Symptom patterns and the course of OCD

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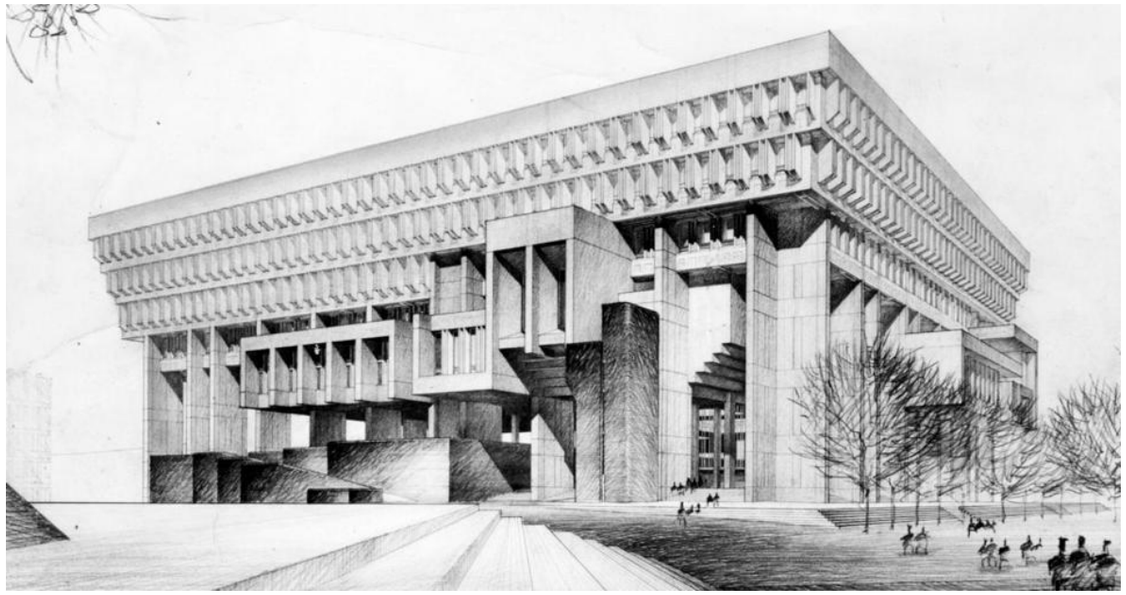
Outline

- Design of the study
- Initial results
- Tackle some issues
- More results
- Conclusion and discussion



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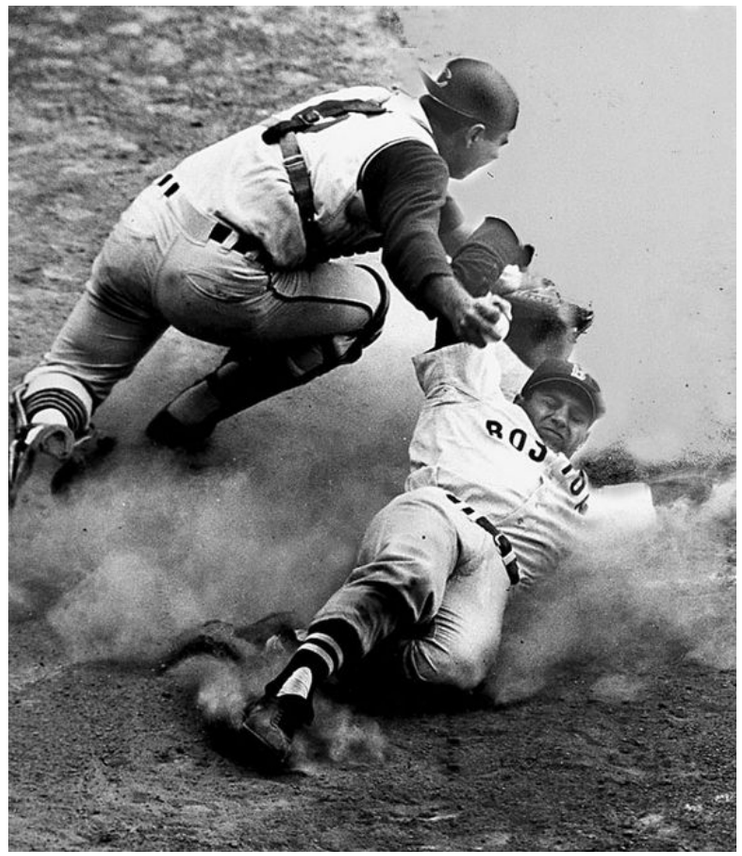

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Design of study

- 449 adults (51% female)
- Exposure and Response Prevention (ERP) at the OCD Center at Rogers Memorial Hospital (Oconomowoc)
- Upon **admission** to ERP and **discharge**:
  - Y-BOCS (Yale-Brown Obsessive and Compulsive Scale)
  - QIDS (Quick Inventory of Depressive Symptomatology)

Design of study

- 449 patients with OCD at baseline

  Two groups: persisters (n = 248) and remitters OCD (n = 201)

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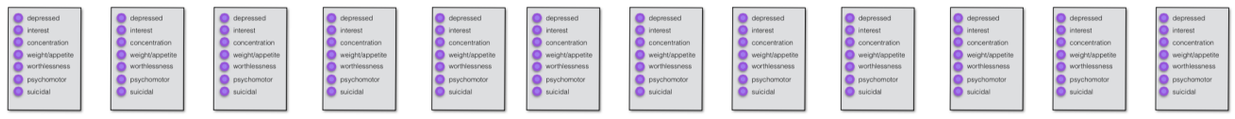

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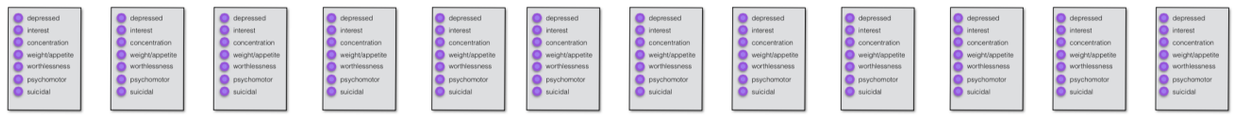
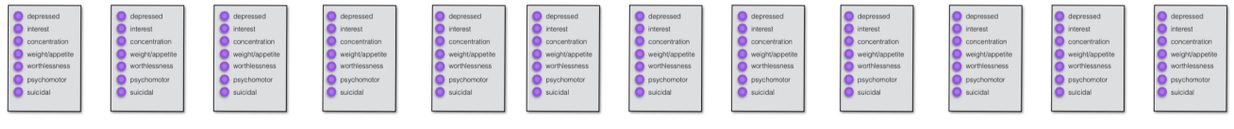


Discharge



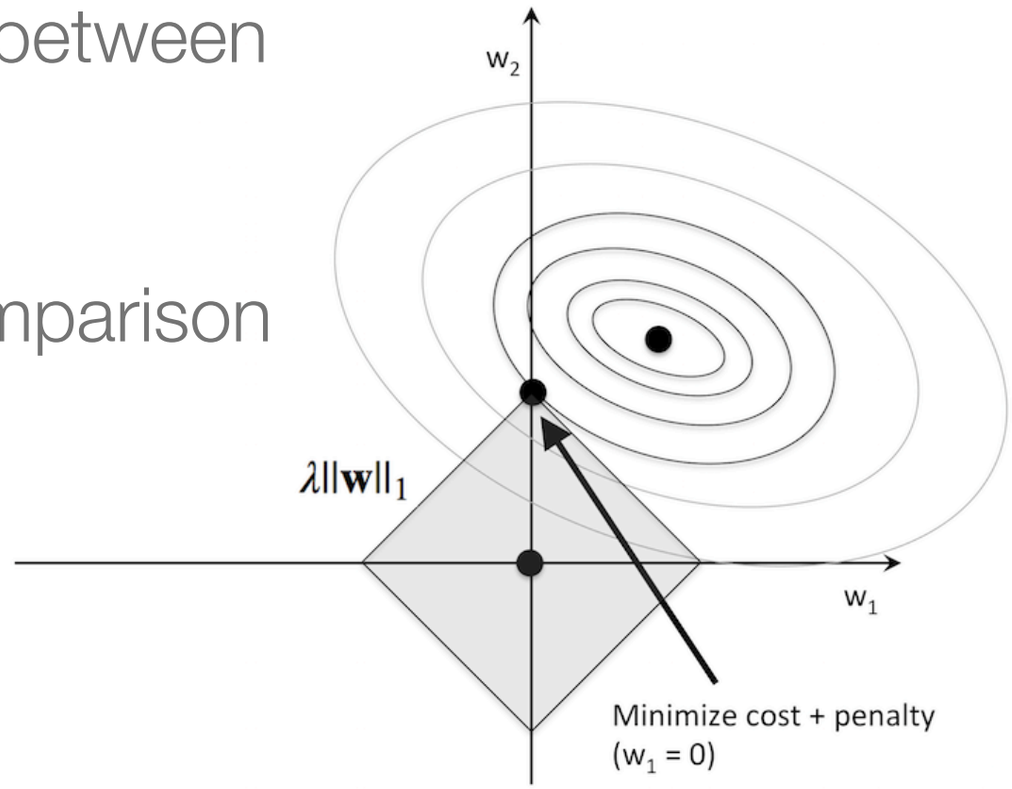
Design of study

- **Networks of 10 OCD symptoms:** from Y-BOCS at baseline

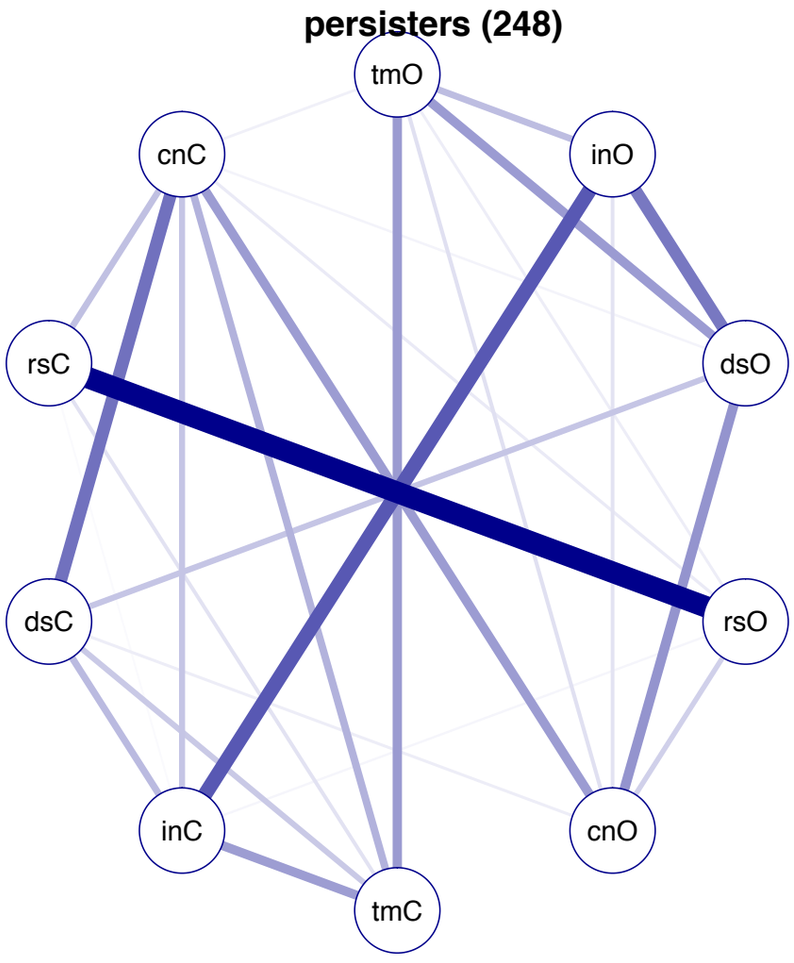
- **Advanced network estimation:** regularized partial correlations (EBICglasso; Epskamp et al. 2016)

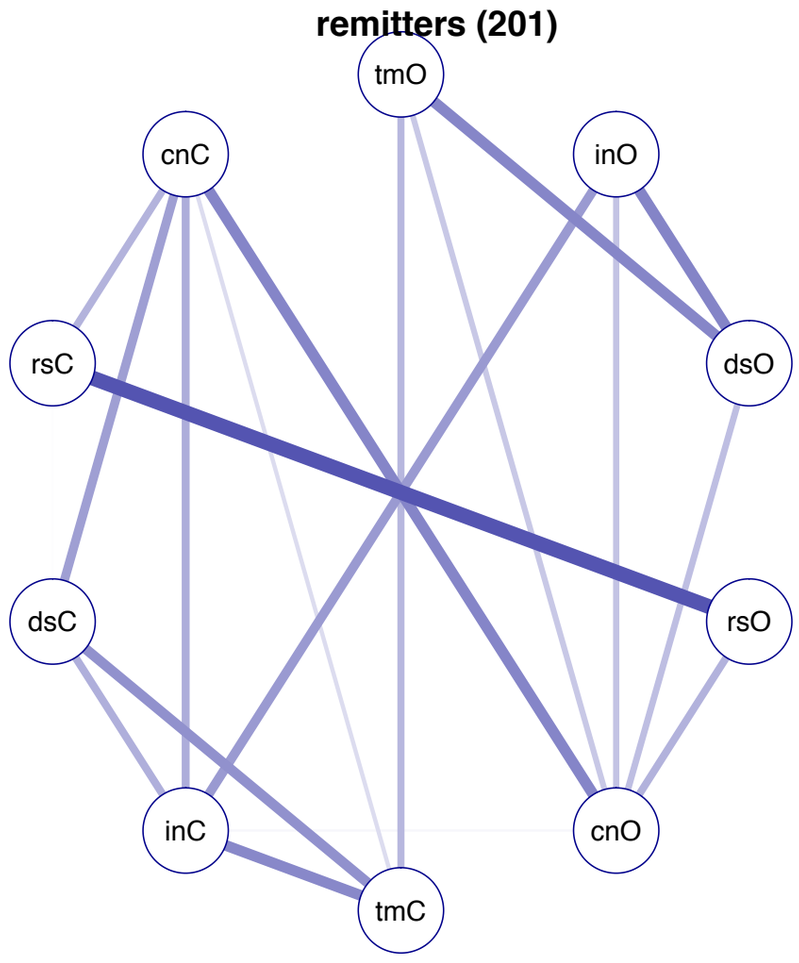
- **Regularization:** to find optimal balance between parsimony and goodness of fit

- **Comparison of networks:** Network Comparison Test (NCT; van Borkulo et al. 2016)



Networks of persisters and remitters





tmO: Time occupied by obsessive thoughts
inO: Interference due to obsessive thoughts
dsO: Distress associated with obsessive thoughts
rsO: Resistance against obsessions
cnO: Degree of control over obsessive thoughts
tmC: Time spent performing compulsive behaviors
inC: Interference due to compulsive behaviors
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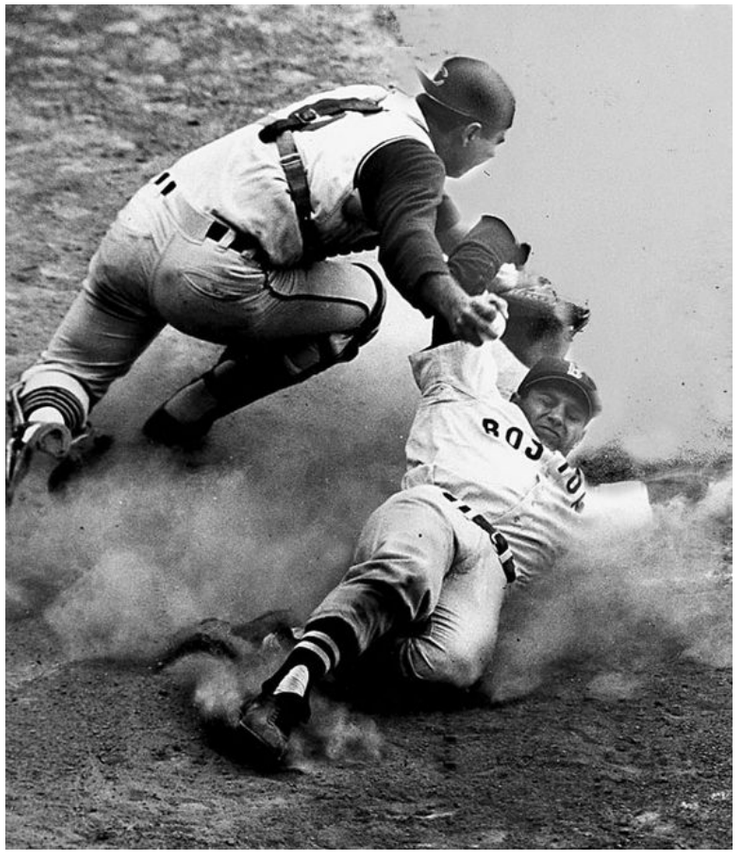
- **Code in R:** NCT(data1, data2, gamma = .5, it = 1000)
- **Persisters have a higher global strength** (p = .011)

But…



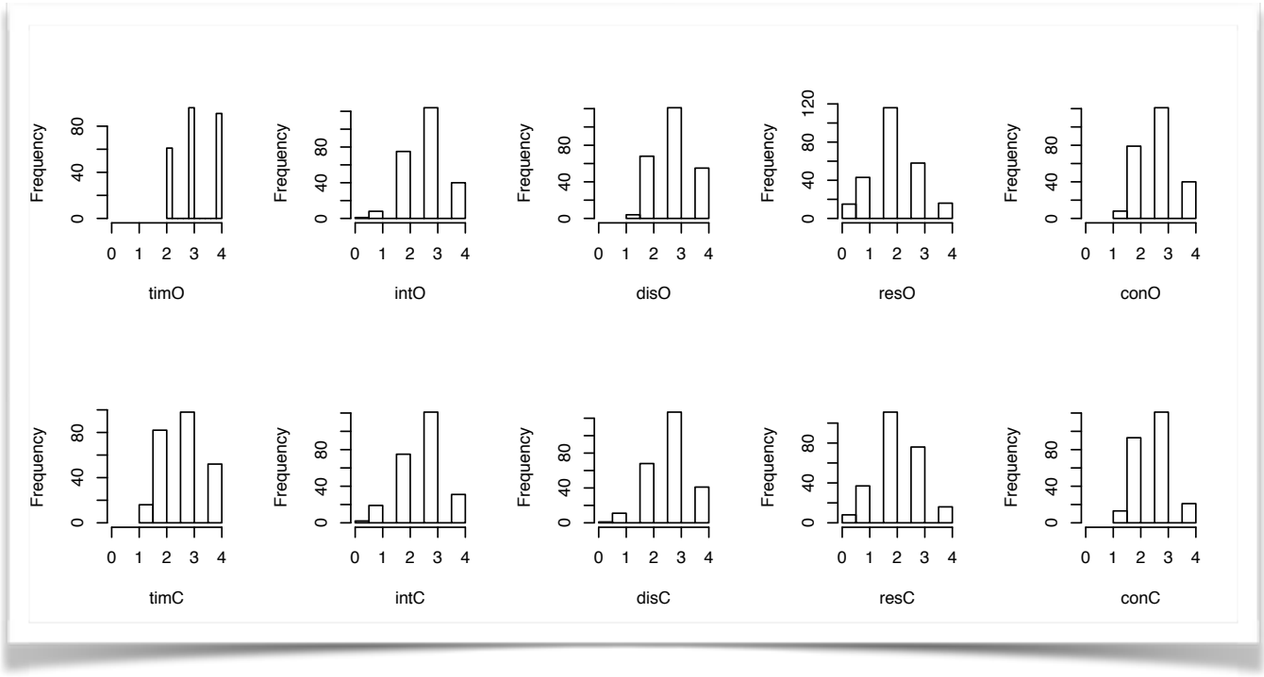
…persister have higher means on almost all symptoms

Confounds

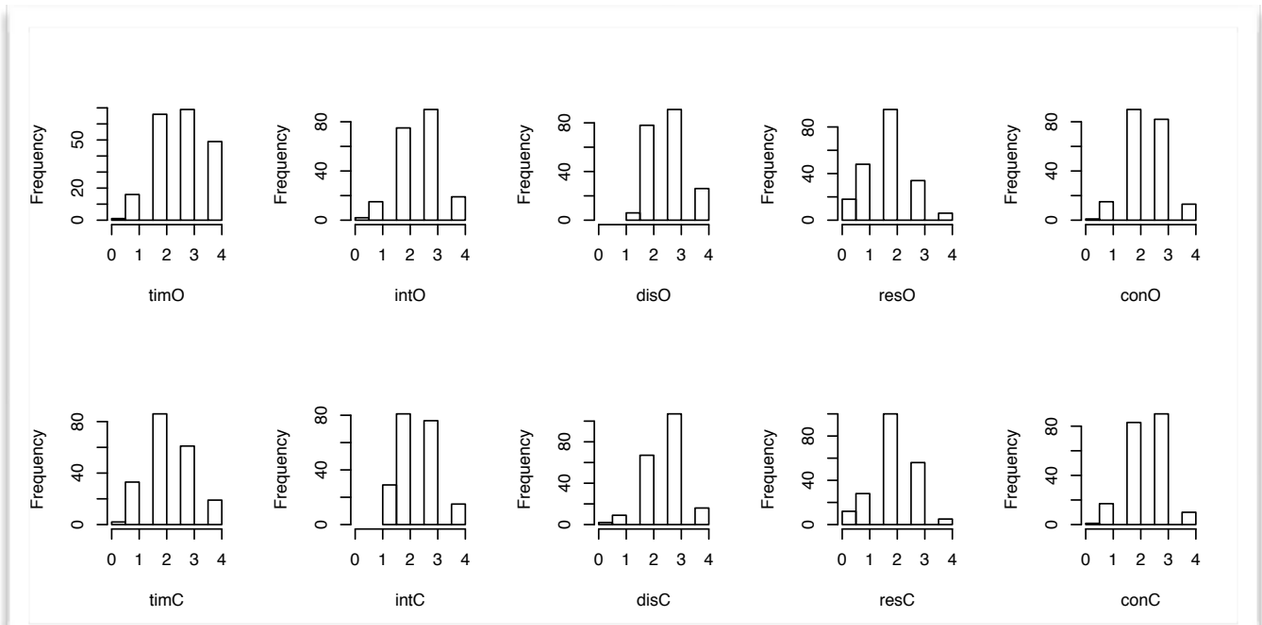
- Severity?
- No. Not by itself (networks are about covariances)
- Possible confounds:
    - floor/ceiling effects (influences (co)variance)
    - An unmodelled latent variable that is related to OCD differently in more severe patients than in less severe patients

Floor/ceiling effects

Persisters



Remitters

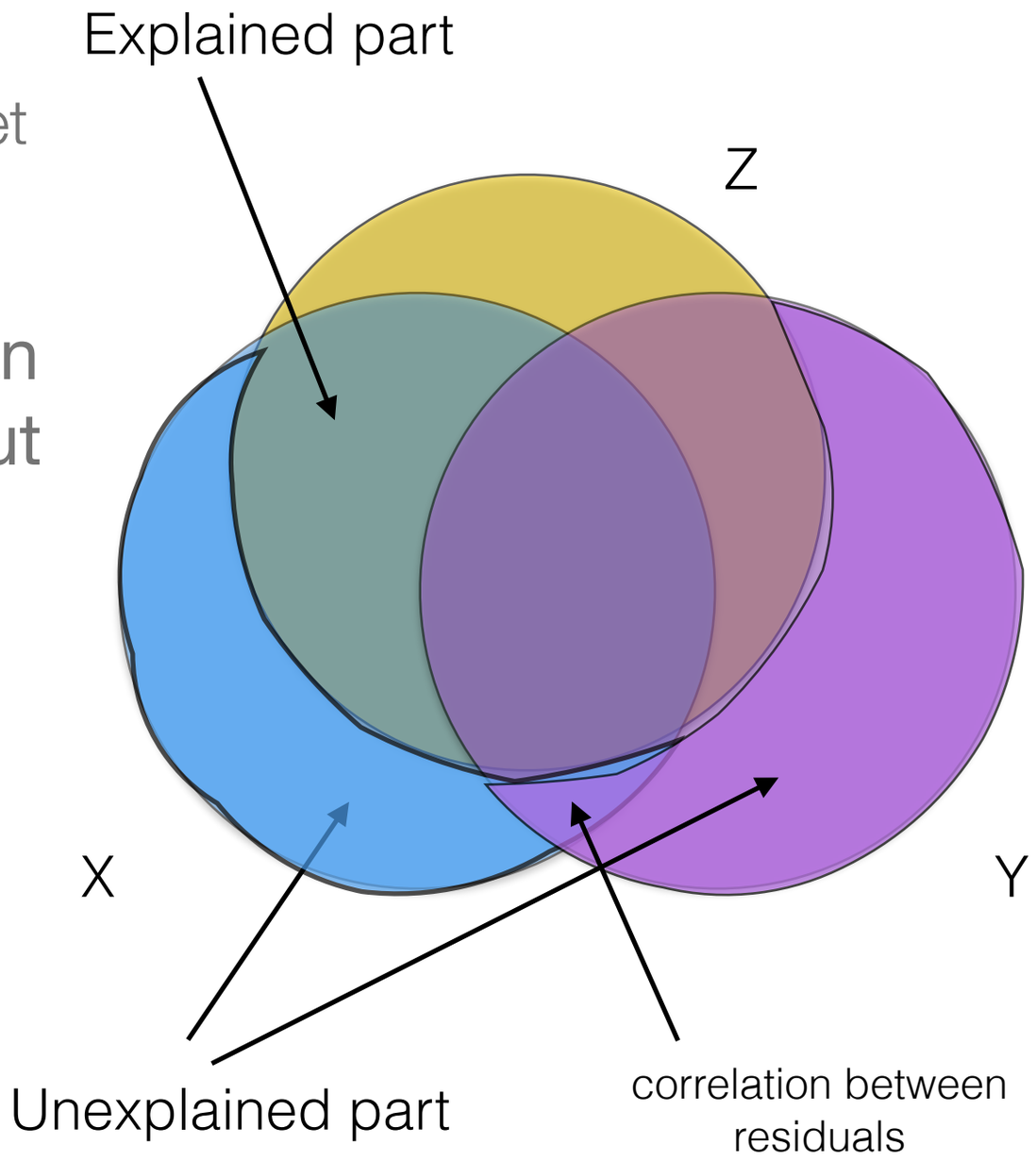


Controlling for differences in severity

- Regressing out (partialling out) external measure of severity:

  QIDS at admission (following van Borkulo et al. 2015)

- All variance in Y-BOCS items that can be explained by QIDS is partialled out



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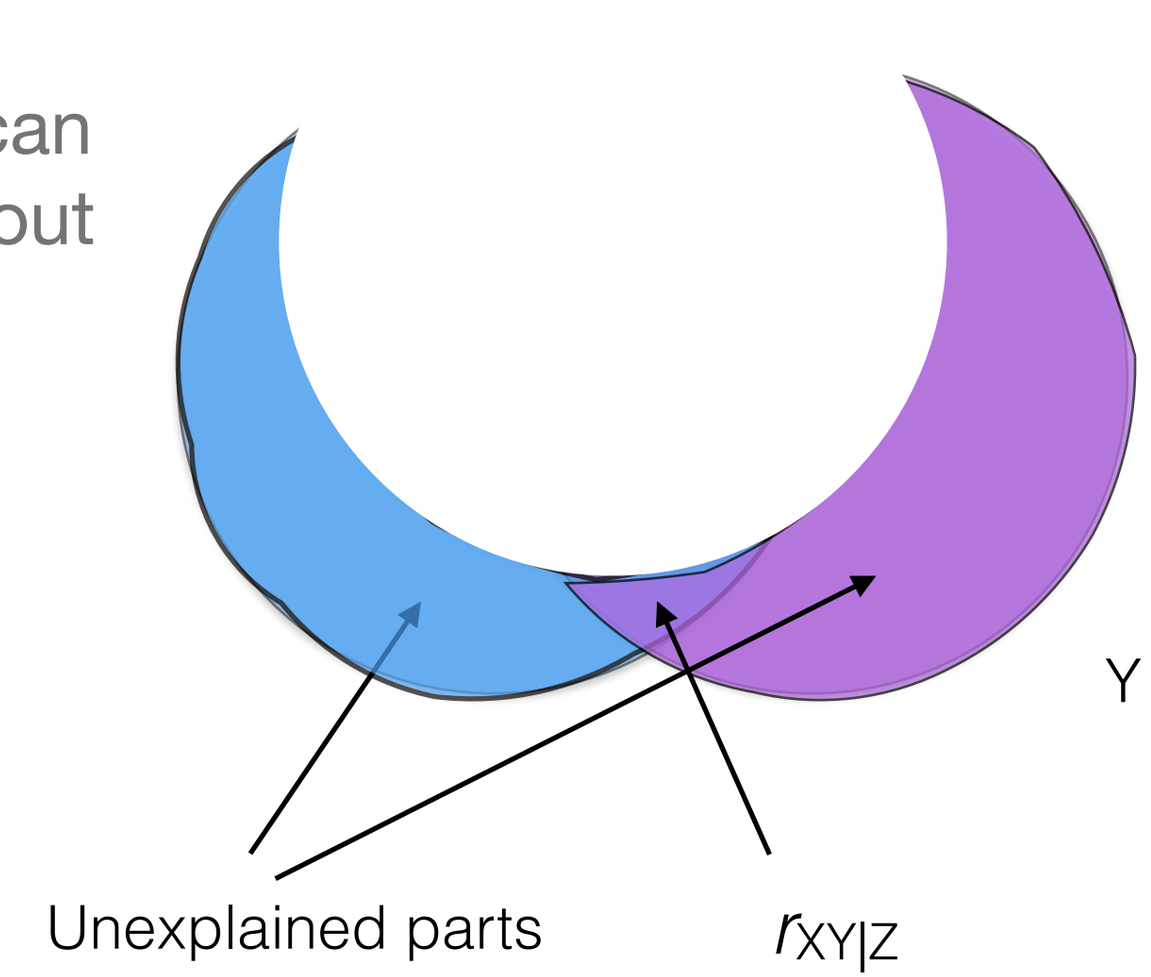

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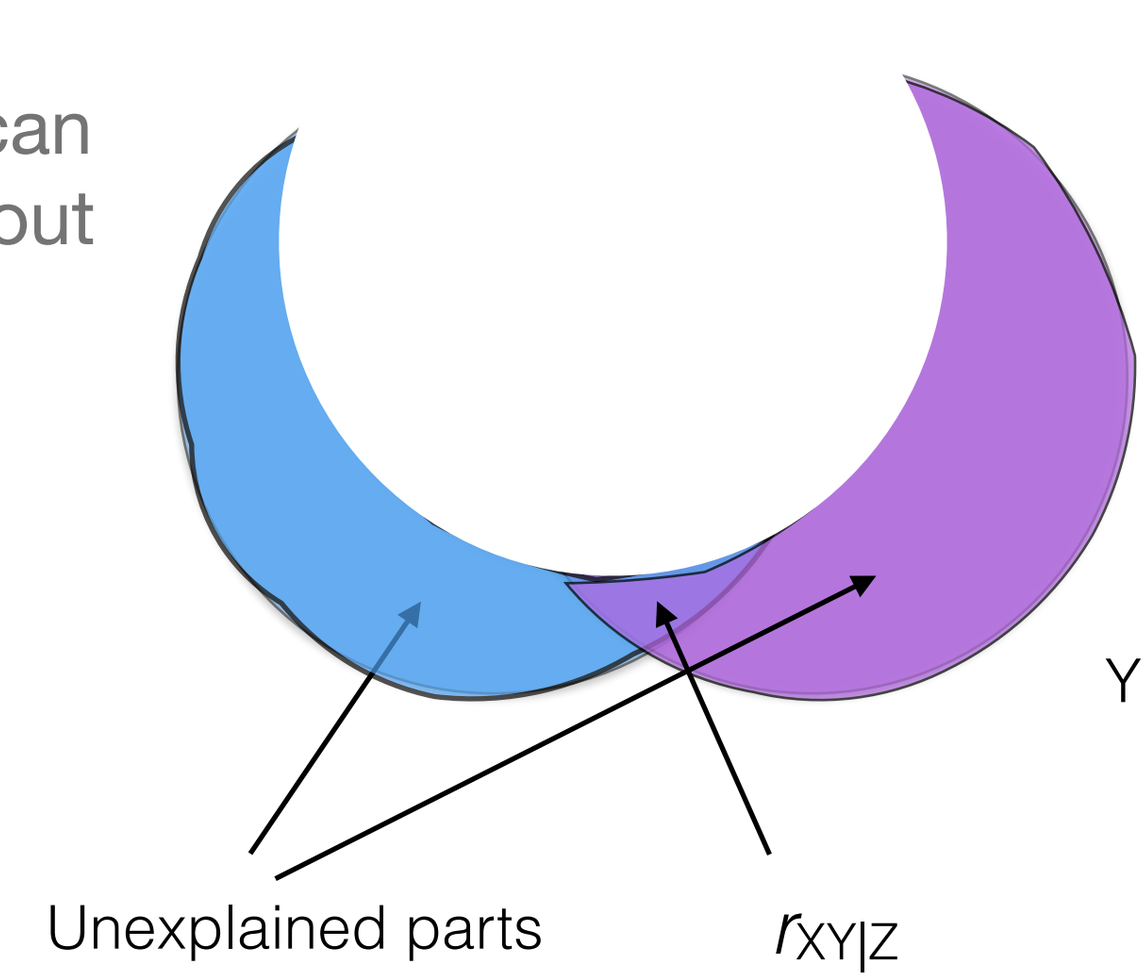
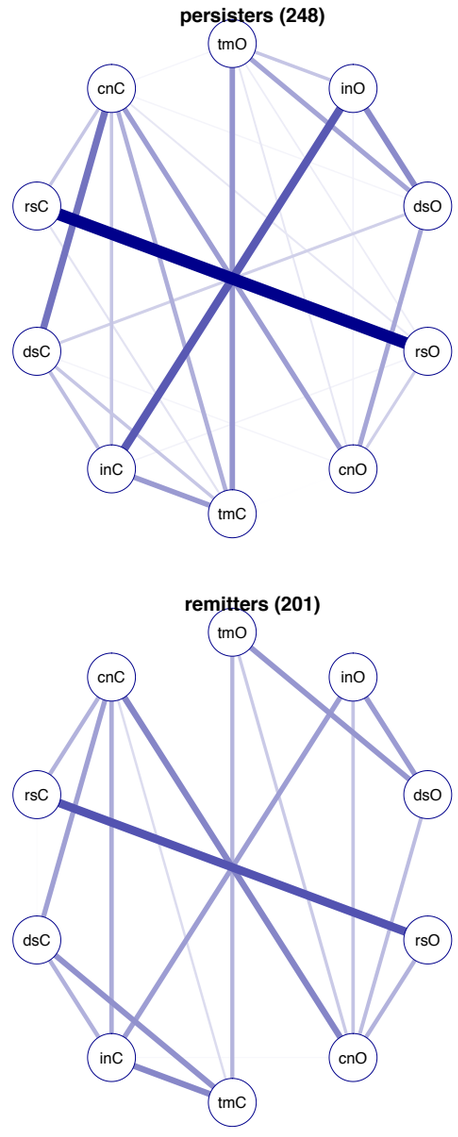
Ask me later if you want to know how this works! ;-)



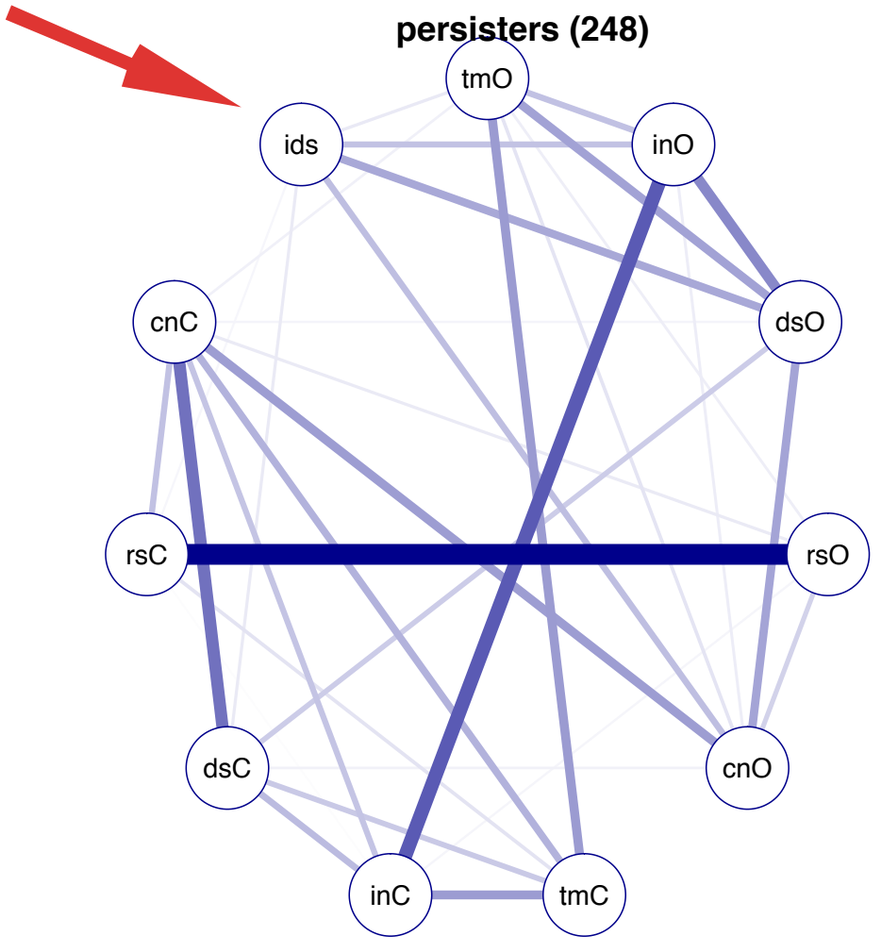
An unmodelled latent variable related to OCD severity systematically

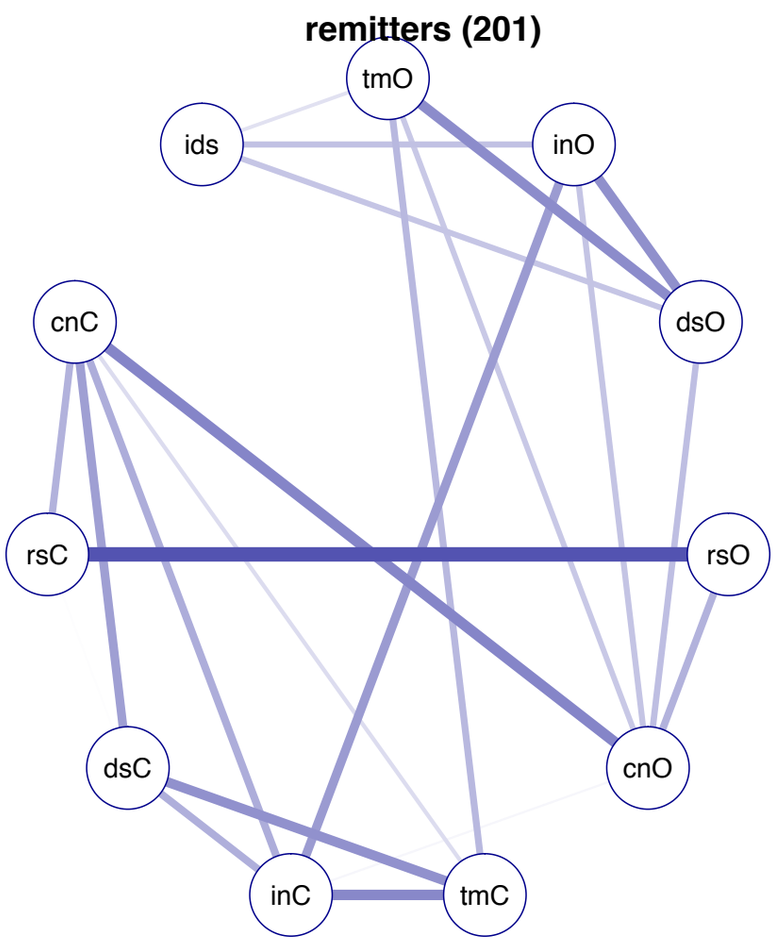
Controlling for severity by partialling out QIDS at admission:

- Global strength invariance test: p = .07
- Depression could be the unmodelled latent variable
- Apparently, depression is related differently to OCD in persisters compared to remitters.
- Let's model it…



Modelling OCD with depression





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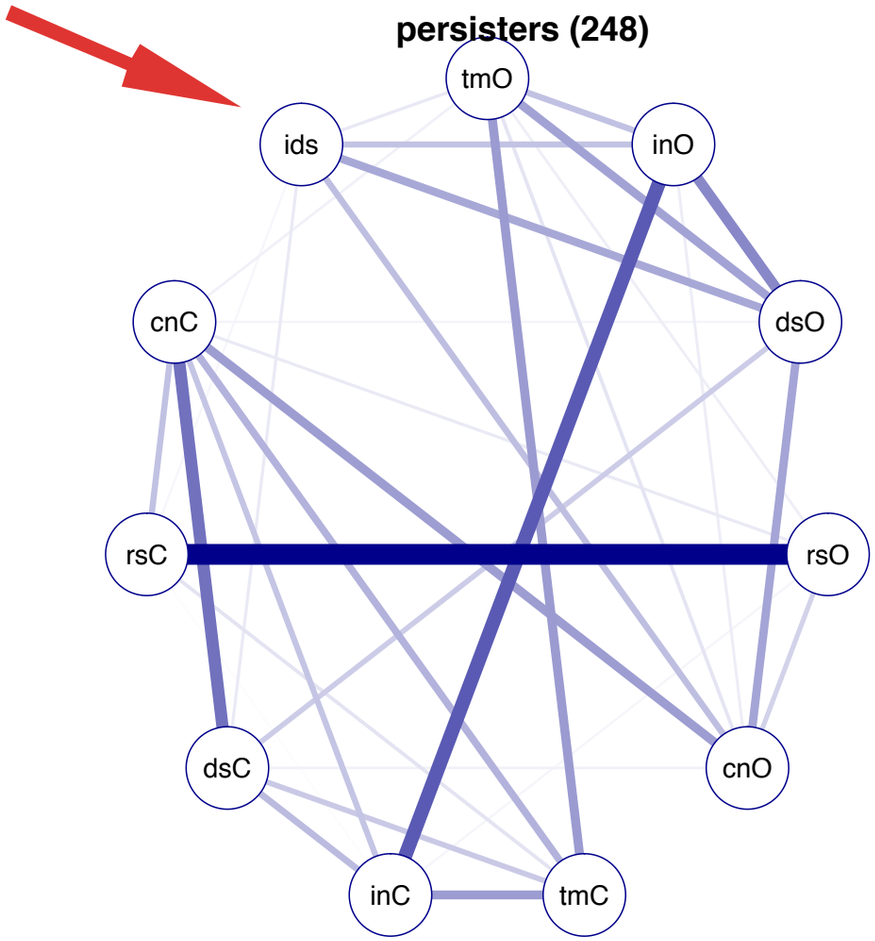

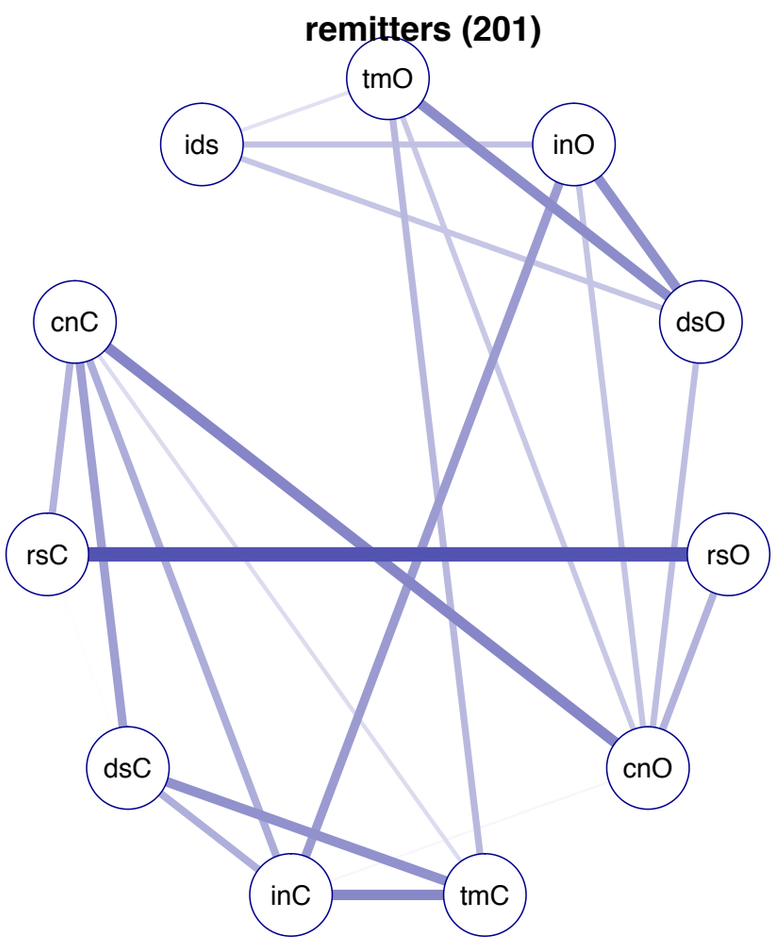

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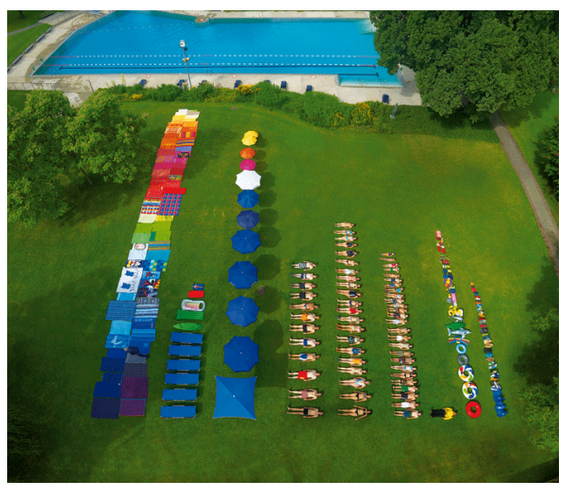
Global strength invariance test: p = .003

Conclusion

- OCD persisters have a higher global strength than remitters
- After controlling for differences in severity this difference becomes smaller
- Depressive symptomatology is differently related to OCD in more severe patients than in less severe patients
- In line with Abramowitz et al. (2000): severe depression interferes with ERP outcome



Discussion

Possible explanation of results (under the assumption that the association patterns in the groups also pertain to the individuals in the groups):

- Hampered effect of ERP in persisters because of stronger and/or more associations between obsessive thoughts and compulsive behaviors
- It is harder for persisters not to perform their usual compulsive behavior
- Depression possibly aggravates the obsessive thoughts component, thereby making it harder to suppress the compulsive behavior.
- Therapist may spend less time treating OCD if also attend to depression


THANK YOU BOSTON
PIERCE

References and contact info

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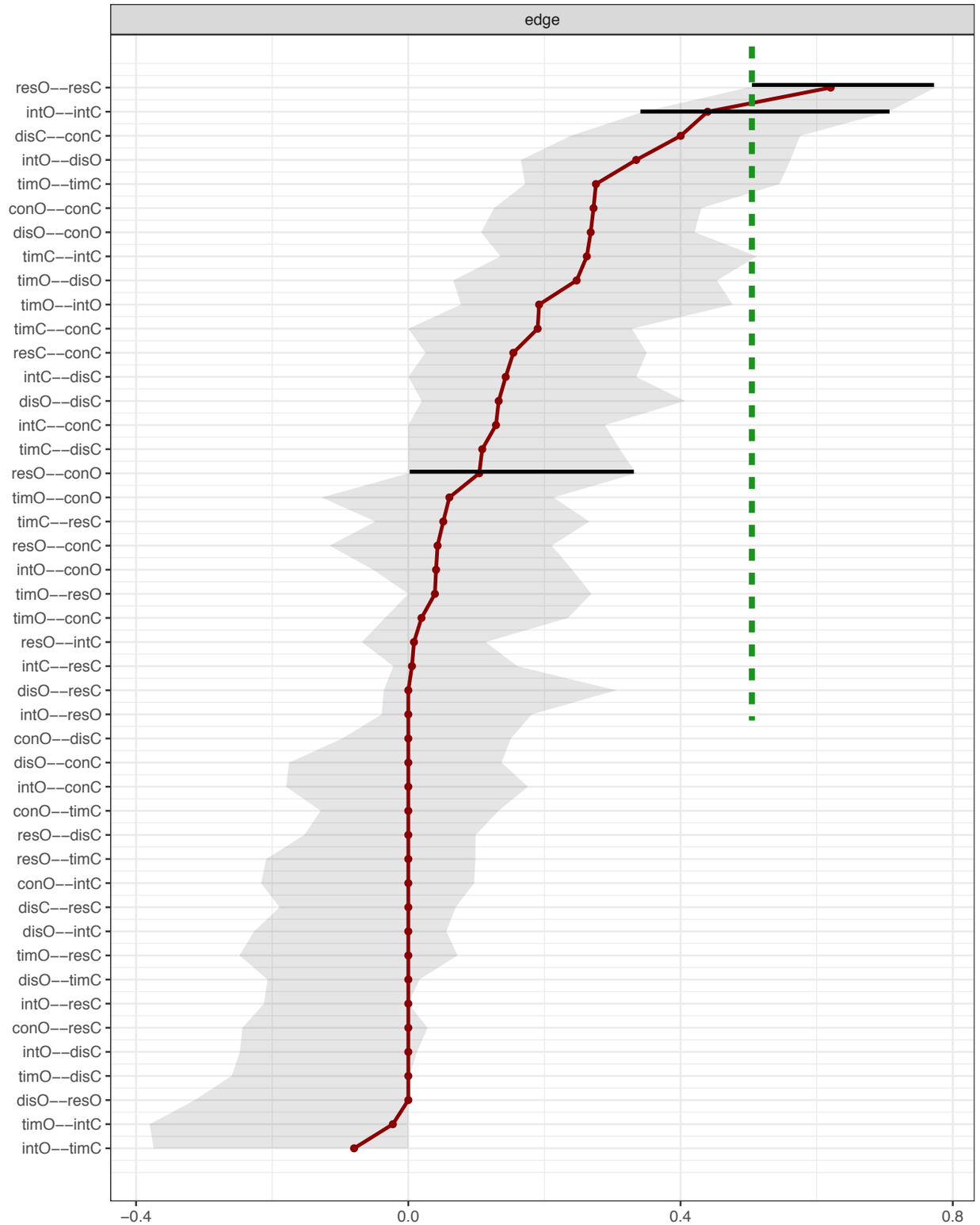
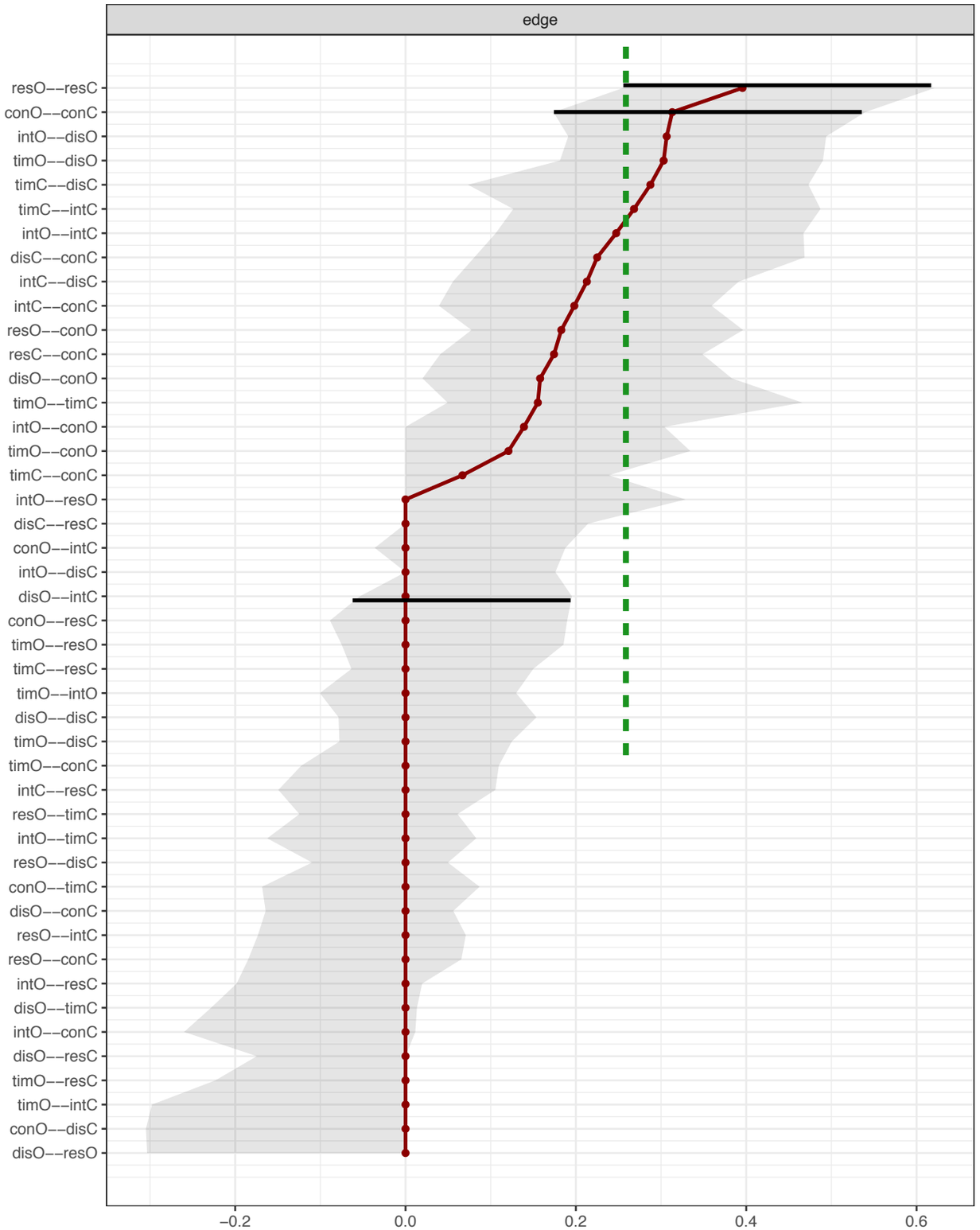
Accuracy



Persisters



Remitters

Black lines as an example to show which CIs overlap and which do not