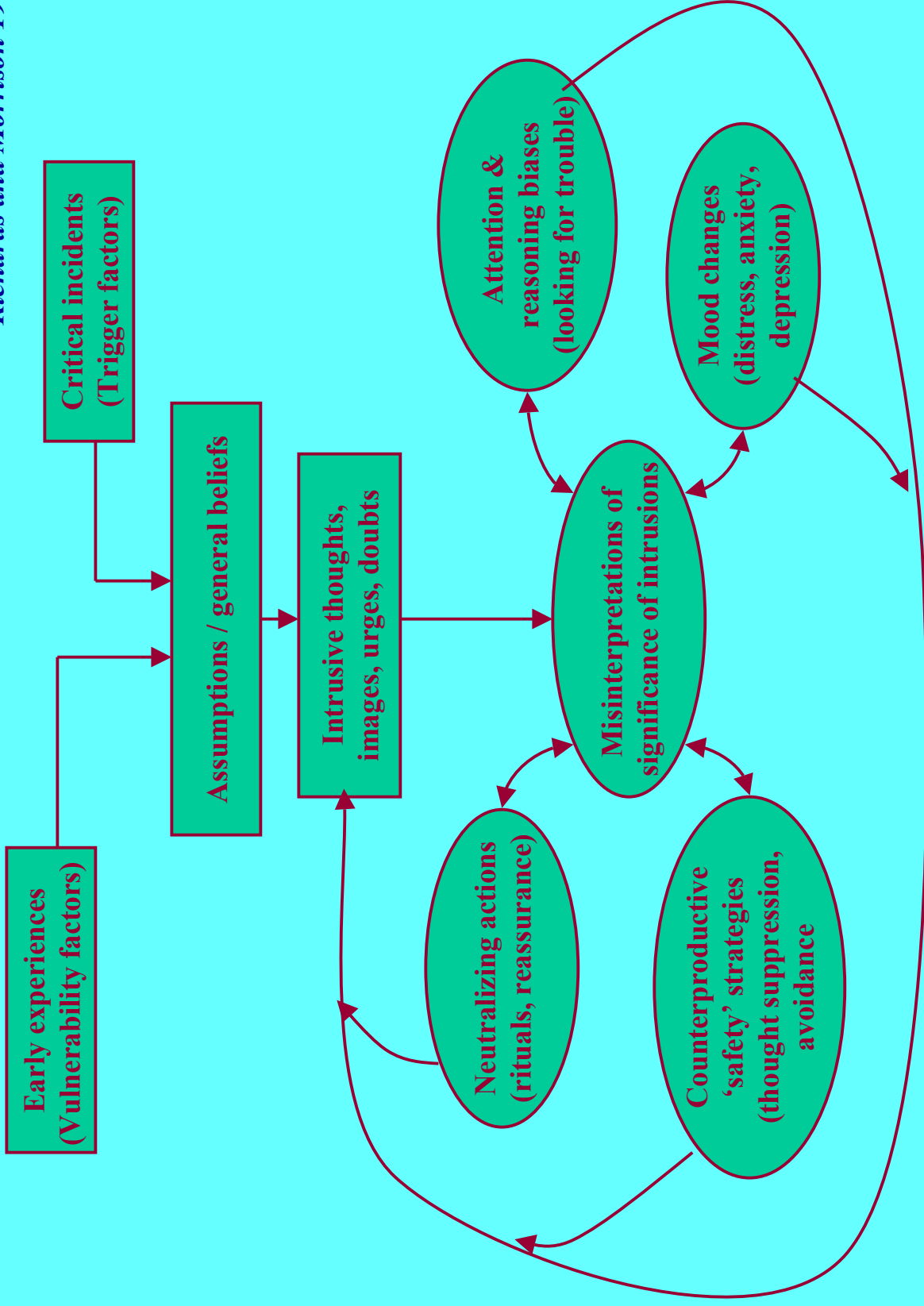
Salkovskis (1985) model of OCD

2: Five dysfunctional assumptions

- **Having a thought about an action is like performing the action**
- **Failing to prevent (or trying to prevent) harm to self or others is the same as having caused the harm in the first place**
- **Responsibility is not attenuated by other factors**
- **Not neutralizing when an intrusion has occurred is similar or equivalent to seeking or wanting the harm involved in that intrusion to actually happen**
- **One should (and can) exercise control over one's thoughts**

INTEGRATED SCHEMATIC MODEL

(adapted from Salkovskis, Forrester, Richards and Morrison 1998)



Patterns involved in development of an inflated sense of responsibility (Salkovskis, Shafran, Rachman & Freeston, 1999)

- (a) individuals have from an early age believed themselves to be crucially responsible, usually because they had excessive responsibility placed on them**
- (b) individuals have been over-protected to the extent that they seldom felt responsibility even for minor actions**
- (c) individuals with a previous experience which led them erroneously to believe that they had caused harm**
- (d) individuals who had an experience which in some way did contribute to harm**
- (e) individuals exposed to rigid and extreme codes of conduct and duty**