Obsessive-Compulsive Disorder

Operational Definition
A. Either obsessions or compulsions:
   • Obsessions as defined by (1) and (2):
     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 person 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)

Common Obsessions
• Unwanted thoughts of harming loved ones
• Persistent doubts that one has not locked doors or switched off electrical appliances
• Intrusive thoughts of being contaminated
• Morally or sexually repugnant thoughts
Operational Definition

• Compulsions as defined by (1) and (2):
  1. Repetitive behaviors or mental acts that the person 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 either are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive

Common Compulsions

• Hand washing
• Ordering
• Checking
• Praying
• Counting
• Thinking good thoughts to undo bad ones

Operational Definition

B. The O/C are time consuming (for example, take more than 1 hour a day) or cause clinically significant distress or impairment in functioning.

C. The O/C symptoms are not due to the direct physiological effects of a substance or a GMC

D. The content of the obsessions or compulsions is not restricted to the symptoms of another mental disorder
OCD Specifiers

- **Good or fair insight**: Recognizes that OCD beliefs are definitely or probably not true, or that they may or may not be true
- **Poor insight**: Thinks OCD beliefs are probably true
- **Absent insight**: Completely convinced OCD beliefs are true
- **Tic-related OCD**: The individual has a lifetime history of a chronic tic disorder

OCD Subtypes

- **Tic-related OCD**
  - May account for up to 40% of pediatric cases
  - Often male-dominated
  - High incidence of symmetry/exactness/ordering
  - Lower cleaning/contamination
  - High rates of trichotillomania and DBDs

Leckman et al. (2010)

- **Early-onset OCD**
  - Pre-pubertal onset of OC symptoms
  - Similar nature of OC symptoms
  - Dominated by males
  - Substantial portion will remit by adulthood
  - Increased risk of tics and trich
  - Confounded/overlapping with tic-related OCD

Leckman et al. (2010)
PANDAS

• Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcus

• Some individuals may develop OC or tics after strep infections and worse during infections

• Highly controversial and contentious area of research, with many for and against

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OCD Symptom Dimensions

• Some disagreement over how many dimensions are present

• Factor analytic and latent class analysis models have come up with different dimensions

• Dimensions appear to be temporally stable

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4-factor

- Hoarding
- Contamination/cleaning
- Symmetry/ordering
- Forbidden thoughts

5-factor

- Hoarding
- Contamination/cleaning
- Symmetry/ordering
- Forbidden thoughts
- Over-responsibility

LCA

- Single spectrum based on severity or number of endorsed symptoms
OCD Prevalence

- Between 2-3% in the adult population
  - Large number of “sub-clinical” cases (5%)
- Around 1% in pediatric population
- 96%+ of patients have both O and C

Abramowitz et al. (2009); Leckman et al. (2010)

OCD Course

- Usually gradual onset
- Chronic, unremitting course if untreated
- Symptoms can change across time, but will rarely disappear

Abramowitz et al. (2009)

Gender Differences

- No sex differences in adults, but many more male youth are diagnosed
- Among men, hoarding associated with GAD and tic disorders, but in women with SAD, PTSD, BDD, nail biting, and skin picking

Vesaga-Lopez et al. (2008)
SES & Cultural Differences

- Similar symptom categories across cultures, but can impact content of O/C

Comorbidity

- Up to 75% present with comorbid disorders
- Most common in pediatrics are ADHD, DBDs, depression, and other anxiety disorders
- Presence of comorbids predict QoL, more so than OCD severity

Comorbidity

- Different primary O/C are associated with certain patterns of comorbidity
  - Symmetry/ordering: Tics, bipolar, OCPD, panic, agoraphobia
  - Contamination/cleaning: Eating disorder
  - Hoarding: Personality disorders, especially Cluster C
- Most prevalent adult comorbid are SAD, MDD, alcohol abuse
Impact of OCD

• Almost all adults and children with OCD report obsessions causing significant distress
• Pervasive decrease in QoL compared to controls
• Youth show problematic peer relations, academic difficulties, and participate in fewer recreational activities

Lack et al. (2009); Fontennele et al. (2010)

Impact of OCD

• Lower QoL in pediatric females
• Compared to other anxiety/unipolar mood:
  – Less likely to be married
  – More likely to be unemployed
  – More likely to report impaired social and occupational functioning

Lack et al. (2009); Abramowitz et al. (2009)

Etiology

• Modestly heritable for adult onset (27-47%)
• Higher heritability for child onset (45-65%)
• Obviously, environment is still very important contributor to OCD

Abramowitz et al. (2009)
Etiology

- Serotonin, glutamate, and dopamine dysfunctions all implicated
- Seems to be highly mediated by frontal cortico-striatal circuitry
- Overactivity of the direct pathway thought to be associated with OCD symptoms

Abramowitz et al. (2009)

Pathways of the orbito-subcortical circuit connecting neuroanatomical structures hypothesised to be associated with symptoms of OCD

Etiology

- CBT model proposes that O/C arise from dysfunctional beliefs
- The stronger the beliefs, the greater chance a person will develop OCD
- Basis is the finding that unwanted cognitive intrusions are experienced by most people, with similar contents to clinical obsessions

Abramowitz et al. (2009)
Etiology

• Intrusions become obsession if appraised as
  – Personally important
  – Highly unacceptable or immoral
  – Posing a threat for which the individual is personally responsible

• One then attempts to alleviate distress this causes via compulsions

Pharmacology for OCD

• Overall, pharmacology (SRIs) shows large effect sizes in adults (0.91), but...
  – Most treatment responders show residuals
  – Very high relapse rate (24-89%)

• Only moderate effect sizes in youth (0.46)
Pharmacology for OCD

- SRIs can be adjuncted with antipsychotics, but only 1/3 will respond
- Presence of tics appears to decrease SSRI effects in children, unclear in adults
- OCD w/ tics responds better to neuroleptics than OCD w/o tics

(Cited: Abramowitz et al. (2009); Leckman et al. (2010))

CBT for OCD

- The treatment of choice, for both adult and child OCD; superior to meds alone
- Primarily focuses on EX/RP, which has shown effect sizes of 1.16-1.72
- Low (12%) relapse rate, but up to 25% will drop out prior to completion of treatment

EX/RP in OCD

- Construction of fear hierarchy is key first step
- Different O/C symptoms are often interwoven in hierarchy
- Start with moderately difficult situations, as ones below will show decrease naturally
CBT Outcomes

• Those with hoarding symptoms appear to respond less well to treatment

• May need to add motivational enhancement techniques for those who are reluctant to engage in exposures

• Group therapy is as effective as individual

Abramowitz et al. (2009)

CBT Outcomes

• Those with comorbidity present higher severity, but respond equally well to EX/RP

• Comorbid anxiety or depressive symptoms tend to show improvements as well, even if not specifically targeted

Storch et al. (2010)
For most people, this is what happens with intrusive thoughts:

- **Trigger**
- **Intrusive Thought**
- **Non-threatening Appraisal** → **No distress**

Decrease in anxiety via compulsion reinforces compulsion and makes obsession more likely to reoccur:

- **Trigger**
- **Intrusive Thought**
- **Compulsion** → **Distress** → **Threatening Appraisal** → **Distress** → **Distress**

**↑ Anxiety**