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Obsessive Compulsive Disorder

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Description of Obsessive Compulsive Disorder

Definition
Diagnostic criteria for Obsessive Compulsive Disorder (OCD) include the following: the presence of obsessions and/or compulsions, recognition of the irrationality of the obsessions and compulsions, and marked distress and interference in normal functioning (Hill & Beamish, 2007 http://onlinelibrary.wiley.com/doi/10.1002/j.1556-6678.2007.tb00618.x/abstract). Obsessions may be described as repetitive and intrusive thoughts that produce anxiety. Compulsions, then, are rituals, behaviors, or activities that are engaged in to reduce this anxiety emergent from the obsessions.

Resource: http://www.nmha.org/index.cfm?objectid=C7DF91A4-1372-4D20-C860E262C7C0517B

Prevalence
The National Institute of Mental Health estimates the prevalence of OCD among adults in the United States to be 1% of the total population (Kessler, Chiu & Walters, 2005). Fifty percent of these cases are classified as severe. http://www.nimh.nih.gov/statistics/1OCD_ADULT.shtml. In the pediatric population, prevalence of OCD is estimated to be between 1 and 4% http://www.ncbi.nlm.nih.gov/pubmed/17613156. However, Snider and Swedo (2000) caution that the high incidence of co-morbidity and misdiagnoses among children with OCD may lead to underestimates of the prevalence of pediatric OCD. http://intramural.nimh.nih.gov/pdn/pubs/pub-4.pdf

IDENTIFICATION/ASSESSMENT STRATEGIES

Resources: Overviews of assessments: Benito, K., & Storch, E. A. (2011). Assessment of obsessive-compulsive disorder: Review and future directions. *Expert Review of Neurotherapeutics, 11(2)*, 287–298. doi: 10.1586/ern.10.195 American Academy of Child and Adolescent Psychiatry. (1998). Practice parameters for the assessment and treatment of children and adolescents with obsessive-compulsive disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 37*, 27S–45S

Clinician Rated Assessments
Yale–Brown Obsessive–Compulsive Scale (Y-BOCS; Goodman et al., 1989). This is a clinician administered instrument that is widely used for the assessment of OCD. It consists of two parts: The Y-BOC-SC which is a 54-item symptom checklist and the Y-BOC-SS which is a ten item Likert-scale measure of symptom severity, ranging from 0 (no symptoms) to 4 (severe symptoms). The Y-BOCS has been shown to have good test-retest and inter-rater reliability and acceptable criterion-related validity (Sulkowski et al., 2008). The Y-BOCS is considered the "gold standard" in the assessment of severity of symptoms (Benito & Storch, 2011, p. 292). There is also a Children's Yale-Brown Obsessive-Compulsive Scale (CY-BOCS; Scahill et al., 1997) which can be effective in assessing symptomatology and severity across time.

National Institute of Mental Health Global Obsessive-Compulsive Scale (GOCS; NIMH). The NIMH Global Obsessive-Compulsive Scale (GOCS) is a very brief and simple scale based on the rating of one item related to overall severity of OCD symptoms ranging from "minimal symptoms" to "very severe." The global nature of the assessment of symptoms is both the greatest advantage and disadvantage of this scale (Benito & Storch, 2011; Kim, Dysken, Kuskowski, & Hoover, 1993).

Self-Report Assessments

Dimensional Obsessive-Compulsive Scale (DOCS; Abramowitz et al., 2010). The Dimensional Obsessive-Compulsive Scale (DOCS; Abramowitz et al., 2010) is a 20 item instrument measuring four symptom dimensions, namely contamination, responsibility for harm, unacceptable obsessional thoughts, and symmetry/completeness/exactness. Each of these four symptom dimensions are assessed with items related to symptom severity, specifically amount of time consumed, avoidance, distress, functional impairment, and inability to disregard. The symptom domains are based on empirically generated system clusters, and the DOCS is evidencing high levels of validity. Because it is relatively new, there continues to be a need to empirically explore psychometric properties. Also, counselors concerned about hoarding compulsions will not receive any symptom severity data from it (Benito & Storch, 2011).

Florida Obsessive Compulsive Inventory (FOCI; Storch et al., 2007). The Florida Obsessive Compulsive Inventory (FOCI; Storch et al., 2007) is comprised of 25 items in two different scales, namely the Symptom Checklist and the Symptom Severity Scale. The Symptom Checklist contains 10 compulsions (i.e. "Ritualized washing, cleaning, or grooming") and 10 obsessions (i.e. "Bothered by thoughts/images such as contamination or acquiring a serious illness"). The Symptom Severity Scale assesses the degree of distress, difficulty in controlling the thoughts and behaviors, level of interference with life, and amount of time spent engaged in the thoughts or behaviors. The FOCI has demonstrated high correlation with the Y-BOCS and can potentially be an easy to administer screening tool for counselors.

Resource: Storch, E. A., Bagner, D., Merlo, L. J., Shapira, N., Geffken, G. R., Murphy, T. K., & Goodman, W. K. (2007). Florida obsessive-compulsive inventory: Development, reliability, and validity. *Journal of Clinical Psychology*, *63*(9), 851-859. doi:10.1002/jclp.20382

Leyton Obsessional Inventory – Short Form (LOI-SF; Kazarian, Evans, & Lefave, 1977; Cooper, 1970). The Leyton Obsessional Inventory – Short Form (Kazarian, Evans, & Lefave, 1977) was developed based on the original Leyton Obsessional Form (Cooper, 1970) and contains 30 items measuring the presence or absence of obsessive-compulsive symptoms. There is some data suggesting that the LOI-SF has adequate psychometric properties, but the research is limited to mostly college student samples. There is also a children's version of the Leyton Obsessional Inventory (Berg, Whitaker, Davies, Flament, & Rapoport, 1988).

Maudsley Obsessive-Compulsive Inventory (MOCI; Hodgson & Rachman, 1977). The Maudsley Obsessive-Compulsive Inventory (MOCI; Hodgson & Rachman, 1977) is a 30 item self-report scale that has four subscales, namely checking, washing, doubting, and slowness. This instrument has been used across multiple populations with various diagnoses. The MOCI provides an assessment of obsessionality that emerges in OCD, but also within symptoms related to eating disorders and anxiety. Its focus on four constructs contributes to the MOCI being less comprehensive in its assessment spectrum than other instruments (Roberts, Lavender, & Tchanturia, 2011).

Obsessive Compulsive Inventory- Revised (OCI-R; Foa et al., 2002). The Obsessive Compulsive Inventory-Revised (OCI-R; Foa et al., 2002) contains 18 items that score participants' level of distress on a 5-point Likert scale. The items assess ordering, washing, hoarding, checking, obsessing, and mental neutralizing. There are three items related to each of these 6 domains of symptoms. The benefits of this inventory are that it explores symptoms from a clustered perspective and has published clinical cutoff scores (Benito & Storch, 2011).

Resources: Foa, E. B., Huppert, J. D., Leiberg, S., Langner, R., Kichic, R., Hajcak, G., et al. (2002). The Obsessive-Compulsive Inventory: Development and validation of a short version. *Psychological Assessment, 14*, 485-496.

Roberts, M., Lavender, A., & Tchanturia, K. (2011). Measuring self-report obsessionality in anorexia nervosa: Maudsley obsessive-compulsive inventory (MOCI) or obsessive-compulsive inventory-revised (OCI-R)?. *European Eating Disorders Review*, *19*(6), 501-508. doi:10.1002/erv.1072

Yale-Brown Obsessive- Compulsive Scale- Self Report (Y-BOCS-SR, Steketee et al., 1996). The Yale-Brown Obsessive- Compulsive Scale- Self Report (Y-BOCS-SR, Steketee et al., 1996) is a client-report instrument that asks respondents to report time spent, interference, resistance, control, and distress related to 58 obsession and compulsions. The self-report version has evidenced strong convergent validity with the interview based Y-BOCS (Goodman et al., 1989) and discriminatory ability between clients with and without Obsessive Compulsive Disorder.

Resource: Steketee, G., Frost, R., & Bogart, K. (1996). The Yale-Brown Obsessive Compulsive Scale: Interview versus self-report. *Behaviour Research and Therapy, 34*, 675-684.

INTERVENTION STRATEGIES

The empirical research on treating Obsessive Compulsive Disorder focuses primarily on behavioral treatment, cognitive treatment, cognitive-behavioral treatment, and combined treatment integrating the use of psychopharmacological interventions (Hill & Beamish, 2007). Within counseling, there continues to be a paucity of action, process, and outcome research related to the treatment of OCD. Across all mental health disciplines, there tends to be the most empirical support for the treatment efficacy of behavioral interventions such as exposure and response prevention.

Resources: Case Studies of Treatment Interventions: Ginsburg, G. S., Burstein, M., Becker, K. D., & Drake, K. L. (2011). Treatment of obsessive-compulsive disorder in young children: An intervention model and case series. *Child and Family Behavior Therapy, 33*, 97-122. doi: 10.1080/07317107.2011.571130

Behavioral Treatment

Behavioral treatment models employed in the field of anxiety disorders include Systematic Desensitization (SD) and Implosion Therapy (IT) (Ougrin, 2011). In SD, the client is gradually instructed to imagine the least to the most feared aspects of the source of anxiety, while employing relaxation techniques. In contrast, IT employs the client's direct exposure to the most feared aspect of the source of anxiety (Ougrin). In either case, behavioral therapy in anxiety disorders involves Exposure and Response Prevention (ERP; Meyer, 1966) which, in conjunction with medication, has been found to be highly effective in the treatment of OCD.

Resource: http://ocd.stanford.edu/treatment/psychotherapy.html

Cognitive Treatment

In his extensive meta-analysis of treatment outcome literature in anxiety disorders, Ougrin (2011) defined the Cognitive Therapy model as follows:

> To identify the unhelpful cognition, to examine it in a collaborative way, to test its validity and then provide the patient with an opportunity to draw conclusions from their experience, often leading to revision of the original cognition (p. 2).

The primary cognitive interventions used with clients diagnosed with OCD are cognitive restructuring, challenging excessive responsibility and perfectionistic thoughts, and thought stopping. There is currently limited research on cognitive treatment and its efficacy with clients diagnosed with OCD.

Resource: Case Study of the Use of Cognitive Treatment: van Oppen, P. (2004). Cognitive therapy for Obsessive-Compulsive Disorder. *Clinical Case Studies, 3*, 333-349. doi: 10.1177/1534650103259647

Cognitive Behavioral Treatments (CBT)

CBT is by far the most frequently studied and arguably the most utilized intervention model in the treatment of Obsessive Compulsive Disorder. In 2004, Deacon and Abramowitz conducted an overview of meta-analyses of treatment outcomes for anxiety disorders. They concluded that CBT is indeed an effective therapeutic interven-

tion for OCD, but cautioned that the literature frequently conflates CBT with the behaviorally-based Exposure and Response Prevention (ERP, Meyer, 1996) in that both can be understood to alter maladaptive cognitive patterns. More recently, Ougrin's (2011) meta-analysis concluded that Cognitive and Behavioral therapies are equally effective in the treatment of OCD. In their review and meta-analysis of research comparing individual and group CBT treatment of Obsessive Compulsive Disorder, Jonsson and Hougaard (2008) found group and individual CBT treatment of OCD to be equally effective. Similarly, Warren and Thomas (2001) found CBT could effectively treat OCD in private practice settings at the same level of effectiveness achieved i randomized controlled trials.

Resource: Farrell, L. J., Schlup, B., & Boschen, M. J. (2010). Cognitive-behavioral treatment of childhood obsessive-compulsive disorder in community-based clinical practice: Clinical significance and benchmarking against efficacy. *Behavior Research and Therapy, 48*, 409-417. doi: 10.1016/j.brat.2010.01.004

Turner, C. (2006). Cognitive-behavioural therapy for obsessive-compulsive disorder in children and adolescents: Current status and future directions. *Clinical Psychology Review, 29*, 912-938. doi: 10.1016/j.cpr.2005.10.004

Acceptance and Commitment Therapy. With its focus on mindfulness and behavior change techniques, Acceptance and Commitment Therapy (ACT) has been implemented with clients diagnosed with OCD. Twohig, Hayes, and Masuda (2006) conducted a study of the effectiveness of 8 sessions of ACT in reducing compulsions. Clients experienced an immediate and prolonged (at a 3 month follow-up) reduction in anxiety, depression, experiential avoidance, and adherence to obsessional rigidity.

Mindfulness-Based Cognitive Therapy. Similar to ACT, Mindfulness-Based Cognitive Therapy was first applied to preventing relapse for clients experiencing depression and has been recently adapted for treatment with clients diagnosed with Obsessive Compulsive Disorder. Hertenstein et al. (2012) created an 8 week group therapy experience and conducted a qualitative study to evaluate its effectiveness. Despite feedback that the intervention was too short in length of time, two thirds of the clients reported the MBCT strategies to be effective in reducing obsessive and compulsive symptoms.

Resource: http://www.biomedcentral.com/1471-244X/12/185

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