Obsessive Compulsive and Related Disorders

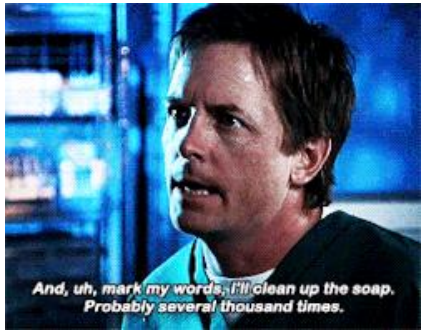
Presentation by Kiran Singh, PGY-3

Obsessive Compulse Disorder

- ***Presence of obsessions, compulsions, or both***
- Obsessions are defined as:
  - Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive, unwanted, and that in most individuals cause marked anxiety or distress
  - The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some thought or action (i.e., by performing a compulsion)

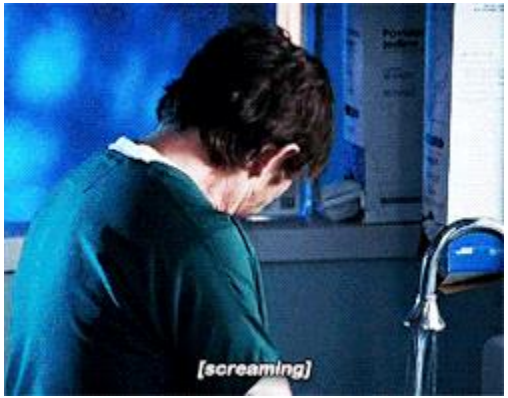
Obsessive Compulse Disorder

- ***Presence of obsessions, compulsions, or both***
- Compulsions are defined as:
  - Repetitive behaviors (e.g., hand washing, ordering checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession or according to the rules that must be applied rigidly
  - The behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation. However, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive



Obsessive Compulse Disorder

- ***Presence of obsessions, compulsions, or both***
- The obsessions or compulsions are time consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning



Obsessive Compulse Disorder

- ***Presence of obsessions, compulsions, or both***
- The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalized anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possession, as in hoarding disorder; hair pulling, as in trichotillomania; skin picking; sterotypies, ritualized eating behavior as in eating disorders; preoccupation with substances or gambling, as in substance related and addictive disorders, sexual urges or fantasies, impulses, impulse control, conduct disorders; guilty ruminations, as in MDD, insertion or delusional preoccupations, schizophrenia, or repetitive patterns of behavior

Obsessive Compulsive Disorder

- ***Presence of obsessions, compulsions, or both***
- The disturbance is not due to the direct physiological effects of a substance (e.g drug of abuse, a medication) or a general medical condition
- Specify if:
  - With good or fair insight: The individual recognizes that obsessive-compulsive beliefs are definitely or probably not true or that they may or may not be true.
  - With poor insight: The individual thinks obsessive-compulsive disorder beliefs are probably true.
  - With absent insight/delusional beliefs: The individual is completely convinced that obsessive-compulsive disorder beliefs are true.
- Specify if:
  - Tic related: The individual has a history of current or past history of tic disorder

Comorbidities

- 55-77% of youth with OCD present with at least one comorbid psychiatric disorder
  - Comorbidities include mood, anxiety, disruptive behavior, ADHD, tic disorder, and internalizing/externalizing disorders
- Can affect treatment response
  - For instance, in one study, children receiving CBT had lower treatment response if they have at least one psychiatric comorbidity

Developmental Considerations

- Younger children have poorer insight and attenuated ability to resist and control OCD symptoms
- Older youth tend to have more intense obsessive-compulsive symptoms
- Children have higher hoarding symptoms than adults
- Early childhood onset (prior to 8 years) were associated with aggressive and catastrophic obsessions, checking compulsions, and contamination symptoms
- Onset prior to 17 years is associated with increased superstitious/magical contamination, symmetry/exactness, religious, hoarding/saving, repeating, counting, tapping/rubbing symptoms

Treatment

- Mild to moderate cases: ERP is the gold standard
  - Behavior based variant of CBT: confront feared stimuli and refrain from engaging in their compulsions
- Moderate to severe cases: pharmacotherapy
  - SSRI
- For all patients, family inclusion therapy
  - Families who accommodate by modifications of family routines, facilitation of avoidance, and completion of rituals reinforce the cycle and maintain the symptomatology

Body Dysmorphic Disorder

- Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others
- At some point during the course of the disorder has performed repetitive behaviors (mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (comparing his or her appearance to that of others) in response to the appearance concerns.
- The preoccupation causes clinically significant distress or impairment in social, occupational, or other areas of functioning
- The appearance preoccupation is not better explained with body fat or weight in an individual whose symptoms meet diagnostic criteria for eating disorder

Body Dysmorphic Disorder

- Specify if:
  - With muscle dysmorphia: The individual is preoccupied with the idea that his or her body build is too small or insufficiently muscular. This specifier is used even if the individual is preoccupied with other body areas, which is often the case.
- Specify if:
  - Indicate if degree of insight regarding BDD beliefs (“I look ugly” or” I look deformed”)
    - With good or fair insight: the individual recognizes that the body dysmorphic disorder beliefs are definitely or probably not true or that they may or may not be true
    - With poor insight: The individual thinks that the body dysmorphic beliefs are probably true
    - With absent insight/delusional beliefs: The individual is completely convinced that the body dysmorphic beliefs are true.

Comparisons:

- Obsessive Compulsive Disorder
  - Similarities: intrusive thoughts, obsessions, repetitive behavior, age of onset, course of illness, sex ratio
  - Differences: focus in BDD on appearance, BDD are more likely to exhibit suicidal ideas and attempts,BDD has earlier onset of comorbid depression
- Social Anxiety Disorder
  - Similarities: Fear and avoidance of social situations. Emotions: shame, fear of negative evaluations, and rejection. Age of onset, sex ratio, course of the disorders
  - Differences: Focus in BDD on appearance concerns, in SAD on possibly embarrassing, negatively evaluated behavior. No compulsive behaviors in SAD.
- Eating Disorders
  - Similarities: Disturbed body image and dissatisfaction, repetitive behaviors (mirror checking, measuring of body parts, hiding body parts, over exercising
  - In ED, body image concerns are only related to body shape and weight, and not to any other parts of the body as is the case in BDD. Patients with Anorexia deviate from normality in their weight, wehearas patients with BDD have normal weight. BDD shows more avoidance behaviors and greater delusionality than ED. In ED, the majority are girls, in BDD, equal sex distribution

Treatment

- CBT, SSRI, or a combination
- CBT consists of psychoeducation, cognitive restructuring, behavioral experiments, exposure and response (ritual) prevention, perceptual retraining, and habit reversal comorbid depression, ambivalence about treatment, and suicidality can affect the treatment

Trichotillomania

Diagnostic Criteria:

- Recurrent pulling out of one's own hair, resulting in hair loss
- Repeated attempts to decrease or stop hair pulling
- Clinically significant distress or impairment in functioning
- Not attributable to a general medical condition (alopecia)
- Not better explained by another mental disorder (BDD)

Comorbidities

- Anxiety disorders, mood disorders, substance use disorders, eating disorders, and personality disorders

Treatment Options

- Primarily adult trials on treatments
- Cognitive behavioral treatments, but relapse appears to be a problem
- SSRIs generally do not appear efficacious in reducing hair pulling symptoms
    - Help with anxiety and depression
- Combined treatments with behavioral therapy plus medication may be useful
- Absence of evidence from randomized controlled trials with pediatric samples hinders standardized treatment planning

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Arch, J. J., & Craske, M. G. (2011). Addressing relapse in cognitive behavioral therapy for panic disorder: Methods for optimizing long-term treatment outcomes. *Cognitive and Behavioral Practice*, *18*(3), 306–315.

Bjornsson, A. S., Didie, E. R., Grant, J. E., Menard, W., Stalker, E., & Phillips, K. A. (2013). Age at onset and clinical correlates in body dysmorphic disorder. *Comprehensive Psychiatry*, *54*(7), 893–903.

Boileau, B. (2011). A review of obsessive-compulsive disorder in children and adolescents. *Dialogues in Clinical Neuroscience*, *13*(4), 401–411.

Buhlmann, U. (2011). Treatment barriers for individuals with body dysmorphic disorder: An internet survey. *Journal of Nervous and Mental Disease*, *199*, 268–271.

Hanna, G. L. (1997). Trichotillomania and related disorders in children and adolescents. *Child Psychiatry and Human Development*, *27*, 255–268.

Samuels, J. F., Riddle, M. A., Hoehn-Saric, R., Liang, K. Y., Cullen, B. A., ... Nestadt, G. (2000). The relationship of obsessive–compulsive disorder to possible spectrum disorders: Results from a family study. *Biological Psychiatry*, *48*(4), 287–293.