

CHAPTER 15

Obsessive–Compulsive and Related Disorders

QUICK GUIDE TO THE OBSESSIVE–COMPULSIVE AND RELATED DISORDERS

Obsessive–compulsive disorder. These patients are bothered by repeated thoughts or behaviors that appear senseless, even to them (p. 285).

Body dysmorphic disorder. Physically normal patients persistently believe that parts of their bodies are misshapen or ugly (p. 291).

Trichotillomania. Pulling hair from various parts of the body is often accompanied by feelings of “tension and release” (p. 289).

Excoriation disorder. Patients so persistently pick at their skin that they traumatize it (p. 291).

Hoarding disorder. An individual accumulates so many objects (perhaps of no value) that they interfere with life and living. Although hoarding begins when the patient is young, it doesn’t usually come to clinical attention until much later (p. 291).

Obsessive–compulsive and related disorder due to another medical condition. Occasionally, obsessions and compulsions can be caused by another physical illness (p. 294).

Substance/medication-induced obsessive–compulsive and related disorder. Rarely, use of a substance can lead to obsessive–compulsive symptoms that don’t fulfill criteria for any of the above-mentioned disorders (p. 294).

Other specified, or unspecified, obsessive–compulsive and related disorder. Use one of these categories for disorders with prominent obsessional or compulsive symptoms that do not fit neatly into any of the groups above (p. 294).

INTRODUCTION

In this chapter, we consider disorders involving thoughts and behaviors that are often intrusive, repetitive, and time-consuming. (The DSM-5 chapter on these disorders is new to the DSMs.) Obsessive–compulsive disorder (OCD) is the best known of these, but there are others—skin picking, hoarding, checking for body defects. Initially, at least, some of these behaviors carry with them a whiff of pleasure, such as the relief of tension a teenager might feel when tweaking out a strand of hair, or the fun some people get from collecting before it has morphed into the burden of hoarding.

The features that bind together this group of conditions include youthful onset, similar comorbidity, family history of OCD, response to the same kinds of treatment, and perhaps dysfunction in the frontostriatal brain circuitry (caudate hyperactivity).

F42 OBSESSIVE–COMPULSIVE DISORDER

For generations, we mental health clinicians have known of OCD. What we have not recognized is that, far from being rare in young people (as was once thought), OCD is actually relatively common, occurring in up to 2% of all children and teenagers. OCD begins earlier in boys, who, as younger children, outnumber girls with the disorder by perhaps 2:1; at puberty, the ratio drifts toward parity. Mean age of onset is about 10 years, earlier in boys than girls. Although the outlook is good relative to adult-onset OCD, in about 40% of children the disorder persists into the adult years. Fully half the adults with OCD first become symptomatic as children.

Until recently, we have failed to appreciate just how often this debilitating condition begins in early childhood. Part of the explanation is that children may keep secret their obsessive thinking and compulsive behavior. They may control repetitive rituals relatively well in public settings (such as school), only letting down their guard at home. Even parents are sometimes surprised to learn the extent of their children's disability. With parents' ignorance and children's reluctance to ask for help, many youngsters with OCD remain undiagnosed and untreated for months or years.

Like adults, children and adolescents experience compulsions more frequently than obsessions. Young children often don't have obsessional thinking that accompanies their compulsions—just “an urge to do it.” The content of children's obsessions most often concerns dirt and contamination, sex (including the possibility of homosexuality), and religious and other moral concerns. These naturally lead to compulsions of cleaning, checking (to ensure that a behavior has truly been accomplished), and repetition. Adolescents are especially prone to religious or sexual obsessions; concerns about cleaning are rare. However, the content of these thoughts and behaviors tends to change with time, so that today's symptoms may be forgotten tomorrow—supplanted by other obsessional ideas and compulsive

behaviors. Major depression is often comorbid, as are anxiety and tic disorders; the presence of a comorbid condition predicts a worse prognosis.

Like most other mental conditions, OCD appears to stem from a variety of causes. Foremost among them is heredity, with rates ranging around 50%. However, many patients have no known family history at all. Some cases appear to involve an immune response to infectious disease (pediatric acute-onset neuropsychiatric syndrome, or PANS, associated with streptococcal infections), which has also been implicated in tic disorders (see sidebar, p. 215).

Although OCD is sometimes episodic, it more commonly runs a chronic course. Follow-up studies of varying length find that although most patients continue to have symptoms, the disorder may remit in some 40% or more by the time they are adults. Early onset, severe symptoms, long duration, comorbidity, and a first-degree relative with OCD all predict persistence of symptoms into adulthood.

Corey

When he was 15, Corey tried to buy a gun. He was tall and had been shaving for a couple of years, and he might have succeeded if he hadn't written his actual telephone number on the form for the 5-day waiting period. The clerk thought he looked depressed, and called Corey's mother after he left the shop.

"That's how I ended up here instead of the morgue," Corey told his clinician the day after he was admitted to a locked mental health unit. "Anything seemed better than feeling rotten all the time."

Information from a number of sources supported a diagnosis of a mood disorder. Several teachers had noticed that Corey's concentration had been impaired for a month or more; his grades had plummeted. His mother had worried that he wasn't eating; his father had observed that he'd seemed to lose interest in the basement color photo-processing lab they had worked on all winter. Corey himself complained of several weeks' sleeplessness and chronic fatigue; he said he felt guilty that he had let his father down about the lab ("I knew he enjoyed it"). His family doctor had said he was physically healthy.

After a diagnosis of major depressive disorder and 10 days' treatment with an antidepressant, Corey improved enough that his name came up in a discharge-planning conference. "What about the compulsions?" asked the evening nurse, who had doubled back that morning to fill in.

"What compulsions?" everyone else wanted to know.

The nurse hadn't known about them either, until Corey's roommate had finally spilled the beans during group therapy. It took Corey 3 hours to get ready for bed. Everything had to be done in a certain order—teeth first, 10 strokes per tooth from roots to crown, beginning with the left upper molars. If he lost count, or if he thought he did, he started over. Toothbrushing alone sometimes occupied 45 minutes.

ESSENTIAL FEATURES OF **OBSESSIVE–COMPULSIVE DISORDER**

The patient has distressing obsessions or compulsions (or both!) that occupy so much time they interfere with accustomed routines.

The Fine Print

Obsessions are recurring, unwanted ideas that intrude into awareness; the patient usually tries to suppress, ignore, or neutralize them.

Compulsions are repeated physical (sometimes mental) behaviors that follow rules (or are a response to obsessions) in an attempt to alleviate distress; the patient tries to resist them. The behaviors are unreasonable, meaning that they don't have any realistic chance of helping the obsessional distress.

The D's: • Distress or disability (typically, the obsessions and/or compulsions occupy an hour a day or more or cause social, educational, occupational, or personal impairment) • Differential diagnosis (substance use and physical disorders; "normal" superstitions and rituals that don't actually cause distress or disability; depressive and psychotic disorders; anxiety and impulse-control disorders, Tourette's and other tic disorders; obsessive–compulsive personality disorder)

Coding Notes

Specify degree of insight:

With good or fair insight. The patient realizes that these thoughts and behaviors are definitely (or probably) not true.

With poor insight. The patient thinks that the OCD concerns are probably true.

With absent insight/delusional beliefs. The patient strongly believes that the OCD concerns are true.

Specify if:

Tic-related. The patient has a lifetime history of a chronic tic disorder.

"If I don't get it right, I feel awful. I squirm." Corey admitted that he didn't know what would happen if he didn't "get it right," but he worried that it could be pretty terrible. "It even sounds dumb to me. Like, rationally, what could possibly happen? But being rational doesn't seem to have much to do with it."

After Corey finally finished brushing his teeth, he would shower—scrubbing away with his washcloth for 100 strokes per body part at a time, until the hot water ran out. He men-

tally divided his towel into four segments: the first for his face and neck, the second for his arms and legs, the third for his upper body, and the fourth for “everything that’s left over.” There had been a few times 6 or 8 months ago, not long after his rituals began to get out of hand, when he became confused about which part of the towel he had used and commenced the whole showering process again. But cold showers and soggy towelings had taught him to pay close attention to the details of his drying process. Other rituals would follow—how many steps to take, which objects to touch (or untouch if he got it wrong), how to arrange his slippers, how to take off his bathrobe—as he physically got, or tried to get, into bed.

Although Corey’s bedtime rituals had begun only about a year ago, even as a small child he had had a variety of fears and obsessional thoughts. “Mainly, I’d count things. You know—how many steps it took to get from one block to the next; how many breaths; how many ceiling tiles, or holes in ceiling tiles, in the classroom. There’s nearly 10,000 in my room here.”

From the time Corey was 5, his mother noted, he had been afraid of a possible terrorist attack. When he would open his eyes in the morning, the light streaming through his window would sometimes be so bright that he would start counting seconds as he waited for the blast that seemed certain to come. She added that the family history was negative for mental disorders—except for her husband’s brother, who had developed a facial tic when he was a teenager. It had lasted until he committed suicide when he was 31.

Evaluation of Corey

Corey’s current OCD symptoms were largely limited to compulsions; obsessions by themselves would also qualify him for this diagnosis. He felt that he had to repeat these behaviors (primarily his bedtime rituals, although his earlier behavior of counting was also still present—Criterion A1). He carried out these behaviors according to strict rules (number of strokes, arranging his slippers, touching), and he felt that if he didn’t follow the rules, something awful would happen (A2). It didn’t matter that he couldn’t define the consequence; this simply underscored the fact that there could be no realistic relationship between the behaviors and the consequences they were intended to avert. The symptoms were important, in that they both caused him distress and wasted a lot of time (B). The family doctor found no evidence of **substance use** or a **medical condition**; the latter would be important to rule out, since obsessive–compulsive behavior has been reported in Lyme disease and streptococcal infections (C). Although as a younger child he might not have had insight into the excessive or unreasonable nature of his symptoms, he did now. The specifier *with good insight* therefore applies.

There is no evidence to support a different mental disorder, such as an **anxiety disorder** or a **different condition related to OCD**, as the source of his symptoms (D). Corey had not reported **panic attacks**, and his fears were of some vague retribution that could occur, not of those typical of the more **specific phobia** or **social anxiety disorder**. Patients with

generalized anxiety disorder also worry a lot, but about a variety of situations that seem realistic (see, for example, the history of Gerald given earlier). Obsessive–compulsive symptoms are often encountered in patients with tic disorders including **Tourette’s disorder**, which should have been considered (and quickly rejected) in Corey’s case.

Depressions like Corey’s are frequently encountered in OCD and are often the reason patients come for evaluation. Corey had more than enough symptoms to diagnose major depressive disorder (see p. 239): For at least 2 weeks (Criterion A for MDD) he had had depressed mood (A1), poor concentration (A8), decreased appetite (A3), loss of interest (A2), insomnia (A4), fatigue (A6), and a suicide plan (A9). They caused him much distress and interfered with school (B); we’ve already ruled out substances and other illnesses as possible causes (C). Because he was not psychotic and had no history of prior mood disorder, he would be diagnosed as having major depressive disorder, single episode, severe (see Table 13.1).

Because it more urgently required attention, we list Corey’s major depressive disorder first:

F32.2	Major depressive disorder, single episode, severe
F42	Obsessive–compulsive disorder, with good insight
CGAS	45 (on admission)
CGAS	70 (on discharge)

F63.3 TRICHOTILLOMANIA

A “passion for hair pulling” (the literal meaning of the word *trichotillomania*) was first described over 100 years ago. Today it is found in at least 1 in 200 persons in the adult population (the actual rate could be several times greater), though it usually begins before puberty. The prevalence in childhood has yet to be accurately defined. Girls and boys are both affected, though the ratio in adults is perhaps 10:1. Despite their discomfort, patients seldom complain about or even mention their symptoms, so relatively few mental health professionals—fewer still who specialize in children and adolescents—have ever encountered a case.

Trichotillomania (see the Essential Features, p. 290) is simply defined. DSM-5 no longer requires a rising sense of tension that is relieved when the patient pulls out a strand of hair. Indeed, a substantial number of patients describe the behavior as occurring “automatically” at times when they are thinking about other matters. However, some individuals still report experiencing the tension-and-release phenomenon.

The head is most often involved, though the affected hair can be growing on any part of the body—face, brows, lashes, extremities, and (in adolescents and adults) underarms and pubic area. Chewing or mouthing of the hair often occurs; about 10% of patients swallow it. However, development of a bezoar (such as Eve’s in the case vignette) is unusual. Hair

pulling is much more common in children than in adults, suggesting that the usual outcome is spontaneous resolution.

Eve

When Eve was 13, she developed acute abdominal pain that gradually worsened over 4 weeks. Her family doctor could make no diagnosis, but one evening the cramping became so severe that her parents rushed her to the urgent care department of their community hospital. An X-ray revealed something blocking her small intestine. It required surgery to remove the object—a bezoar, or hairball, nearly 2 inches in diameter.

That discovery prompted the doctor to look closely at Eve's scalp. "In several patches of scalp the size of a half-dollar, I saw a pattern of thinning of hair, with the characteristic intermingling of long and short hairs growing back in a pattern typical of chronic hair pulling," read the report that accompanied Eve to the mental health counselor. "This conclusion was subsequently confirmed by a dermatologist."

When questioned about her habit, Eve readily admitted that she had been pulling out her hair, a strand or two at a time, for many months. Though she didn't seem to understand why it happened, she acknowledged that many times a day she would feel increasingly "wired." After several minutes of rising tension, she would twirl a single hair around her ring finger, then gently tug until the strand came away at the root. If no one was watching, she would then roll the strand over and over in her mouth until it was as compact as her tongue could make it. As she swallowed, the sense of tension would evaporate. Although the hair pulling produced no sense of pain, she noted that her scalp seemed to itch where her hair was growing back.

Eve was a slender girl whose figure had barely begun to develop. She wore her blond hair tucked under a knit cap, which she resisted removing. Once the cap was off, it was easy to see why she preferred to wear it. Downy, new, short hairs sprouted in the patches where hair was either missing or thinned.

The initial interview revealed no information to suggest another diagnosis. Eve denied

ESSENTIAL FEATURES OF TRICHOTILLOMANIA

Repeated pulling out of the patient's own hair results in bald patches and attempts to control the behavior.

The Fine Print

The D's: • Duration ("recurrent") • Distress or disability (social, educational, occupational, or personal impairment) • Differential diagnosis (substance use and physical disorders; mood and psychotic disorders; body dysmorphic disorder; OCD; ordinary grooming)

having any other mental or physical problems (among other issues, her mother had reported no evidence of hallucinations, delusions, depression, obsessions, or compulsions). As she slouched in her chair, she grumbled, “I just wish I could stop. I hate wearing that hat, and the kids all call me ‘Baldy.’ But if I don’t do it, I just feel grody.”

Evaluation of Eve

The facts of Eve’s hair pulling speak for themselves: It was recurrent (Criterion A) and it caused distress (C). We’ll have to infer from her statement about wishing to stop that she had repeatedly attempted to do so (B). Eve’s hair pulling had lasted several months, though there is no absolute time requirement for diagnosis. Children often do not report the tension-and-release phenomenon (which DSM-5 no longer requires for adults, either). Eve, however, spontaneously noted that her unpleasant sensation of feeling “wired” (or “grody”) abated once she had completed her ritual.

In an evaluation of patchy hair loss, **other medical conditions** (especially **dermatological disorders**) must be considered (D). Eve had no evidence of such a problem, or of another mental disorder (such as a **psychosis**, **OCD**, or **factitious disorder**) that could explain her symptoms better (E). Her entire diagnosis would be as follows:

F63.3	Trichotillomania
CGAS	70

F45.22 BODY DYSMORPHIC DISORDER

L98.1 EXCORIATION (SKIN-PICKING) DISORDER

F42 HOARDING DISORDER

Some studies suggest that even people without body dysmorphic disorder (BDD) can become distressed upon prolonged gazing into a mirror. But when dissatisfaction with an aspect of personal appearance becomes so intense that a person begins to engage in repetitive behaviors (see the Essential Features of BDD, p. 292), a diagnosis of BDD may be warranted. Early onset of BDD is more gradual, more severe, and carries with it greater comorbidity, including attempts at suicide.

People with excoriation disorder pick or dig at their skin, sometimes to the point that it causes physical damage (pitting, scarring)—in addition to the psychological trauma of shame and embarrassment.

Although hoarding disorder tends to begin young, two features protect children and adolescents from the full extent of the problem: (1) Kids don’t have full control over their

environments (“Clean your room, Billy”). (2) It takes years to accumulate a mountain of stuff, pushing the age of total involvement well into young adulthood or beyond.

Each of these conditions typically begins during the teen years, though clinical attention may not be sought until many years later. Each disorder has a prevalence of perhaps 2% in the general adult population; BDD and excoriation disorder are distributed more or less equally between males and females, whereas hoarding disorder may be more typical of males.

All three disorders tend to be familial. For BDD and excoriation disorder, OCD in a first-degree relative is a risk factor, and major depressive disorder may be comorbid. Hoarding disorder has been found in 16% of children with learning disabilities.

Clinicians who care for children and adolescents are not often presented with these conditions, so we have provided no vignettes here. Interested readers can find more about these disorders in *DSM-5 Made Easy* by James Morrison.

ESSENTIAL FEATURES OF **BODY DYSMORPHIC DISORDER**

In response to a miniscule, sometimes invisible physical flaw, the patient repeatedly checks in a mirror, asks for reassurance, or picks at patches of skin—or makes mental comparisons with other people.

The Fine Print

The D’s: • Distress or disability (social, educational, occupational, or personal impairment) • Differential diagnosis (substance use and physical disorders; mood and psychotic disorders; anorexia nervosa or other eating disorders; OCD; illness anxiety disorder; ordinary dissatisfaction with personal appearance)

Coding Notes

Specify if:

Muscle dysmorphia form. These people believe that their bodies are too small or lack adequate musculature.

Specify degree of insight:

With good or fair insight. The patient realizes that these thoughts and behaviors are definitely (or probably) not true.

With poor insight. The patient thinks that the BDD concerns are probably true.

With absent insight/delusional beliefs. The patient strongly believes that the BDD concerns are true.

ESSENTIAL FEATURES OF EXCORIATION DISORDER

The patient repeatedly tries to stop recurrent digging, scratching, or picking at skin that has caused lesions.

The Fine Print

The D's: • Duration (“recurrent”) • Distress or disability (social, educational, occupational, or personal impairment) • Differential diagnosis (substance use and physical disorders; psychotic disorders; OCD; body dysmorphic disorder; stereotypic movement disorder)

ESSENTIAL FEATURES OF HOARDING DISORDER

These patients are in the grip of something powerful: the overwhelming urge to accumulate stuff. They experience trouble—indeed, distress—when trying to discard their possessions, even those that appear to have little value (sentimental or otherwise). As a result, things pile up, cluttering up living areas to render them unusable.

The Fine Print

The D's: • Duration (not stated, other than “persistent”) • Distress or disability (social, educational, occupational, or personal impairment) • Differential diagnosis (substance use and physical disorders; mood and psychotic disorders; major neurocognitive disorder [dementia]; OCD; normal collecting)

Coding Notes

Specify if:

With excessive acquisition. If symptoms are accompanied by excessive collecting, buying, or stealing of items that are not needed or for which there is no space available.

Specify degree of insight:

With good or fair insight. The patient realizes that these thoughts and behaviors cause problems.

With poor insight. The patient mostly believes that hoarding isn't a problem.

With absent insight/delusional beliefs. The patient strongly believes that hoarding isn't a problem.

F06.8 OBSESSIVE–COMPULSIVE AND RELATED DISORDER DUE TO ANOTHER MEDICAL CONDITION

SUBSTANCE/MEDICATION–INDUCED OBSESSIVE–COMPULSIVE AND RELATED DISORDER

F42 OTHER SPECIFIED OBSESSIVE–COMPULSIVE AND RELATED DISORDER

F42 UNSPECIFIED OBSESSIVE–COMPULSIVE AND RELATED DISORDER

Quite frankly, these diagnoses are pretty darned uncommon, even in adults. Occasionally, you might need to use a diagnosis of other specified or unspecified obsessive–compulsive and related disorder, but the other two are so infrequently encountered that their chief value is the reminder that we should *always* be alert to the possibility of an “organic” causation of a mental disorder. In any patient. Always.

ASSESSING OBSESSIVE–COMPULSIVE AND RELATED DISORDERS

General Suggestions

Due to shame or embarrassment, neither children nor adolescents are likely to mention obsessions and compulsions, or their related behaviors, spontaneously. You will probably have to ask young patients a question like this: “Have you ever felt you had to do something, or had certain habits, that might seem senseless to you but that you felt you just had to keep on doing?” Be prepared to give some examples, such as dressing or bathing or bedtime routines that must be done a certain number of times, rituals that involve repeatedly checking the stove or oven to be sure it is off, or looking repeatedly into a mirror. A cap may be worn indoors to conceal a bald spot. (Because skin picking so often involves the face, it may be more obvious.)

Be sure to query family members about their own behaviors: Because the demands of OCD are insatiable, siblings and parents, in trying to help an affected child or adolescent cope, sometimes become enmeshed in carrying out the very behaviors they would like to discourage. Brace yourself for quite a few false positives; many children have the odd obsession or compulsion without meeting criteria for diagnosis.

Obsessions often center on themes of contamination (germs, dirt), danger (to self or others), the drive for symmetry, and morality (scrupulosity). Compulsions include

washing for cleanliness, carefully drawing numbers or letters until they are perfect, and ordering things into appropriate groupings. Rituals can be quite elaborate, and are much more likely to be reported by parents than to be observed during an office visit. Symptoms tend to change over time, so that in the course of a year or two a young patient may sequentially develop counting, washing, and ordering rituals.

Developmental Factors

OCD and related symptoms also tend to change with increasing age. Preoccupation with counting and symmetry is especially prevalent in grade school children; concerns about cleanliness become more prominent during adolescence. It is important not to diagnose OCD in children who are merely experiencing typical developmental rituals, such as games with stringent rules (“Step on a crack and break your mother’s back”) and hobbies that require careful attention to detail (collecting stamps, match covers, and the like).

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