Definition and Criteria

Obsessions and compulsions are the central features of OCD. Obsessions are defined as “persistent ideas, thoughts, impulses, or images that are experienced as intrusive and inappropriate.” The individual with OCD recognizes these distressing experiences as coming from her own brain. These obsessions cause significant anxiety and she will attempt to ignore, suppress, neutralize or undo these thoughts with some other thought or action. Conversely, compulsions reduce anxiety. They are repetitive behaviors or mental acts that are aimed at preventing or reducing the anxiety and distress caused by the obsessions. Typical compulsions include: hand washing, checking, counting, repeating words or phrases. To reach criteria for OCD these obsessions and compulsion must be unreasonable or excessive, cause marked distress and functional impairment, and interfere with normal activity (DSM-IV).

It is important to distinguish OCD from normal behavior. Many people may “obsess” or worry about things from time to time in their lives, or may be very neat and consider themselves “compulsive”. Symptoms of this nature are probably representative of ego defenses, whereas symptoms of OCD are pervasive and lead to dysfunction. It is important to remember that there is often shame and secrecy associated with OCD and the clinician needs to have a high index of suspicion and directly inquire about these symptoms.

When considering the diagnosis of OCD, it is important to consider other disorders with similar symptoms. People with GAD are typically “worriers”. They may have multiple obsessions, but compulsions are not part of this disorder. Women with PTSD may obsess about past injury or trauma and compulsively
check their houses for safety. These symptoms revolve around the past trauma, whereas the symptoms in OCD do not involve a specific triggering event. Obsessive-compulsive personality disorder (OCPD) is distinguished from OCD in that the rigid lifestyle does not cause distress for her. On the contrary, the rigid behaviors of OCPD cause much distress in those people around her.

Epidemiology
The Epidemiologic Catchment Area Study found the prevalence of OCD to be approximately 1%. Reversing a previously held view, the study showed that women and men appear to be affected equally (Regier 1988). Further study has shown that women develop OCD later in life, have more comorbid depression, develop trichotillomania (compulsive hair pulling), and have a more severe course when compared to men. Like GAD, OCD is usually lifelong and has a waxing and waning course (Pigott 1998, Yonkers 1995). Genetic factors play a significant role in OCD, especially cases with early onset (Pauls 1992).

OCD frequently co-occurs with other psychiatric disorders. This is particularly true with major depression, which is comorbid in 33-75% of patients with OCD (Sciuto 1995, Steketee 1999). This strong association between the two disorders, coupled with OCD’s secrecy, reminds the clinician how important it is to look for OCD when diagnosing major depression.

Observation has shown an association between OCD and Tourette’s syndrome. About one half of people with Tourette’s syndrome have OCD, and 10% of people with OCD have Tourette’s. This connection has been further studied in children. PANDAS (Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal infections) describes a subset of children who develop OCD and tics after streptococcal infection (Swedo 1998). Further research is underway in this interesting area.
Treatment

SSRIs are the mainstay of pharmacotherapy, but the TCA clomipramine is equally effective (Piccinelli 1995). Psychotherapy, particularly cognitive and behavioral therapies, are at least as effective as pharmacotherapy (van Balkom 1998). In the hands of a good psychotherapist, behavioral therapy has virtually no side effects and the therapeutic gains are maintained over long-term follow-up (O’Sulliavan 1991).

Bibliography

OCD

DSM-IV


