Obsessive Compulsive Disorder

Differential Diagnosis & Rationale for Treatment

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Presenter

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1 | Objectives

- Discuss diagnostic criteria, changes
- Recognize differential diagnosis for OCD
- Identify common comorbid diagnosis/es
- Identify primary symptoms of OCD and "Pure-O"
- Recognize and Identify OCD themes in complex presentations
- Identify (refer if needed) to appropriate and adjunctive strategies to aid in OCD treatment

2 | Topic Overview

- ✓ Helpful terms
- ✓ Criteria and DSM-IV – DSM 5 changes
- ✓ General and brief overview of statistics
- ✓ OCD themes, subtypes as well as "Pure-O"
- ✓ Differential Diagnosis/es
- ✓ Comorbidities
- ✓ Assessment and Case Conceptualization
- ✓ Case Examples
- ✓ Rationale for treatment & Referrals
- ✓ Limitations & Considerations

3 | Helpful Terms

➢ Obsessions/Intrusive

- Unwelcome, distressing ideas, thoughts, images, impulses that repeatedly enter your mind

➢ Compulsions/Rumination/Rituals

- Behaviors and/or mental acts; excessive/senseless but urged to do so
- Difference between depressive rumination (no attempts to neutralize)
- Worries related to real-life concerns*/**Rituals vs Compulsions**

➢ Egosyntonic

- Refers to behaviors, thoughts, feelings, impulses that <u>are</u> aligned with values-system and values-guided goals, beliefs

➢ Egodystonic

- Refers to behaviors, thoughts, feelings that are <u>not</u> aligned with values-system/values-guided goals and belief, impulses that cause distress as they feel disturbing, repugnant, senseless or inconsistent with self-concept.

4 | DSM Criteria & Changes

DSM-IV	DSM-5
Disorder Class: Anxiety Disorders	***Disorder Class: Obsessive-Compulsive and Related Disorders***
***Either* obsessions or compulsions:**	**Presence of obsessions, compulsions, or both:**
Obsessions as defined by (1),(2), (3) and (4):	***Obsessions are defined by (1) and (2):***
1. Recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress.	**1. Recurrent and persistent thoughts, urges or images that are experienced, at some time during the disturbance, as intrusive, unwanted, and that in most individuals cause marked anxiety or distress.**

4 | DSM Criteria & Changes

DSM-IV	DSM-5
2. The thoughts, impulses, or images are not simply excessive worries about real-life problems.	DROPPED
3. The person attempts to ignore or suppress such thoughts, impulses, or images or to neutralize them with some other thought or action.	2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some thought or action (i.e., by performing a compulsion).
4. The person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as with thought insertion).	DROPPED

4 | DSM Criteria & Changes

DSM-IV	DSM-5
Compulsions as defined by (1) and (2):	***Compulsions are defined by (1) and (2):***
1. Repetitive behaviors (e.g., hand washing, ordering checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to the rules that must be applied rigidly.	**SAME**
2. The behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation. However, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive.	**SAME**

4 | DSM Criteria & Changes

DSM-IV	DSM-5
At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable.	**DROPPED**
The obsessions and compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.	**The obsessions or compulsions are time consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.**

4| DSM Criteria & Changes

DSM-IV	DSM-5
If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted (e.g., preoccupation with food in the presence of an eating disorder, hair pulling in the presence of trichotillomania; concern with appearance in the presence of bdd: preoccupation with drugs in the presence of a SUD:: preoccupation with having a serious illness in the presence of hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a paraphilia: or guilty ruminations in the presence or MDD).	The disturbance is not better explained by the sxs of another mental disorder (e.g., excessive worries, as in GAD, preoccupation with appearance, as in BDD; difficulty discarding or parting with possession, as in hoarding disorder; hair pulling, as in trichotillomania; skin picking, as in excoriation disorder); stereotypic movement disorder; ritualized eating behavior, preoccupation with substances/gambling, as in substance-related/addictive disorders; sexual urges/fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in MDD; thought insertion or delusional preoccupations, as in schizophrenia spectrum/psychotic disorders; or repetitive patterns as in autism spectrum disorder).
The disturbance is not due to the direct physiological effects of a substance (e.g., drug of abuse, a medication) or a general medical condition.	**SAME**

4 | DSM Criteria & Changes

***DSM IV – Specify* if:**	***DSM 5 – Specify* if:**
With poor insight: If, for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable.	**With good or fair insight:** The individual recognizes that obsessive-compulsive beliefs are definitely or probably not true or that they may or may not be true. **With poor insight:** The individual thinks obsessive-compulsive disorder beliefs are probably true. **With absent insight/delusional beliefs:** The individual is completely convinced that obsessive-compulsive disorder beliefs are true. ***Specify* if:** Tic related: The individual has a current or past history of a tic disorder.

200,000,000

8,500,000

OCD: ***More than just being clean***

"You only have obsessions, you know, Pure-O"

5 | OCD Types and Themes*

Symptoms Common → Presentation Different → Doubt

"Pure-O" | Subtype with no visible compulsions/rituals. *Examples* of mental compulsions include mental review, mental checking, questioning, self-reassurance

Harm-Violent OCD | Subtype involves harming self/others, with distress*

Existential OCD | Philosophical about existence, purpose, meaning. *Examples* of compulsions include review, physical checking, research, avoidance, external reassurance.

Scrupulosity OCD | Moral, ethical concerns* *Examples of compulsions include review, avoidance, confessing, praying* Consider religiosity vs scrupulosity*

False Memory/Real Events | ***** Guilt, concern about past events that may or may not have happened but often rooted in a real event

5 | OCD Types and Themes

Symptoms Common → Presentation Different

Relationship OCD | Doubting, questioning. *Examples* of compulsions: Reassurance seeking, tracking, mental review, comparisons, checking own feelings.

Sensorimotor/Somatic OCD | Obsessions surrounding bodily sensations and processes (e.g., about breathing, blinking, chewing, swallowing). *Examples* of compulsions: counting, checking, researching, setting up rules.

Sexual Orientation/Gender OCD | Obsessions about own orientation.

Just Right/Symmetry OCD | Fear of making mistakes, "must be perfect."

Responsibility OCD | Responsible for something terrible happening.

5 | OCD Types and Themes

Symptoms Common → Presentation Different

Contamination (illness/germs/emotional) | Related to germ contamination, around food, around cooking, causing other illness, emotional contamination.*

Taboo OCD | can relate to incest, pedophilia, beastiality, violent sex, racism.

Perinatal OCD | common obsessions include (not limited to) contamination, sexual, harm, scrupulosity (religion). Obsessions and compulsions often related to unborn or newborn child.

⁝ **Mental compulsions |**
Checking, reviewing, self-reassurance, cancelling out/replacing words/images, praying, counting.

5 | OCD Types and Themes

Obsession

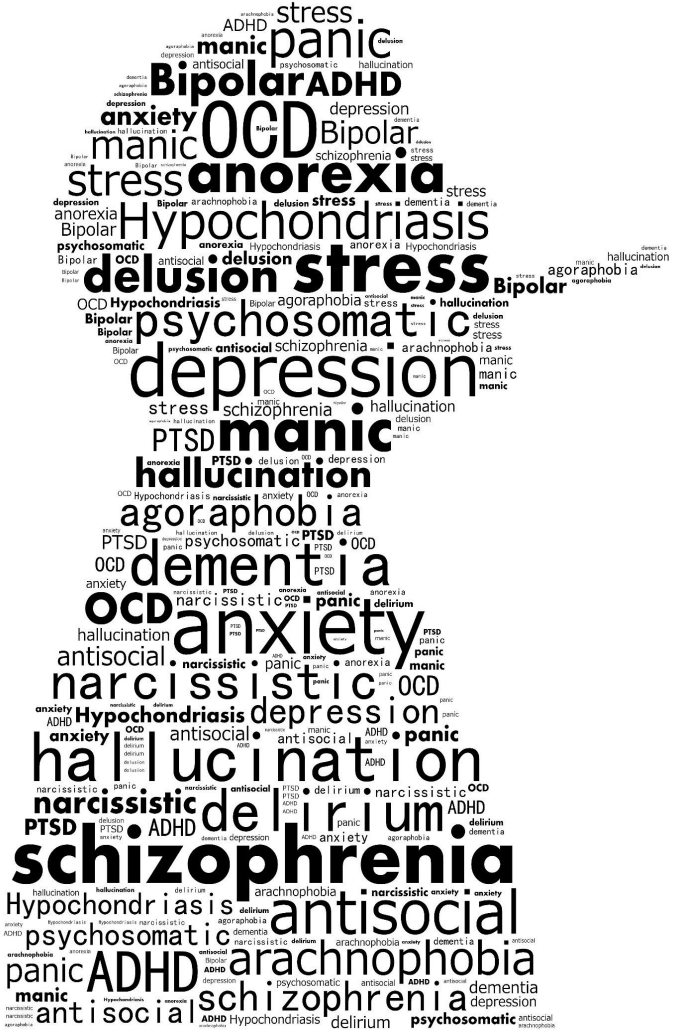
- Intrusive thoughts are unwanted & extremely distressing (ego-dystonic)
- Can be sexual, religious, or violent
- No desire to act on thoughts
- May engage in avoidance or in checking/reassuring compulsions to ease distress
- Preserved insight* (could be poor insight as well)
- ***Example:*** A Mother has intrusive thoughts about throwing baby out the window. She locks all windows, closes blinds, repeatedly checks locks, and refuses to go to the side of the room where windows are.

Delusion

- Intrusive thoughts may be unbidden but no significant distress* (ego-syntonic)
- Can be sexual, religious, or violent; content often bizarre or unusual
- May want to or feel compelled to act on thoughts
- No compulsions*
- Poor insight, distortion of reality
- ***Example:*** Mother believes child has sinned and that God has commanded mother to drop child out the window to punish this sin.

Hudepohl, N., MacLean, J. V., & Osborne, L. M. (2022). Perinatal obsessive–compulsive disorder: epidemiology, phenomenology, etiology, and treatment. *Current psychiatry reports*, *24*(4), 229-237.

17 Years



6 | Differential Diagnosis

6 | Differential Diagnosis

1. Anxiety Disorders/Illness Anxiety Disorder
2. Major Depressive Disorder
3. Other Obsessive-Compulsive and Related Disorders *BDD, Hoarding, Trichotillomania
4. Eating Disorders
5. Tics and Stereotyped Movements
6. Psychotic Disorders
7. Other Compulsive-like Behaviors
8. Obsessive-Compulsive Personality Disorder
9. Substance/Medication/Medical Condition-Induced Obsessive-Compulsive Related Disorders
10. Acute Stress/PTSD/Trauma
11. Traumatic Brain Injury

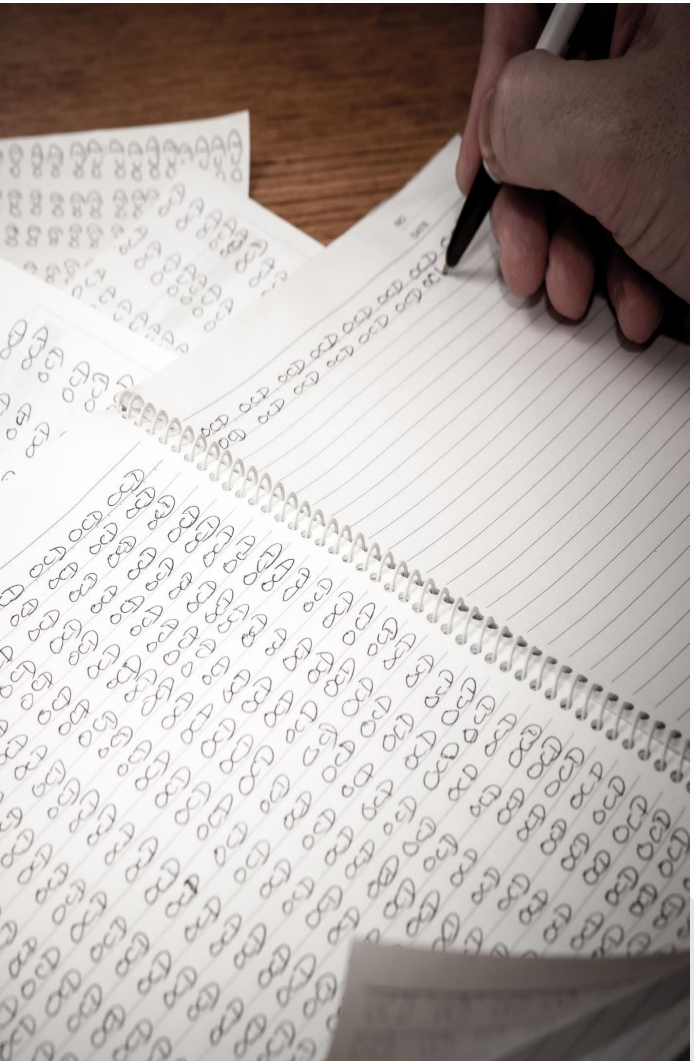
6 | Differential Diagnosis

1.Anxiety Disorders e.g., GAD, Phobia	GAD: 'real-life' concerns, often no magical thinking, and no compulsions; no compulsions in Phobia
2.Major Depressive Disorder	MDD Rumination often mood-congruent and not distressing/intrusive always with no compulsions
3.Other Obsessive-Compulsive and Related Disorders	In BDD: O/C limited to physical appearance In Trichotillomania: Compulsive behaviors limited to hair pulling. Hoarding d/o: Focused on difficulty of discarding of/parting with possessions, marked distress* *Dx of OCD should be given if hoarding is compulsive as a result of obsessions (e.g., not getting rid of all spam mail because they may contain information that could prevent harm)
4. Eating Disorders	OCD will not be limited to concerns about weight and food
5. Tics and Stereotyped Movements	Tics and stereotyped movements are less complex than compulsions and not aimed at neutralizing obsessions.* Both can be warranted.

American Psychiatric Association, D. S. M. T. F., & American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5* (Vol. 5, No. 5). Washington, DC: American psychiatric association.

6 | Differential Diagnosis

6. Psychotic Disorders	Poor insight and OCD can be overvalued and even delusional. However, OCD has the compulsions, as well as often egodystonic. No other sxs of psychotic d/o. E.g., not disorganized.
7. Other Compulsive-like Behaviors	Certain behaviors can be described as "compulsive" (e.g., sexual behavior, gambling, substance use – difference is no pleasure derived in OCD.
8. Obsessive Compulsive Personality	Clinical manifestations are different. OCPD involves excessive perfectionism/rigid control; no intrusive images/thoughts/compulsions. Both can be given.
9. Substance/Medication/Medical Condition-Induced Obsessive-Compulsive Related Disorders	Consider intoxication, repetitive behaviors, traumatic brain injuries. In delirium, must be diagnosed separately if symptoms occur during.
10. Trauma	In OCD, the recurrent intrusive thoughts are not related to an experienced traumatic event, compulsions are present; and other symptoms of PTSD/Acute stress are absent.



7 | Comorbidities

- Anxiety Disorders
- Mood Disorders
- Tic Disorders
- Obsessive Compulsive Personality
- Other obsessive-compulsive and related disorders (e.g., BDD, Trichotillomania, Excoriation)
- OCD elevated with Bipolar, Eating Disorders, Tourette's

8 | Considerations

- Pediatric | Onset 8-12, differentials differ, PANDAS/PANS
- Autism Spectrum | Stims, Spins, Sensory; not obsessions/compulsions; use of reassurance
- Perinatal/Postpartum OCD | Severity and distress. Different from postpartum psychosis. More research needed
- Hormones | Data about role of thyroid/hormones and fluctuating severity
- Gender | Considerations to current research; consider **cultural** presentations that impact this data/overall intersectionality/cultural
- Remission | Waxes & Wanes

⁉ **Risk and Prognostic Factors |**
Temperamental, Environmental, Genetic

ACTIVITY

9 | Case Example "Lucy"

Female, early 50s:
Referred to treatment following suicide attempts (OD on medications) hospitalizations and recent increase in ***depressive*** symptoms, ***anxiety*** as well as reported ***psychotic*** symptoms "I was psychotic," but with no reports of AVH/RTIS. Client had been in treatment for ***AN-R*** in her younger teens and adulthood, struggled with ***GAD.*** Outpatient therapy for 20 years. History of trauma with ***PTSD*** symptoms including severe hypervigilance, disrupted sleep, altered arousal. Had ***medical history*** and medical trauma, ***health anxiety.*** She had participated in ECT treatment. No history of SUD.
Tx history: Pharmacotherapy/talk therapy, ECT.
Three months in, DBT/CBT, EMDR/Brainspotting, intensive therapy and was medication compliant; however, her symptoms were not improving significantly.

9 | Case Example "Lucy"

- Fear: Hurting others emotionally/Emotional Contamination
- Fear: Making mistakes
- Fear: Accidentally hurting someone by being careless
- Fear: Being in trouble/Getting in Trouble

- Compulsions/Rituals: External and internal reassurance seeking (Verbal)
- Compulsions/Rituals: Mental checking of memory
- Compulsions/Rituals: Meaning seeking/meaning building
- Compulsions/Rituals: Signs/Superstitious checking of numbers, colors
- Compulsions/Rituals: Questioning
- **Past compulsions/rituals:** e.g., placed valuables outside door, as compulsive behavior to "not get in trouble."

Insight: Fair–Poor. In the past: limited = overvalued = psychotic
Review: No other symptoms of psychosis; paranoia, distress. 48 sessions.

10 | Case Example "Olivia"

Female, early 20s:
First treatment episode inpatient for reported ***SI*** and ***psychotic*** symptoms as well as ***polysubstance*** abuse. Reported ***GAD*** since teens. Reported ***sex addiction***, as well as ***trauma***. Referred to treatment at PHP level of care with supported housing. Appeared to struggle with severe anxiety, and struggling to focus; due to hypervigilance and reports of SI, required PERT for further assessment. Client returned to treatment and participated in OCD assessment. Client was struggling with consistent intrusive thoughts/obsessional thoughts related to taboo topics (e.g., pedophilia, racism, harm). Intermittent substance abuse of ETOH and THC, possibly substance-induced psychosis.

Review: No other symptoms of psychosis, SI appeared egodystonic.

10 | Case Example "Olivia"

- Fear: Harming others and self accidentally/unintentionally
- Fear: Being attracted to children/babies, being a pedophile
- Fear: Wanting to engage in incestuous acts
- Fear: Being a racist

- Compulsions/Rituals: External and internal reassurance seeking (Verbal/non-verbal)
- Compulsions/Rituals: Mental checking of memory (e.g., did I do that)
- Compulsions/Rituals:
- Compulsions/Rituals: Signs/Superstitious checking of numbers, colors
- Compulsions/Rituals: Questioning

Insight: Good-Fair-Poor. In the past: limited = overvalued = psychotic

11 | Case Example "Finn"

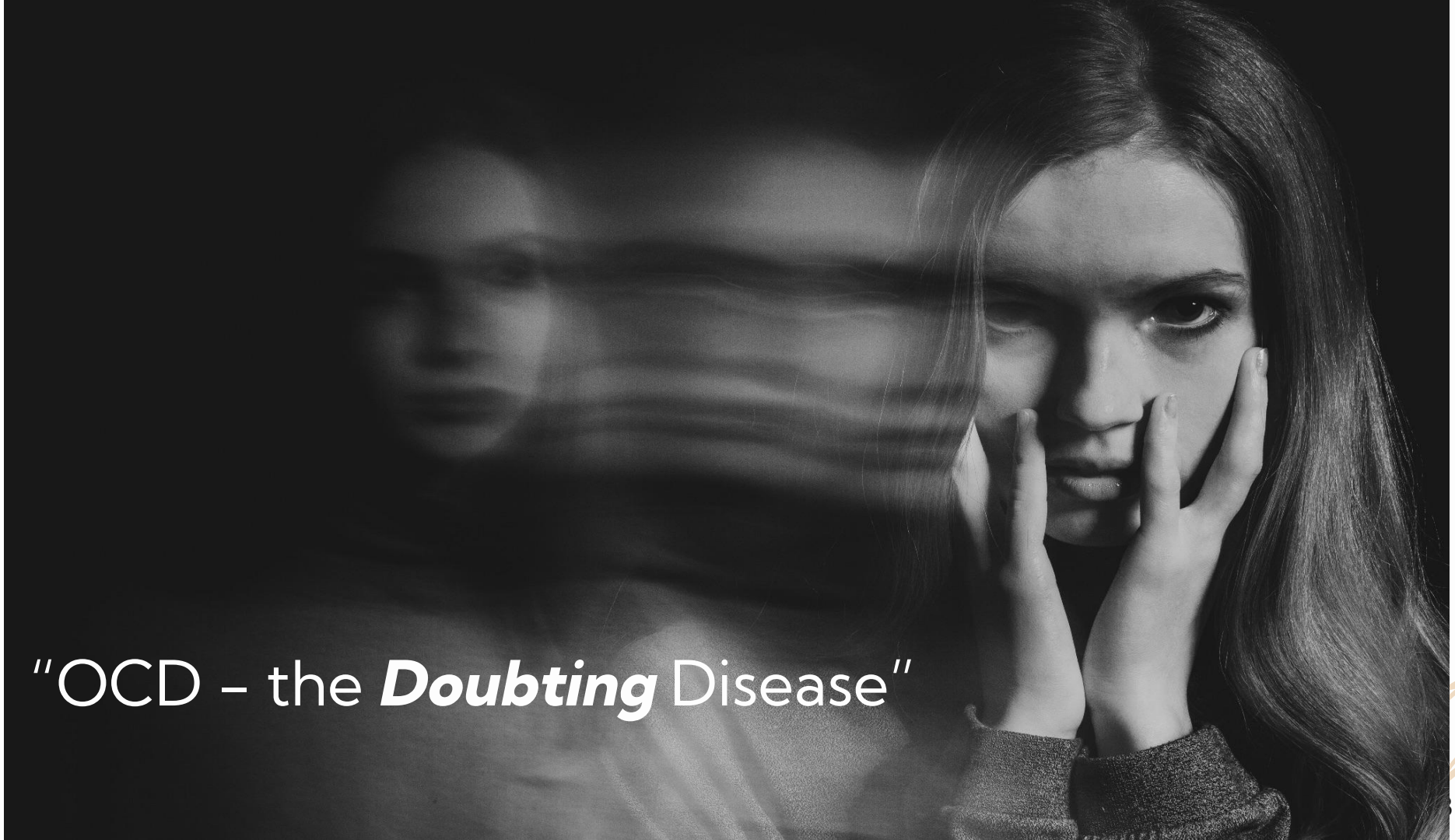
Male, early 20s:
Arrived to CCI treatment after 2 years of extensive treatment. ***MDD-R*** with ***SI,*** medical concerns, extensive lab work and evaluations, all inclusive. ***Past OCD*** dx by history with symmetry, and superstition. Denied requiring OCD treatment as he was convinced he had "conquered" his OCD when he participated in brief ERP therapy 4 years prior. Client had reportedly gotten progressively worse in terms of depression and SI. Client also had ***SPD***, high functioning with potential Bipolar sxs. No SUD.

11 | Case Example "Finn"

- Denied any and all fears. Reported "something is wrong with my head." His fears were related to that something was wrong with his head/brain. That this would lead to low quality of life, and that he would end up lonely and "unsuccessful."

- Compulsions/Rituals: Change of medications, researching
- Compulsions/Rituals: Checking sensations
- Compulsions/Rituals: Questioning, analyzing
- Compulsions/Rituals: Body checking

Insight: Fair–Poor.


"OCD – the *Doubting* Disease"

12 | Assessment

Relevant Training for Effective delivery of Treatment
Assessment of symptoms and severity
Assessment of insight
Assessment of primary
Cognitive-Behavioral Conceptualization
Yale Brown Obsessive Compulsive Scale (Y-BOCS)
ERP Protocol
Augmentation Psychopharmacology

13 | Treatments

- **TMS,SGB, NAD+**
- **Ex/Rp, I-CBT*, ACT, Groups**
- **Medication Management**
- **Other**

13 | Treatments

Exposure Response Prevention (ERP/EXRP) |

12-20 sessions (90 min)*, Exposure in-vivo/Imaginal Exposure, Ritual Prevention, Processing

In-between session assignments/check-ins

Goals/Rationale: increase and learn tolerance of anxiety; inhibitory learning via habituation, anxiety and compulsions, engage in imagination, embracing uncertainty

Medications |

Clomipramine, Riluzole

SSRIs (e.g., Prozac, Zoloft, Paxil, Luvox

Atypical antipsychotic (e.g., Zyprexa, Risperidone)

13 | Treatments

What about psychodynamic, EMDR or other mindfulness based treatments?


OCD

15 | References

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Images: Shutterstock

16 | Resources

Websites |

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https://ocdsocal.org/
www.semel.ucla.edu/catp/child-ocd-intensive-treatment-program (child/adolescent)
https://www.med.upenn.edu/ctsa/
www.rogersbh.org
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Thanks!

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