

# Chapter 19: Obsessive-Compulsive and Related Disorders

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## Introduction

The Obsessive-Compulsive and Related Disorders have arisen from the broader concept of Obsessive-Compulsive Spectrum Disorders first proposed by Hollander in 1993 (Hollander, 1993) which included related and co-occurring disorders. For the first time, DSM-5 (American Psychiatric Association, 2013) grouped a number of disorders into a new chapter called “Obsessive-Compulsive and Related Disorders” based on the presence of an obsessive preoccupation and/or repetitive behaviours. These disorders are listed in the box below. It is important to note that these disorders co-occur and that their treatment usually involves serotonergic antidepressants and/or psychological therapies based on similar principles.

### **Obsessive-compulsive and related disorders**

- Obsessive-compulsive disorder
- Body dysmorphic disorder
- Hoarding disorder
- Trichotillomania
- Excoriation disorder (Skin picking disorder)
- Body-focused repetitive behaviour disorder (e.g., excessive nail biting)
- Obsessional jealousy
- Jikoshu-Kyofu (Olfactory reference syndrome)

## Obsessive-Compulsive Disorder

Obsessive-compulsive disorder (OCD) is characterised by obsessions and/or compulsions. Obsessions are defined as recurrent, intrusive and distressing thoughts, images or impulses. Classically obsessions were defined as *ego-dystonic* in that they were thought to be in sharp contrast to the individual's wishes and desires. Compulsions are repetitive behaviours or mental acts. Obsessions and compulsions are usually recognized as irrational and most sufferers have full insight into their unreasonable and excessive nature. See the box below for some examples of common obsessions and compulsions. OCD can also present with indecisiveness, obsessional slowness, avoidance and excessive reassurance-seeking.

Obsessions	Compulsions
<ul style="list-style-type: none"> <li>• I have left the stove on and the house will burn down.</li> <li>• If I touch something, I will be contaminated.</li> <li>• I might accidentally stab someone.</li> <li>• I feel an urge to touch a stranger's genitals.</li> <li>• A recurrent blasphemous thought or image.</li> <li>• I become distressed if I see a dining chair out of place.</li> <li>• If I am not clean, I might give my children food poisoning.</li> </ul>	<ul style="list-style-type: none"> <li>• Repeated checking of knobs, locks and windows.</li> <li>• Excessive handwashing or cleaning.</li> <li>• Excessive ordering and arranging.</li> <li>• Repeated praying.</li> <li>• Inability to stop counting.</li> <li>• A need to ask people things repeatedly.</li> <li>• A need to repeatedly touch things.</li> </ul>

### Epidemiology

OCD is thought to occur in 0.8 to 2% of the population (Karno et al., 1988). Subclinical obsessive-compulsive symptoms occur at a much higher rate, as do obsessive-compulsive or "perfectionistic" personality traits, which are commonly confused with OCD by the general public. Obsessive-compulsive disorder often has its onset in early adolescence, but also has a later peak in the mid-twenties. Early onset is associated with a male preponderance, tic disorders and higher incidence of OCD in other family members (Steven, 2011). Early onset OCD is also associated with greater severity of symptoms. Despite the common misperception that OCD is a trivial disorder, OCD has been ranked among the top ten most disabling of all

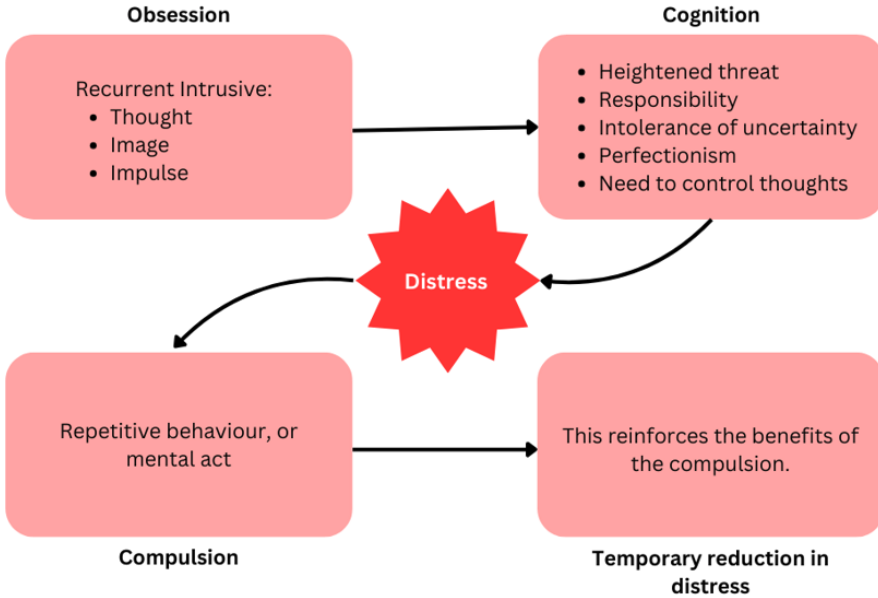
medical conditions (Murray and Lopez, 1996). Rates of OCD are similar in men and women and across different cultures, unlike anxiety disorders where women have higher rates of anxiety disorders than men (Weissman et al., 1994).

## Aetiology

The aetiology of OCD is unknown but is likely to be multifactorial. Although no single gene has been linked to the development of OCD, twin studies indicate that both genetic and environmental factors play a role in its development (Taylor et al., 2010). Functional neuroimaging has shown abnormal and heightened connectivity of the ventrolimbic corticostriatal regions of people with OCD (Harrison et al., 2009). Cognitive models link OCD to an inflated sense of responsibility that has hypothesised to have arisen from over-protective parenting (Salkovskis, 1999), and psychoanalytic models propose a regression to the anal stage of psychosexual development (Freud, 1958). A cognitive model of understanding OCD symptoms is presented in Figure 19.1.

## Presentation

It is important to appreciate that people with OCD are often too ashamed or embarrassed to present for help. They commonly present because their relatives can no longer tolerate their behaviour, or due to a co-occurring anxiety or mood disorder. When people with OCD self-present, they can no longer tolerate the distress associated with their OCD or their OCD symptoms are causing functional impairment. Compulsions can take many hours a day and can lead to delays in completing tasks and getting to appointments on time. The only common physical sign is the presence of erythematous and dry hands caused by excessive hand washing.



**Figure 19.1.** A cognitive model for OCD.

## Assessment

Screening for OCD involves screening for common symptoms for OCD. Symptom severity is most commonly assessed using the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) (Goodman et al., 1989). OCD is diagnosed when the symptoms are distressing, time consuming (i.e. when they take more than one hour per day) or when they cause significant functional impairment.

## Differential Diagnosis and Important Comorbidities

The most commonly co-occurring disorders are major depression and generalised anxiety disorder. It can be difficult to differentiate obsessions from depressive ruminations (reflections on the past) and excessive worries (worries about the future) associated with generalised anxiety disorder. The other diagnosis which one must be aware of is schizophrenia as obsessive-compulsive symptoms occur in approximately 15% of patients with schizophrenia, they can also occur in the prodrome of schizophrenia (see Chapter 15). Patients with severe OCD can present with poor insight where they are convinced that they need to do something compulsively, or where they believe that their obsession is reasonable.

Another important co-occurring disorder is tic disorder. Tics occur more commonly in patients who have early onset OCD and a family history of OCD. Tics are defined as spasmodic movements that often occur in facial musculature.

Tourette's syndrome is diagnosed when motor tics co-occur with vocal tics, for example, coughing or grunting noises.

## Evidence-Based Treatments

OCD can be treated with either cognitive behavioural therapy (CBT; see Chapter 33) in the form of exposure and response prevention (ERP), or with high dose selective serotonin reuptake inhibitor (SSRIs). If either is ineffective, treatments are then combined.

### Exposure and Response Prevention

The most effective psychological treatment for OCD is ERP for both adults and children (Abramowitz et al., 2006; Foa et al., 2007). This involves exposing the sufferer to the thing they fear and preventing their response or compulsion. For example, asking someone with contamination fears to touch a door handle and then to prevent their response of compulsively washing their hands. ERP typically involves 15 to 30 sessions which means that psychological treatment usually takes longer than for other anxiety disorders. ERP is thought to work by disconfirming any threat-related cognitions associated with OCD and improving one's confidence when faced with anxiety provoking situations. As family members often accommodate to the requests of sufferers associated with their compulsions or avoidance in order to reduce their loved one's distress, it can help to explain to family members how they can help reduce OCD behaviour and assist the patient with their ERP tasks.

### Pharmacotherapy

Pharmacotherapy usually consists of a high dose serotonergic medication (SSRIs and clomipramine). SSRI medications are increased in dose over a number of weeks providing they are tolerated and that there is some degree of improvement. Providing there has been some improvement, the SSRI should be continued for at least 3 months to determine the maximum effect of the medication. Clomipramine, a serotonergic tricyclic antidepressant, is also effective in treating OCD. High doses are usually necessary and clinical response takes considerable time. In practice, it is not used first line because of a high rate of adverse effects. Common adverse effects include dry mouth, dizziness, low blood pressure, drowsiness, blurred vision, urinary retention, and sexual dysfunction. When high dose serotonergic antidepressants have only had a partial response, augmentation with antipsychotic medication can be useful.

## Outcome

With appropriate therapy, most people with OCD can expect a reduction in the severity of their OCD symptoms. However, complete remission is

uncommon and many people with OCD remain chronically disabled by their symptoms. Hence, OCD is usually considered a difficult to treat relapsing and remitting disorder. Some patients have severe, intractable OCD which may require treatment with intensive in-patient ERP, deep brain stimulation or various forms of psychosurgery.

## Body Dysmorphic Disorder

Body dysmorphic disorder is characterised by an excessive preoccupation with one's appearance or with a part of their body. People with body dysmorphic disorder believe that a part of their body, e.g. their nose, is misshapen, discoloured or deformed. This preoccupation can lead to repetitive checking in the mirror, seeking plastic surgery, and/or avoidance of social situations. The treatment of body dysmorphic disorder is similar to OCD. Despite a higher rate of more strongly held beliefs than OCD, SSRI treatment is more effective than antipsychotic medication.

## Hoarding Disorder

Hoarding disorder refers to the excessive accumulation of household items accompanied by the inability to discard these items. In community surveys, hoarding disorder appears to affect approximately 1% of the population (Nordsletten et al., 2013). To meet criteria for a disorder, at least one room of the person's house is required to be cluttered to such an extent that it can no longer be used, for example the person with hoarding disorder is unable to sleep in his or her bedroom as it has too many items in it. Hoarding disorder is often confused with squalor which is characterised by much more disorganisation and filth with the aetiology of squalor often being dementia, schizophrenia or chronic alcohol abuse. Hoarding disorder is challenging to treat, but some studies have supported tailored cognitive behavioural strategies and SSRIs.

## Trichotillomania

In trichotillomania, also known as "*hair pulling disorder*", sufferers excessively pull out hair from their head, eyebrows, eye lashes or pubic area to the extent that baldness develops. There is often a sense of pleasure associated with feeling the hair and a sense of relief when the hair is pulled out. The hair loss can be so severe that the sufferer needs to wear hats or wigs to hide their patches of hair loss. Children can swallow their hairs and this can lead to hair balls (bezoars) forming in the gastrointestinal tract that can lead to gastrointestinal obstruction. Although there is some evidence for treating trichotillomania with SSRIs, trichotillomania had traditionally been regarded as an impulse control disorder (i.e. a failure to resist

temptation, urges or impulses to hurt oneself or others) and behavioural techniques modified for trichotillomania such as habit reversal therapy are usually tried first. Habit reversal therapy is a psychological therapy that involves reversing bad habits or impulses by introducing other less deleterious actions, e.g. squeezing a stress ball rather than engaging in hair pulling. The amino acid supplement N-acetylcysteine may also be useful for treating trichotillomania when administered at doses between 600mg and 1200mg twice daily.

## Excoriation Disorder (Skin Picking Disorder)

Excoriation disorder (also known as dermatillomania) is defined by recurrent picking of the skin to the extent that skin lesions develop. Similar behaviour can result from stimulant abuse. There is some evidence that habit reversal therapy, SSRIs and N-acetylcysteine can help reduce skin picking.

## Body-Focused Repetitive Behaviour Disorder

Body-focused repetitive behaviour disorder refers to distressing and/or damaging repetitive behaviours that focus on the body and cannot be easily stopped by the sufferer. Examples of body-focused repetitive behaviours include excessive nail biting, lip biting, cheek chewing and chewing of the knuckles. As with trichotillomania, habit reversal therapy is often used as a specific psychological therapy aiming to reverse the body-focused behaviour by introducing a less harmful behaviour.

## Obsessional Jealousy

In obsessional jealousy there is an excessive preoccupation with the idea that one's spouse or partner might be having an affair. This preoccupation is usually accompanied by excessive checking, e.g. of the spouse's underwear, telephone records, car seats for hairs, and car speedometer. There may also be associated stalking. If the preoccupation becomes delusional where the patient firmly believes that their spouse or partner has been unfaithful without any proof to substantiate their claim, then the disorder is regarded as delusional jealousy or Othello's Syndrome. As some patients with delusional jealousy have been known to murder their spouse, one must always assess for any risk that the preoccupied individual may pose towards their spouse or the person that they might suspect that their spouse is having an affair with. Treatment with SSRIs and psychotherapy has been used (Stein et al., 1994).

## Olfactory Reference Syndrome (Jikoshu-Kyofu)

Olfactory reference syndrome is also known as Jikoshu-Kyofu as it has been well documented in the Japanese literature. It refers to a disorder where effected individuals are preoccupied with a belief that they smell or that they are emitting a foul odour when they do not obviously smell. This belief is associated with avoidance of social settings and the excessive use of deodorants or mouth fresheners. This disorder can be treated with SSRIs (Matsunaga et al., 2001).

### Further Reading

- Abramowitz, J. S., Taylor, S., & McKay, D. (2009). Obsessive-compulsive disorder. *The Lancet*, 374(9688), 491-499.
- Stein, D. J., Costa, D. L., Lochner, C., Miguel, E. C., Reddy, Y. J., Shavitt, R. G., ... & Simpson, H. B. (2019). Obsessive-compulsive disorder. *Nature Reviews Disease Primers*, 5(1), 52.

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## References

- Abramowitz JS, Whiteside SP and Deacon BJ (2006) The effectiveness of treatment for pediatric obsessive-compulsive disorder: A meta-analysis. *Behavior Therapy* 36(1): 55-63.
- American Psychiatric Association (2013) *The Diagnostic and Statistical Manual for Mental Disorders DSM 5*. Arlington, VA: American Psychiatric Publishing.
- Foa EB, Liebowitz MR, Kozak MJ, et al. (2007) Randomized, Placebo-Controlled Trial of Exposure and Ritual Prevention, Clomipramine, and Their Combination in the Treatment of Obsessive-Compulsive Disorder. *FOCUS* 5(3): 368-380.
- Freud S (1958) The disposition to obsessional neurosis, a contribution to the problem of the choice of neurosis. *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XII (1911-1913): The Case of Schreber, Papers on Technique and Other Works*. pp.311-326.
- Goodman WK, Price LH, Rasmussen SA, et al. (1989) The Yale-Brown Obsessive Compulsive Scale. I. Development, use, and reliability. *Archives of general psychiatry* 46(11): 1006-1011.
- Harrison BJ, Soriano-Mas C, Pujol J, et al. (2009) Altered corticostriatal functional connectivity in obsessive-compulsive disorder. *Archives of general psychiatry* 66(11): 1189-1200.
- Hollander E (1993) *Obsessive-compulsive-related disorders*. Amer Psychiatric Pub Inc.
- Karno M, Golding JM, Sorenson SB, et al. (1988) The epidemiology of obsessive-compulsive disorder in 5 United-States communities. *Archives of general psychiatry* 45(12): 1094-1099.
- Matsunaga H, Kiriike N, Matsui T, et al. (2001) Taijin kyofusho: a form of social anxiety disorder that responds to serotonin reuptake inhibitors? *The International Journal of Neuropsychopharmacology* 4(03): 231-237.
- Murray C and Lopez AD (1996) Summary: The global burden of disease: A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020. *Geneva and Boston: World Health Organization and Harvard School of Public Health*.
- Nordsletten AE, Reichenberg A, Hatch SL, et al. (2013) Epidemiology of hoarding disorder. *The British Journal of Psychiatry*. bjp. bp. 113.130195.
- Salkovskis PM (1999) Understanding and treating obsessive-compulsive disorder. *Behaviour Research & Therapy* 37 Suppl 1: S29-52.
- Stein DJ, Hollander E and Josephson SC (1994) Serotonin reuptake blockers for the treatment of obsessional jealousy. *Journal of Clinical Psychiatry*.
- Steven T (2011) Early versus late onset obsessive-compulsive disorder: Evidence for distinct subtypes. *Clinical Psychology Review* 31(7): 1083-1100.

- Taylor S, Jang KL and Asmundson GJ (2010) Etiology of obsessions and compulsions: A behavioral-genetic analysis. *Journal of abnormal psychology* 119(4): 672-682.
- Weissman MM, Bland RC, Canino GJ, et al. (1994) The cross-national epidemiology of obsessive-compulsive disorder. *Journal of Clinical Psychiatry* 55: 5-10.