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Obsessive Compulsive Disorder: A Clinical Intervention Syllabus

Presenter:

Gary Mitchell, MSW, LCSW is a clinical social worker that specializes in the treatment of children and adults with anxiety disorders and related problems. He is the Assistant Director of the Anxiety Disorders Center of St. Louis Behavioral Medicine Institute, which specializes in the treatment of refractory and complicated cases. Mr. Mitchell has also worked in residential treatment providing Cognitive, Behavioral and Family Therapy for emotionally disturbed children. He is an Adjunct Assistant Professor at the St. Louis University School of Social Services, where he teaches Cognitive-Behavioral Family Therapy.

Description:

In this video, Mr. Mitchell describes Obsessive Compulsive Disorder (OCD) and identifies the criteria for its diagnosis. In addition, Mr. Mitchell describes how OCD is manifested in behavior and identifies treatment options for the disorder. Further discussion centers on how family and other support systems are affected by the person with OCD.

Key Concepts:

OCD is characterized by the experience of obsessions and compulsions that greatly affect the quality of an individual's life.

Obsessions are thoughts, feelings, urges that result in great discomfort

Compulsions are strategies that people use to decrease or neutralize discomfort.

Mental compulsions or rituals are mental strategies that people use in order to undo the feeling associated with the obsession.

In order to meet the criteria for a diagnosis of OCD, a person must spend 1 hour a day in either mental or behavioral ritual or the obsession must cause great distress and/or it must cause significant problems in their life.

OCD has an impact of the individual's family and other systems of support.

Glossary of Terms:

OCD – A disorder characterized by obsessions and compulsions that greatly affect the quality of an individual's life.

Obsessions – Thoughts, feelings, and urges that result in great discomfort.

Compulsion – Strategies that people use to decrease or neutralize the discomfort associated with obsessions.

Avoidant strategy – Planned avoidance of situations that the individual with OCD finds threatening or fearful.

Obsessional slowness - The experience of a person taking a tremendous amount of time to engage in any activity.

Selective Serotonin Reuptake Inhibitor (SSRI) - A type of medication that inhibits the reuptake of selective serotonin in the pre-synaptic neuron. SSRIs are prescribed to treat OCD.

Exposure and response prevention - A cognitive/behavioral approach in which the therapist and client identify the client's fear and then sets up a hierarchy of situations of engagement to help the client face his/her fears. This hierarchy of engagement starts with low risk and gradually increases to high risk in order to increase the client's awareness of their avoidant strategies so that he/she can discontinue them.

Imaginable exposure - Either a preparatory stage of engagement with the therapist in which the individual begins to think about his/her fear, or a form of engagement utilized in lieu of actual feared object such as blood.

Exposure therapy – Actual exposure to the feared object.

Summary:

OCD is characterized by the experience of obsessions and compulsions that greatly affect the quality of an individual's life. Obsessions are thoughts, feelings, and urges that result in great discomfort. Compulsions are the strategies that people use to decrease or neutralize discomfort experienced by the obsessions.

Mental compulsions or rituals are mental strategies that people use in order to undo the feeling associated with the obsession. In order to meet the criteria for a diagnosis of OCD, a person must spend 1 hour a day in either mental or behavioral ritual or the obsession must cause great distress and/or it must cause significant problems in their life. OCD has an impact on the individual's family and other systems of support.

Points of Application:

- Think about a time in your life where you obsessed about something and review that experience by identifying the time in your life that it occurred, how it felt, what the obsession was, and how you eliminated it.
- Think about what you might say to an individual who shares with you they have OCD.
- Identify one or two fears you have and think about how you work through these fears.
- Identify a time when you had a recurring thought and identify what it was and it made you feel, and the method you used to get it to go away.
- Imagine how uncomfortable you might feel if you felt compelled to do something repeatedly to avoid harm, how would you want someone to respond to you in that situation? What response do you think might help?
- Review your agency resource manual or local phone directory to identify any agencies, organizations in your city whose purpose is to provide support or services to those who have OCD.

Contact Hours:

The University of Missouri-Columbia will be responsible for this program. The School of Health Professions (SHP) will award 1 contact hour (.1 CEU) for this activity.

The SHP credit will fulfill Clinical Social Work, Nursing, and Psychologist licensure requirements in the State of Missouri. Attendees with licensure from other states are responsible for seeking appropriate continuing education credit, from their respective boards, for completing this program.

Transcript:

Hello and welcome to this training video on Obsessive Compulsive Disorders. I'm Mark Brennan, Project Director for Continuing Education Television (CETV) at the Missouri Institute of Mental Health in St. Louis, Missouri. With me today is Gary Mitchell who is a Licensed Clinical Social Worker who specializes in treatment of children and adults with Anxiety Disorder and other related problems. He is the Assistant Director of the Anxiety Disorders Center at St. Louis Behavioral Medicine Institute, which specializes in the treatment of refractory and complicated cases. Mr. Mitchell also is an Adjunct Assistant Professor at St. Louis University School of Social Services where he teaches Cognitive Behavioral Family Therapy.

Hi, Gary, I appreciate you coming in today.

Gary Mitchell

Thank you.

MB

I think a good place for us to start in understanding obsessive compulsive disorders is for you to tell us about some of the basic characteristics of the disorder and some of the diagnostic criteria that would help us to understand how you diagnose that disorder.

GM

Obsessive Compulsive Disorder, also called OCD, is characterized by obsessions and compulsions. Obsessions are thoughts or feelings or urges or images that result in great discomfort and the compulsions are the strategies the person engages in, in order to neutralize the discomfort associated with the obsessions. So, a compulsion could be an actual behavior that I engage in. The classic example is a person with contamination fears, who feels that they're somehow contaminated and then washes their hands until that feeling of contamination goes away.

There is also a category of compulsions that are a little more difficult to address and more difficult to identify that we identify as mental compulsions or mental rituals and there's a number of them that we will be talking about later, but essentially they're cognitive strategies; they're mental strategies that people use in order to try to undo that feeling associated with the obsession.

They are people who are sometimes identified as pure obsessional and many clinicians when they're diagnosing and assessing miss the mental rituals. They don't get that part and perceive that the patient is not ritualizing. It's not to say that a pure obsessional doesn't exist, but I haven't met one yet.

In order to qualify for the diagnosis, the person must spend at least an hour a day in either some sort of ritual, either mental or behavioral or the obsessions. It must cause great distress, and/or it must cause significant problems in their life.

MB

So those three areas are pretty much standard in diagnosing someone with obsessive compulsive disorder?

GM

Correct.

MB

Okay. So what percentage of the population has OCD?

GM

The *DSM -IV* indicates that it's anywhere between two and two and a half percent of the population at some point in their life will have OCD. And when I'm working with, particularly with kids who perceive they're the only one; we'll talk about the number of people in the St. Louis and surrounding areas, say one and a half, or I'll stretch it and say two million and then I'll suggest, imagine Busch Stadium filled with 40,000 people and that's how many people in St. Louis and the surrounding area, at some point who would have Obsessive Compulsive Disorder.

MB

That's a lot of people.

GM

A lot of people!

MB

Let me ask you, since you just mentioned children, what's the earliest age that you would see a child demonstrating those kinds of behaviors?

GM

There are children as young as four or five who come into our clinic. I don't treat children that young. I do have colleagues who do. Diagnostically, it's difficult because classically they would not have the kind of specific obsessions you would see in an older person and what you see more is ritualized behavior that appears to be an attempt to undo some negative feeling, some difficulty feeling and in those cases it's much more difficult diagnostically and our approach is much more behavioral. Generally speaking, when we're talking about a clearly identifiable obsession, we have children as young as eight or nine.

MB

Gosh, that's pretty young!

GM

That's young.

MB

Let's talk about how OCD is manifested in people's behaviors.

GM

Behaviors, if we think about the way that OCD affects people, remember that their motivation is to decrease the discomfort associated with the obsession. So what they might do is purely avoid. And we see many people who get to the point where they can no longer work and sometimes can no longer leave their home. So, they're not necessarily engaging in active rituals, active undoing of the obsession, they're just trying to stay away from triggers that would make that obsession occur.

MB

For instance, if I had a fear of dogs maybe, I would not want to be around areas where there are dogs. Is that the kind of avoidance that you're speaking of?

GM

That's correct. It's more passive avoidance.

And the people with OCD sometimes get to the point where they rarely leave their bed. They don't shower. They don't leave the home and we're talking now about more passive avoidance.

You would see a lot of active avoidance, also, which is what we call compulsions and that would be the classic either checking or washing, or repeating or there's a great number of behavioral types of rituals that people would engage in. If I'm afraid of contamination, I'm likely to wash. I'm likely to be hypervigilant to the possibility of contamination. If I'm afraid of being responsible for harm coming to other people, I'm likely to check and make sure the stove is off and make sure the appliances are unplugged and make sure that the doors are locked. If I'm fearful that I'm going to make a mistake, I'm likely to read and re-read. I'm likely to write and re-write and teachers will often see this in the classroom. There are other forms of OCD, called 'obsessional slowness,' where the person takes a tremendous amount of time to engage in any activity. Just getting up from my chair and walking across the room can take an hour. It can be debilitating.

GM

So, you see a broad range of behaviors in OCD and the important thing is to have a functional analysis to understand that behavioral response.

MB

In all the examples that you give, it suggests to me that there is, at least in the mind of the person whose doing these behaviors, a consistent approach, I mean there's a reason why they're doing these things; a connection between the behavior and what they're worried about.

GM

Correct

MB

So, that doesn't necessarily, just because they do those things, it doesn't necessarily make them ill, it's the frequency with which they do them and how it affects their life?

GM

Correct, I suppose what you're talking about is the difference between a quirk and a disorder.

MB

For instance like I and maybe you've done this, too, and I think, I know for certain I have, there are times when I have an appointment in the morning and I set the alarm and I go to bed and I turn out the lights and I can remember thinking that I needed to set the alarm, but I have to check the alarm to make sure that I set it. That's similar, in some ways, to what an obsessive compulsive person might experience briefly, right?

GM

Briefly, right. Or did I lock the door and I come back, or if I leave and I'm in a hurry and a little stressed, did that garage door close. But, with OCD, what would happen is I would drive back, check the garage door, turn around, leave, be affected by the doubt again, turn around and check and check and check and check. There are literally people who take hours to get out of the home because they're checking.

MB

So, there are differences in the behaviors that people manifest, depending on the type of OCD that they have?

GM

Oh, sure.

MB

What are the treatments for OCD?

GM

Treatments, generally, the well researched treatment fall into two categories; one is psychotropic medication. Generally the SSRIs, the serotonin reuptake inhibitors are the main class of medications that seem to be helpful with OCD. In our clinic, often people by the time they get to us have been through almost every medication that is available in therapeutic doses and have either none, or some relief, from the medication. The other well-researched approach to treatment of OCD is a cognitive behavioral intervention called exposure and response prevention. And essentially we would help a person to identify what their fears are. We would then set up a hierarchy of situations to help them face, to help them engage in, in order to face their fears from less difficult to more and would also help them to very clearly identify the avoidance strategies; the rituals and the avoidances they're engaging in and help them to discontinue those. So, the exposure is facing your fear. The ritual prevention or response prevention is discontinuing the rituals while you're facing your fear and there are other strategies that we use to help prepare people to get to that point. But, the real therapy, the therapy that will ultimately help people get better is that behavioral component, the exposure in response to that fear.

MB

Now when you do that, do you do that only in theory? Like, for instance, if I had a particular fear of contamination, would you talk me through these steps and help me to imaging doing these things, or would we actually do something physical that would help me alleviate the fears?

GM

Depending on the situation, everybody's different; we would do both or either. When possible, when it's possible to do the in vivo exposure to actually do it, ultimately we want to help people do it. But, there are times when it's important to do imaginable, what we call imaginable exposure and sometimes that's in preparation. People are so anxious that they can't even go close to the actual situation, so we help them to do the exposure of imagination step first.

There are other times when there's no way we're going to be able to really do what the person fears. It wouldn't be prudent. If I fear that there's blood on particular surfaces. We are not going to put blood on surfaces. What we will do is help them to touch surfaces that other people touch normally and deal with their fear and help them to try to disengage from having certainty. So to learn to deal with the doubt by allowing it to be until it dissipates. But we might have them, in their imagination, imagine touching blood and imagine doing those things and help them do that until the anxiety begins

to dissipate, until they have a sense that this is not really happening. And, if it were to happen, that the catastrophic beliefs I have about it, are probably even worse than the situation would actually be.

MB

It sounds like what you've been talking about is that it's important to go slowly with the individual after a thorough assessment to figure out how to help that person deal with the anxiety around whatever their perceiving to be a difficulty?

GM

Absolutely.

MB

Obviously, you're talking about treating people in an outpatient setting, but what are alternatives for individuals who need a higher level of care? Where would they go?

GM

There are only a few places in the country. We have, at our institute, an intensive treatment program, but not residential. So we do have people who come from across the country for specialized treatment for Obsessive Compulsive Disorder. Once they need a higher level of care than that, say residential treatment, there are only a few places that really have the specialty to provide that. There is Menninger's Clinic in Houston. There's McClain OCD Institute in Boston connected to Harvard. There's Rogers Memorial in Wisconsin and a program at UCLA. There are knowledgeable providers across the country. Not enough, not nearly enough. But there are providers who are quite knowledgeable who often get to the point where just outpatient therapy is not enough and they need to refer that person for more intense therapy.

MB

What would be the percentage of individuals that you might refer to one of those programs?

GM

Well, the only time we would refer to one of the other programs is if the person with us needs residential. You know we can provide up to six hours a day of intensive therapy. And, sometimes what happens is they may do good in therapy with us, but say go home and get stuck in the shower and not be able to come back and if they're not able to attend therapy, we can't help them. So, it's fewer people who we would refer to another program, simply because we tend to screen them up before they get to us. It happens from time-to-time. The bulk of the cases of the obsessive compulsive disorder do not need intensive therapy, but there are populations that do because people come to us for specialized treatment. So we see more people who need it than the average clinician.

MB

When we were talking about OCD and you were talking about treatment strategies, you had mentioned medication and cognitive behavioral interventions of various and sundry kinds. I'm curious though about the system that the individual is in, for instance their family. How does OCD affect family?

GM

That's a great question. We could spend an hour on it, but I'll try to be brief. The family is gradually and significantly brought into the disorder and it often happens subtly where say, as an example, parents with the child, the child feels anxious about certain things, so the parents compensate. They accommodate and as they do so, of course, the child becomes more anxious because they're avoiding more which leads them to fear even more and the system becomes more and more dependent on the parents accommodating for the child. Then often what we see is because of the impact on the family, how much the family has to change their lives, the family members come in the house and the child says, "You can't come in until you wash your hands." Then the child is saying, "You have to go directly to the shower and shower before we can do anything." The parents will gradually accommodate. Then they start to get angry, appropriately, but unfortunately, they express it in unhealthy ways and they often flip back and forth between this pattern of accommodation and then anger and then guilt over being angry and back to accommodation; which becomes part of the problem. So the families often have – you can see depression in the family that's clearly connected

with what they're living through. A tremendous amount of anger, sometimes even escalating to violence because the system just becomes so stressed.

MB

I guess they're pretty frustrated by the behavior.

GM

Oh, yeah.

MB

Do you involve the family at all in treatment and dealing with the OCD person? Like would they come into your clinic while you're doing some of the desensitizing of the fear?

GM

We sometimes involve particularly with kids. We sometimes involve the parents in the actual exposure therapy. Although that's tricky, because parents are, even if they were mental health professionals, they're still parents. It's hard to be a therapist with your kid. We include them more often in the individual therapy, in helping to negotiate rules and how you interact when you begin to discontinue doing certain things and setting up reinforcement strategies.

MB

Tell us about how families can be supportive of their children's efforts or your efforts at therapeutic approaches.

GM

When the child is in therapy?

MB

Yes.

GM

Well, if the child is in therapy, particularly if it's a child or an adolescent living with a parent, the parents need to be included in at least part of that therapy. There are the rare occasions when the child will come to me and say, "I don't want my parents involved. I really want to get better." As long as they are doing the therapy and we don't have to have the parents involved, I'm okay with it, but it's rare. So, generally speaking, we want the parents to understand what we're doing, to negotiate and for all of us to work together and for the child or adolescent to understand that parents will begin at a certain point to discontinue the accommodation that they were doing. It will be on a schedule and the child or adolescent will be able to help negotiate that as long as they're in therapy.

MB

How does a family deal with a client who is treatment resistant?

GM

That's more difficult and it's often painful for the family and for the clinicians working with them. But if we have an OCD sufferer whose either not admitting a problem or saying that they are not going to get help, then we strongly encourage and that's even an understatement, the family members to get help for themselves and what we want to help the family members to do is to disengage from the power struggle. To disengage from the accommodation and to normalize their lives in order to help the sufferer really experience life without being accommodated and life without the, the flip side of that coin, without being told just to pull yourself up by your boot straps because you can't. At times we will help the sufferer have more incentive to admit a problem and engage in therapy. If the sufferer doesn't though, at least it will help the parents to as best as they can normalize their lives. There are times when the parents might make the agreement not to challenge their child, not to set limits, even an adult child and it's our job then just to make sure that their eyes are wide open of what the results of that may be, including perhaps planning for the future when the parents ultimately die if we have a child or an adult child who is disabled, how will they be taken care of. But to help the parents really make clear decisions and to look accurately at what the consequences of their decisions are.

MB

What community resources exist for people who have OCD?

GM

Many and not enough. [Obsessive Compulsive Foundation.org](http://ObsessiveCompulsiveFoundation.org) and OCFoundation.org is a great resource. They have a list of referral sources. Locally, here in St. Louis, we have an OCD Support Group. We have Obsessive Compulsive Anonymous. We have a number of clinicians who are trained in treatment. So there are some good resources, but not nearly enough.

MB

Some final thoughts about OCD that the audience would need to know about.

GM

I suppose the most important message is there is help. People can get better. The treatment is not easy, but what I often say to sufferers is that you are going to feel bad if you do treatment or if you don't and the question really is are you going to feel bad getting better or are you going to feel bad staying stuck, but there is help. People can get better.

MB

Thanks Gary, I appreciate you coming in with us and sharing with us your expertise on OCD. I would encourage everyone out in the audience to review the Key Concepts prior to taking the test. If you do that and look at the Glossary, you won't have any problem succeeding.

Thank you.