OBSESSIVE -COMPULSIVE AND RELATED DISORDERS

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OBSESSIVE COMPULSIVE DISORDER(OCD)

Obsessive-compulsive disorder (OCD) is represented by a diverse group of symptoms that include intrusive thoughts, rituals, preoccupations, and compulsions. These recurrent obsessions or compulsions cause severe distress to the person. The obsessions or compulsions are time-consuming and interfere significantly with the person's normal routine, occupational functioning, usual social activities, or relationships. A patient with OCD may have an obsession, a compulsion, or both.

A patient with OCD realizes the irrationality of the obsession and experiences both the obsession and the compulsion as ego-dystonic (i.e., unwanted behavior).

OBSESSIVE COMPULSIVE DISORDER(OCD)

Per DSM-5, *obsessions* are defined by (1) and (2) and must be time consuming or cause significant distress or impairment in social, occupational, or other important areas of functioning:

1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.

2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

OBSESSIVE COMPULSIVE DISORDER(OCD)

Per DSM-5, *compulsions* are defined by (1) and (2) and must be time consuming or cause significant distress or impairment in social, occupational, or other important areas of functioning:

1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.

2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

Although the compulsive act may be carried out in an attempt to reduce the anxiety associated with the obsession, it does not always succeed in doing so. The completion of the compulsive act may not affect the anxiety, and it may even increase the anxiety. Anxiety is also increased when a person resists carrying out a compulsion.

OBSESSIVE COMPULSIVE DISORDER(OCD)

Most patients with OCD have both obsessions and compulsions-up to 75 percent in some surveys. For example, an obsession about hurting a child may be followed by a mental compulsion to repeat a specific prayer a specific number of times. Other researchers and clinicians, however, believe that some patients do have only obsessive thoughts without compulsions. Such patients are likely to have repetitious thoughts of a sexual or aggressive act that is reprehensible to them. For clarity, it is best to conceptualize obsessions as thoughts and compulsions as behavior.

Typical obsessions associated with OCD include thoughts about contamination ("My hands are dirty") or doubts ("I forgot to turn off the stove").

No matter how vivid and compelling the obsession or compulsion, the person usually recognizes it as absurd and irrational. The person suffering from obsessions and compulsions usually feels a strong desire to resist them.

OBSESSIVE COMPULSIVE DISORDER(OCD)

OCD has four major symptom patterns:

Contamination.

The most common pattern is an obsession of contamination, followed by washing or accompanied by compulsive avoidance of the presumably contaminated object. The feared object is often hard to avoid (e.g., feces, urine, dust, or germs). Patients may literally rub the skin off their hands by excessive hand washing or may be unable to leave their homes because of fear of germs. Patients with contamination obsessions usually believe that the contamination is spread from object to object or person to person by the slightest contact.

Pathological Doubt.

The second most common pattern is an obsession of doubt, followed by a compulsion of checking. The obsession often implies some danger of violence (e.g., forgetting to turn off the stove or not locking a door). The checking may involve multiple trips back into the house to check the stove, for example. These patients have an obsessional self-doubt and always feel guilty about having forgotten or committed something.

Patients can literally take hours to eat a meal or shave their faces.

OBSESSIVE COMPULSIVE DISORDER(OCD)

Intrusive Thoughts.

In the third most common pattern, there are intrusive obsessional thoughts without a compulsion. Such obsessions are usually repetitious thoughts of a sexual or aggressive act that is reprehensible to the patient. Patients obsessed with thoughts of aggressive or sexual acts may report themselves to police or confess to a priest. Suicidal ideation may also be obsessive; but a careful suicidal assessment of actual risk must always be done.

Symmetry.

The fourth most common pattern is the need for symmetry or precision, which can lead to a compulsion of slowness.

Other Symptom Patterns.

Religious obsessions and compulsive hoarding are common in patients with OCD. Compulsive hair pulling and nail biting are behavioral patterns related to OCD.

EPIDEMIOLOGY

The rates of OCD are fairly consistent, with a lifetime prevalence in the general population estimated at 2 to 3 percent. Some researchers have estimated that the disorder is found in as many as 10 percent of outpatients in psychiatric clinics. These figures make OCD the fourth most common psychiatric diagnosis after phobias, substance-related disorders, and major depressive disorder.

Among adults, men and women are equally likely to be affected. The mean age of onset is about 20 years. Overall, the symptoms of about two thirds of affected persons have an onset before age 25, and the symptoms of fewer than 15 percent have an onset after age 35. The onset of the disorder can occur in adolescence or childhood, in some cases as early as 2 years of age. Single persons are more frequently affected with OCD than are married persons, although this finding probably reflects the difficulty that persons with the disorder have maintaining a relationship.

OBSESSIVE COMPULSIVE DISORDER(OCD)

Obsessive-compulsive and related symptoms have been reported following viral and bacterial encephalitis. Additionally, there have been enough reports of the onset of obsessive-compulsive and related symptoms following streptococcal infection that a syndrome called pediatric acute-onset neuropsychiatric syndrome (PANS) has been defined. In PANS, children affected by streptococcus may exhibit obsessive-compulsive and related symptoms that sometimes (but not always) resolve after effective treatment of the streptococcal infection. Studies have found that the basal ganglia must be affected by the infection in order for PANS to occur.

COMORBIDITY

Persons with OCD are commonly affected by other mental disorders. The lifetime prevalence for major depressive disorder in persons with OCD is about 67 percent and for social phobia about 25 percent.

OCD exhibits a superficial resemblance to obsessive-compulsive personality disorder, which is associated with an obsessive concern for details, perfectionism, and other similar personality traits. The incidence of Tourette's disorder in patients with OCD is 5 to 7 percent, and 20 to 30 percent of patients with OCD have a history of tics.

ETIOLOGY

Biological Factors

SEROTONERGIC SYSTEM.

The many clinical drug trials that have been conducted support the hypothesis that dysregulation of serotonin is involved in the symptom formation of obsessions and compulsions in the disorder. Data show that serotonergic drugs are more effective in treating OCD than drugs that affect other neurotransmitter systems

Brain Imaging Studies .

Various functional brain-imaging studies for example, positron emission tomography (PET}- have shown increased activity (e.g., metabolism and blood flow) in the frontal lobes, the basal ganglia (especially the caudate), and the cingulum of patients with OCD. Both computed tomographic (CT) and magnetic resonance imaging (MRI) studies have found bilaterally smaller caudates in patients with OCD. Both functional and structural brain-imaging study results are also compatible with the observation that neurological procedures involving the cingulum are sometimes effective in the treatment of OCD.

ETIOLOGY

Genetics

Available genetic data on OCD support the hypothesis that the disorder has a significant genetic component. Relatives of probands with OCD consistently have a threefold to fivefold higher probability of having OCD or obsessive compulsive features than families of control probands. Studies of concordance for the disorder in twins have consistently found a significantly higher concordance rate for monozygotic twins(with concordance rates of 80%–87%) than for dizygotic twins. Some studies also demonstrate increased rates of a variety of conditions among relatives of OCD probands, including generalized anxiety disorder, tic disorders, body dysmorphic disorder, hypochondriasis, eating disorders, and habits such as nail-biting.

ETIOLOGY

Psychosocial Factors

Personality Factors.

OCD differs from obsessive-compulsive personality disorder, which is associated with an obsessive concern for details, perfectionism, and other similar personality traits. Most persons with OCD do not have premorbid compulsive symptoms, and such personality traits are neither necessary nor sufficient for the development of OCD. Only about 15 to 35 percent of patients with OCD have had premorbid obsessional traits.

Psychodynamic Factors.

Many patients with OCD may refuse to cooperate with effective treatments such as selective serotonin reuptake inhibitors (SSRIs) and behavior therapy Even though the symptoms of OCD may be biologically driven, psychodynamic meanings may be attached to them. Patients may become invested in maintaining the symptomatology because of secondary gains. For example, a male patient, whose mother stays home to take care of him, may unconsciously wish to hang on to his OCD symptoms because they keep the attention of his mother.

Often, interpersonal difficulties increase the patient's anxiety and, thus, increase the patient's symptomatology as well. Research suggests that OCD may be precipitated by a number of environmental stressors, especially those involving pregnancy, childbirth, or parental care of children. An understanding of the stressors may assist the clinician in an overall treatment plan that reduces the stressful events themselves or their meaning to the patient .

DIFFERENTIAL DIAGNOSIS

Medical Conditions

A number of primary medical disorders can produce syndromes bearing a striking resemblance to OCD. The current conceptualization of OCD as a disorder of the basal ganglia derives from the phenomenological similarity between idiopathic OCD and OCD-like disorders that are associated with basal ganglia diseases, such as Sydenham's chorea and Huntington's disease.

Tourette's Disorder

OCD is closely related to Tourette's disorder, as the two conditions frequently co-occur, both in individuals over time and within families. About 90 percent of persons with Tourette's disorder have compulsive symptoms, and as many as two thirds meet the diagnostic criteria for OCD.

In its classic form, Tourette's disorder is associated with a pattern of recurrent vocal and motor tics that bears only a slight resemblance to OCD. The premonitory urges that precede tics often strikingly resemble obsessions, however, and many of the more complicated motor tics are very similar to compulsions.

OCPD

OCD exhibits a superficial resemblance to obsessive-compulsive personality disorder, which is associated with an obsessive concern for details, perfectionism, and other similar personality traits. The conditions are easily distinguished in that only OCD is associated with a true syndrome of obsessions and compulsions.

COURSE AND PROGNOSIS

More than half of patients with OCD have a sudden onset of symptoms. The onset of symptoms for about 50 to 70 percent of patients occurs after a stressful event, such as a pregnancy or the death of a relative. Because many persons manage to keep their symptoms secret, they often delay 5 to 10 years before coming to psychiatric attention, although the delay is probably shortening with increased awareness of the disorder. The course is usually long but variable; some patients experience a fluctuating course, and others experience a constant one.

About 20 to 30 percent of patients have significant improvement in their symptoms, and 40 to 50 percent have moderate improvement. The remaining 20 to 40 percent of patients either remain ill or their symptoms worsen.

OBSESSIVE COMPULSIVE DISORDER(OCD)

A poor prognosis is indicated by yielding to (rather than resisting) compulsions, childhood onset, bizarre compulsions, the need for hospitalization, a coexisting major depressive disorder, delusional beliefs, the presence of overvalued ideas (i.e., some acceptance of obsessions and compulsions), and the presence of a personality disorder (especially schizotypal personality disorder).

A good prognosis is indicated by good social and occupational adjustment, the presence of a precipitating event, and an episodic nature of the symptoms.

The obsessional content does not seem to be related to the prognosis.

TREATMENT

Pharmacotherapy

Each of the SSRIs available in the United States-fluoxetine , fluvoxamine, paroxetine , sertraline , citalopram has been approved by the US Food and Drug Administration (FDA) for the treatment of OCD. Higher dosages have often been necessary for a beneficial effect . The best clinical outcomes occur when SSRIs are used in combination with behavioral therapy.

Clomipramine. Of all the tricyclic and tetracyclic drugs, clomipramine is the most selective for serotonin reuptake versus norepinephrine reuptake and is exceeded in this respect only by the SSRIs. Clomipramine was the first drug to be FDA approved for the treatment of OCD.

Initial effects are generally seen after 4 to 6 weeks of treatment, although 8 to 16 weeks are usually needed to obtain maximal therapeutic benefit.

TREATMENT

Behavior Therapy

Behavior therapy is as effective as pharmacotherapies in OCD, and some data indicate that the beneficial effects are longer lasting with behavior therapy. Many clinicians, therefore, consider behavior therapy the treatment of choice for OCD. Behavior therapy can be conducted in both outpatient and inpatient settings. The principal behavioral approaches in OCD are exposure and response prevention. In behavior therapy, patients must be truly committed to improvement.

Other Therapies

For extreme cases that are treatment resistant and chronically debilitating, electroconvulsive therapy (ECT) and psychosurgery are considerations. ECT should be tried before surgery. A psychosurgical procedure for OCD is cingulotomy, which may be successful in treating otherwise severe and treatment-unresponsive patients. Other surgical procedures (e.g., subcaudate tractotomy, also known as capsulotomy) have also been used for this purpose.

BODY DYSMORPHIC DISORDER

The DSM-5 diagnostic criteria for body dysmorphic disorder stipulate preoccupation with a perceived defect in appearance or overemphasis of a slight defect. If a slight physical anomaly is actually present, the person's concern with the anomaly is excessive and bothersome.

It also stipulates that at some point during the course of the disorder, the patient performs compulsive behaviors (i.e., mirror checking, excessive grooming) or mental acts (e.g., comparing their appearance to that of others). The preoccupation causes patients significant emotional distress or markedly impairs their ability to function in important areas. There can be attempts to hide the presumed deformity (with makeup or clothing) . The effects on a person's life can be significant; almost all affected patients avoid social and occupational exposure. As many as one-third of patients may be housebound because of worry about being ridiculed for the alleged deformities; and approximately one-fifth of patients attempt suicide.

The most common concerns involve facial flaws, particularly those involving specific parts (e.g., the nose) . Other body parts of concern are hair, breasts, and genitalia.

DSM-5 reports that be 7 to 8 percent of the patients in a plastic surgery clinic had the diagnosis,. The overall percentage may be much higher, however.

BODY DYSMORPHIC DISORDER

BODY DYSMORPHIC DISORDER

Epidemiology

Available data indicate that the most common age of onset is between 15 and 30 years and that women are affected some what more often than men. Affected patients are also likely to be unmarried. Body dysmorphic disorder commonly coexists with other mental disorders. One study found that more than 90 percent of patients with body dysmorphic disorder had experienced a major depressive episode in their lifetimes; about 70 percent had experienced an anxiety disorder; and about 30 percent had experienced a psychotic disorder.

Etiology

The cause of body dysmorphic disorder is unknown. The high comorbidity with depressive disorders, a higher-than-expected family history of mood disorders and OCD, and the reported responsiveness of the condition to serotonin-specific drugs indicate that, in at least some patients, the pathophysiology of the disorder may involve serotonin and may be related to other mental disorders.

BODY DYSMORPHIC DISORDER

Differential Diagnosis

Excessive bodily preoccupation is generally restricted to concerns about being fat in anorexia nervosa; to discomfort with, or a sense of wrongness about, his or her primary and secondary sex characteristics occurring in gender identity disorder; and to mood-congruent cognitions involving appearance that occur exclusively during a major depressive episode. Individuals with avoidant personality disorder or social phobia may worry about being embarrassed by imagined or real defects in appearance, but this concern is usually not prominent.

a separate or additional diagnosis of OCD is made only when the obsessions or compulsions are not restricted to concerns about appearance and are ego-dystonic. An additional diagnosis of delusional disorder, somatic type, can be made in people with body dysmorphic disorder only if their preoccupation with the imagined defect in appearance is held with a delusional intensity. Unlike normal concerns about appearance, the preoccupation with appearance and specific imagined defects in body dysmorphic disorder and the changed behavior because of the preoccupation are excessively time-consuming and are associated with significant distress or impairment.

BODY DYSMORPHIC DISORDER

Course & Prognosis

Body dysmorphic disorder usually begins during adolescence. The onset can be gradual or abrupt. The disorder usually has a long and undulating course with few symptom-free intervals. The part of the body on which concern is focused may remain the same or may change over time.

TREATMENT

Treatment of patients with body dysmorphic disorder with surgical, dermatological, dental, and other medical procedures to address the alleged defects is almost invariably unsuccessful.

SSRIs and Clomipramine are reported to reduce 50% of the symptoms.

HOARDING DISORDER

The disorder is characterized by acquiring and not discarding things that are deemed to be of little or no value, resulting in excessive clutter of living spaces. Hoarding was originally considered a subtype of obsessive-compulsive disorder (OCD), but is now considered to be a separate diagnostic entity. It is commonly driven by an obsessive fear of losing important items that the person believes may be of use at some point in the future, by distorted beliefs about the importance of possessions, and by extreme emotional attachment to possessions. It causes significant distress and impairment in functioning.

Epidemiology

Hoarding is believed to occur in approximately 2 to 5 percent of the population. It occurs equally among men and women, is more common in single persons. Hoarding usually begins in early adolescence and persists throughout the lifespan.

HOARDING DISORDER

HOARDING DISORDER

Comorbidity

The most significant comorbidity is found between hoarding disorder and OCD, with as many as 30 percent of OCD patients showing hoarding behavior.

ETIOLOGY

Little is known about the etiology of hoarding disorder. Research has shown a familial aspect to hoarding disorder, with about 80 percent of hoarders reporting at least one first-degree relative with hoarding behavior.

HOARDING DISORDER

Course & Prognosis

The disorder is a chronic condition with a treatment-resistant course. Treatment seeking does not usually occur until patients are in their 40s or 50s, even if the hoarding began during adolescence.

Treatment

Hoarding disorder is difficult to treat. The most effective treatment for the disorder is a cognitive behavioral model that includes training in decision making and categorizing; exposure and habituation to discarding; and cognitive restructuring.

Hair-Pulling Disorder (Trichotillomania)

Hair-pulling disorder is a chronic disorder characterized by repetitive hair pulling, leading to variable hair loss that may be visible to others. It is also known as trichotillomania.

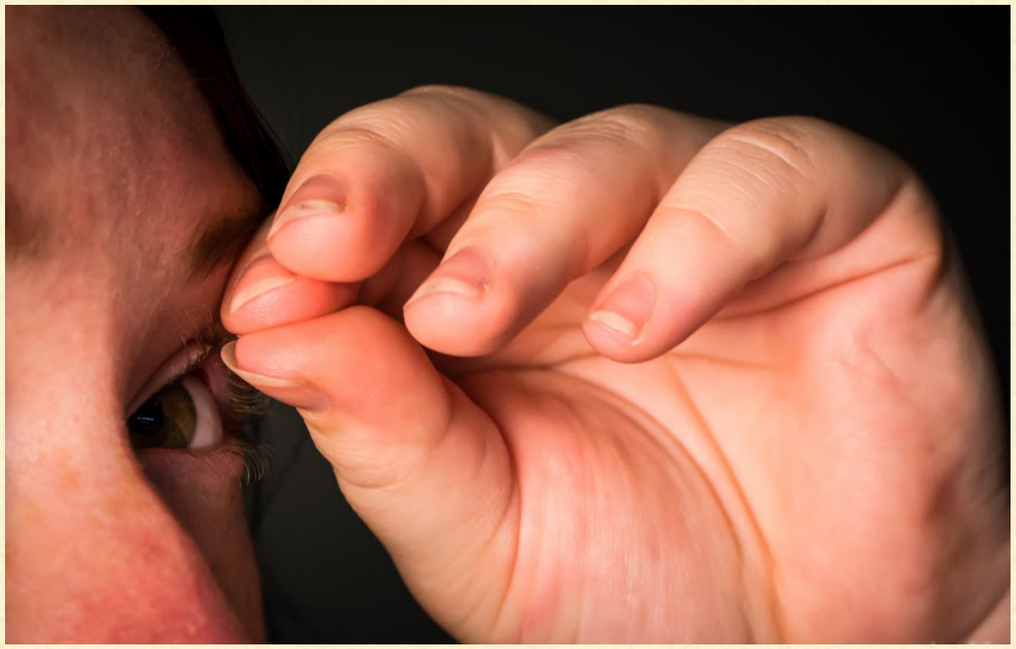
Before engaging in the behavior, patients with hair-pulling disorder may experience an increasing sense of tension and achieve a sense of release or gratification from pulling out their hair. All areas of the body may be affected, most commonly the scalp . Other areas involved are eye brows, eyelashes, and beard; trunk, armpits, and pubic area are less commonly involved .

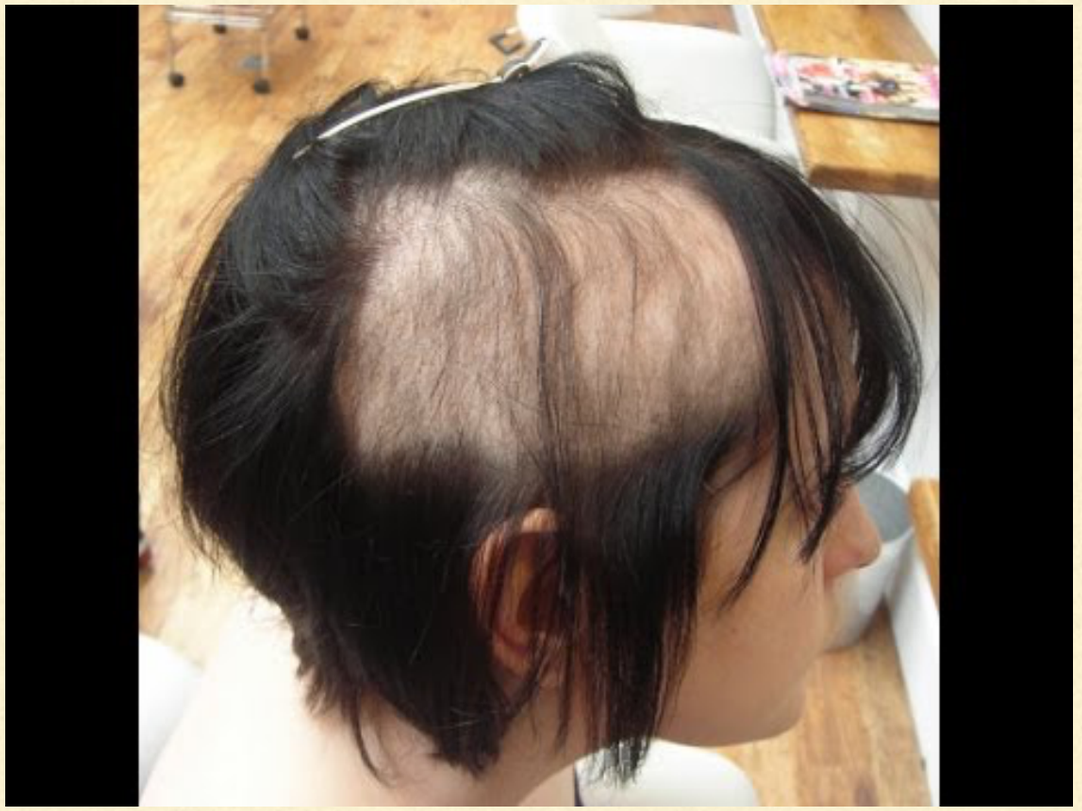
Hair-Pulling Disorder (Trichotillomania)

Hair pulling is not reported as being painful, although pruritus and tingling may occur in the involved area. Trichophagy, mouthing of the hair, may follow the hair plucking. Complications of trichophagy include trichobezoars, malnutrition, and intestinal obstruction.

Patients usually deny the behavior and often try to hide the resultant alopecia. Head banging, nail biting, scratching, excoriation, and other acts of self-mutilation may be present.

Hair-Pulling Disorder (Trichotillomania)





Hair-Pulling Disorder (Trichotillomania)

Epidemiology

The most serious, chronic form of the disorder usually begins in early to mid-adolescence, with a lifetime prevalence ranging from 0.6 percent to as high as 3.4 percent in general populations and with female to male ratio as high as 10 to 1.

Comorbidity

Significant comorbidity is found between hair-pulling disorder and obsessive-compulsive disorder (OCD); anxiety disorders; Tourette's disorder; depressive disorders; eating disorders; and various personality disorders.

Etiology

Its onset has been linked to stressful situations in more than one-fourth of all cases. Disturbances in mother-child relation ships, fear of being left alone, and recent object loss are often cited as critical factors contributing to the condition. Substance abuse may encourage development of the disorder

Hair-Pulling Disorder (Trichotillomania)

Course & Prognosis

The mean age at onset of hair-pulling disorder is in the early teens, most frequently before age 17, but onset has been reported much later in life. The course of the disorder is not well known; both chronic and remitting forms occur.

Treatment

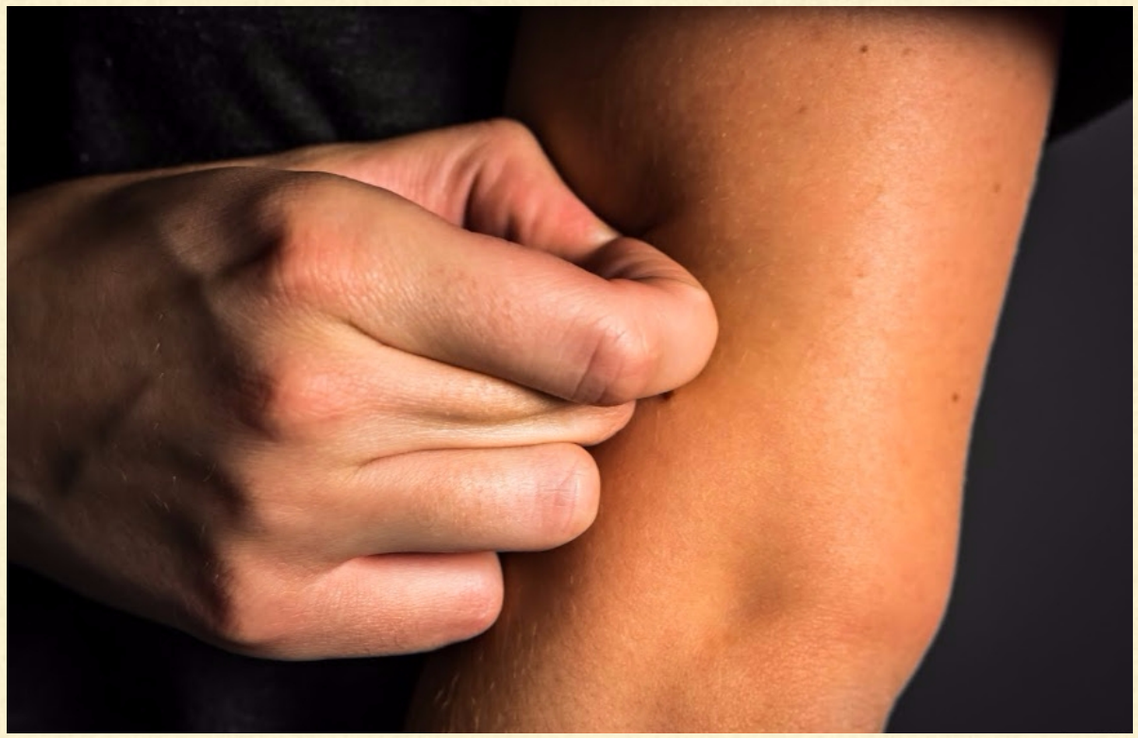
Treatment usually involves psychiatrists and dermatologists in a joint endeavor. Psychopharmalogical methods that have been used to treat psycho-dermatological disorders include topical steroids and hydroxyzine hydrochloride . There is efficacy of selective serotonin reuptake inhibitors (SSRIs) for hair-pulling disorder. behavioral treatments, such as biofeedback, self-monitoring, desensitization, and habit reversal .

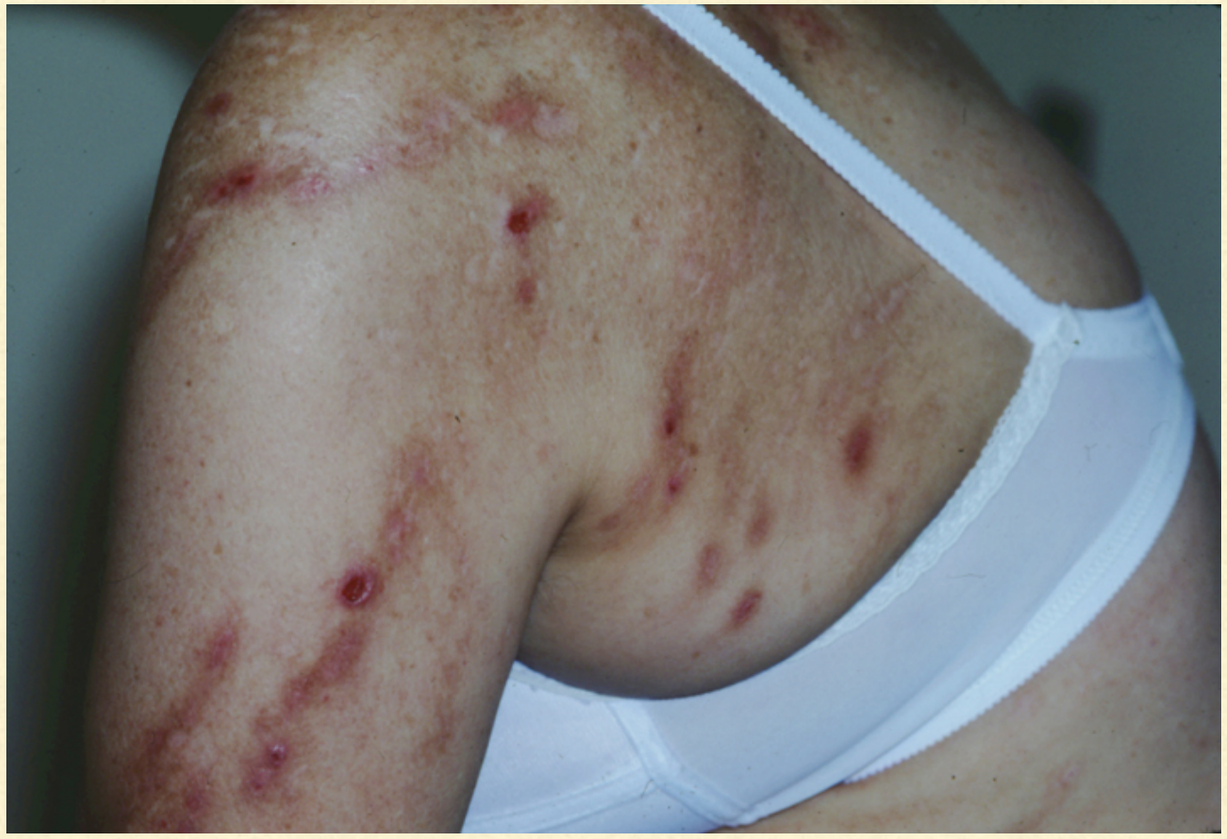
Excoriation (Skin Picking) Disorder

Excoriation or skin-picking disorder is characterized by the compulsive and repetitive picking of the skin. It can lead to severe tissue damage and result in the need for various dermatological treatments.

The face is the most common site of skin-picking. Other common sites are legs, arms, torso, hands, cuticles, fingers, and scalp. Although most patients report having a primary picking area, many times they pick other areas of the body in order for the primary area to heal. In severe cases, skin picking can result in physical disfigurement and medical consequences that require medical or surgical interventions (e.g., skin grafts or radiosurgery). Patients may experience tension prior to picking and a relief and gratification after picking. Many report picking as a means to relieve stress, tension, and other negative feelings. In spite of the relief felt from picking, patients often feel guilty or embarrassed at their behavior .

Excoriation (Skin Picking) Disorder





Excoriation (Skin Picking) Disorder

Epidemiology

Skin-picking disorder has lifetime prevalence between 1 to 5 percent in the general population. It is more prevalent in women than in men.

ETIOLOGY

The cause of skin-picking is unknown, however, several theories have been postulated. Some theorists speculate that skin-picking behavior is a manifestation of repressed rage at authoritarian parents.

COMORBIDITY

The repetitive nature of skin-picking behavior is similar to the repetitive compulsive rituals found in obsessive-compulsive disorder (OCD). Other comorbid conditions include hair-pulling disorder (trichotillomania), substance dependence and major depressive disorder .

Excoriation (Skin Picking) Disorder

Treatment

Skin-picking disorder is difficult to treat. There is support for the use of selective serotonin reuptake inhibitors (SSRIs).

Nonpharmacological treatments include habit reversal and brief cognitive behavioral therapy (CBT).

Good Luck