APPLIED EVIDENCE

New research findings that are changing clinical practice

Obsessive-compulsive disorder: Tools for recognizing its many expressions

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Practice recommendations

- For a person with symptoms suggestive of obsessive-compulsive disorder (OCD), inquire about a family history of OCD or other anxiety disorders, either of which increases the likelihood of a diagnosis of OCD.
- Keep in mind that, with children, symptoms suggestive of OCD may simply indicate developmentally appropriate rituals.
- Become familiar with the alternative methods of assessment to facilitate evaluation in your particular office setting.
- Consider OCD when a patient exhibits or complains of intrusive thoughts, anxiety-based avoidance of places or objects, excessive reassurance-seeking, or repetitive behaviors/rituals (**B**).

Has a parent in your practice reported odd behavior in their child (eg, new fears or rituals) following a streptococcal viral illness? Does your dialogue with an adult patient reveal undue anxiety about hygiene or personal safety? These examples are just 2 of many that signal a person may be suffering from obsessive-compulsive disorder (OCD)—a relentless, debilitating disorder if unrecognized and left untreated.

In this article, we explain the relative advantages of evaluative tools available (which can also help distinguish OCD in children from developmentally appropriate rituals).

In part 2 of this article (to be publishe d in the April 2006 JOURNAL OF FAMILY PRACTICE), we discuss how to find professionals appropriately trained in cognitive-behavioral therapy (CBT), and recommend strategies for employing pharmacotherapy.

The tragedy of unrecognized OCD

OCD is an anxiety disorder characterized by recurrent or persistent thoughts, impulses, or images experienced as intrusive or distressing (obsessions), and repetitive behaviors or mental acts (compulsions) often performed in response to an obsession.

Estimates in the early 1980s suggested that OCD affected less than 1% of adults and children, but lifetime prevalence of OCD is now known to be between 2% to 4% in the US.[1,2]

OCD begins in childhood for as many as 80% of cases,[3] and it follows a chronic, unremitting course.[4] Impairments in vocational, academic, and social and family functioning are often substantial.[5,6] And patients are often unable to work, attend school, or socialize.

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TABLE 1

Common obsessions in OCD

CATEGORIES	OBSESSIVE CONCERNS
Contamination	Dirt; germs; animals/insects; illnesses; bodily waste; contaminants; household cleaners; "sticky" substances; spreading contamination, germs, illnesses, etc
Aggression	Harming self or others (even accidentally); causing harm to self or others due to thoughts or behaviors; acting upon aggressive impulses; blurting out inappropriate words/phrases; stealing or breaking things; causing something terrible to happen; frightening/violent images
Sexual	Forbidden/perverse sexual thoughts, images; disturbing sexual impulses, desires; homosexuality; molestation; sexual acts toward others
Hoarding/saving	Losing things; throwing away objects that might be important
Magical thinking	Lucky/unlucky numbers, colors, names, etc
Health/body	Contracting illness (especially if fatal or rare); appearance; physical abnormalities (real or imagined)
Mortality/religion	Dying and not going to Heaven; offending God; being sinful; morality/perfection; right/wrong
Miscellaneous	Knowing/remembering certain things; saying things exactly right; not saying certain words/phrases; intrusive images sounds, words, music, numbers, etc

Adapted from the Yale-Brown Obsessive-Compulsive Scale[14–15] and the Children's Yale-Brown Obsessive-Compulsive Scale.[16]

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OCD should be diagnosed when symptoms cause significant distress or impairment

Diagnosis: telltale clues, reliable evaluation tools

Consider a diagnosis of OCD when a patient exhibits or complains of intrusive thoughts (eg, specific phrases, worries, images, or numbers), anxiety-based avoidance of certain places (eg, public restrooms) or objects (eg, doorknobs), excessive reassurance-seeking, or repetitive behaviors/rituals (eg, checking, cleaning, hoarding).

Common intrusive thoughts (obsessions) and repetitive behaviors (compulsions) are listed in **TABLES 1 AND 2**, respectively. According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV),[7] OCD should be diagnosed only if these symptoms cause significant distress or impairment to the individual; however, subclinical presentations of OCD are also relatively common. DSM-IV diagnostic criteria for OCD are outlined in **TABLE 3**.

Unique aspects of childhood OCD

The incidence and presentation of symptoms in pediatric-onset OCD may differ somewhat from those of adult-onset OCD. For example, strongly consider a diagnosis of OCD if a child or adolescent displays behavioral changes (eg, develops new fears or rituals) after exposure to the streptococcal virus. OCD falls under the category of Pediatric Autoimmune Neurological Disorders Associated with Streptococcus (PANDAS),[8] and rapid symptom-onset may reflect this phenomenon.

Symptoms may cause no distress... Though many pediatric patients report multiple symptoms,[9] some will not recognize that their symptoms are bizarre or excessive.[10] In fact, a subset of pediatric patients may appear undistressed by their symptoms or report that they enjoy engaging in OCD behaviors.[11]

TABLE 2

Common compulsions in OCD

CATEGORIES	COMPULSIVE RITUALS
Washing & cleaning	Excessive/ritualized handwashing, showering, bathing, toothbrushing, grooming, toileting; cleaning clothing/personal items; avoiding "contaminated" objects/places
Checking	Checking locks, alarms, school supplies, homework, toys, books, etc; checking associated with washing, dressing, undressing, somatic concerns; checking that did/will not harm self or others; checking that nothing terrible did/will happen; checking for mistakes
Repeating	Rewriting; rereading; recopying; retying (eg, shoelaces); erasing; going in/out door or taking items in/out of schoolbag; getting up/down from seat; repeating words/phrases
Counting	Counting objects; mental counting (especially up to a "magic" number); counting steps, chewing, hair-brushing, etc
Ordering/arranging	Lining up objects in a certain way; arranging things in specific patterns; making objects/piles/groups "even"; making things symmetrical; "balancing" actions (eg, doing thing on the right and on the left)
Hoarding & saving	Keeping unimportant/unnecessary items and/or trash; storing items of no particular value; having difficulty throwing things away; sorting through trash to ensure that nothing important has been thrown away
Superstitions	Touching/tapping routines to prevent bad things from happening; avoiding stepping on cracks, lines, etc; avoiding "unlucky" objects/places
Reassurance-seeking	Asking a parent to repeatedly answer the same questions; asking parents to describe what they are doing/planning to do; forcing family members to do things in a certain way or at a certain time; forcing family members to avoid certain things/activities
Miscellaneous	Mental rituals; needing to tell/ask/confess; ritualized eating behaviors; excessive list-making; needing to touch/tap/rub; needing to do things until it feels "just right"; hair-pulling; measures to prevent something bad from happening

Adapted from the Yale-Brown Obsessive-Compulsive Scale[14–15] and the Children's Yale-Brown Obsessive-Compulsive Scale.[16]

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Parents may report that their child "melts down" if family members do not help complete rituals

...or may be incapacitating. However, other children find OCD symptoms overwhelming and may even enlist the help of others (eg, family members) to complete their rituals. Parents of these children frequently report that their child experiences "meltdowns" when the OCD symptoms are not accommodated. Pediatric patients frequently report feeling "stuck" because OCD symptoms interfere with their ability to complete day-to-day tasks (eg, bathing, homework, eating, chores, etc). If you suspect this level of incapacitation, obtain information from parents regarding the impact of symptoms on both child and family functioning.

How to approach the evaluation

Given that symptoms of OCD overlap significantly with other psychiatric and neurologic disorders (eg, general anxiety, psychosis, and mood, pervasive-developmen-

TABLE 3

Checklist of diagnostic criteria for OCD
(adapted from the DSM-IV)[7]

CRITERION	PRESENT?
1. The patient exhibits/reports obsessions • Obsessions are experienced as intrusive/inappropriate and cause anxiety or distress • Obsessions are not simply excessive worries about actual problems • The patient attempts to ignore the obsessions or make them go away with some "neutralizing" action • The patient understands that the obsessions originate from within his/her own mind, rather than being imposed on him/her (eg, thought insertion)	_____
AND/OR	AND/OR
The patient exhibits/reports compulsions • The patient feels compelled/driven to perform compulsions either in response to an obsession or according to strict rules • The compulsions are performed in order to prevent or relieve anxiety/distress; however, the activities are either a clearly excessive response or unrelated in a realistic way to the distress they are designed to neutralize	_____
2. The adult patient recognizes (or has recognized in the past) that the obsessions or compulsions are excessive and/or unreasonable. *This condition does not apply to pediatric patients.*	_____
3. The symptoms (obsessions and/or compulsions) are significantly distressing, take more than one hour per day, or cause significant interference or impairment in day-to-day functioning (eg, school, work, social or interpersonal activities).	_____
4. The symptoms are not accounted for by another psychiatric condition (e.g., preoccupation with food due to an eating disorder; repetitive hair-pulling due to trichotillomania, or guilty ruminations due to Major Depressive Disorder.	_____
5. The symptoms cannot be explained by substance use or a general medical condition.	_____

tal, and tic disorders), a thorough assessment is crucial to the differential diagnosis of OCD.

Particularly with children, you need to distinguish possible symptoms of OCD from developmentally appropriate rituals (eg, bedtime routines) and fears.[12]

Inquire about a family history of OCD or other anxiety disorders, either of which increases the likelihood of a diagnosis of OCD.[13]

Several methods of assessment have been developed that may facilitate your attempt to identify OCD. These include diagnostic interviews, clinician-administered inventories, self-report measures, and (for pediatric patients) parent-report and teacher-report measures.

Diagnostic interviews effective but time consuming. In general, diagnostic interviews are reliable and valid measures that facilitate diagnostic decisions by using questions developed specifically to assess DSM-IV symptoms.[7] Good examples include the Anxiety Disorders Interview Schedule for DSM-IV: Child & Parent Versions (ADIS),[14] the Schedule for Affective Disorders and Schizophrenia for School-Age Children—Present & Lifetime version (K-SADS-PL),[15] and the Structured Clinical Interview Diagnostic for DSM-IV (SCID).[16]

Each method is highly structured and clinician administered. Such interview techniques assess for anxiety disorders and also include sections to help uncover other

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psychiatric disorders (ie, disruptive behavior disorders, psychotic disorders, and mood disorders).

However, these interviews are fairly time-consuming and require training to administer. As a result, they are typically administered by a psychologist or other mental health professional.

Clinician-administered measures are reliable and efficient. These inventories allow trained clinicians to rate a patient's level of impairment and distress compared with other patients they have seen. The most commonly-used "gold standard" measures are the Yale-Brown Obsessive Compulsive Scale (Y-BOCS)[17,18] for adults, and the Children's Yale-Brown Obsessive Com-pulsive Scale (CY-BOCS)[19] for youth. The Y-BOCS and the CY-BOCS are semi-structured inventories of OCD symptom presence and severity over the previous week. Both measures have repeatedly demonstrated good reliability and validity,[17–22] and they can be completed in approximately 15 minutes.

Self-report and parent-report questionnaires may be most helpful. You may find self- or parent-report questionnaires most useful in your practice, because they can be completed quickly and without your assistance. The measures are particularly useful as screening devices, and thus can also be used to identify patients who may benefit from referral to a psychologist or psychiatrist for a more comprehensive evaluation. An additional strength of these questionnaires is that they can easily be readministered to assess posttreatment change.

For the assessment of adult OCD, we use the Florida Obsessive Compulsive Inventory (FOCI)[23] and Obsessive Compulsive Inventory—Revised (OCI-R).[24] The FOCI, which is reprinted in **APPENDIX A** (available online at www.jfponline.com), is a brief measure that screens for common OCD symptoms and assesses the severity of OCD impairment in patients with OCD. The OCI-R is a theoretically-driven instrument that assesses the extent to which individuals are "distressed or bothered" by common OCD symptoms.

For assessment of pediatric OCD, several self-report and parent-report measures have been developed,[25] and many are useful for diagnostic decisions.

First, the Children's Obsessional Compulsive Inventory (ChOCI)[26] assesses for obsessive symptoms and compulsive symptoms, and the degree of impairment experienced as a result of symptoms.

Second, the Children's Yale-Brown Obsessive-Compulsive Scale—Child Report and Parent Report[27] consist of 2 subscales assessing the distress and impairment caused by Obsessions and Compulsions. Items are related to 1) time devoted to obsessions/compulsions, 2) functional impairment, 3) level of distress, 4) attempts to resist obsessions/compulsions, and 5) success in resisting obsessions/compulsions. The parent-report version of this questionnaire is included in **APPENDIX B** (available online at www.jfponline.com).

Third, the Child Obsessive Compulsive Impact Scale (COIS)[28] assesses the extent to which symptoms cause impairment in specific areas of child psychosocial functioning (eg, school activities, social activities, and home/family activities).

Fourth, the Florida Obsessive-Compulsive Student Inventory[29] is a teacher-rated measure that can be used to assess symptom presence and severity in the school setting. ■

Part 2 of this article discusses treatment strategies for OCD. Look for it in next month's JFP.

FAST TRACK

Self- or parent-report questionnaires are done quickly without your aid, and can give you helpful baseline data

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Four assessment methods for pediatric OCD yield varying kinds of information

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