Obsessive Compulsive Disorder

DSM-IV-TR Diagnostic Code: 300.3 Obsessive-Compulsive Disorder (OCD)

Diagnostic Guidelines

1. Establish Diagnostic accuracy according to DSM-IV-TR.
2. Carefully evaluate for presence of similar or co-morbid diagnoses such as obsessive-compulsive personality disorder, anxiety disorder due to a general medical condition, substance induced anxiety disorder, other anxiety disorders impulse control disorders or psychoses.
3. Adults with OCD may recognize that the obsessions or compulsions are excessive or unreasonable. However, children may not have the developmental capacity to have a similar recognition. Such insight may vary significantly from time to time or situation to situation in otherwise insightful individuals. Additionally, essential features of obsessions or compulsions include consuming more than one hour per day or causing marked distress or significant impairment.
4. Distinguish Obsessive Compulsive Disorder from Obsessive-Compulsive Personality Disorder, as the treatment approach to these disorders is quite different. (See CHN Guideline on OCPD). OCPD involves a pervasive pattern of preoccupation with orderliness, perfectionism and control but does not involve specific obsessions or compulsions.
5. OCD presents similarly in children and adults and is equally common in males and females. However, onset for males tends to be at a younger age (6-15) than for females (20-29). Onset is usually gradual. The majority of individuals have a chronic waxing and waning of symptoms.
6. Use of the Yale-Brown Obsessive Compulsive Scale (YBOCS) or a similar screening instrument may assist with diagnosis or provide information about the effectiveness of treatment over time.

Treatment Guidelines

1. Educate the individual and family/significant other about OCD and its treatment as a medical illness. There is growing evidence that OCD represents abnormal functioning of brain circuitry. Persons with OCD have patterns of brain activity that differ from people with other mental illnesses or people with not mental illness. One may see a familial pattern of OCD, although we should stress that OCD is not caused by family problems, attitudes or beliefs. Family members and significant others should be involved in education and treatment in order to assist the client outside the therapy hour and to resolve family dysfunction related to the client's condition.
2. Two effective treatments for OCD are cognitive-behavioral therapy (CBT) and medication with a serotonin reuptake inhibitor (SRI) that has been approved by the FDA. A combination of both methods is generally considered to be the most acceptable and most successful approach, depending on severity of the illness.

3. Specific CBT treatment strategies include Exposure and Response Prevention and Cognitive Therapy. Voluntary, gradual and repeated exposure to a feared stimulus is associated with anxiety-reducing strategies until the patient no longer fears such exposure and has developed new responses to situations in which such exposure is likely to occur. Cognitive Therapy directly targets distorted "OCD beliefs" and helps persons to comply with Exposure and Response Prevention efforts. Thought stopping, distraction, self-soothing, satiation, habit reversal, relaxation, and contingency management may also be useful techniques.

4. Cognitive Therapy may be more useful for pathological doubt, aggressive obsessions, and scrupulosity or other "OCD beliefs" than for "urge symptoms" such as arranging or touching rituals. Clients with less insight do not do as well in treatment, but CT may help sharpen insight.

5. Treatment typically occurs in an outpatient setting with visits ranging in frequency of daily CBT for 50 hours over three weeks, to weekly visits with homework assignments. Higher levels of service, such as partial hospitalization or inpatient interventions, may be used to treat behaviors that cause significant risk to the individual.

6. Treatment for OCD may take place at the same time or sequentially, with treatment for comorbid conditions.

7. The likelihood that medication will be included varies with the severity of the OCD and the age of the individual. Milder OCD may be effectively treated with CBT alone, but as severity increases, medications are typically added. The use of medications may not be appropriate for younger individuals, pregnant women, or persons with medical conditions that may be compromised by any chosen medication. Generally persons should have a trial of 8-13 weeks on one medication before switching to another or augmenting with a secondary medication.

8. Once individuals have responded to the acute phase of treatment for OCD, a maintenance program of monthly visits for at least 3-6 months is recommended. Additional CBT visits may be necessary during a period in which the client is trying to discontinue medication.

9. Rapid discontinuation of medication is not an acceptable practice.

10. Long term or lifelong prophylactic maintenance of medication is recommended after two to four severe relapses or three to four mild to moderate relapses.

11. Self-help/support groups may be used as an adjunct to treatment if the client can tolerate the level of social contact.

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WEBSITE INFORMATION AND SUPPORT

1. Obsessive-Compulsive Foundation, Inc.   http://www.ocfoundation.org
2. Anxiety Disorders Association of America   http://www.adaa.org
3. ICQ (I See You) Chat Room OCD Support
   http://icq.com/groups/group_details/?gid=612213
4. Obsessive Compulsive Information Center
   http://www.miminc.org/aboutocic.html
5. National Institutes of Mental Health   http://www.nimh.nim.gov