Psychopathology of Everyday Life LECTURE 7 notes

Obsessive-compulsive and related disorders

DSM5: OC and related disorders

- Obsessive-Compulsive Disorder (most common)
- Body Dysmorphic Disorder
- Hoarding Disorder (new standalone disorder in the DSM-5)
- Trichotillomania (Hair-Pulling Disorder)
- Excoriation (Skin-Picking Disorder)
- Substance/Medication-Induced Obsessive-Compulsive and Related Disorder
- Obsessive-Compulsive and Related Disorder Due to Another Medical Condition
- Other Specified Obsessive-Compulsive and Related Disorder
- Unspecified Obsessive-Compulsive and Related Disorder

Obsessive-compulsive disorder

**Definition: recurrent obsession or compulsions that are time-consuming or cause marked distress or impaired functioning.

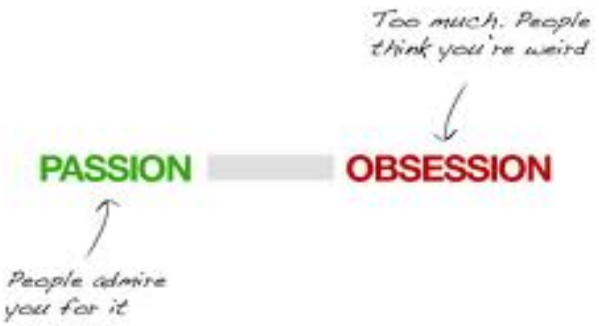
Watch documentary: House of Obsessive Compulsives on YouTube

- Obsessions and compulsions are recurrent and persistent;
- Individual recognizes they are excessive or unreasonable;
- Obsessions/compulsions cause marked distress, are time consuming (>1 hr/day) and significantly interfere with functioning and relationships. (DSM5 criteria)

Obsessions

**Definition: are defined as recurrent and persistent thoughts, impulses or images that are experienced as intrusive and inappropriate or distressing. The person must attempt to ignore the thoughts or to neutralise them by engaging in some other mental routine or behaviour. Lastly, the person must recognise that the obsessional thoughts are the product of his/her own mind.

- Persistent ideas, thoughts, impulses, or images that are experienced as intrusive and inappropriate and cause marked anxiety or distress;
- Individual recognizes thoughts are product of their own mind (differentiating from delusional disorder = needed for a diagnosis of OCD)

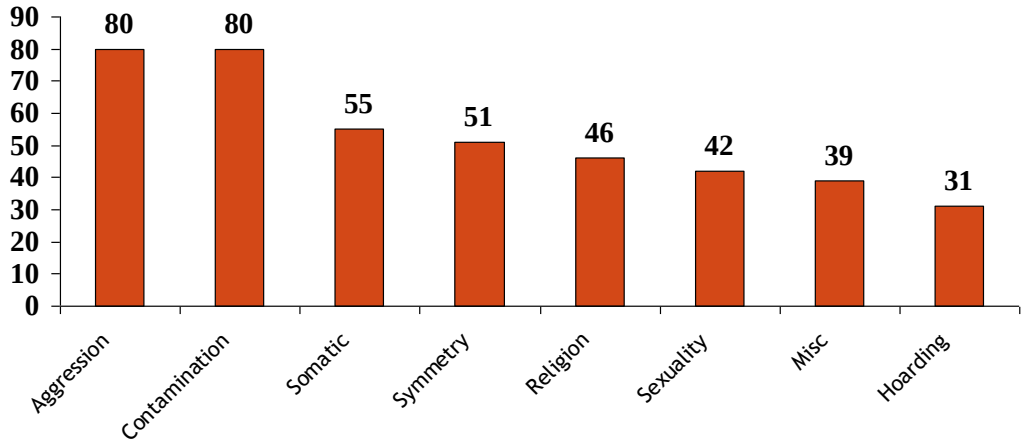


Obsessions: common types

- Fears of contamination

- Repeated doubts (safety, scruples)
- Need to have things in a particular order
- Sexual, horrific or blasphemous imagery
- Aggressive or inappropriate impulses
- Nonsensical thoughts or images

Sobin et al., (1999). Phenotype characteristics of Obsessive Compulsive Disorder ascertained in adulthood. *Journal of Psychiatric Research*, 33, 265-273. Highlights the most common types.



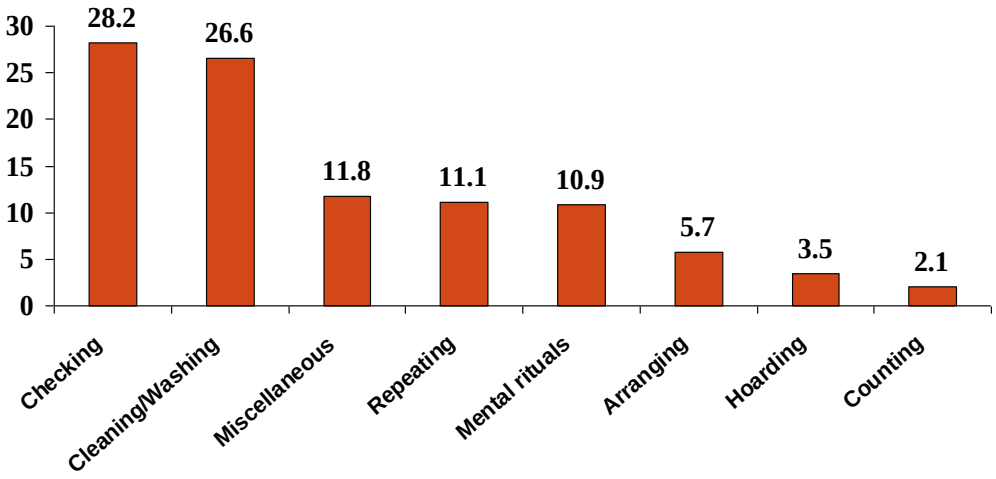
Compulsions

**Definition: defined as repetitive behaviours (including mental routines) that the person feels compelled to perform in response to an obsession or according to strict rules. The behaviour must be aimed at reducing anxiety (usually triggered by an obsession) or preventing a threatening outcome.

- Repetitive behaviour (handwashing, checking) or mental acts (praying, counting, repeating words silently) the goal of which is to prevent or reduce anxiety;
- Can include rigid/stereotyped acts according to elaborate rules without any real explanation of them.
- Response is often way out of proportion to the thought (e.g., washing hands with bleach or for hours on end)

Compulsions – common types

- Washing and cleaning
- Checking
- Repeating
- Ordering
- Mental rituals (eg. Counting, prayers)
- Reassurance seeking
- Hoarding
- Compulsive shopping



Foa, E., Kozak, M., Goodman, J., Hollander, R., Jenike, M., & Rasmussen, S. (1995). DSM-IV Field trial: Obsessive compulsive disorder. *American Journal of Psychiatry, 152*(1), 90-94. Types of compulsions in terms of how common they are. NOTE: that hoarding is now considered its own disorder.

Obsessions and compulsions

- Up to 80% of population may experience intrusive, unpleasant, unwanted thoughts;
- More than 50% population may engage in ritualised behaviour
  - Crino, Slade & Andrews, 2005

OCD

- 12 month prevalence: 0.6% (DSM-IV criteria);
- No difference b/w OCD and non-OCD in gender, marital status, education, migration status, urbanicity;
- Average age of onset- m: 27 years (mode: 6-15); f: 25 years (mode: 20-29);
  - Crino et al. (2005)
- Usually fluctuating course- often waxing and waning in conjunction with stress levels;
- Chronic course in approx 50% of cases.

Common symptom profiles

- 90% of patients with OCD have obsessions and compulsions
- 8-20% have obsessions and mental rituals, but not behavioural compulsions
- 2% report obsessions without any compulsions
- 2% report compulsions only

OCD – gender

- Equally common in males and females;
- However childhood-onset OCD more common in boys than girls;
- Female: cleaning and 'aggressive obsessions';
- Male: slowness, symmetry, numbers, touching rituals, and 'sexual' symptoms.
  - Lochner & Stein, 2003.

OCD comorbidity

- 80% of sufferers- had one other DSM disorder;
- 46% with OCD had 3+ other disorders in 12 months prior to interview.
    - Crino et al. (2005)
- Comorbidity with other Axis I conditions:
    - MDD (55%)
    - Social phobia (23%)
    - Specific phobia (21%)
    - GAD (20%)
        - Eisen et al. 1999

OCD – neuropsychiatric disorder

- OCD involves various brain regions:
    - orbitofrontal–subcortical circuits, caudate nucleus, thalamus
        - Whiteside et al., 2004.
    - Frontal lobes and/or basal ganglia
        - Kuelz et al., 2004.
- Possible dysfunction in serotonin neurotransmission**;**
- Neuropsych. functioning: deficits in executive functioning as well as memory & organisational skills (Greisberg & McKay, 2003).

OCD – risk factors

- Family history with evidence of dominant or codominant mode of transmission (Jenike, 2004);
- Early childhood experiences and critical learning incidents → maladaptive beliefs about responsibility and threat (Clark & O'Connor ,2005);
- Personality factors- neuroticism, psychoticism and sensitivity to punishment (Fullana et al., 2004).

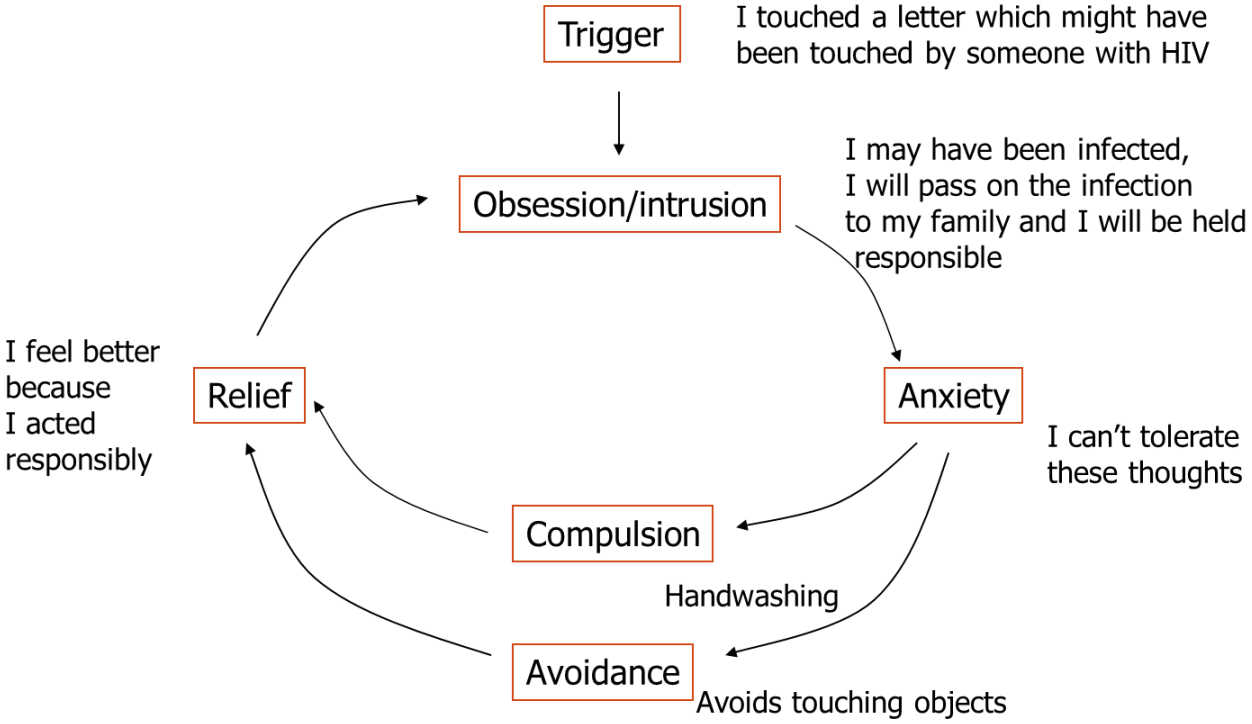
Obsessions and compulsions

- Up to 80% of population may experience intrusive, unpleasant, unwanted thoughts;
- More than 50% population may engage in ritualised behaviour
    - Crino, Slade & Andrews, 2005

OCD – cognitive behavioural model

1. Begins with the premise that intrusive thoughts are normal
2. However, certain individuals place meaning on these thoughts, and thus respond to them in some way (avoid, suppress, ritualise etc).
3. These responses increase vigilance for the intrusive thoughts and protects the meaning of the intrusion.

OCD – cognitive model



OCD –x cognitive factors

Intrusive thoughts might become obsessions if they are evaluated as:

- Overly important ('if I'm thinking this way, it must be important');
- Highly threatening ('if I continue to think like this, something bad will happen');
- Requiring complete control ('I've got to stop thinking this way');
- Necessitating a high degree of certainty ('I need to be certain that nothing bad will happen')
- Associated with a state of perfection ('I can't stop thinking about this until I do it perfectly')
    - Clark & O'Connor, 2005

Body Dysmorphic Disorder

A. Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others.

B. At some point during the course of the disorder, the individual has performed repetitive behaviours (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (e.g., comparing his or her appearance with that of others) in response to the appearance concerns.

C. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- *Specify* if:**With muscle dysmorphia:** The individual is preoccupied with the idea that his or her body build is too small or insufficiently muscular. This specifier is used even if the individual is preoccupied with other body areas, which is often the case.

BDD: Prevalence

- 0.7- 2.4% (Buchanan et al., 2011- review article on LMS)
- Higher rates amongst dermatology, cosmetic surgery, adult orthodontic and oral/maxillofacial surgery patients;

BDD: onset and course

- The mean age at disorder onset is 16–17 years- although not usually diagnosed until 10-15 years later.
- Patients generally present to services for secondary or associated disorder (OCD, depression etc);
- Approximately 25% patients attempt suicide;
- Disorder usually chronic, although improvement is likely when evidence-based -treatment is received;
- Individuals with disorder onset before age 18 years are more likely to attempt suicide, have more comorbidity, and have gradual (rather than acute) disorder onset than those with adult-onset body dysmorphic disorder.

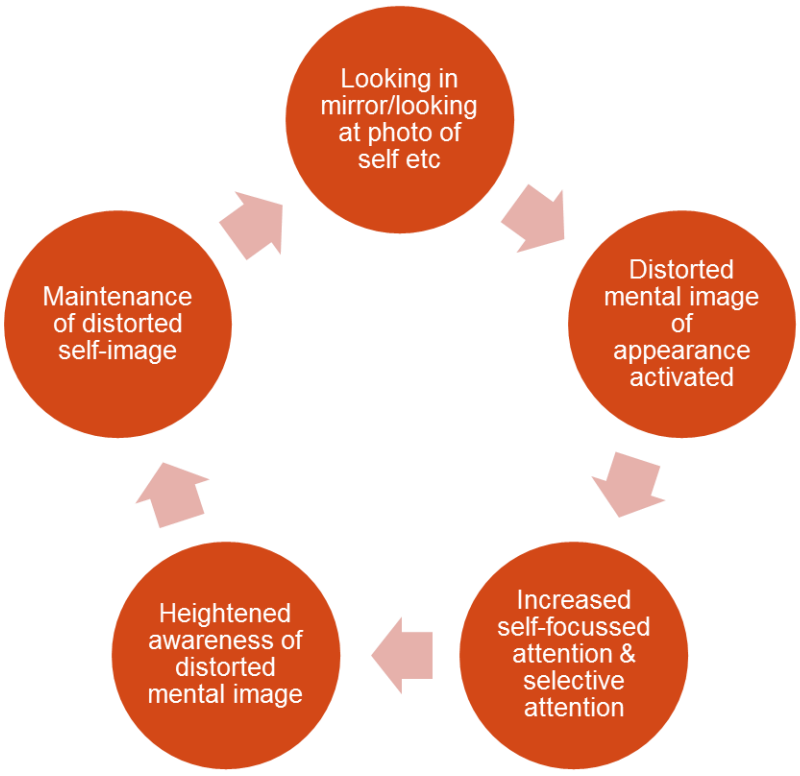
BDD: gender differences

- No difference in prevalence rates;
- More similarities than differences in most clinical features—for example, disliked body areas, types of repetitive behaviors, symptom severity, suicidality, comorbidity, illness course, and receipt of cosmetic procedures;
- However, males are more likely to have genital preoccupations, and females are more likely to have a comorbid eating disorder.
- Muscle dysmorphia occurs almost exclusively in males

BDD: impact on functioning

- Can range from moderate (e.g., avoidance of some social situations) to extreme and incapacitating (e.g., being completely housebound);
    - job, academic, or role functioning (e.g., as a parent or caregiver), which is often severe (e.g., performing poorly, missing school or work, not working)
    - social functioning (e.g., social activities, relationships, intimacy),
    - psychiatric hospitalisation

BDD: Veale's model (2004)



BDD: Cognitive processes

Compared to healthy controls individuals with BDD:

- Evaluate appearance more negatively
- Endorse assumptions about appearance such as "If my appearance is defective then I am worthless"
- Overvalue physical appearance and attractiveness
- Experience more anxiety and discomfort after mirror gazing
- Experience more distress and self-focussed attention after mirror gazing
- Engage in ruminative thinking- such as 'Why am I so ugly'
- Engage in repeated reviews of past-appearance related experiences
    - Kollei & Martin, 2014

BDD & medical interventions

- Of 268 patients seeing dermatologist ~12% met criteria for BDD (Phillips et al., 2000);
- Approx 45% of BDD pts seeking dermatological treatment and 23% seeking plastic surgery (Phillips et al., 2001)
- Therefore individuals with BDD:
    - Make up a significant proportion of people seeking assistance from dematology or plastic surgery- BUT
    - Unlikely to be happy with the result, may return time and again for treatment and can be litigious.

Beauty and culture

BDD and culture

Hoarding Disorder

A. Persistent difficulty discarding or parting with possessions, regardless of their actual value.

B. This difficulty is due to a perceived need to save the items and to distress associated with discarding them.

C. The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas and substantially compromises their intended use. If living areas are uncluttered, it is only because of the interventions of third parties (e.g., family members, cleaners, authorities).

D. The hoarding causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (including maintaining a safe environment for self and others).

Hoarding disorder: prevalence

- Estimated to be between 2-6% adults in Europe and US
- Nordsletten et al. (2013)- 1.5% adults in South London
- Affects males and females- possibly more common in males (although more females present for treatment);
- More common in older adults than younger adults.

Cognitive factors associated with Hoarding behaviour

- Control over possessions

- Concern about memory
- Responsibility over possessions
    - (After age, mood (depression and anxiety), OCD symptoms and other OCD-related cognitive variables controlled for)
        - Steketee, Frost and Kyrios, 2003

Hoarding animals

- The compulsive need to collect and own animals for the sake of caring for them that results in accidental or unintentional neglect or abuse.
- Animals may provide a conflict-free relationship with the individual, unconditional love;
- Alternatively, perceptions of being a refuge for unloved animals may provide the individual with a sense of purpose, a special role, means that they are loving and caring;
- BUT…
- In many cases, everyone suffers with animal hoarding—the animals, the hoarder, and those who love the hoarder.

Tricotillomania and Excoriation

Trichotillomania (hair pulling)

A. Recurrent pulling out of one's hair, resulting in hair loss.

B. Repeated attempts to decrease or stop hair pulling.

C. The hair pulling causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The hair pulling or hair loss is not attributable to another medical condition (e.g., a dermatological condition).

E. The hair pulling is not better explained by the symptoms of another mental disorder (e.g., attempts to improve a perceived defect or flaw in appearance in body dysmorphic disorder).

Trichotillomania

Prevalence

- 1-2% adults (Stein et al., 2010)
- ?More females affected

Course of illness

- Usually chronic- but can wax and wane

Functional consequences

- Social/occupational impairment
- musculoskeletal injury (e.g., carpal tunnel syndrome; back, shoulder and neck pain),
- blepharitis,
- dental damage (e.g., worn or broken teeth due to hair biting).
- Swallowing of hair (trichophagia) may lead to trichobezoars, with subsequent anemia, abdominal pain, hematemesis, nausea and vomiting, bowel obstruction, and even perforation (taken from DSM5)

Excoriation (skin-picking) disorder

A. Recurrent skin picking resulting in skin lesions.

B. Repeated attempts to decrease or stop skin picking.

C. The skin picking causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The skin picking is not attributable to the physiological effects of a substance (e.g., cocaine) or another medical condition (e.g., scabies).

E. The skin picking is not better explained by symptoms of another mental disorder (e.g., delusions or tactile hallucinations in a psychotic disorder, attempts to improve a perceived defect or flaw in appearance in body dysmorphic disorder, stereotypies in stereotypic movement disorder, or intention to harm oneself in nonsuicidal self-injury).

Excoriation

Prevalence

1-2% adults (Stein et al., 2010)

?More females affected

Course of illness

Usually chronic- but can wax and wane

Functional consequences

Social and occupational impairment

tissue damage, scarring, infection

frequently requires antibiotic treatment for infection, and on occasion it may require surgery (taken from DSM5)

Trichotillomania and Excoriation: psychological aspects

- Motivated by stimulation of positive mood or feelings (i.e., pleasure, gratification or relief) or regulation of states of high or low arousal (i.e., anxiety or boredom);
- Approximately 1/5- 1/3 people with SPD or trich report being in a trance/feeling mesmerized/ experiencing depersonalisation while picking/ hair pulling;
- Substantial proportion of sufferers in both groups report little or no reflective awareness of the act as it occurs
    - Two subtypes proposed
        - "automatic pulling/picking" that occurs out of reflective awareness in sedentary situations;
        - "focused pulling/picking", happens in full awareness in response to urges or negative affective states.
            - (Snorrason et al., 2012)
- Shame, distress, embarrassment;
- BUT
- Hair pulling and scratching also reduce unpleasant emotions

OCD and related disorders – summary

- Considered together in DSM because they are all characterised to some extent by intrusive thoughts and repetitive behaviours;
- Can all be highly distressing and associated with severe levels of disability, dysfunction and comorbidity;
- Are all amenable to psychological treatment- but motivation is the key.