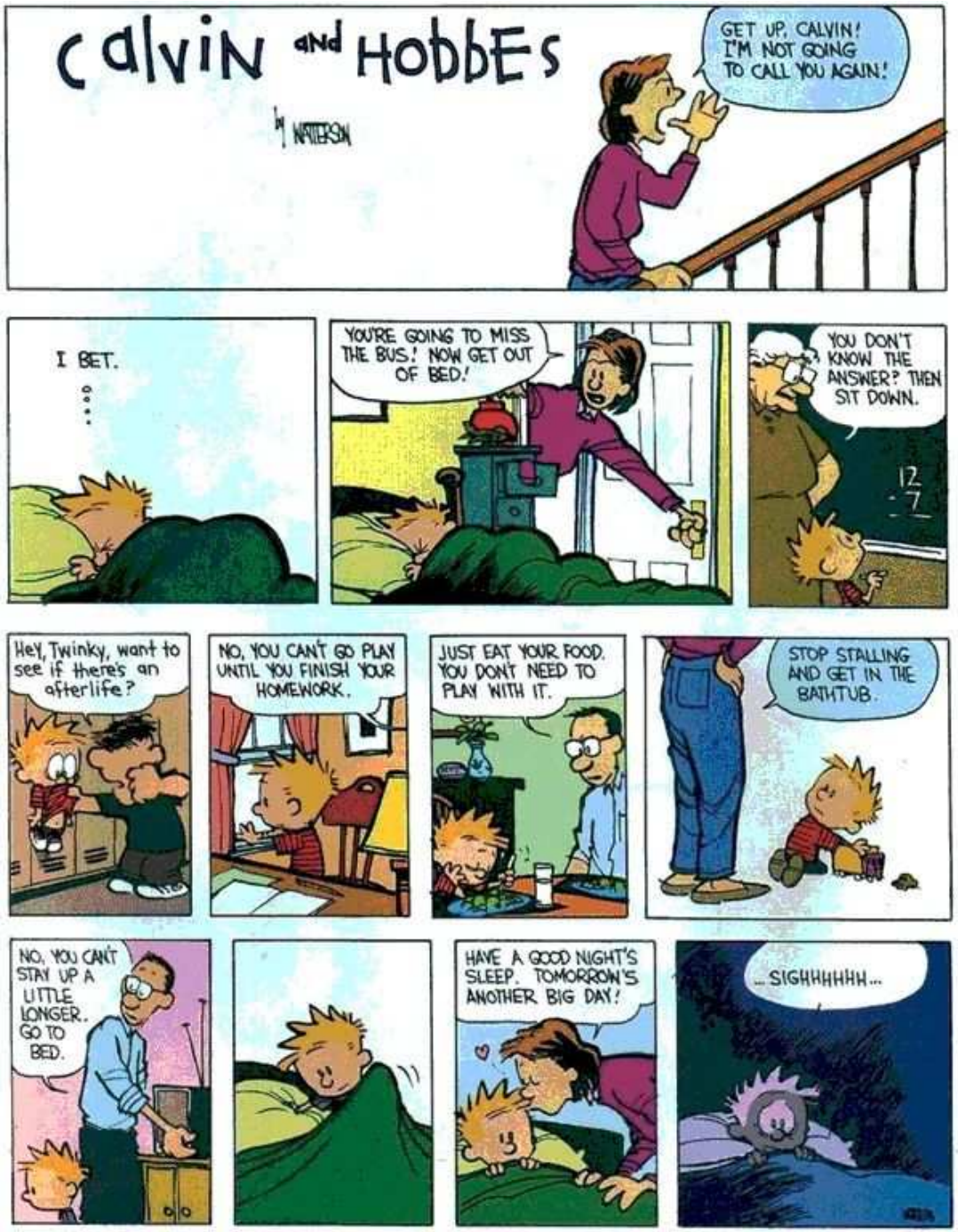

Calvin and Hobbes
by Watterson
GET UP, CALVIN! I'M NOT GOING TO CALL YOU AGAIN!
I BET.
YOU'RE GOING TO MISS THE BUS! NOW GET OUT OF BED!
YOU DON'T KNOW THE ANSWER? THEN SIT DOWN.
12 - 7
Hey, Twinky, want to see if there's an afterlife?
NO, YOU CAN'T GO PLAY UNTIL YOU FINISH YOUR HOMEWORK.
JUST EAT YOUR FOOD. YOU DON'T NEED TO PLAY WITH IT.
STOP STALLING AND GET IN THE BATHTUB.
NO, YOU CAN'T STAY UP A LITTLE LONGER. GO TO BED.
HAVE A GOOD NIGHT'S SLEEP. TOMORROW'S ANOTHER BIG DAY!
...SIGHHHHHH...

ONCE MORE WITH FEELING

Understanding OCD


AAUGH! THE PEANUT BUTTER IS RUINED!
1993 Watterson/Distributed by Universal Press Syndicate
YOU'RE SUPPOSED TO SCOOP ONE HALF STRAIGHT DOWN AND THEN DIG OUT THE OTHER SIDE FROM THE BOTTOM, SO PART OF THE TOP REMAINS UNDISTURBED UNTIL THE VERY END.
WHAT ON EARTH FOR?
IT'S A RITUAL! YOU HAVE TO KEEP THE TOP OF THE PEANUT BUTTER SMOOTH!
MAYBE YOU SHOULD MAKE YOUR OWN SANDWICHES.
IF YOU CAN'T CONTROL YOUR PEANUT BUTTER, YOU CAN'T EXPECT TO CONTROL YOUR LIFE. DID YOU CUT THE BREAD DIAGONALLY?

Update on Managing OCD

Dr. JD Vanderkooy
Child and Adolescent Psychiatrist, CAIP Unit
Dept. of Psychiatry- GRH

A Day in Psychiatry- 2017
Wednesday November 8th, 2017
Bingeman's Conference Centre
Kitchener, Ontario

Update on Managing OCD

Dr. JD Vanderkooy

Day in Psychiatry 2017

Declaration of Conflict of Interest:

I DO NOT have any affiliation with any pharmaceutical, medical device or communication organization.

I DO INTEND to make therapeutic recommendations for medications that have not received regulatory approval (e.g “off-label”use). **I will specifically note when I am making off-label recommendations that have not yet received regulatory approval.**

Update on Managing OCD

Dr. JD Vanderkooy

Day in Psychiatry 2017

This 2017 Day in Psychiatry educational event has received unrestricted educational grants from the following organizations:

- Lundbeck
- Otsuka
- Pfizer
- Janssen
- Purdue
- Shire
- Sunovion
- KW Guardian Pharmacy
- HLS Therapeutics
- Allergan

Update on Managing OCD

Dr. JD Vanderkooy

Day in Psychiatry 2017

Mitigating Potential Conflicts of Interest:

Not applicable

Update on Managing OCD

Dr. JD Vanderkooy

Day in Psychiatry 2017

Learning Goals

1. Discuss the new diagnostic classification of OCD in the DSM V and its implications for clinicians.
2. Review the diagnostic criteria, incidence, prevalence and natural history of Obsessive-Compulsive Disorders.
3. Discuss the differential diagnosis and common co-morbid conditions.
4. Review any testing that may aid in diagnosis.
5. Evaluate management options
    1. For pharmacotherapy- present information on NNT and NNH
    2. Is there a role for therapy?
    3. Ways of assisting families in dealing with the diagnosis
        1. Therapy options
        2. Sources of information
        3. Advocacy agencies
        4. Bibliography

Introduction

1. What is OCD? - review of changes in DSM5

2. A brief history of OCD - overview and history of the diagnosis

3. OCD and development - onset, course, and psychology

4. Clinical Course and Natural History - onset, course, outcomes

5. Etiology - what we know about what causes OCD

6. Diagnostic Approaches - building up and breaking down the “spectrum”

7. Treatment Options - knowing what to treat, and how

Savage Chickens by Doug Savage

OCD SANTA

www.savagechickens.com

What is OCD?

DSM-IV Classification

Anxiety Disorders

- 300.02 Generalized anxiety disorder
- Panic disorder
- 300.21 With agoraphobia
- 300.01 Without agoraphobia
- 300.22 Agoraphobia without history of panic disorder
- 300.29 Specific phobia
- 300.23 Social phobia
- 300.3 Obsessive-compulsive disorder
- 309.81 Posttraumatic stress disorder
- 308.3 Acute stress disorder
- 293.84 Anxiety disorder due to general medical condition
- 300.00 Anxiety disorder NOS

What is OCD?

DSM-IV Classification

Impulse Control Disorders

- 312.34 Intermittent Explosive Disorder
- 312.32 Kleptomania
- 312.31 Pathological Gambling
- 312.33 Pyromania
- 312.39 Trichotillomania
- 312.30 Impulse-Control Disorder NOS

What is OCD?

DSM5 Classification

-separated from Anxiety Disorders

-"Obsessive Compulsive and Related Disorders"

-includes impulse control disorders

(excoriation, hoarding, trichotillomania, others)

-2 new diagnoses:

1. body-focused repetitive behaviour disorder
2. unspecified OC/related disorder

American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (Fifth ed.)

What is OCD?

DSM5 Classification

-“impulse” replaced with “urge”

-“inappropriate” replaced with “unwanted”

-“unrealistic”, “excessive” no longer criteria

-substance-induced and GMC

-expansion of body dysmorphic disorder

-specifiers for level of insight

American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (Fifth ed.)

What is OCD?

DSM5 Classification

A. Presence of obsessions, compulsions, or both

Obsessions:

-recurrent and persistent

-thoughts, urges, or images

-intrusive and unwanted

-cause marked anxiety or distress AND

-attempts to ignore or suppress or neutralize,

AND…

American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (Fifth

What is OCD?

DSM5 Classification

A. Presence of obsessions, compulsions, or both

Compulsions:

-repetitive behaviours or mental acts

-felt need to perform in response

-rigidly applied rules

-aim is to reduce anxiety/distress, or

-prevent dreaded event

-excessive or unrealistic,

AND…

American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (Fifth ed.)

What is OCD?

DSM5 Classification

B. Time consuming or cause significant distress or impairment in social, occupational, or other areas.

C. NOT attributable to effects of substance use

D. NOT better explained another disorder
(eg. PTSD, GAD, BDD, excoriation, stereotypes, etc. etc.)

OCD CSI

"Oh no! That painting's askew!

A Brief History of OCD

1850
OCD considered a variant of insanity

Rapoport and Shaw, 2008

1903 Pierre Janet
classic descriptions of OCD described childhood onset

Janet, 1903

AUTRE OUVRAGE DE MM. LES Pres RAYMOND ET JANET

Travaux du laboratoire de psychologie de la clinique à la Salpêtrière. Deuxième série. **Névroses et Idées fixes.** II. *Fragments des leçons du mardi sur les névroses, les maladies produites par les émotions, les idées obsédantes et leur traitement.* 1 fort vol. gr. in-8, avec 67 figures dans le texte. . . . . 14 fr.

AUTRES OUVRAGES DE M. LE Pr RAYMOND

Maladies du système nerveux. Atrophies musculaires et maladies amyotrophiques. 1 vol. grand in-8 de 540 pages (Doin, éditeur).

Maladies du système nerveux. Scléroses systématiques de la moelle. 1 vol. in-8 de 440 pages, avec 122 fig. (Doin, éditeur).

L'étude des maladies du système nerveux en Russie. 1 vol. in-8, 1889.

Leçons sur les maladies du système nerveux *(Hospice de la Salpêtrière)*, recueillies et publiées par le Dr E. Rikelis (Doin, éditeur) :

Première série, 1896, 1 vol. gr. in-8.
Deuxième série, 1897, 1 vol. gr. in-8.
Troisième série, 1898, 1 vol. gr. in-8.
Quatrième série, 1900, 1 vol. gr. in-8.
Cinquième série, 1901, 1 vol. gr. in-8.

Des dyspepsies. 1 vol. in-8 de 284 pages (Doin, éditeur).

AUTRES OUVRAGES DE M. LE Pr PIERRE JANET

L'automatisme psychologique. *Essai de psychologie expérimentale sur les formes inférieures de l'activité mentale.* 1 vol. in-8 de la *Bibliothèque de philosophie contemporaine*, 3e édition (F. Alcan, éditeur). . . . . 7 fr. 50

État mental des hystériques. *Les stigmates mentaux*, etc. Préface de M. le Pr Charcot (Rueff et Cie, éditeurs).

État mental des hystériques. *Les accidents mentaux* (Rueff et Cie, éditeurs).

Travaux du laboratoire de psychologie de la clinique à la Salpêtrière. Première série. **Névroses et idées fixes.** I. *Études expérimentales sur les troubles de la volonté, de l'attention, de la mémoire; sur les émotions, les idées obsédantes et leur traitement.* 1 vol. in-8, avec 68 fig. dans le texte (F. Alcan, éditeur) . . . . . 12 fr.

Travaux du laboratoire de psychologie de la clinique à la Salpêtrière. Troisième série. **Les obsessions et la psychasthénie.** I. *Études cliniques et expérimentales sur les idées obsédantes, les impulsions, les manies mentales, la folie du doute, les tics, les agitations, les phobies, les délires du contact, les angoisses, les sentiments d'incomplétude, la neurasthénie, les modifications du sentiment du réel, leur pathogénie et leur traitement.* 1 vol. gr. in-8, avec gravures dans le texte. . . . . 18 fr.

CHARTRES. — IMPRIMERIE DURAND, RUE FULBERT.

Travaux du laboratoire de Psychologie de la Clinique à la Salpêtrière

QUATRIÈME SÉRIE

LES OBSESSIONS

ET

LA PSYCHASTHÉNIE

II

FRAGMENTS DES LEÇONS CLINIQUES DU MARDI
SUR LES ÉTATS NEURASTHÉNIQUES, LES ABOULIES,
LES SENTIMENTS D'INCOMPLÉTUDE,
LES AGITATIONS ET LES ANGOISSES DIFFUSES, LES ALGIES, LES PHOBIES,
LES DÉLIRES DU CONTACT, LES TICS, LES MANIES MENTALES,
LES FOLIES DU DOUTE, LES IDÉES OBSÉDANTES, LES IMPULSIONS,
LEUR PATHOGÉNIE ET LEUR TRAITEMENT

PAR

Le Dr F. RAYMOND
Professeur
de clinique des maladies du système nerveux
Médecin de la Salpêtrière.

Le Dr Pierre JANET
Professeur de psychologie au Collège de France
Directeur du laboratoire de Psychologie
à la Salpêtrière.

Avec 22 figures dans le texte.

PARIS
FÉLIX ALCAN, ÉDITEUR
ANCIENNE LIBRAIRIE GERMER BAILLIÈRE ET Cie
108, BOULEVARD SAINT-GERMAIN, 108

1903

A Brief History of OCD

1850
OCD considered a variant of insanity

Rapoport and Shaw, 2008

1903 Pierre Janet & 1965 Anna Freud
classic descriptions of OCD described childhood onset

Janet, 1903
Freud, 1965

1980s ECA Study
18,500 individuals across 5 sites
-prevalence rose from 0.05% to 1.9-3.3%
-rates 25-60 times greater than clinical estimates!

Karno, Golding, et al. 1988, 1991

1990s Assessment Tools
Diagnostic Interview Schedule (DIS) facilitated diagnosis
Clinicians vs. Non-Clinicians completing assessment
Prevalence accepted to be 0.7-2.9%

Herjanic and Campbell, 1977

Rapoport et al., 2000

OCD and Development

Age 2

repetitive behaviours
ritualistic behaviours
expectations of routines
familiarity preferred over transitions
(especially at mealtimes, bathing, bedtime)
separation anxiety
mastery and cognitive control

Freud, 1965
Leonard et al., 1990

Gesell et al., 1974

Age 3-4

normally less rigid about rituals
more comfort with transitions, changes
bedtime ceremonies still seen
(insomnia, nightmares, fears, lead to
repeated stories, reassurance-seeking) until age 8-9

Nagera, 1980

Age 5

solitary play develops into collective play

Rubin, 1983

International Standard 30 Square Hopscotch Rules

(As agreed by the International Hopscotch Federation.)

Rules apply to all international class matches including Grand Hops, Invitational Classics, Olympic Games, etc.

How to play:

Standing behind the throw line, the first player throws their selected stone into square one of the hopscotch grid and then proceeds to hop on each un-stoned square (or jump onto pairs of squares which are next to each other) to the turnaround arch, turn around and proceed back to the start collecting their thrown stone in the process.

Rules

1. The grid must be laid out according to the attached diagram.
2. The grid must be drawn using chalk.
3. The thickness of the line and size of numbers must be clearly visible to all players but shall be no thicker than 2 cm or 1 inch.
4. The squares must be drawn freestyle and look squarish in shape. The four sides of the squares must be about one and half times the length of the longest foot of the competitors without shoes on plus one inch or 2.5 centimetres whichever is the greater or lesser.
5. The surface may be concrete or asphalt and must be relatively flat. If drawn on a non horizontal surface such as an inclined driveway the incline of that surface shall be no greater than 20 degrees either up or down and tilted no more than 5 degrees to either side.
6. The grid shall be drawn in a straight line unless no such suitable surface area is available then it may be drawn around a 90 degree corner. All 30 squares must be included but an additional "safety triangle" may be added at the bend if a bend is necessary. See additional rules for the safety triangle.
7. The throwing device shall be a stone of whatever shape or size as chosen by the player. No wood, bone, plastic or any other substance other than that classifiable as stone by a qualified geologist may be used. Hollow stones are not permitted, nor shall any stone be hollowed and refilled with any substance.
8. The stone must land within the required square. It may bounce or skip across other squares but must come to rest on the required square. It may touch or protrude beyond the outer edge of the line but if so some part of it must still be touching the line.
9. A player must hop into every single square or jump onto those squares which are opposite each other by putting only one foot in each square, except those squares which have a stone or another player standing in them.
10. A player may hop or jump using feet or hands but no other body part. For the sake of simplicity the hand when used for hopping or jumping shall be referred to as a foot in these rules.
11. A player's foot must land inside the square. It may touch the line but must not protrude beyond the other edge of the line.
12. A player may reposition their foot in the square.
13. A player must collect their stone on their home run after reaching the turnaround arch. They must stop on the square numbered one higher than the square their stone is on, stand on one leg (or two if the squares are opposite each other) and pick up their stone. They must then hop onto the square their stone was in and complete their run back to the start.

13a. In the case where another player or their stone is in the square immediately higher, then the player must stop and pick up their stone from two numbers higher and so forth when other squares higher are occupied by a stone or another player.

14. A player may not touch the ground with any other part of their body except their feet regardless of the need to keep their balance. It is considered poor sportsmanship for a player to allow themselves to fall in an injurious way and it is recommended they catch their balance and get judged out rather than do a face plant or hurt themselves in some other way through excessive effort to prove they don't need to touch the ground.

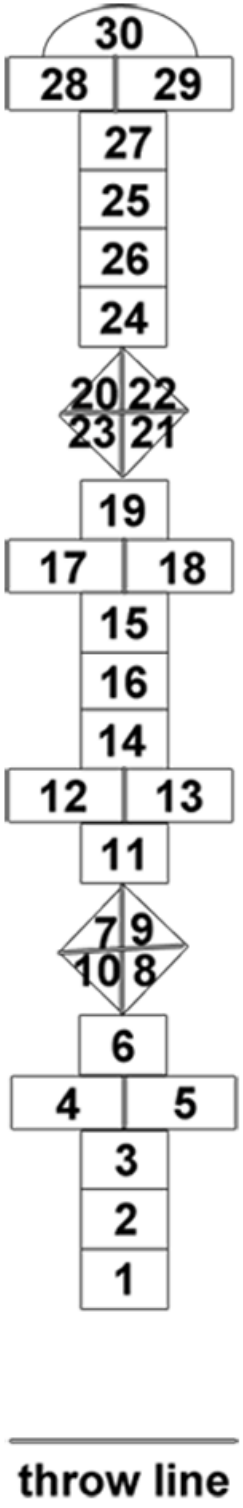
14a. The exemption to rule 14 is slight and only applies when a player is collecting their stone on the return run: they may slightly touch the ground in the name of picking up their stone. This is considered fair play. However should the umpire consider the touching to be excessive or as an obvious effect of the player to keep their balance they shall be considered out.

15. If when attempting to collect their stone a player touches the ground with their hand or other non-permitted body part, other than as fair play, they are required to remain on that last square before the square their stone is on until it is their turn again when they may again attempt to collect their stone and complete their run home.
16. When a player is in the path of another player they are called a stationary player.
17. A square where there is a stationary player must not be hopped on by another player.
18. A player may not purposefully block or charge another player
19. The umpire may require a stationary player to reposition themselves so the playing player has a fair chance of proceeding but the stationary player's foot must remain in their square.
20. A player may put both feet down in the thirty square or turnaround arch and may move around and rest for up to ten secs within the arch before proceeding back to the start. However this does not apply when a player's own stone is in the arch in which case they must hop over the arch and outside the grid where they are free to move around outside the grid for up to ten secs before collecting their stone and hopping back to the start to complete their involvement in the game.
21. Only one of a player's feet may land in any one square.
22. A square with any player's stone in it must not be landed on by a player but two or more stones may occupy the same square.
23. If all players miss throwing their stone into their squares for three turns in a row the referee may elect to move the throw line up to within two squares of the lowest targeted number.

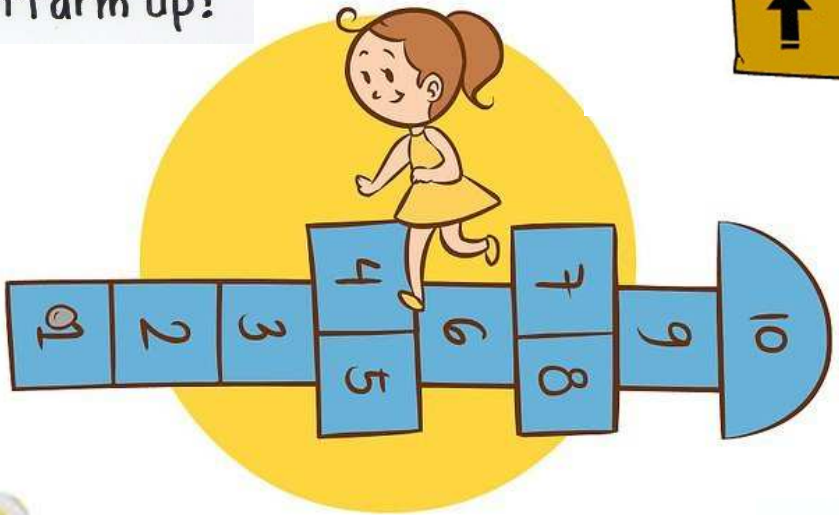
Additional rules for the safety triangle.

Due to the additional skill and bravery required by players to negotiate a 90 degree bend in the Internationally standard hopscotch grid when a straight course is not possible, and to conform with safety requirements, these additional rules apply.

a. Players are not required to throw their stone into the safety triangle.
b. Players are not required to hop into the safety triangle and may simply proceed from the numbered square before the safety triangle to the next sequentially numbered square taking into account the primary rules of the game.
c. A player may use the safety triangle as it is intended, to regain their balance or reposition for the turn and may place two feet in the triangle if desired for up to ten seconds.
d. No other player, official, commentator or spectator may tease or taunt a player for using the safety triangle.



MOTHER MAY I?



OCD and Development

Age 6-11

rules dominate play
themes of control and dominance
(eg. freeze tag)
cooties and contamination
the “jinx” game
emergence of superstitious ideas
magical thinking, lucky numbers

Leonard et al., 1990

Oremland, 1973
Adams, 1973

Age 7

collecting objects
hobbies, obsessive interests, “impulsions”
baseball cards, pokemon, stuffed animals
sentimentality, toys kept despite dysfunction
introjection of peer values

Bender and Schilder, 1940
Vitale, 1954

Age 8-9

bedtime rituals, reassurance seeking tends to wane

van Amerongen, 1980

OCD and Development

Functional or Non-Functional

rituals may serve purpose — Albert et al., 1979
delaying bedtime — Luskin, 1981
acquiring social relationships
continuity with normal adult behaviours
e.g.. superstition — Marmor, 1956

Normal

later age of onset
mastering anxiety
enhancing socialization
later age of onset

Pathological

earlier age of onset — Leonard, 1990
emotionally distressing
isolating
incapacitating

Clinical Course and Natural History

Onset

-33%-50% have onset in childhood

Douglas et al. 1995
Stewart et al. 2008

Prodromal Phase probable

-half of parents of youth <18 reported “micro-episodes” occurring years before full symptoms

Swedo et al. 1989

-brief, excessive rigidity and repetitive rituals

Past depression, Substance abuse predictive

-sample of 18 year-olds

Douglass et al., 1995

Other Predictors

-tics, ADHD predict OCD symptoms

Peterson, 2001

Clinical Course and Natural History

2 Peaks of Onset

10-12yo - transition to adolescence
-increased performance pressure
-decrease in normal need for reassurance
-biological changes associated with puberty

18-20+ - transition to adulthood
-separation and individuation
-transition to independence
-significant increase in anxiety

Stewart et al. 2008
Leonard, 1990

Clinical Course and Natural History

Course

-symptoms change over time
-sensitivity to developmental stage
-presenting obsessions and compulsions change in 90%

Swedo et al. 1989
Rettew, 1992.

Change in symptoms presentation

-most children begin with single obsession
-gradual acquirement others
-counting and symmetry in grade school
-washing rituals during early adolescence

Maina et al., 1999

Past depression, Substance abuse predictive

-sample of 18 year-olds

Douglass et al., 1995

Other Predictors

-tics, ADHD predict OCD symptoms
-tics and PANDAS predict waxing and waning course

Peterson et al., 2001
Bloch et al., 2006

Clinical Course and Natural History

Outcomes over time

-adolescents more likely to develop MDD, ADHD
-early adolescents develop more anxiety, phobias
-sensitivity to developmental stage
-presenting obsessions and compulsions change in 90%

Peterson et al., 2001

Spontaneous remission uncertain

-one third of adults spontaneously remit
-study of 54 children, 3 remitted (5.5%)
-assessment tools vary (eg. DSM5, ICD10)

Karno & Golding, 1990
Leonard et al., 1993
Horwath and Weissman, 2000

Improvement over time

-591 adults, 60% chronic OCD, considerable improvement
-41% (full) and 60% (full+subthreshold) persistence

Angst et al., 2004

Prognostic factors

-earlier age of onset
-comorbid psychiatric illness
-poor treatment response

Stewart et al., 2004

Etiology: What causes OCD?

Biology

-uncontrolled activity of discrete loops of brain

Cortico-Striatal-ThalamoCortical (CSTC)

-basal ganglia
-pre-frontal cortex
-orbito-frontal region
-anterior cingulate gyrus
-thalamus
-globus pallidus
-dorsal raphe nucleus

Alexander et al., 1986

Direct and Indirect Pathways

-positive FB loop
-initiation and continuation of thought & action

Etiology: What causes OCD?

Neuroanatomy

-abnormal findings in these areas consistent in OCD

Basal Ganglia

-Huntington's chorea, Parkinsons linked with OCD
-post-encephalitic development of OCD
-acquired lesions of caudate, putamen

PANDAS and the Caudate

-autoimmune sequelae trigger Sydenham's chorea

Ventromedial and Polar Frontal Cortex

-acquired lesions lead to *de novo* onset of OCD
-localized thinning in early onset OCD

The OCD loop: What may go wrong

Current research into obsessive compulsive disorder focuses on a feedback loop involving three brain areas: the frontal lobe (prefrontal and frontal cortices), striatum and thalamus. The loop involves multiple circuits and signals that can stimulate or inhibit brain activity. At its most basic:

Frontal lobe

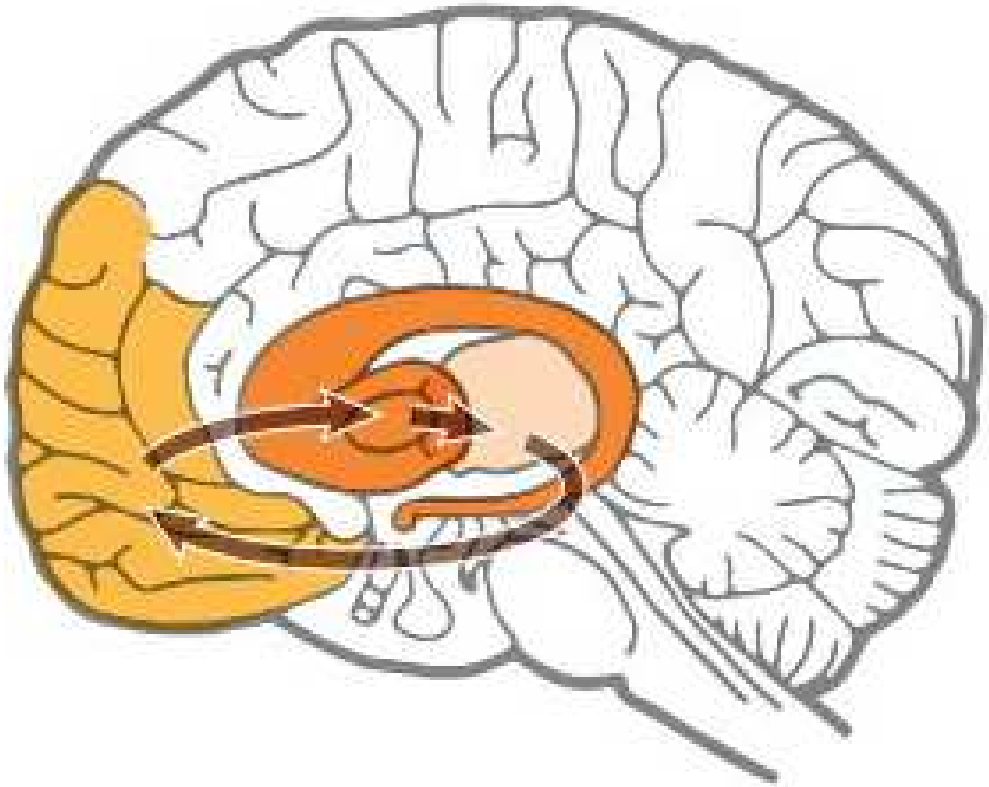
The frontal lobe, which is responsible for such functions as error detection, working memory and goal-directed behavior, sends a signal through the striatum.

Striatum

The striatum either passes the signal on or acts like a brake and inhibits it.

Thalamus

The thalamus, which in part controls subconscious movements, receives the signal from the striatum and sends it back to the frontal lobe. If the signal is too "loud," it can disrupt activity there.



OCD may result from dysfunction in this loop. One theory is that the compulsive behaviors a person experiences are caused by a misfiring in one or more neural circuits within the loop.

Source: Staff reports

AMY ELLIS NUTT AND PATTERSON CLARK/THE WASHINGTON POST

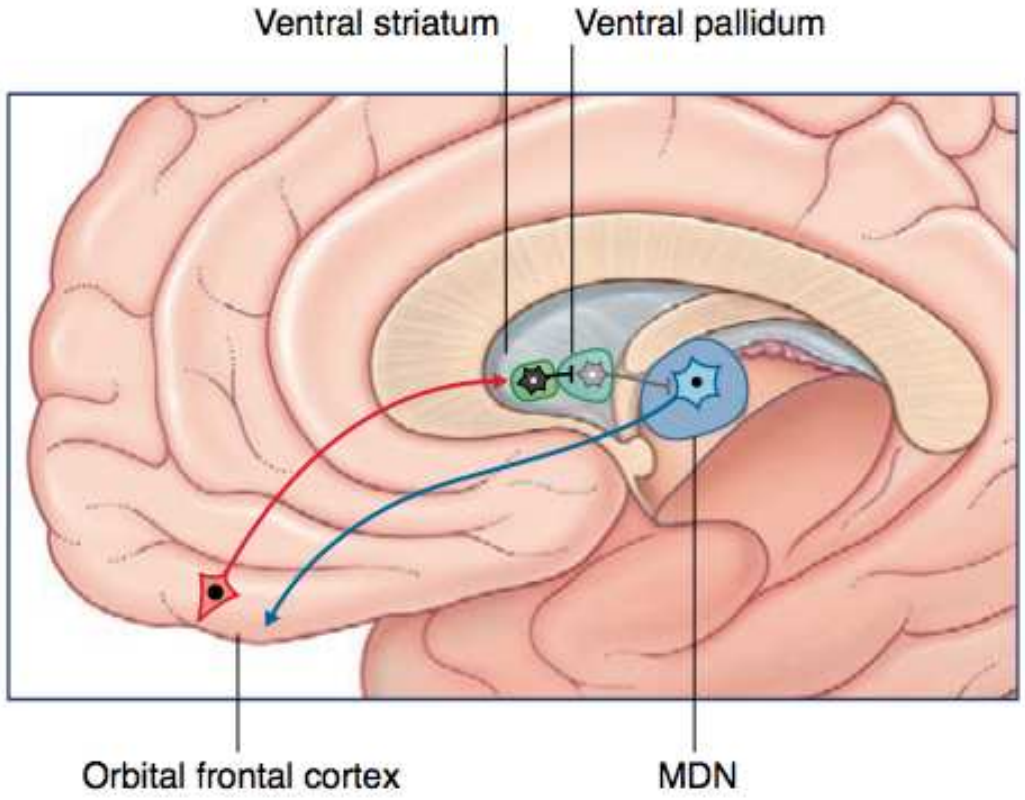


Figure 33.5 The limbic basal ganglia loop, right hemisphere. The medial dorsal nucleus of thalamus (MDN) is being released by means of disinhibition.

Image taken from Clinical Neuroanatomy and Neuroscience, 6th edition

Leisman et al., 2016

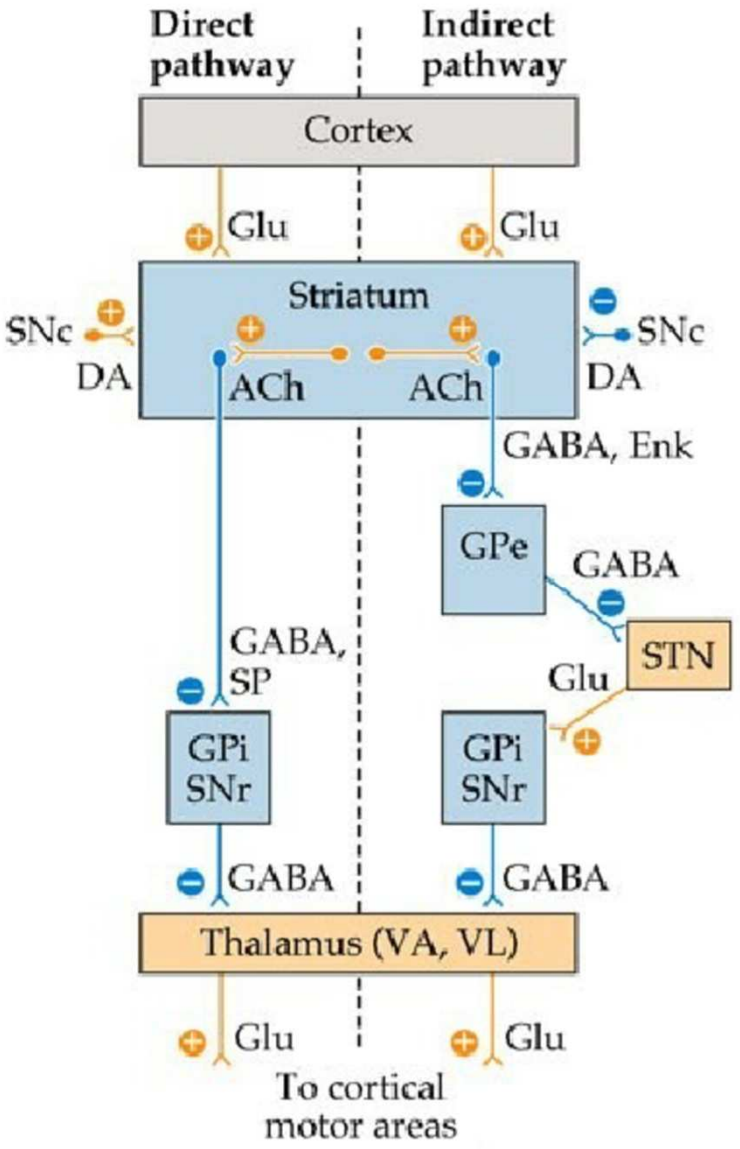


Figure 5. Circuit diagram for direct & indirect pathways. Neurotransmitters: Ach, acetylcholine; DA, dopamine; Glu, glutamate; Enk, enkaphalin; SP, substance P. Nuclei: SNc, substantia nigra pars compacta; SNr, substantia nigra pars retriculata; GPe, globus pallidus pars externa; GPi, globus pallidus pars interna; STN, subthalamic nucleus; VL, ventral lateral nucleus; VA, ventral anterior nucleus.

Etiology: What causes OCD?

Neurochemistry

-serotonin (5HT) agonists exacerbate symptoms
-SSRIs are most effective therapeutic agents

-reduction of 5HT synthesis in ventral PFC, caudate

Neuroendocrine

-OCD tends to worsen during menses
-improvement with anti-androgen therapy

-shorter stature in children with OCD
-reduced sensitivity for GH
-clonidine challenge showed intact GH-axis

Am J Psychiatry. 1992 Jul;149(7):947-50.

Onset of obsessive-compulsive disorder in pregnancy.

Neziroglu F[1], Anemone R, Yaryura-Tobias JA.

Author information

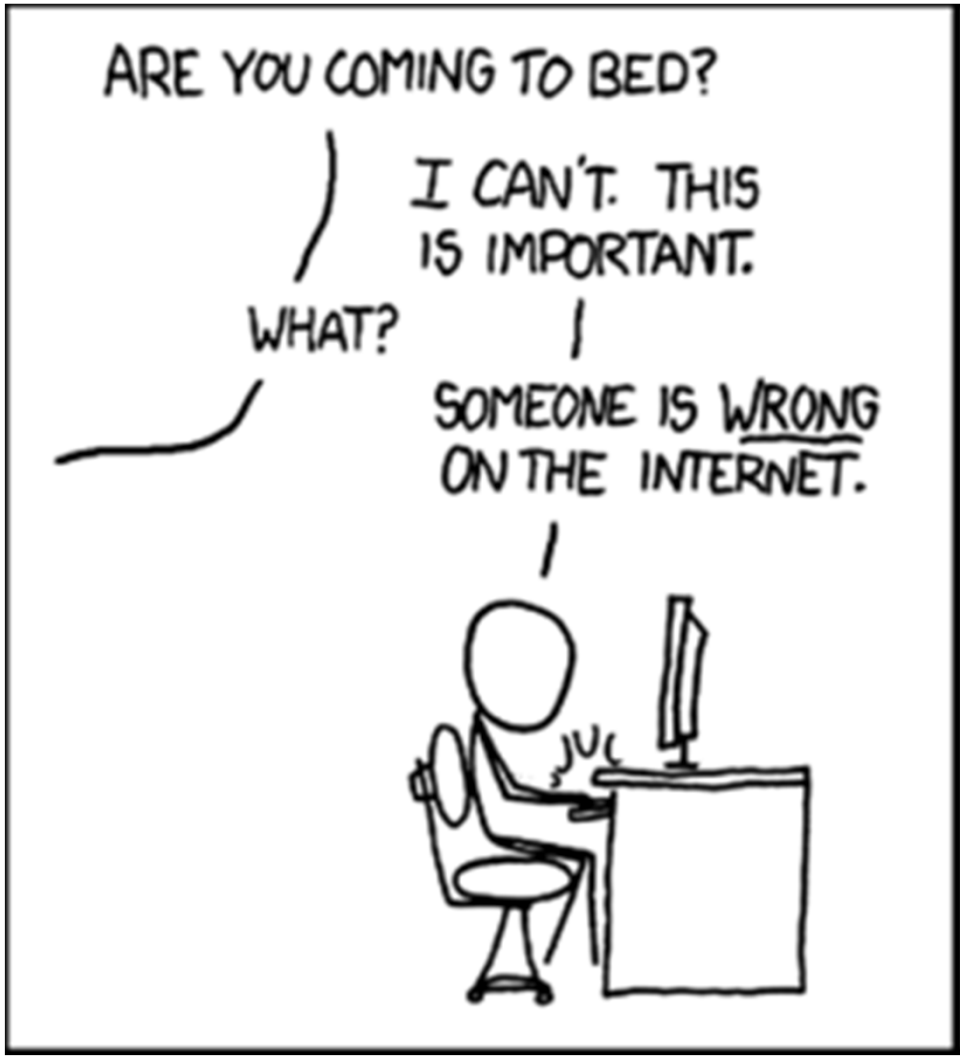
Abstract

OBJECTIVE: Although the role of pregnancy and childbirth in postpartum psychosis and depression has been studied, the association between pregnancy and obsessive-compulsive disorder has not been specifically addressed. The authors evaluated the role of pregnancy in the onset of obsessive-compulsive disorder.

METHOD: Female patients with obsessive-compulsive disorder (N = 106) completed a questionnaire assessing age at onset of symptoms, marital status, number of children, age at each pregnancy, and life events associated with the onset of obsessive-compulsive disorder.

RESULTS: Of the 106 women, 42 were childless and 59 had at least one child each; five others were also childless but had had abortions (N = 4) or a miscarriage (N = 1). Of the 42 women without children, 12 (28.6%) had first experienced obsessive-compulsive symptoms between the ages of 13 and 15 years, but there were two peaks of onset for the women with children: ages 22-24 and 29-32 years. Of the 59 patients with children, 23 (39.0%) had experienced symptom onset during pregnancy; this was the first pregnancy for 12, the second pregnancy for eight, and the third pregnancy for three. Four of the five women who had had abortions or a miscarriage had experienced the onset or an exacerbation of obsessive-compulsive symptoms during pregnancy.

CONCLUSIONS: The association between pregnancy and the onset of obsessive-compulsive symptoms in these female patients highlights the need for further research on psychological and biological factors associated with pregnancy and obsessive-compulsive disorder.


ARE YOU COMING TO BED?
I CAN'T. THIS IS IMPORTANT.
WHAT?
SOMEONE IS WRONG ON THE INTERNET.

Is OCD an anxiety disorder?

Building up and breaking down the spectrum

-"spectrums" - lumping and splitting

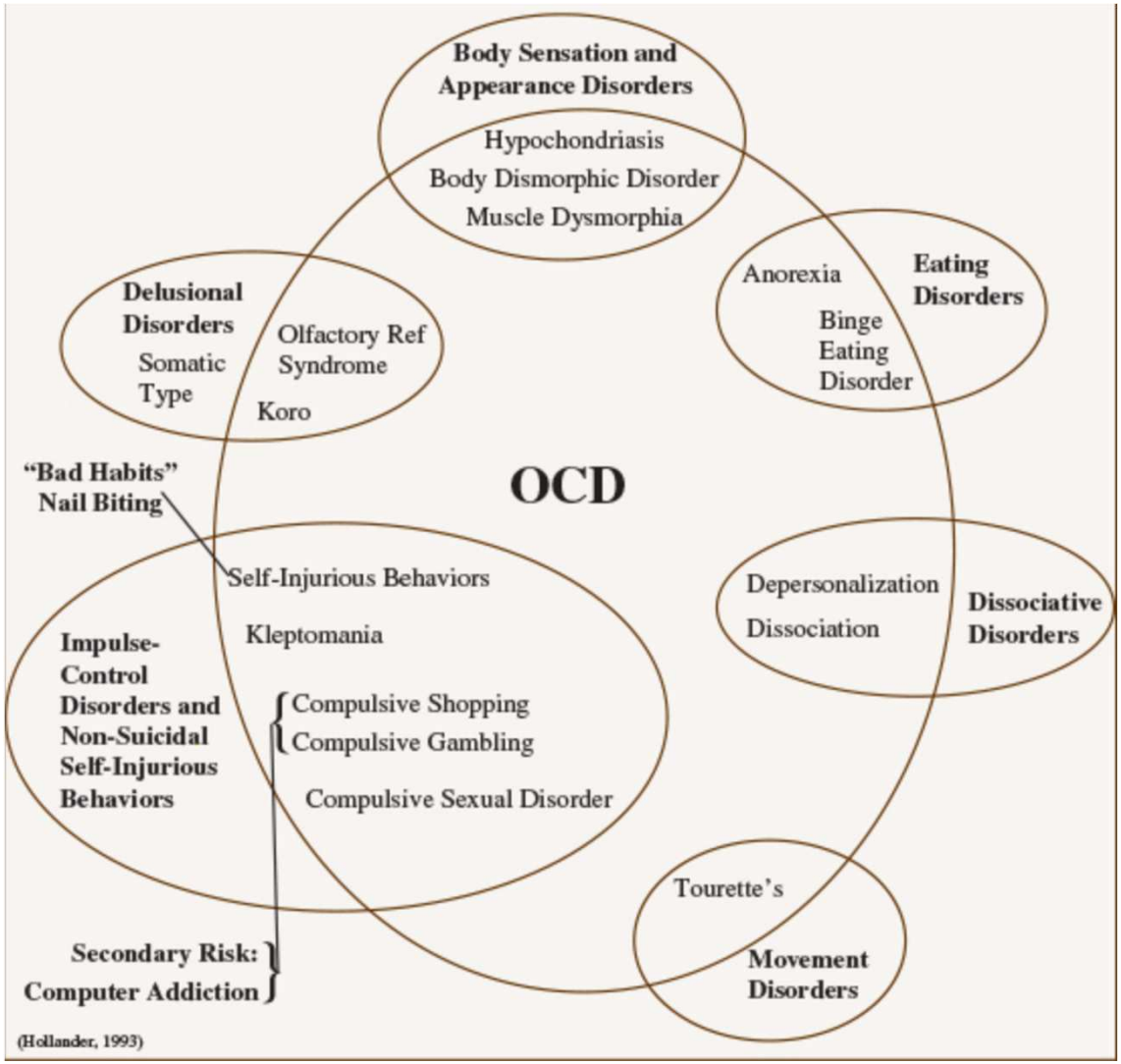
-similar phenotype, similar treatment?

-tics and disorders of impulse-control respond poorly to SSRIs

-trichotillomania, excoriation, repetitive behaviours

-contamination compulsions sensitive to tx

-repetitive thoughts respond better to SSRIs


Body Sensation and Appearance Disorders
Hypochondriasis
Body Dismorphic Disorder
Muscle Dysmorphia
Delusional Disorders
Somatic Type
Olfactory Ref Syndrome
Koro
Anorexia
Eating Disorders
Binge Eating Disorder
"Bad Habits" Nail Biting
OCD
Self-Injurious Behaviors
Kleptomania
Impulse-Control Disorders and Non-Suicidal Self-Injurious Behaviors
Compulsive Shopping
Compulsive Gambling
Compulsive Sexual Disorder
Depersonalization
Dissociation
Dissociative Disorders
Tourette's
Movement Disorders
Secondary Risk: Computer Addiction
(Hollander, 1993)

What is OCD?

Essence of OCD:

1. anxiety-arousing stimuli
2. anxiety-reducing response

Is OCD an anxiety disorder?

OCD subtypes

-pure obsessions

-contamination *(most pathognomonic)*

-symmetry/order *(heritable)*

-hoarding *(poor response to treatment)*

Significant overlap with tic disorders

-neuranatomical similarities *(eg. basal ganglia)*

Table 1.—Major Presenting Symptoms in 70 Consecutive Children and Adolescents With Severe Primary Obsessive-Compulsive Disorder

Compulsions	Reported Symptom at Initial Interview, No. (%) of Patients*
Excessive or ritualized hand washing, showering, bathing, tooth brushing, or grooming	60 (85)
Repeating rituals (eg, going in/out door, up/down from chair)	36 (51)
Checking (doors, locks, stove, appliances, emergency brake on car, paper route, homework, etc)	32 (46)
Rituals to remove contact with contaminants	16 (23)
Touching	14 (20)
Measures to prevent harm to self or others	11 (16)
Ordering/arranging	12 (17)
Counting	13 (18)
Hoarding/collecting rituals	8 (11)
Rituals of cleaning household or inanimate objects	4 (6)
Miscellaneous rituals (eg, writing, moving, speaking)	18 (26)
Concern with dirt, germs, or environmental toxins	28 (40)
Something terrible happening (fire, death/ illness of self or loved one, etc)	17 (24)
Symmetry, order, or exactness	12 (17)
Scrupulosity (religious obsessions)	9 (13)
Concern or disgust with bodily wastes or secretions (urine, stool, saliva)	6 (8)
Lucky/unlucky numbers	6 (8)
Forbidden, aggressive, or perverse sexual thoughts, images, or impulses	3 (4)
Fear might harm others/self	3 (4)
Concern with household items	2 (3)
Intrusive nonsense sounds, words, or music	1 (1)

*Obsessions or compulsions are totaled, so the total exceeds 70.

Clinical Presentation of OCD

Obsessions

40% - Contamination concerns

24% - Calamity

17% - Coordination *(symmetry/order)*

13% - Confession *(scrupulosity/religious)*

8% - Crap *(waste/secretions)*

8% - Counting *(numbers, evens/odds, unlucky)*

Others:

-perverse thoughts,images,impulses
-fear of causing harm
-intrusive sounds,words,music

Clinical Presentation of OCD

Compulsions

86% - Contamination *(hand-washing,showering,grooming)*

51% - Closing *(repeating actions, eg. doors/drawers)*

46% - Checking

26% - Curses *(miscellaneous rituals of writing, speech, movement)*

20% - Contact *(touching)*

16% - Clench *(prevent harm to self/others)*

17% - Coordination *(order/arranging)*

18% - Counting

11% - Collecting/hoarding

6% - Cleaning

Clinical Presentation of OCD

Other Symptoms

-tracing with eye movements

-walking carefully on tiles

-tantrums

-distress during activities

-“just so”

-hand-wiping, licking

-invisible string

-heritability

Table 2.—Comparison of Primary Symptoms in 14 Probands and Affected First-Degree Relatives

Proband		Relative		
Sex/Age at Onset, y	Primary Symptoms	Relationship	Age Onset, y	Primary Symptoms
M/11	Checking, rituals	Mother	12	Counting, rituals regarding eating and drinking
F/10	Rituals, checking, fear of illness	Father	8	Scrupulosity
M/13	Washing	Father	5	Hand washing (now mild)
M/12	Hand washing, perfectionism, checking	Father	17	Obsessive preoccupation with moral things, checking
F/11	Checking	Father	26	Compulsion to talk
M/12	Obsessive thoughts, checking	Father	6	Tapping, hoarding
M/7	Hand washing, showers, checking, blinking	Mother	7	Obsessive thoughts, preoccupation with numbers, perfectionistic, worry, over whether "done right," and repeats until "right"
		Father	8	Checking
		Sister	3	Hair pulling
F/9	Hand washing, showering	Father	5	Checking, counting
M/12	Obsessive thoughts, hand washing, and bathing	Father	Unknown	List making, organizing, checking, from early childhood
F/15	Checking rituals	Father	13	Checking
M/6	Obsessive thoughts, washing rituals	Father	7	Fear of contamination
		Sister	5	Repetition of words, demanding others say certain words
M/5-8	Washing, checking	Brother	10	Washing, fear of contamination
M/7	Obsessive fear of vomiting	Mother	7	Superstitions, jerky mannerism
F/12	Checking, washing, rituals, hoarding	Mother	8	Ordering compulsions, perfectionism
		Brother	16	Hand washing, showering
F/9	Repeating phrases, ritual crawling	Mother	8	Bureau drawer arranging
M/3	Touching	Father	14	Ritual dressing
M/5	Doorway rites, washing, dressing	Sister	10	Contamination fears, avoidance

Assessment of OCD

Rating Scales / Standardized Interviews

Diagnostic Interview for Children and Adolescents

Schedule for Affective Disorder and Schizophrenia for School-Age Children

Leyton Obsessional Inventory

Yale-Brown Obsessive Compulsive Scale (Y-BOCS)

TABLE 3

Yale-Brown Obsessive Compulsive Symptom Checklist

Obsessions

- Aggressive Obsessions
  - Fear might harm others
  - Fear might harm self
  - Violent or horrific images
  - Fear of blurting out obscenities or insults
  - Fear of doing something embarrassing
  - Fear will act on other impulses (eg, to rob bank, to steal groceries, to overeat)
  - Fear will be responsible for things going wrong (eg, others will lose their job)
  - Fear something terrible might happen (eg, fire, burglary)
  - Other
- Contamination Obsessions
  - Concerns or disgust with bodily waste or secretions (eg, urine, feces, saliva)
  - Concern with dirt or germs
  - Excessive concern with environmental contaminants (eg, asbestos, radiation, toxic wastes)
  - Excessive concern with household items (eg, cleansers, solvents, pets)
  - Concerned will get ill
  - Concerned will get others ill (Aggressive)
  - Other
- Sexual Obsessions
  - Forbidden or perverse sexual thoughts, images, or impulses
  - Content involves children
  - Content involves animals
  - Content involves incest
  - Content involves homosexuality
  - Sexual behavior toward others (Aggressive)
  - Other
- Hoarding/Collecting Obsessions
- Religious Obsessions
- Obsession with Need for Symmetry or Exactness
- Miscellaneous Obsessions
  - Need to know or remember
  - Fear of saying certain things
  - Fear of not saying things just right
  - Intrusive (neutral) images
  - Intrusive nonsense sounds, words, or music
  - Other

Compulsions

- Somatic Obsession/Compulsion
- Cleaning/Washing Compulsions
  - Excessive or ritualized handwashing
  - Excessive or ritualized showering, bathing, toothbrushing, or grooming
  - Involves cleaning of household items or other inanimate objects
  - Other measures to prevent contact with contaminants
- Counting Compulsions
- Checking Compulsions
  - Checking that did not/will not harm others
  - Checking that did not/will not harm self
  - Checking that nothing terrible did/will happen
  - Checking for contaminants
  - Other
- Repeating Rituals
- *Ordering/Arranging Compulsions*
- Miscellaneous Compulsions
  - Mental rituals (other than checking/counting)
  - Need to tell, ask, or confess
  - Need to touch
  - Measures to prevent: harm to self, harm to others, terrible consequences
  - Other

Differential Diagnosis of OCD

Obsessions?, or…

…depressive ruminations?
…flashbacks of PTSD?
…phobic avoidance or worry?
…overvalued ideas / psychotic preoccupations?
…anorexia nervosa?
…Asperger's perseverations?

Compulsions?, or…

…tics?
…stereotypies?
…pathological gambling?
…normal play or activity?
…religious ritual?

MentalHealthHumor.com By: Chato B. Stewart

Obsessive-Compulsive Disorder To Do List

Treatment of OCD: off label?

FDA Approval?

Clomipramine - OCD to age 10

Fluvoxamine - OCD to age 8

Sertraline - OCD to age 6

Paroxetine - OCD, social phobia

Fluoxetine - OCD to age 7, MDD to age 8

Citalopram - nope

Escitalopram - MDD > age 12

Venlafaxine - nope

Duloxetine - GAD > age 7

Treatment of OCD

Cognitive Behavioural Therapy

Psychoeducation about OCD important

Fear hierarchy *(look for core symptoms)*

Exposure and Response Prevention *(ERP)*

Observe family interaction pattern

Family Resistance Triad

1. High conflict
2. Low cohesion
3. High blame

Treatment of OCD

Time Course of SRIs

-25-33% reduction in symptoms over 10-13 weeks

-4-6 month duration of treatment

Treat comorbidities

eg. BDD, SPD, excoriation, anxiety, depression

-the goal is to REDUCE DISTRESS

-BE AWARE OF SUICIDALITY

-10-15% of patients experience activation (not mania!)

Treatment of OCD

Creative pharmacology

-Clomipramine vs. SSRIs

-desmethylclomipramine 96h half-life vs. 24 for clomipramine

-desmethylclomipramine more noradrenergic

-Fluvoxamine inhibits 2C19

-Lithium augmentation

-Antipsychotics

-second SSRI (stall at cross-taper)

-Buspirone

-stimulants for comorbid ADHD

Summary

1. What is OCD? - review of changes in DSM5

2. A brief history of OCD - overview and history of the diagnosis

3. OCD and development - onset, course, and psychology

4. Clinical Course and Natural History - onset, course, outcomes

5. Etiology - what we know about what causes OCD

6. Diagnostic Approaches - building up and breaking down the “spectrum”

7. Treatment Options - knowing what to treat, and how

Questions?