Examining co-occurring OCD and depression: Research and clinical strategies

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Wednesday, August 11, 2021

ROGERS Behavioral Health

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Disclosures

Martin E. Franklin, PhD, and **Rachel C. Leonard, PhD,** have each declared that they do not, nor does their family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation. Drs. Franklin and Leonard each declared that they do not have any relevant non-financial relationships. Additionally, all planners involved do not have any financial relationships.

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Learning objectives

Upon completion of the instructional program, participants should be able to:

1. List at least two indicators that more targeted depression treatment may be needed in the context of OCD treatment.
2. Identify at least one suicide risk assessment tool.
3. Identify at least two strategies for differentiating OCD intrusive thoughts from ego-syntonic suicidal ideation/NSSI urges.

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What we'll cover in this webinar

An overview of co-occurring OCD and major depressive disorder

- Review of the co-occurrence of OCD and MDD
- Frequency and treatment considerations

Assessing risk of suicide and non-suicidal self-injury

- Suicide risk and OCD
- NSSI and OCD
- Risk assessment

Intrusive thought or not? Differentiating OCD from non-OCD suicidal ideation

- Distinguishing ego-syntonic suicidal ideation and NSSI urges from OCD intrusive thoughts
- Case example

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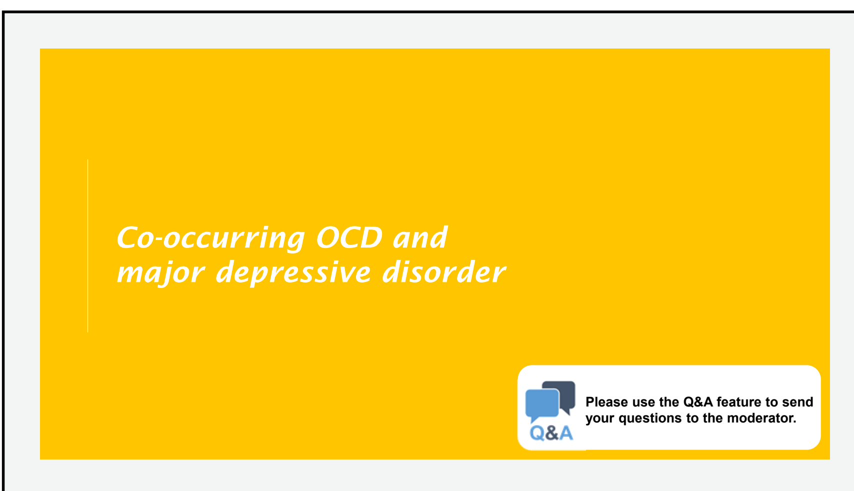

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OCD: Diagnostic criteria (APA, 2013)

Obsessions:

- Recurrent thoughts, urges, or images that are experienced at some point as being intrusive and unwanted, and that cause significant anxiety or distress in most individuals.
- Individuals attempt to ignore or suppress these thoughts, urges, or images, or to neutralize them by engaging in a compulsion/ritual.

Compulsions:

- Repetitive behaviors or mental acts that are performed in response to an obsession or according to rigidly applied rules.
- Completed in order to reduce anxiety or prevent feared event.
- Clearly excessive or not logically connected to feared event.

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Common OCD symptom dimensions

Obsessions	Compulsions
Contamination	Cleaning/washing
Responsibility for causing harm/mistakes	Checking
Symmetry and order	Ordering and arranging
Unacceptable thoughts (i.e., aggressive, sexual, religious content)	Mental rituals, neutralizing

(Abramowitz et al.; 2010)

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Major Depressive Disorder (APA, 2013)

5 or more symptoms during 2-week period that demonstrate a change from previous functioning and lead to clinically significant impairment or distress.

Must include either:

- Depressed mood, most of the day nearly every day, or
- Loss of interest/pleasure in most activities

Additional symptoms:

- Sig. change in weight/appetite
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive inappropriate guilt
- Difficulty concentrating or making decisions
- Recurrent thoughts of death or suicide

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OCD and African Americans

NSAL (Himle et al., 2008) suggests comparable base rates across racial and ethnic groups, yet:

- Only 2.8% of DSM-IV Field Trial (Foa et al., 1995)
- Only 2% of North American RCTs run out of urban medical centers (Williams et al., 2010)
- Only 0.9% in private residential treatment setting (Williams et al., 2015)

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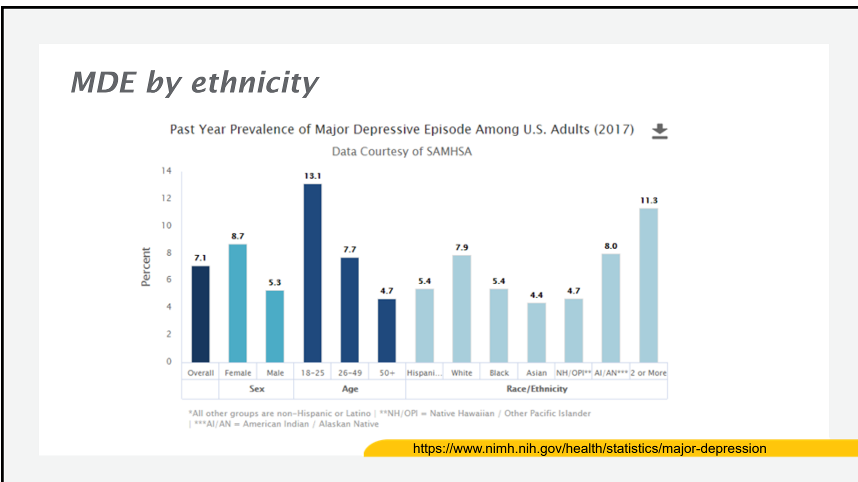
MDE by ethnicity



https://www.nimh.nih.gov/health/statistics/major-depression

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Disparities

- African Americans and Caribbean blacks much less likely to receive treatment for MDD and more likely to rate their MDD as severe/very severe compared to whites (Williams et al., 2007).
- Prevalence disparities complex and involving many factors (Bailey, Mokonogho, & Kumar, 2019)
  - Discrimination (-)
  - Higher SES/job security (+)
  - Marital status (Married +)
  - Strong sense of ethnic identity (+)

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OCD and depression

- Avoidance of many different types of activities
- Often involves problematic mental processes
- World shrinks over time

Goal for both: Gradually reduce avoidance and engage in avoided activities.

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Research on OCD and depression

Lifetime occurrence

- Approximately **63%** of individuals with OCD have met criteria for a **depressive or bipolar disorder** during their lifetime (APA, 2013).
- **Major Depressive Disorder** is the most commonly co-occurring mood disorder, with **41%** of individuals with OCD meeting criteria during their lifetime (APA, 2013).

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Which comes first?

OCD → MDD

- ***OCD tends to precede MDD*** (Bellodi, Sciuto, Diaferia, Ronshi, & Smeraldi, 1992; Demal, Lenz, Mayrhofer, Zapotoczky, & Zitterl, 1993; Diniz et al., 2004).
- MDD in response to distress and impairment associated with OCD?
  - Shrinking of world through avoidance of OCD triggers
  - Lack of engagement in rewarding activities
  - May relate to distress over OCD symptoms leading to sadness (McNally, Mair, Mugno, & Riemann, 2017)

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When to treat the depression?

Targeted depression treatment **may not be necessary.**

- Often, as OCD symptoms improve, depression symptoms improve as well as a result.

When should targeted depression treatment be implemented?

- *If the depression is interfering with engagement and compliance with OCD treatment.*
- *If OCD symptoms significantly improve but depressive symptoms do not.*
- *If depression is related to significant suicidal ideation.*

Add depression treatment (BA)

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Assessing risk of suicide and non-suicidal self-injury

Please use the Q&A feature to send your questions to the moderator.

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Suicide risk and OCD: Risk factors

- Greater likelihood of having lifetime suicidal ideation for those with OCD compared to the general population.
- Greater risk of suicide associated with:
- Severity of OCD symptoms
  - Experiencing symptoms in the unacceptable thoughts dimension
  - Comorbidity with other mental disorders – esp. PTSD, depression, substance use disorders, and impulse control disorders
  - Severity of any co-occurring depression and/or anxiety symptoms
  - Past history of suicidality
  - Hopelessness and alexithymia

Albert, De Ronchi, Maina, & Pompili, 2019; Torres, Ramos-Cerqueira, Ferrão, Fontenelle, do Rosário, & Miguel, 2011.

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Suicide risk and OCD: Plan

- Careful assessment of suicide at admission is always recommended, with safety planning following this as needed.
- Treatment of depression may reduce suicide risk in individuals with OCD.
- May be particularly helpful to focus on ERP related to symptoms in the unacceptable thoughts dimension.
  - This may be complicated by the presence of both unwanted, intrusive thoughts about suicide and ego-syntonic/not intrusive thoughts about suicide related to hopelessness, depression, and distress.

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SAMHSA SAFE-T risk assessment with C-SSRS

***SAFE-T = Suicide Assessment Five-step Evaluation and Triage**

1. Identify risk factors (modifiable/non-modifiable)
2. Identify protective factors (& strength)
3. Assess suicidal thoughts, plans, behavior, and intent

   Can use the Columbia – Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011).
4. Determine level of risk and intervention needed
5. Document risk determination, rationale, intervention, and follow-up instructions.

* Available at https://cssrs.columbia.edu/documents/safe-t-c-ssrs/

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Assessment challenges due to OCD

- Difficulty answering suicide risk questions due to doubt
  - More likely to impact reporting of intent
  - Suicidal behavior versus testing to reassure themselves that they do not want to harm themselves?
    - Harm done?
    - Preparatory behaviors?
- May be easier to determine risk and protective factors, history of attempts

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SAFE-T risk levels

High
- Suicidal ideation with intent, or with plan and intent in the past month – OR –
- Suicidal behavior in the past 3 months

Moderate
- Suicidal ideation with method but without plan, intent, or behavior in the past month – OR –
- Suicidal behavior more than 3 months ago
- Multiple risk factors with few protective factors

Low
- Wish to die or suicidal ideation without method, intent, plan, or behavior – OR –
- Modifiable risk factors with strong protective factors – OR –
- No reported history of suicidal ideation or behavior

https://cssrs.columbia.edu/documents/safe-t-c-ssrs/

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Means restriction

- Acute period of risk fairly brief (Hawton, 2007)
  - A study of 82 survivors of suicide attempts found that almost half reported their first current thought of suicide occurred within **10 minutes or less** of their attempt (Diesenhammer et al., 2009).
- Means restriction during times of acute crisis can save lives.

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Safety planning

Patient	Support Individuals	Contact Information
Warning signs that they are starting to feel more distressed.	Warning signs that indicate to them that the patient is feeling distressed.	Friends/family to call for support when struggling.
Unsafe behaviors that follow these warning signs (e.g., suicidal thinking, NSSI).	Helpful things they can do to assist the patient in reducing distress.	Treatment providers.
Helpful things they can do to reduce their distress.		Psychiatric emergency center.
Serious Trouble: Warning signs the patient or other may notice that indicate the patient is in serious trouble/high risk.		Crisis lines/support services.

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Obsessions about suicide if:

- Thoughts are experienced as intrusive
- Primary affect is anxiety
- Behaviors are intentional efforts to neutralize or reduce thoughts and the associated anxiety
- Individual does not report an intent to die
- “What if?” language is used

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Suicidal ideation if:

- Intention to die is prominent
- Direct efforts to intentionally end one's own life
- Function is to escape negative affect; negative urgency
- Perceived burdensomeness
- Thwarted belonging
- Precautions taken against being discovered

Anestis & Joiner (2011); Wenzel et al., (2011)

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Non-suicidal self-injury if:

- Direct, deliberate destruction of one's own body tissue ***in the absence of intent to die***
- Intent to reduce negative affect
- Preceded by acute negative affect
- Decreased negative affect & relief thereafter
- Pain analgesia
- Self-punishment function

Klonsky (2007); Nock, Joiner, Grodon, Lloyd-Richardson, & Prinstein (2006)

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Intrusive thought or not? Differentiating OCD from non-OCD suicidal ideation

Please use the Q&A feature to send your questions to the moderator.

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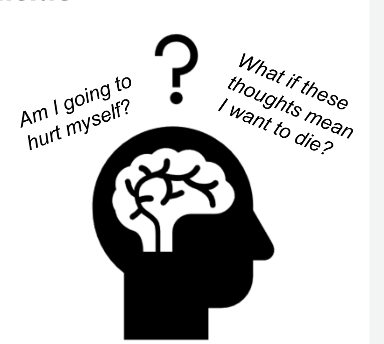
Intrusive thoughts about suicide

- Experienced as unwanted and intrusive.
- Increased anxiety, fear, doubt and uncertainty.



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Intrusive thoughts about suicide

Associated with **avoidance**, **safety behaviors**, and **rituals** to decrease anxiety / doubt / uncertainty in response to these thoughts and / or reduce the chances of their feared outcomes.

- Avoidance of items that could be used to harm themselves
- Refusal to be alone
- Seeking reassurance that they will not act on these thoughts
- Mentally reviewing past behavior to provide self-assurance that they will not act
- Mental neutralization

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Intrusive thoughts about suicide

INTERVENTION = ERP

- **Exposure to thoughts about suicide**
  - Decrease avoidance and safety behaviors
  - Purposefully face triggers that may lead to thoughts
- **Response prevention**
  - Allow anxiety, doubt, uncertainty without doing anything to decrease it

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Ego syntonic suicidal ideation

Mood congruent

- Often think about benefits to suicide. May ***want*** to act on the thoughts.
- May include associated **suicidal behaviors.**
  - Obtaining items needed for suicide plan
  - Giving away items
  - Preparing goodbye notes
  - Preparing a will
- May have **history of suicidal behavior or self-harm**.

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Ego syntonic suicidal ideation

INTERVENTION = Risk Mitigation & Distress Tolerance

Plus longer term treatments for depression or other symptoms contributing to suicidal ideation

- Consider **inpatient hospitalization** as needed
- **Means restriction** with family members involved
- Use of **distress tolerance skills** to reduce distress (e.g., DBT skills)
- Reminders of **reasons for living**
- **Following safety plan and updating it as needed**

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What about patients who experience both?

OCD may be so severe that it leads to hopelessness and suicidal thoughts.

- Start with detailed suicide risk assessment with safety planning and use this to inform approach.
- Are they high risk with current /recent intent?

Yes

Do not proceed with exposures related to suicide / self-harm that involve risk. Periodically re-assess.

No

Proceed with caution with ERP.
Get safety ratings beforehand.

- Consider when/where they will be doing exposures.
- Hierarchy may work to advantage (more risk later).

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What about patients who experience both?

- Prioritize treatment strategies to reduce ego-syntonic suicidal ideation.
  - Depression treatment
  - DBT skills
  - Problem solving specific stressors that impact SI (e.g., relationship difficulties, sleep difficulties, etc.)
- Consider overall makeup of OCD symptoms and which are contributing most to distress and impairment.

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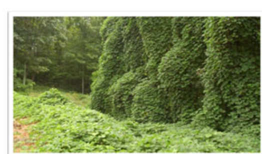
Which do you target first?

Anxiety / Depression comorbidity

- Severity and associated impairment
- History of onset
- Patient preference
- Two birds with one stone?
- Can I swing the axe?



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OCD and MDD: General treatment considerations

A combination that works well:

- Exposure plus Response Prevention (OCD)
- Behavioral Activation (MDD)

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Psychological Bulletin
1986, Vol. 99, No. 1, 20–35

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0033-2909/86/$00.75

Emotional Processing of Fear: Exposure to Corrective Information

Edna B. Foa and Michael J. Kozak
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In this article we propose mechanisms that govern the processing of emotional information, particularly those involved in fear reduction. Emotions are viewed as represented by information structures in memory, and anxiety is thought to occur when an information structure that serves as program to escape or avoid danger is activated. Emotional processing is defined as the modification of memory structures that underlie emotions. It is argued that some form of exposure to feared situations is common to many psychotherapies for anxiety, and that confrontation with feared objects or situations is an effective treatment. Physiological activation and habituation within and across exposure sessions are cited as indicators of emotional processing, and variables that influence activation and habituation of fear responses are examined. These variables and the indicators are analyzed to yield an account of what information must be integrated for emotional processing of a fear structure. The elements of such a structure are viewed as cognitive representations of the stimulus characteristic of the fear situation, the individual's responses in it, and aspects of its meaning for the individual. Treatment failures are interpreted with respect to the interference of cognitive defenses, autonomic arousal, mood state, and erroneous ideation with reformation of targeted fear structures. Applications of the concepts advanced here to therapeutic practice and to the broader study of psychopathology are discussed.

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Journal of Consulting and Clinical Psychology
2006, Vol. 74, No. 4, 658–670

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0022-006X/06/$12.00 DOI: 10.1037/0022-006X.74.4.658

Randomized Trial of Behavioral Activation, Cognitive Therapy, and Antidepressant Medication in the Acute Treatment of Adults With Major Depression

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Antidepressant medication is considered the current standard for severe depression, and cognitive therapy is the most widely investigated psychosocial treatment for depression. However, not all patients want to take medication, and cognitive therapy has not demonstrated consistent efficacy across trials. Moreover, dismantling designs have suggested that behavioral components may account for the efficacy of cognitive therapy. The present study tested the efficacy of behavioral activation by comparing it with cognitive

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CBT theory: A succinct explanation

"Blah, blah, blah…do the thing you're afraid of…
Blah, blah, blah…the more you do it, the easier it gets."

~ Gwen Franklin, age 6, to her father

Modified for depression / BA:

"Blah, blah, blah…do the thing you're unmotivated or uninterested in doing…
Blah, blah, blah…the more you do it, the easier it gets."

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Case example

27-year-old female with OCD characterized by intrusive thoughts about harming herself with corresponding avoidance of being alone or using sharp objects as well as frequent reassurance seeking and mental rituals (e.g., reviewing reasons for living).

Her OCD symptoms have become increasingly impairing and she secondarily experienced depressive symptoms due to this impairment and distress.

Recently, she has been reporting increased hopelessness and some suicidal ideation. She stated, "Maybe it would be easier to just kill myself rather than continue to live with this."

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About the presenters….

Martin E. Franklin, PhD

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Dr. Franklin is an internationally renowned expert on OCD, OC-spectrum disorders, and body-focused repetitive behaviors, as well as the study and treatment of anxiety and related conditions. In addition to serving as the clinical director of Rogers' Philadelphia location, Dr. Franklin is an associate professor emeritus of clinical psychology in psychiatry at the University of Pennsylvania Perelman School of Medicine.

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Dr. Leonard is a licensed clinical psychologist who oversees clinical programming provided throughout Rogers' Regional Division. She specializes in utilizing behavioral activation and other cognitive behavioral-based interventions for individuals with mood, anxiety, and obsessive-compulsive spectrum disorders.

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