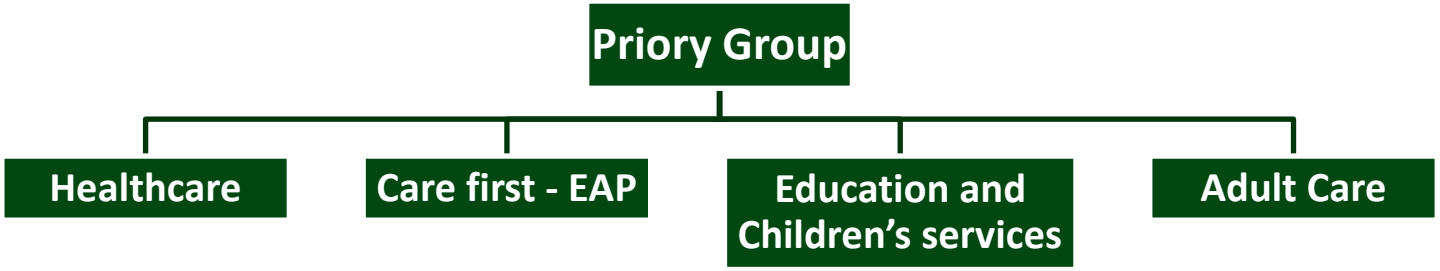
About the Priory Group

The Priory Group of Companies is the **leading provider of behavioural care in the UK**



Priory Locations

Priory Healthcare is committed to providing the highest quality of care to help individuals overcome a wide range of mental health conditions

- Across **24 Wellbeing Centres and Hospitals** Priory supports over 10,000 private patients each year
- With a network of the UK's leading consultant psychiatrists, psychologists and therapists we offer a range of therapies
- Priory offer:
  - **Outpatient for adults and young people** (one on one therapies, couples therapy & family therapy)
  - **Daycare** (group therapies which is increasingly popular)
  - **Inpatient treatment** (mental health & addictions)

Priory Sites

What we treat

- **Depression**, including post-natal depression
- **Anxiety**-related conditions
- **Obsessive compulsive disorder**
- **Post-traumatic stress disorder**
- **Addiction**
- **Stress**
- **Life difficulties**, such as relationships, work and bereavement
- **Mood swings**
- **Eating disorders**
- Assessment of **medically unexplained** symptoms
- **Child and adolescent mental health**

OCD, overview and treatment principles.

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Epidemiology

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- common psychiatric diagnosis

- 12 months prevalence 0.5-1%
- Lifetime prevalence 2-3%
    - 31% b/n 10-15yrs age
    - 75% by 30yrs

- Similar rates across cultural boundaries

- Boys > girls; men = women

- Single > married

Aetiology

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WHAT CAUSES OCD?

3 MAIN RISK FACTORS THAT CAN CAUSE OCD TYPES

GENETICS

People with 1st degree relatives who developed OCD as a child or teen, significantly higher risk of developing OCD

BRAIN STRUCTURE

Research suggests that specific areas of the brain can be identified as being affected

ENVIRONMENT

Experiencing physical, sexual, or emotional abuse at a young age

Aetiology

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- **Genetic**
  - 4x more common in relatives if <18yrs age of onset.

- **Evidence of a brain disorder**
  - associations with other brain disorders (Tourette's syndrome).

  - brain imaging studies (CT, MRI→ no structural brain abN; SPET & PET → ↑ activity in orbitofrontal cortex, ant cingulate, caudate nucleus & parts of thalamus; treatment appears to reverse at least some of these abNs)

Aetiology (cont)

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- **Early experience**
  - uncertain, ?imitative learning
  - children of OCD parents have ↑ risk of non-specific neurotic symptoms but not more OCD symptoms

- **Psychoanalytical theories**
  - not supported by evidence
    - Freud:
    - O symptoms result from unconscious impulses of an aggressive or sexual nature → anxiety, which is ↓ by repression (defence mechanism)

Description of OCD

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- Unwanted, recurrent obsessions and/or compulsions
- Recognised as alien to person but coming from within the self
  - Absurd and irrational
  - Strong desire to resist (although ~50% offer little resistance)
- Sufficiently severe to cause marked distress
- Interfere significantly with normal routine & functioning
- (Healthy people have intrusive thoughts)

Definitions

- **Obsession** (a mental event) → a recurrent and intrusive thought, feeling, idea, image or sensation, usually unpleasant, may be obscene or blasphemous

- **Compulsion** (a behaviour) → a conscious, recurrent behaviour such as counting, checking or avoiding

OCD Cycle

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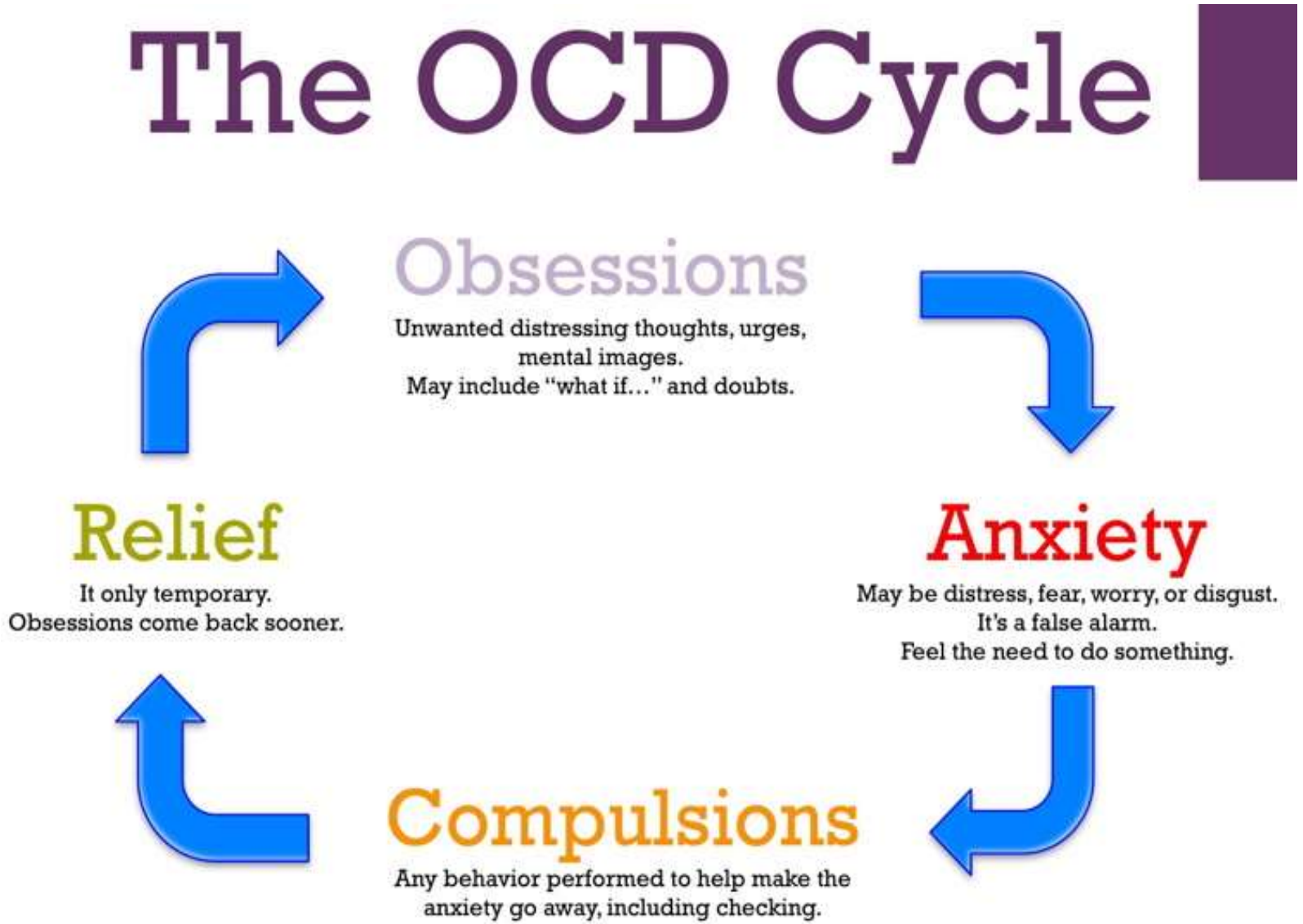

Clinical features

- Average time between onset and diagnosis is on average 7.5 years (Yaryura-Tobias & Neziroglu 1997)

- Up to 75% pts have both O & C

Symptom patterns

Content of primary obsessions – often multiple

• Contamination	37.8%
• Fear of harm	23.6%
• Symmetry	10.0%
• Somatic	7.2%
• Sexual	5.5%
• Violence/aggression	4.3%
• Miscellaneous	1.0%

Intrusions

- Intrusive thoughts, images, urges, doubts are normal

- Surveys fail to detect any difference between the content of intrusive thoughts/images in normal population and OCD

- Difference is the *appraisal* of the thought/image or urge and the response (and therefore the frequency and distress of the intrusions)

Cognitive theory of OCD

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Unacceptable intrusions are a normal occurrence.

When intrusions have occurred, the obsessional patient believes that they might be responsible for harm if they don't react to prevent it.

They respond by TRYING TOO HARD (to get rid of the thought, to prevent harm, to be sure, to be clean…..and so on).

As time goes by, THE SOLUTION BECOMES THE PROBLEM.

Compulsions in OCD

- Repetitive behaviours or mental acts in response to obsessions.
- Aimed at reducing distress or preventing a feared event.
- More likely to avoid a situation when there is an immediate threat.
- See-saw between avoidance and compulsions

Compulsions in OCD

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Checking	28.8%
Cleaning/ Washing	26.5%
Miscellaneous	11.8%
Repeating	11.1%
Mental rituals	10.9%
Ordering	5.9%
Hoarding/ Collecting	3.5%
Counting	2.1%

Hoarding

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Why do compulsions persist?

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- Washing and checking persist because they "work" by reducing anxiety/ distress / uncertainty/ not in control

  (Rachman & Hodgson, 1980)
- Over time compulsions do not always "work" (or there is a memory of them working) or take a very long time (obsessional slowness)
- See saw between compulsions and avoidance

Linking obsessions, compulsions and avoidance behaviour

When avoidance is high, the frequency of compulsions may be low, and vice versa.

e.g. If someone with OCD contamination has to touch something that he or she normally avoids, then it increases compulsive washing.

e.g. If a woman's obsession is of stabbing her baby, she might avoid being alone with her baby and put all knives or sharp objects out of sight, 'just in case' she has the urge to harm her baby. When this does not work, she may ensure that someone is with her all the time (a safety-seeking behaviour), or try to neutralize the thought in her head.

Differential diagnosis

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- Tourette's disorder (frequent, daily motor and vocal tics, similar age of onset and symptoms)
- O-C personality disorder
- Hypochondriasis / health anxiety
- Body dysmorphic disorder
- Autism spectrum disorder
- Abuse / Trauma
- Other impulse control disorders (kleptomania , pathological gambling)

Assessment OCD

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- Context and historical development
- Obsession or cues for anxiety (YBOCS checklist)
- What are the feared consequences?
- Affect (degree of anxiety, guilt)
- Avoidance behaviour (put in graded hierarchy)
- Compulsions and neutralising or safety behaviours (YBOCS checklist)
- Comorbidity (depression, substance abuse)
- Readiness to change/ expectations of therapy
- Goals to achieve

Nice Guidelines

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Obsessive compulsive disorder: core interventions in the treatment of obsessive compulsive disorder and body dysmorphic disorder (2005)

Last update June 2018

Screening OCD NICE

- Do you wash or clean a lot?
- Do you check things a lot?
- Is there a thought that keeps bothering you that you'd like to get rid of but can't?
- Do your daily activities take a long time to finish?
- Are you concerned about putting things in a special order or are you very upset by mess?
- Do these problems trouble you?

Treatment NICE

Mild functional impairment

IAPT, up to 10 hours of CBT inc. ERP

Moderate f. i.

IAPT, more CBT/ERP or SSRI

Severe f.i.

Secondary MH, CBT/ERP and SSRI

Consider:

- adding low dose anti-psychotic to an SSRI or clomipramine (not BDD)
- combining clomipramine and citalopram

SSRI's in OCD

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- Specific response compared to NRI anti-depressant
- Average 50% reduction on YBOCS
- About 2/3 benefit
- Low placebo response
- Effective in absence of depression
- Dose response relationship (higher doses do better)
- Earliest response 4-6 weeks, minimum trial 12 weeks
- No real differences between SSRI's
- High rate of relapse on discontinuation (especially if abrupt)

Discharge after recovery

When in remission, review regularly for 12 months by a mental health professional – frequency to be agreed between the healthcare professional and person with OCD

At the end of the 12-month period if recovery is maintained the person can be discharged to primary care

If relapse – see as soon as possible

CBT for OCD

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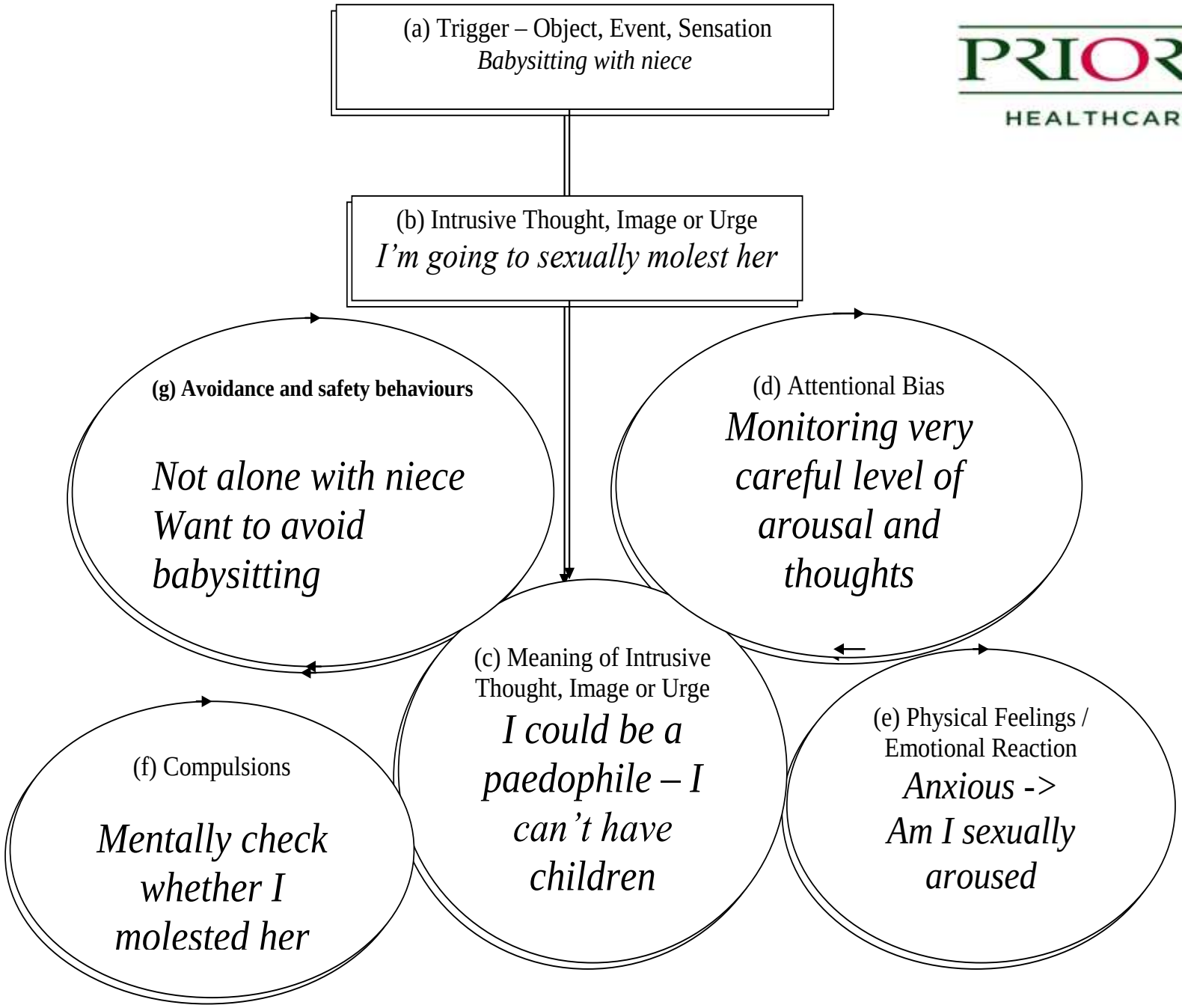
- Normalise experience of intrusive thoughts, images, urges and the differences to an obsession
- Discuss the similarities of intrusive thoughts between OCD patients and healthy controls
- Intrusive thoughts and urges are part of the human condition and necessary for problem solving and thinking creatively – you should have them
- Problem is not with the intrusive thoughts but the relationship with the thought


(a) Trigger – Object, Event, Sensation
Babysitting with niece
(b) Intrusive Thought, Image or Urge
I'm going to sexually molest her
(g) Avoidance and safety behaviours
Not alone with niece
Want to avoid babysitting
(d) Attentional Bias
Monitoring very careful level of arousal and thoughts
(c) Meaning of Intrusive Thought, Image or Urge
I could be a paedophile – I can't have children
(f) Compulsions
Mentally check whether I molested her
(e) Physical Feelings / Emotional Reaction
Anxious -> Am I sexually aroused

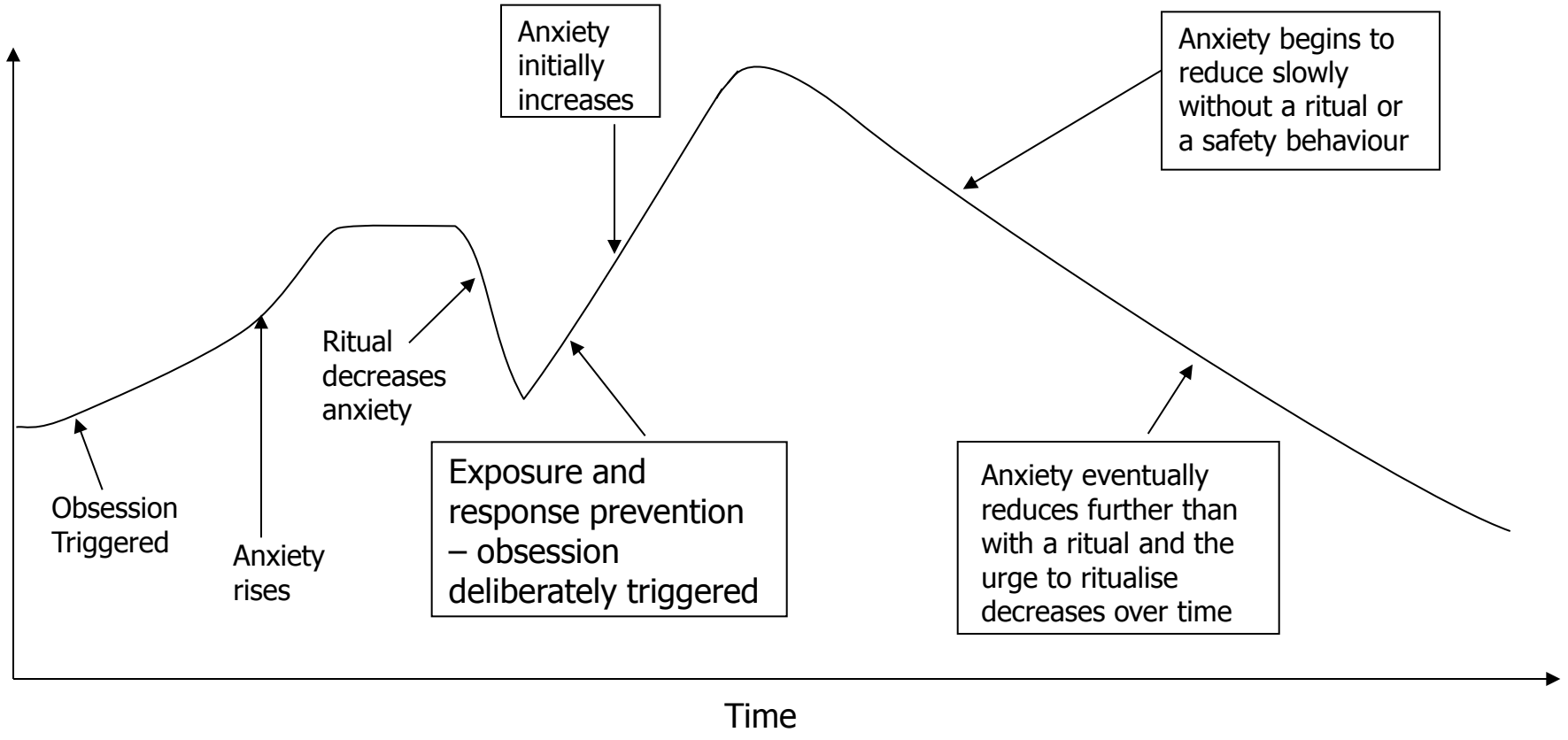


Fig. 1. Effect of exposure and response prevention on anxiety within a session

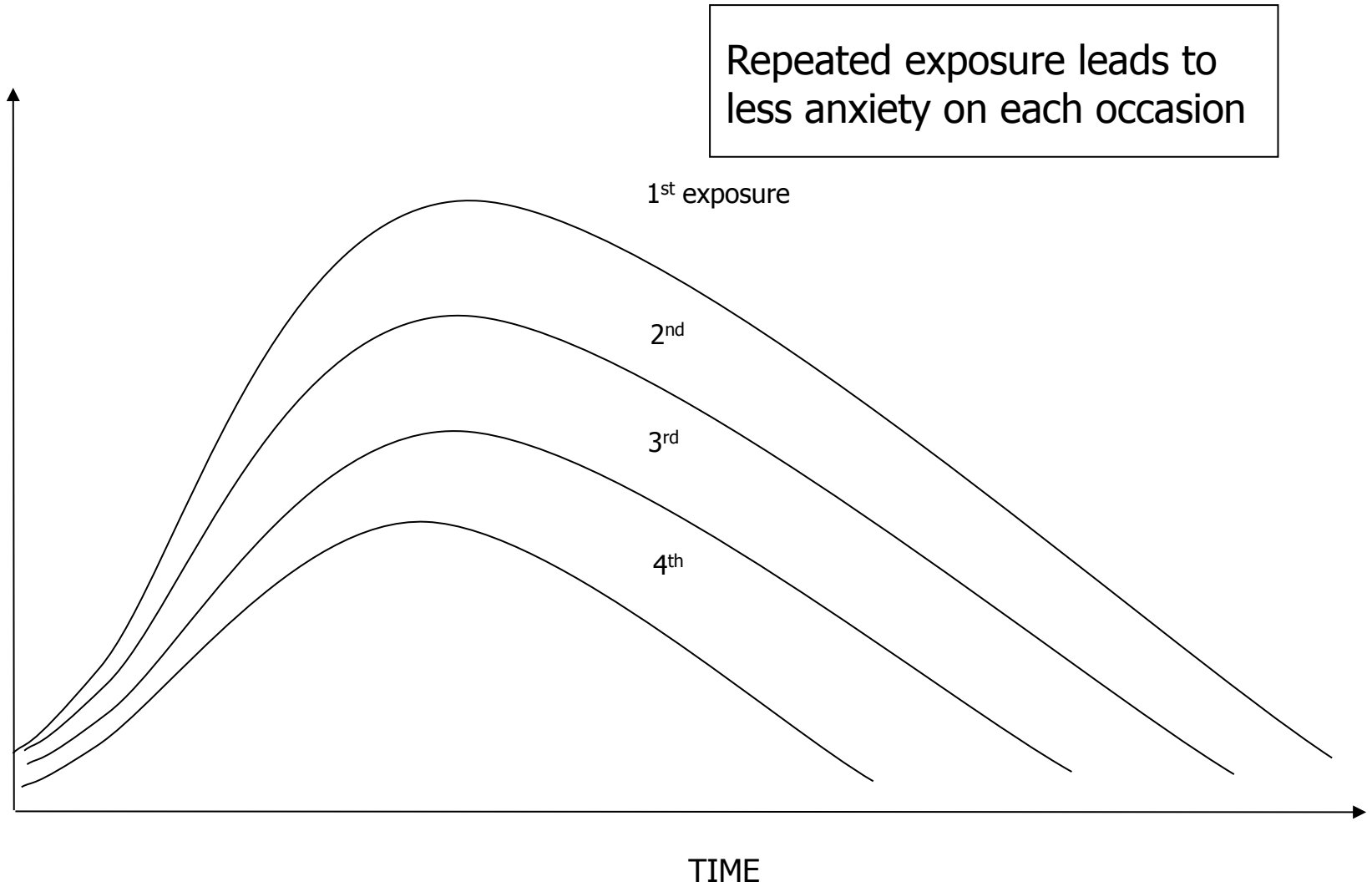


Fig. 2. Effect of repeated exposure and response prevention

Exposure

1. Prolonged ("Wait until anxiety subsides -up to an hour")
2. Tasks challenging not overwhelming
3. Repeat tasks daily in homework and monitor on diary
4. Adherence to graded hierarchy better than "flooding"
5. Exposure "in vivo" more effective than in imagination

Exposure

6. No alcohol or tranquilisers before task
7. No safety behaviours
8. Therapist aided exposure not necessary but may be helpful initially or in severe cases
9. Rate distress level 0-100
10. Encourage patient to tolerate uncertainty, risk, high frustration level & humour

Response prevention

- Resisting urge to perform a compulsion
- Accepting anxiety and tolerating the uncertainty (exposure to thought/images)
- Aim not therapist aided or never forced
- If perform compulsion, then follow with exposure

ERP in OCD

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- 25% refuse or drop-out
- Of those that comply, about 75% improve
- Mean reduction of 60% on YBOCS
- Lower rate of relapse in E & RP than SSRI
- Cognitive therapy might enhance outcome

Mindfulness

Compulsions easier to treat then intrusions

A thought is only a thought

None engagement with the thought

Headspace app

Case study

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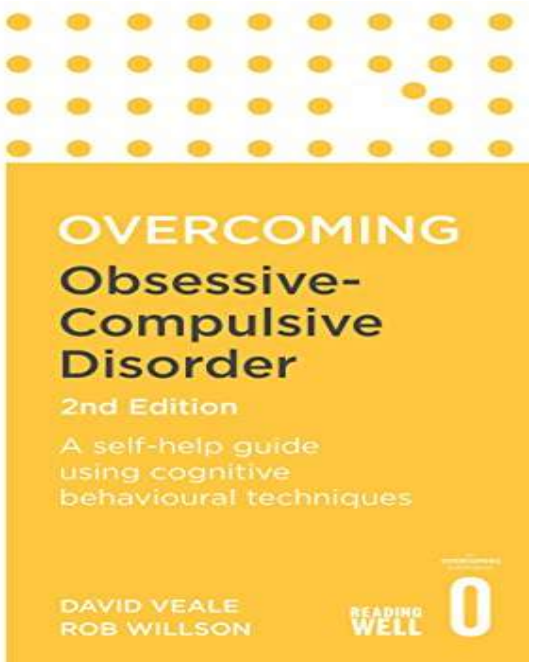
Voluntary organisations and self help

- OCD Action 22/24 Highbury Grove, Suite 107, London N5 2EA Tel: 020 7226 4000

  www.ocdaction.org.uk

- Selfhelp books
- Overcoming OCD
- David Veale



Points to remember

- Look for symptoms
- Establish severity
- Refer IAPT / Private sector in mild and moderate
- Refer to MH / Private sector in severe
- SSRI in moderate + severe (higher dose, longer duration)
- Self help resources / Mindfulness

Thank you – Q&A

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