



# OBSESSIVE COMPULSIVE AND RELATED DISORDERS

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# LIST OF DISORDERS WITH BRIEF DESCRIPTORS

- Obsessive Compulsive Disorder (OCD):
  - Obsessions – recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted, AND/OR;
  - Compulsions – repetitive behaviors or mental acts that an individual feels driven to perform in response to obsession or according to rules that are applied rigidly
- Body Dysmorphic Disorder: preoccupation with perceived body flaw (which others don't perceive)
- Hoarding: can't get rid of things, and clutter ensues
- Trichotillomania: compulsively removing hair from head, eyelashes, eyebrows
- Excoriation (Skin Picking) Disorder: compulsively picking at one's skin

# OBSESSIVE COMPULSIVE DISORDER

- Obsessions, compulsions, or both...
  - **Obsessions:**
    - Recurrent persistent thoughts, urges or images that are experienced as unwanted/ intrusive and usually cause distress
    - The individual attempts stop ignore/suppress thoughts, urges, and images OR attempts to neutralize them with some other thought or action (compulsion)
  - **Compulsions:**
    - Repetitive behaviors that an individual feels driven to perform in response to obsessions
    - The behaviors are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation, **BUT** the acts are not connected with what they are meant to prevent in any realistic way.
- Significant distress, disability, or time spent on obsessions or compulsions.

# SPECIFIERS

- With good or fair insight: Individual recognizes that obsessive-compulsive disorder beliefs are definitely or probably not true
- With poor insight: Patient thinks that they are probably true
- With absent insight/delusional beliefs: Person is absolutely convinced that they are true
- Tic related: Patient has current or past history of Tic Disorder
  - Tics happen in 30% of persons with OCD, more common in males with childhood onset

# USUAL OCD OBSESSIONS/COMPULSIONS

Cleanliness, germs, contamination

Symmetry (repeating, counting, arranging)

Forbidden or taboo thoughts  
(aggressive, sexual, religious)

Harm (fear of harming self, others,  
and need to check things)



# SOME FACTOIDS...

1. 12 month prevalence 1.2%. Females affected slightly more often than males. Males more likely to have onset in childhood.
2. Mean age of onset is 19.5, 25% of cases by the age 14.
3. Onset after 35 is rare, but not unheard of.
4. 25% of males have onset before age 10.
5. Usual onset is gradual, but acute onset is noted.
6. Usual course is waxing and waning.
7. Remission rates in adults low (~20%)
8. Childhood onset remits by adulthood in 40% of cases.
9. 50% contemplate suicide, 25% attempt.
10. Increased risk amongst physically, sexually abused in childhood, or other stressful/traumatic events.

# COMORBIDITY

76% HAVE ANOTHER ANXIETY DISORDER

63% HAVE ANOTHER MOOD DISORDER  
(41% HAVE MAJOR DEPRESSIVE DISORDER)

23-32% HAVE OBSESSIVE COMPULSIVE  
PERSONALITY DISORDER

# OCD VERSUS OCPD

Most people who say that they have OCD actually mean that they have **OCPD (obsessive compulsive PERSONALITY disorder)**.

This personality disorder applies to people who are overly structured, rigid, and perfectionistic in a way that is damaging to their relationships. They have a hard time being "flexible."

Many people with OCD also have OCPD, but the treatments are different.

# Screening Questions for OCD

Do you wash or clean a lot?

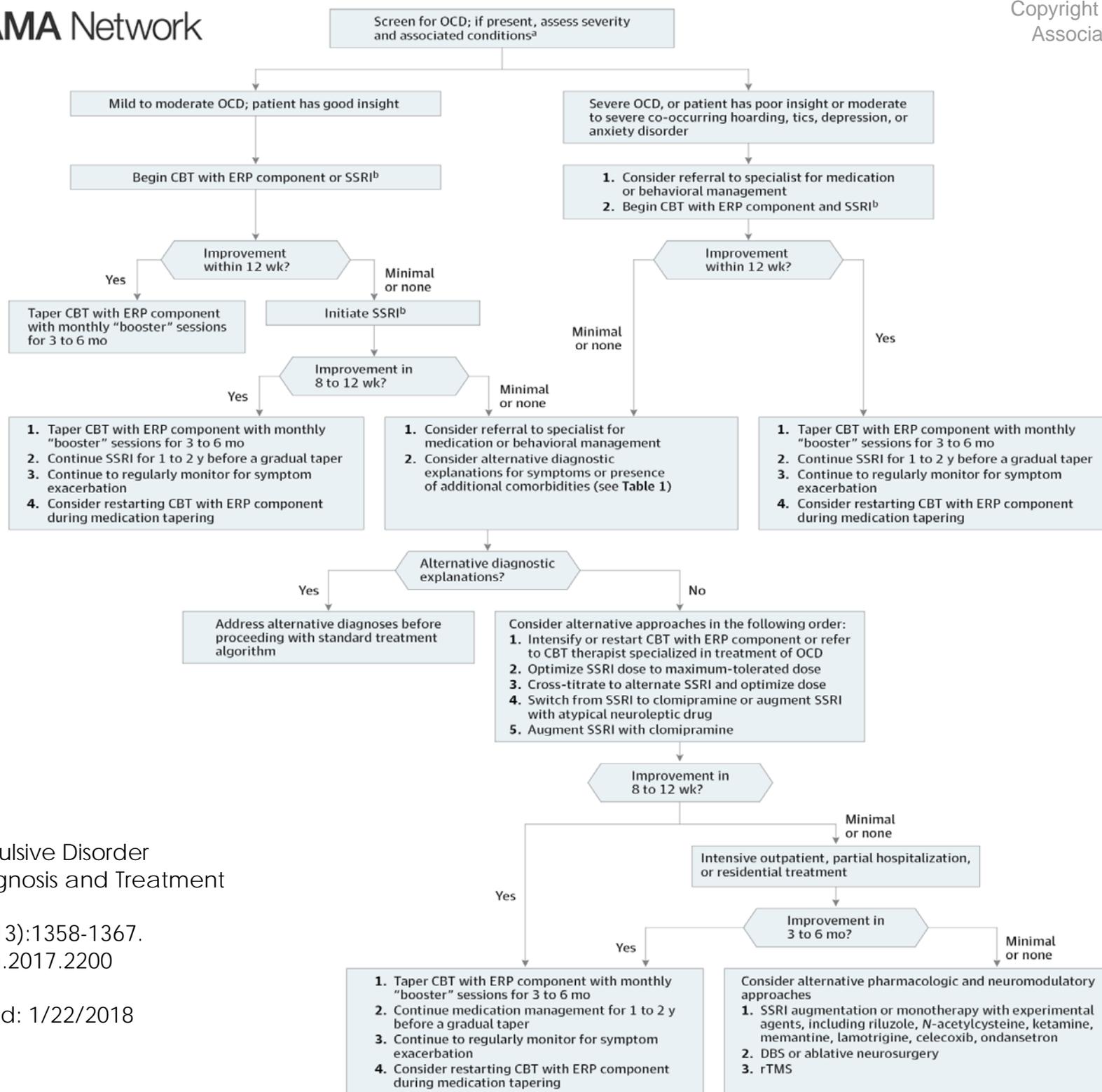
Do you check things a lot?

Is there any thought that keeps bothering you that you would like to get rid of but cannot?

Do your daily activities take a long time to finish?

Are you concerned about putting things in a special order, or are you very upset by mess?

If patient screens +, consider having them look at the **Yale Brown Obsessive Compulsive Inventory** which is widely available for free on the internet. *(Best, if you have time, review it with them).*



Source:

Obsessive-Compulsive Disorder  
Advances in Diagnosis and Treatment

JAMA. 2017;317(13):1358-1367.  
doi:10.1001/jama.2017.2200

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# KEY TAKEAWAYS FROM THE LAST SLIDE...

- For mild/ moderate cases you can choose between starting ERP therapy OR an SSRI. For more severe cases, both an SSRI and ERP therapy should be pursued concurrently.
- SSRI doses should be pushed as high as tolerated as long as patient is still not well. Experts will often push past maximum FDA recommended doses and monitor the patient carefully.
- The TCA clomipramine is very serotonergic and could be used after a failed trial of high dose of an SSRI. SE limit use.
- Augmentation with an atypical antipsychotic is the next step in the treatment algorithm, especially if the patient has TICS or very poor insight.
- Remember that comorbidities are common. Consider ECT if depression is severe. Last resort for many patients is a deep brain stimulator or ablative neurosurgery.

# BEHAVIORAL THERAPIES: EXPOSURE RESPONSE PREVENTION

- The go-to for phobias and OCD.
- Basically, consists of formulized exposures to aversive stimuli paired with prevention of phobic behaviors.
- *As an example:* someone has OCD with many obsessions and compulsions around cleanliness. Have patient list all things that make him anxious and pick things at about 4-6/10 level of distress to start working on (e.g. don't wash your hands for the session after you shake mine).

# First line medications for OCD from AFP

<i>DOSAGE (MG PER DAY)</i>				
<i>SSRI</i>	<i>STARTING</i>	<i>TARGET</i>	<i>MAXIMAL</i>	<i>COST*</i>
Citalopram (Celexa)	20	40†	40†	\$4 (\$200)
Escitalopram (Lexapro)	10	20	40	\$13 (\$240)
Fluoxetine (Prozac)‡	20	40 to 60	80	\$4 (\$305)
Fluvoxamine‡	50	200	300	\$17 (not available)
Paroxetine (Paxil)‡	20	40 to 60	60	\$4 (\$160)
Sertraline (Zoloft)‡	50	200	200	\$10 (\$215)

## THIS MIGHT BE A GOOD TIME TO TALK ABOUT ANTIPSYCHOTICS IN THE SETTING OF ANXIETY DISORDERS...

- OCD is the only “anxiety” disorder in which antipsychotics are routinely recommended for severe cases.
- **Risperidone** has the best evidence because it is the atypical antipsychotic which has been around the longest.
- You can use others. Next slide lists the most commonly used...

Drug/ usual doses.	Pro	Con
<b>Risperidone</b> (Risperdal®) 1-6mg	Cheap. Has the most evidence. Side effects are reasonable especially at low doses.	Of "atypicals" most likely to cause EPS and Prolactin Elevation (galactorrhea and breast development in men).
<b>Olanzapine</b> (Zyprexa®) 5-30mg	Now generic. Besides Clozapine, widely considered the most effective antipsychotic. Cause sedation (if that is needed). Little EPS. Effective for a wide range of psychiatric problems.	Very significant weight gain and metabolic side effects. And sedation which makes it intolerable for many.
<b>Quetiapine</b> (Seroquel®) 12.5-800mg	Very sedating even in low doses. Can help if sleep is a major issue. One of the few antipsychotics that has a small street value (people like it).	Sedation can be intolerable, especially as you edge towards effective antipsychotic doses.
<b>Aripiprazole</b> (Abilify®) 2-20mg	Not usually sedating. People can still go to work/school on this medicine easily. Has been shown to be a good augmentation agent for MDD.	Can cause extreme restlessness (akathisia). Still quite expensive (best place to get it is Costco).
<b>Ziprasidone</b> (Geodon®)	Much better metabolic profile compared to others. Good for people with comorbidities/ excessive weight gain on others.	Sedating, needs to be taken with meals, need to watch QTc interval closely. Likely somewhat less effective for severe illness.
<b>Lurasidone</b> (Latuda®)	Very good metabolic profile. One of the few drugs approved for bipolar depression. No QT prolongation.	Sedating, needs to be taken with food. Very expensive. Not cheaper than \$110 anywhere. Likely less effective for severe illness.

<b>DISORDER</b>	<b>DIAGNOSTIC CRITERIA</b>	<b>CLINICAL FEATURES</b>	<b>PREFERRED TREATMENT</b>
<b>Body dysmorphic disorder</b>	Preoccupation with perceived defects or flaws in physical appearance that leads to repetitive behaviors or mental acts in response to the apparent concerns	Poor insight Seeks care from dermatologists and cosmetic surgeons to address perceived defects Symptom onset during adolescence Waxing and waning course	Cognitive behavior therapy (exposure and response prevention) Some evidence for SSRIs
<b>Excoriation (skin-picking) disorder</b>	Recurrent skin picking resulting in skin lesions Repeated attempts to decrease or stop skin picking	More common in females Symptom onset at the beginning of puberty	Habit reversal therapy Limited studies evaluating response to pharmacotherapy
<b>Hoarding disorder</b>	Persistent difficulty discarding or parting with possessions because of strong urges to save items and/or distress with discarding items Accumulation of possessions to a degree that the space where possessions accumulate cannot be used as intended	75% of patients with hoarding disorder have comorbid mood or anxiety disorders The hoarding causes significant distress or impairment in function Symptom onset between 11 and 15 years of age Symptoms or hoarding behaviors progressively worsen	Behavior therapy targeted toward removal of hoarded items and reduction in

# 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, the person performs repeated behaviors (checking, skin picking, grooming, reassurance seeking) or medical care.
- The preoccupation causes dysfunction and/or distress.
- Muscle dysmorphia: thoughts that one is scrawny or insufficiently muscular.
- With good, fair, poor, or absent insight.



# TIDBITS ON BODY DYSMORPHIC DISORDER...

- 2.4% point prevalence, slightly higher in women (higher than OCD)
- Common in patients who are not seeking psychiatric help (dermatological patients, cosmetic surgery patients, oral surgery pursuant). Many go on to actually get surgery, and many of these go on to sue because they are unhappy with the surgery.
- Mean age of onset, 16-17, 2/3 before age 18. Childhood onset usually more gradual and more likely to result in suicide attempts.
- Associated with physical abuse and neglect in childhood.
- Suicide risk increased. 1/4 have attempted. Annual suicide rate 45X general population.
- High comorbidity with MDD and SAD

# TIDBITS ON BODY DYSMORPHIC DISORDER...

- >70% of people affected have poor or absent insight
- On average people with BDD spend 3-8 hours a day worrying about their bodies

# TREATMENT FOR BDD

- As for OCD, SSRIs are the first line and have been shown to decrease symptoms by about 50%, 1/4 have full remission.
- Antipsychotics can also be helpful.
- CBT can be tailored to Body Dysmorphic Disorder:
  - Start by clarifying goals
  - Challenge dysfunctional cognitions
  - Exposure to situation that are avoided.
  - Experiments to test the accuracy of beliefs about appearance.
  - Response prevention (spend less time in front of mirror)
  - Work on dysfunctional core beliefs (“I am unlovable”)
  - Mindfulness (learning to see one’s self in a mindful non-judgmental way)
  - Relapse Prevention.

Megan Kelly and Katharine Phillips  
Psychiatric Annals, November 2017, pgs 552-557

# HOARDING DISORDER

- Persistent difficulty discarding or parting with possessions, regardless of their actual value.
- Difficulty is due to perceived need to save the items and distress associate with discarding them.
- The difficulty discarding possessions results in the accumulation of possessions that congest and clutter living areas and compromise their intended uses.
- The hoarding caused significant distress or impairment.
- Not attributable to medical condition (brain injury, stroke, Prader Willi Syndrome).
- Modifiers:
  - With excessive acquisition
  - Good/ fair/ poor/ absent insight

# TIDBITS ON HOARDING DISORDER...

- Individual often indecisive, perfectionistic, avoidant, procrastinators, difficulty planning and organizing tasks.
- Animal hoarding is a thing.
- Estimated prevalence is 2-6%
- Symptoms usually start 11-15 years old, with symptoms and impairment usually getting worse as a person ages.
- Usually chronic and progressive.
- Many report stressful and traumatic life events.
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- Women tend to have more acquisitional traits, especially from buying things.
- 75% have comorbid mood or anxiety disorder, >50% have MDD

Medications only for comorbid conditions.

### CBT for Hoarding (from MAYO Clinic):

- Learn to identify and challenge thoughts and beliefs related to acquiring and saving items.
- Learn to resist the urge to acquire more items.
- Learn to organize and categorize possessions to help you decide which ones to discard.
- Improve your decision-making and coping skills.
- De-clutter your home during in-home visits by a therapist or professional organizer.
- Learn to reduce isolation and increase social involvement with more meaningful activities.
- Learn ways to enhance motivation for change.
- Attend family or group therapy.
- Have periodic visits or ongoing treatment to help you keep up healthy habits.



# TRICHOTILLOMANIA

- Recurrent pulling out of one's hair, resulting in hair loss.
- Repeated attempts to decrease or stop hair pulling.
- The hair pulling causes significant distress or impairment.
- Not the result of a dermatological condition.
- Usually scalp, eyebrows, eyelashes.
- Many experience an itch-like need to pull hair.
- Usually pull hair in secret or in front of family members.

# TIDBITS ON TRICHOTILLOMANIA...

- 12 month prevalence is 1-2%
- F>M 10:1 (but in children, more equal representation)
- More common if relatives have OCD

# TREATMENT OF TRICHOTILLOMANIA

As with Excoriation Disorder (which I will talk about next), the evidence for treating these illnesses is spotty and likely similar between these two disorders.

# EXCORIATION

- Recurrent skin picking resulting in skin lesions.
- Repeated attempts to decrease or stop skin picking.
- The picking causes clinically significant distress or impairment.
- Not result of a substance (Methamphetamines) or a medical condition (scabies).
- Not better explained by another problem (psychotic disorder, non-suicidal self-harm).

## TIDBITS ON EXCORIATION...

- Lifetime prevalence is 1.4% in adults
- 75% of individuals are female
- Usually starts in adolescence, but people present at various ages
- Chronic, waxing/waning course, large periods of relative wellness are all common

# TREATMENT OF TRICHOTILLOMANIA AND EXCORIATION DISORDER

- Cognitive and Behavioral Approaches like those listed here.
- Sparse evidence for medication treatments:
  - SSRIS have the best evidence (fluoxetine, citalopram, and escitalopram have been studied, usually up to high doses)
  - Augmentation with antipsychotics is likely helpful in severe cases.
  - N-acetyl Cysteine is promising
  - Evidence for Lamictal is equivocal
  - Some case reports of using Naltrexone and Inositol

Lochner et al, Neuropsychiatric Disease and Treatment, July 2017, pgs 1867-1871

# HABIT REVERSAL THERAPY

- **Awareness training**
  - Help person gain awareness of behaviors
  - Patient watches self, tries to understand what he does, how he knows he is about to have a tic or a behavior.
- **Development of a Competing Response**
  - The competing response should be the opposite of the tic or the behavior and should be able to be carried out longer.
  - *For example:* a competing response to hair-pulling might be to ball the hands into a fist and hold them rigidly alongside the body. Someone who repeatedly sticks out his tongue might purse his lips instead.
- **Developing Motivation**
  - Have patient list why he wants to be free of behaviors, have other praise him, and/or have him demonstrate his ability to control tics/ behaviors in front of therapist.
- **Generalization of skills**
  - Have patient continue to practice in settings where it counts (where it may be more difficult to control behaviors)

# OCD & RELATED DISORDERS DUE TO DRUGS/MEDICAL CONDITIONS

- Stimulant intoxication, synthetics (bath salts) or heavy metal/ other toxicity can cause symptoms of OCD or picking/pulling hair.
- Group A strep infection can cause OCD symptoms as part of Sydenham's Chorea (motor symptoms, obsessions, compulsions, attention-deficit, emotional lability, acute rheumatic fever, carditis, arthritis)
- PANDAS (Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal infections)