

OBSESSIVE COMPULSIVE DISORDER (OCD) – AWARENESS, UNDERSTANDING AND TREATMENT

Much of the focus of the OCD Inpatient Program is on the active learning and implementation of our specific OCD Models and the treatments that arise from them, namely Exposure and Response Prevention (ERP) and cognitive therapy for appraisals of intrusive thoughts and obsessions. The cognitive behavioural model of OCD seems simple and clear cut when reviewed theoretically and in isolation, but the practice of ERP and other Cognitive Behaviour Therapy (CBT) approaches remains difficult, requiring persistence, resilience and work over usually many months.

This is due to a range of non-specific factors relating to a person's understanding of their OCD, their determination and motivation to change, sometimes a gradual development of understanding and insight into the condition and the problems that it causes for them, as well as associated problems with depression and anxiety. These issues also affect the condition and the person's ability to understand treatment, commence treatment and maintain it.

To my mind, there are a number of phases or stages that people with OCD pass through (or sometimes don't) before they can successfully achieve significant reduction in their symptoms and maintenance of this over the long-term. Some of these ideas have been borrowed and adapted from the Stages of Change Model developed by Prochaska and Di Clemente, initially developed for people suffering from alcohol and drug difficulties. They talked about the phases of pre-contemplation, contemplation, preparation, action, maintenance and, in the end, long-term behavioural change. I want to use some of these ideas in discussing people's journey in addressing their OCD and gradually improving from it. I would note here that while this is presented as a series of phases or stages, there is clearly overlap between these phases, not always do we see a clear step from one to the next phase, and finally we sometimes see regression and return to other phases after a period of treatment or during a setback. Not all people will progress at the same rate, whilst it is unlikely that everyone in our OCD groups will be at the same stage at any one time.

PHASE 1 – IGNORANCE

Many people first present with symptoms of OCD in childhood and sometimes in primary school years. Occasionally, OCD presents in a severe and continual form from this time of life, but more commonly children describe sometimes brief episodes of OCD symptoms in the first 15 years or so of life. Common symptoms include fears of contamination with associated washing and cleaning compulsions, fears of violence and harm occurring to important people (usually family) with associated checking, repeating and sometimes praying compulsions, plus ordering and arranging compulsions, counting and other superstitious fears resulting in a wide variety of related compulsive behaviours. Usually OCD of significant severity becomes prominent, consistent and affecting functioning in the late teens, or sometimes early 20's.

In childhood and adolescence the symptoms are often concealed from parents and friends, and intervention is unlikely in this situation, occurring only when the symptoms become overt and clearly affect the child/adolescent's functioning. During this period it is common for the patient and/or the family to acknowledge the presence of the compulsive or ritualistic behaviours, but not understand that this is a symptom of OCD or that a specific treatment is available for this problem. Ignorance of the diagnosis of OCD can continue over many years, although the

diagnosis is usually made in the 20's or 30's at the latest. Nevertheless, I have seen a patient in his early 70's who had experienced OCD symptoms for almost 50 years and been treated for "depression" without the diagnosis of OCD being made.

PHASE 2 – AWARENESS

As stated, there is often a lengthy delay in the recognition of OCD and this clearly delays the treatment of the problem as well. Awareness of the diagnosis can arise from a variety of different sources. Sometimes it is relatives who are aware of other family members with OCD who put two and two together and make the diagnosis, on other occasions information obtained via the media can provide the breakthrough and on some other occasions a diagnosis by health professionals including general practitioners and sometimes psychiatrists is needed. In each of these situations there remains the potential for lengthy delays in diagnosis and this is one of the reasons that a number of self-help groups and support groups have been developed and flourished over recent years. Examples include the Obsessive Compulsive and Anxiety Disorders Foundation, otherwise known as Anxiety Recovery Centre Victoria (ARC VIC) and the Anxiety Disorders Association of Victoria (ADAVIC).

There remain issues with all of these sources of information.. With regard to diagnoses made by relatives, it is recognised that OCD does run in families and that children of OCD patients have a higher risk of developing the condition themselves (6% compared to 2% community average). In this situation, it is common for my OCD patients to be concerned about their children developing OCD and this usually leads to OCD in children of OCD patients being picked up quite early with the commencement of treatment also starting at an early date. This is likely to be beneficial with research in a number of conditions including depression and schizophrenia suggesting that delayed treatment leads to slower response to treatment, incomplete response to treatment and ongoing functional impairment. On the other hand, diagnosis via media productions are entirely dependent on who watches these shows or reads the newspaper or magazine articles. Recent examples including "The House of Obsessive Compulsives" TV production from the UK and news media articles about the tennis/golf player Scott Draper's diagnosis with OCD do raise the awareness of OCD and probably lead to increased diagnoses and eventually treatment. Finally, general practitioners' knowledge of OCD as a whole remains limited with only a proportion of general practitioners well versed in mental health issues and the diagnosis of anxiety and OCD conditions.

PHASE 3 – MOTIVATION TO CHANGE

Motivation remains a major issue in the failure of treatment for some patients. Certainly a number of patients with mild to moderate OCD have low motivation to make changes, tolerating minor and sometimes major levels of incapacity and functional impairment without any wish to change or seek treatment. Many issues affect patients' motivation to receive treatment. In many cases there may be a refusal to acknowledge the presence of OCD, fear of the stigma associated with psychiatric treatment or labelling with a psychiatric condition, secondary gain issues, a lack of priority assigned to treatment for OCD, a fear that treatment for OCD involves only medications and "control" by a psychiatrist, as well as other concerns. In some cases patients do not acknowledge their OCD as problematic, eg hoarding in particular and have little real wish to change. Such situations often lead to significant conflict between the patient and family members and this stage needs to be handled sensitively in many circumstances. In my opinion, much of the avoidance of treatment at this point relates to a lack of knowledge of OCD as well as a wide variety of inaccurate beliefs and myths about the condition, its treatment and often psychiatry in general. Explanation of the condition and its treatment is an appropriate first step in this context.

PHASE 4 – KNOWLEDGE AND UNDERSTANDING OF OCD

Perhaps the most important step in the management of OCD. This relates to its central role in improving motivation and interest in getting better, as well as providing the knowledge and cognitive behavioural models to explain how OCD works and how treatment will help. In my practice this step can take many forms including detailed discussion of the form, nature, course and models of OCD, use of the whiteboard to draw up these models, provision of written information and providing details of OCD self-help books and the support organisations. This process commences from the very first contact with the patient, whether this be over the telephone or during the first consultations and continues throughout the remainder of treatment. In many cases information such as the OCD Model needs to be provided repetitively and specific aspects stressed depending on the patient's situation or progress. I will not describe the OCD Model in this setting, this will be discussed in another context and with a separate handout. Other topics of information should include the age of onset, common presenting symptoms, the importance of avoidance, neutralising and reassurance seeking, the treatment options including medications and CBT, the likely outcomes and the probability of significant functional improvement with successful treatment. An optimistic note is conveyed at all times, given the positive research findings on the likelihood of improvement for OCD with both medications, CBT and a combination of the two. Discussion of comorbidities including depression, panic, Generalised Anxiety Disorder (GAD), social phobia and other OCD spectrum disorders including Tourette's, trichotillomania, etc, can also be added at this point.

PHASE 5 – ACCEPTANCE OF THE MODEL

Understanding the current CBT models and accepting this process is essential to successful treatment with both ERP and cognitive therapy for OCD appraisals. For this reason much time and energy is spent describing the model and reviewing and revising it both as outpatients and during the Inpatient OCD Program. For many, there remain a number of potential difficulties in understanding the way we see OCD and the current model. For example, many patients have difficulty separating the obsessions from the compulsions, particularly if their compulsive actions are subtle, performed mentally or are difficult to describe. Secondly, it remains difficult for many people to come to terms with and accept the fact that the obsessions or intrusive thoughts cannot be completely abolished or removed. Many patients start treatment with a strong belief that "if you could just get rid of these thoughts I'd be fine". Obviously the OCD Model stresses the importance of acceptance that intrusive thoughts are ubiquitous and occur in all people and that at least part of the difficulty for people with OCD is their tendency to assign excessive meaning to these thoughts (their appraisals). Thirdly, there remains a reluctance for many patients to accept that tolerating anxiety is important in recovering from OCD, particularly when performing ERP. Fourthly, a number of people have difficulty accepting the general requirement that all compulsions be removed. A good example of this are patients who wish to be able to check doors, gas and electricity once before they leave or go to bed "just to be safe", or those who wash hands excessively for similar reasons. Another good example in this area are those who choose to squat and not sit on toilet seats in public because "my mother told me not to". Similarly, the need to remove reassurance seeking and more sneaky or covert rituals and neutralisation is also important and these need to be presented as the equivalent of compulsions, serving the same purpose and in that context reinforcing the person's fears about their intrusions.

There are also a wide variety of other issues that are relevant in helping people to accept the model and the basic principles and requirements of ERP. This process too can take significant time and from a psychiatrist's or psychologist's perspective this is time well spent gaining rapport and alliance with the patient and perhaps discussing similar issues with the patient's relatives as well.

PHASE 6 – EXPOSURE AND RESPONSE PREVENTION (ERP)

By now the patient has accepted the CBT Model and the need for exposure, fewer compulsions and acceptance of anxiety in these situations. The issues raised above need to be continually stressed throughout the ERP process, while the two basic components of ERP need to be continually restated. This relates to the importance of both exposure AND response prevention, knowing that avoidance of the intrusive thoughts will maintain the person's fear of them, whilst the performance of compulsions, by providing immediate relief from anxiety, encourages the continued performance of compulsions whilst also keeping the person unaware that the non-performance of compulsions leads to a natural reduction and decay of anxiety and no catastrophic outcomes.

Exposure needs to be based on simple principles with the tasks relevant, graded, repeated and specific. In some circumstances a hierarchy of gradually increasing tasks can be developed, although this is not always possible, in which case tasks need to be assigned on a very regular basis with the recognition that they should get gradually more difficult as treatment continues. A general principle is that the patient should be approximately 80% confident that they can perform the task, noting that this represents the likelihood of capacity to perform this task whilst acknowledging a degree of uncertainty and challenge as well.

PHASE 7 – END POINT OF ACTIVE TREATMENT

Exposure and Response Prevention (ERP) is a process that can take one to three months to complete on rare occasions and equally can sometimes continue over some years. An average ERP treatment program lasts between six to nine months. The decision as to when to cease active treatment is a difficult one and is almost always decided by the patient's assessment. Patients often work hard for a period of time, but then become somewhat exhausted with the demands of ERP and may cease active treatment whilst remaining significantly symptomatic. This remains a difficulty and suggests that it is important to "strike while the iron is hot" at the start of treatment and in the first six to 12 months. Premature cessation of treatment can relate to slow progress, development of depression and other anxiety problems, a lack of understanding or acceptance of the model and the need for ERP and sometimes occurs in more severe cases of OCD.

On the other hand, there are occasional patients who insist upon continuing treatment until they are absolutely free of all OCD symptoms. This may relate to a degree of perfectionism and is also not entirely helpful, although clearly in this context the person may be substantially free of their OCD symptoms. The bottom line is that OCD broadly consists of intrusive thoughts, anxiety, compulsions and avoidance behaviours. Of these, the latter two, namely compulsions and avoidance can be eliminated completely, whilst the first two phenomena can be reduced to a minor level, but probably cannot be completely eliminated. The choice of when to cease active treatment should be a collaborative one involving the patient, the therapist and perhaps any important and significant others as well.

PHASE 8 – MAINTENANCE

At this point, the patient enters a maintenance phase. This issue will be discussed in fuller detail in a later article, although it needs to be stated here that there will become a point where the patient will not need to attend the therapist on an extremely regular basis and will gradually take over responsibility for being "their own therapist". At this point, they need to act as a "OCD detective" carefully examining their behaviours on a regular basis for the presence of any

returning OCD symptoms. One way to achieve this is to set aside a review time on a regular basis whether this be weekly, fortnightly or monthly where the patient reviews their past symptoms, analyses whether any have returned, develops methods involving ERP and cognitive therapy to reduce these symptoms and sets about doing this.

There are a variety of issues that need to be reviewed in the maintenance or relapse prevention stage – some of these include the need to recognise the likelihood of occasional slips or lapses, the need to prepare for stressful situations and the occasional return of symptoms, issues related to medication and the possible reduction of OCD medications in the context of its successful treatment, the need to develop alternative activities and exercises to fill in the time previously occupied by OCD compulsions, etc. Most of all, patients need to be encouraged to give themselves credit and “pat themselves on the back” for the hard work they have put in to that point. Assistance from relatives in this context is also very helpful.