OBSESSIVE-COMPULSIVE AND RELATED DISORDERS

Obsessive-Compulsive Disorder

OCD

DSM-5-TR 300.3 | ICD-10-CM F42.2

Intrusive, ego-dystonic obsessions driving ritualized compulsions that briefly relieve anxiety and steadily consume daily life.

LIFETIME PREVALENCE	TYPICAL ONSET	SEX RATIO	COURSE
~2.3% (US adults)	Bimodal: ~10 and ~21 years	Equal in adults; male in youth	Chronic, waxing and waning

CLINICAL PICTURE

- Obsessions are intrusive, unwanted, and ego-dystonic; patients recognize them as their own thoughts yet experience them as senseless and repugnant.
- Common symptom dimensions include contamination and washing, harm and checking, symmetry and ordering, and taboo sexual, religious, or aggressive themes.
- Compulsions are rule-bound rituals, overt or mental, performed to neutralize distress or prevent a feared outcome, with only transient relief.
- Patients often conceal taboo obsessions for years, and the average delay from symptom onset to adequate treatment approaches a decade.
- Reassurance seeking, family accommodation, and avoidance sustain the cycle and are the most common reasons an otherwise sound treatment stalls.
- Insight ranges from good to absent or delusional; poor insight predicts greater severity, more accommodation, and weaker treatment response.

DIAGNOSTIC CRITERIA AT A GLANCE

- Requires obsessions, compulsions, or both, defined by intrusive repetitive thoughts and by repetitive behaviors or mental acts aimed at reducing distress.
- Symptoms must be time consuming, generally exceeding one hour per day, or must cause marked distress or clear functional impairment.
- Not attributable to a substance, medication, or another medical condition, and not better explained by another mental disorder's content.
- Specify insight as good or fair, poor, or absent and delusional, and specify whether tic-related, which shapes augmentation choices.
- Hoarding, body-focused repetitive behaviors, and appearance preoccupations are coded as separate related disorders rather than as OCD.

NEUROBIOLOGY & PHYSIOLOGY

- Hyperactivity in the cortico-striato-thalamo-cortical loop, especially orbitofrontal cortex, anterior cingulate, and caudate, normalizes with successful treatment.
- Serotonergic modulation is central; response requires higher SSRI doses and 10-12 weeks, implicating downstream receptor adaptation rather than acute reuptake block.
- Glutamatergic excess in striatal and cingulate regions supports augmentation trials of **memantine**, **riluzole**, and **N-acetylcysteine** in resistant cases.
- Twin heritability is roughly 40-50% in adults and higher in pediatric-onset illness; SLC1A1 and glutamate-pathway variants are the most replicated signals.
- Dopaminergic striatal involvement helps explain the efficacy of low-dose antipsychotic augmentation, particularly in tic-related presentations.
- Abrupt pediatric onset with tics, restricted eating, and emotional lability raises suspicion for PANS or PANDAS and warrants targeted infectious workup.

PSYCHOLOGICAL MECHANISMS

- Cognitive model holds that intrusions are universal and pathology arises from catastrophic misappraisal of their meaning and an inflated sense of responsibility.
- Thought-action fusion, intolerance of uncertainty, and perfectionism convert ordinary doubt into an unending and unmeetable demand for certainty.
- Compulsions are negatively reinforced by immediate anxiety reduction, which prevents disconfirmation of feared outcomes and strengthens the loop.
- Family accommodation, present in most households, predicts poorer outcome and must be measured directly and targeted as a treatment goal.
- Mental rituals, covert neutralizing, and reassurance seeking masquerade as ordinary thinking and are routinely missed on standard screening questions.

DIFFERENTIAL & COMORBIDITY

- Distinguish from generalized anxiety, where worries concern realistic life domains, and from psychosis, where beliefs are not experienced as ego-dystonic.
- Body dysmorphic disorder, hoarding, illness anxiety, and eating disorders share ritual structure but differ in the content that drives the behavior.
- Lifetime comorbidity is high: major depression in up to 40%, other anxiety disorders, and tic disorders in roughly 30% of pediatric cases.
- Suicidal ideation occurs in about a quarter of patients and tracks with depression severity and taboo obsessions; screen at every visit.
- Screen for autism spectrum traits and OCPD, where rigid routines and perfectionism are ego-syntonic rather than distressing and resisted.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- First-line **SSRIs** at high doses: **fluoxetine 40-80 mg/day**, **sertraline 100-200 mg/day**, or escitalopram 20-30 mg/day as tolerated.
- Allow 10-12 weeks at the maximal tolerated dose before declaring nonresponse; expect 40-60% response with 25-35% symptom reduction.
- **Clomipramine 150-250 mg/day** remains the most potent agent; monitor ECG, anticholinergic burden, and seizure risk above 250 mg/day.
- Augment partial responders with low-dose **aripiprazole 5-15 mg/day** or **risperidone 0.5-3 mg/day**, most useful in tic-related OCD.
- Continue treatment at least 1-2 years after remission and taper slowly; relapse exceeds 50% after abrupt discontinuation.

PSYCHOTHERAPY

- **Exposure and response prevention** is first-line, typically 12-20 sessions combining therapist-guided exposures with daily self-directed practice.
- ERP effect sizes exceed medication monotherapy, and adding ERP to an SSRI outperforms medication alone in moderate to severe illness.
- **Cognitive therapy** targeting inflated responsibility, thought-action fusion, and intolerance of uncertainty is effective when ERP is refused.
- **Acceptance and commitment therapy** and inhibitory-learning exposure improve engagement for patients unwilling to tolerate a habituation framing.
- Family-based ERP is the standard for children and adolescents and explicitly targets reduction of parental accommodation.

ADJUNCT & SUPPORTIVE

- Track severity with the **Y-BOCS** or **CY-BOCS** at baseline and every 4-6 weeks; a 35% score reduction defines treatment response.
- Intensive outpatient, partial hospitalization, and residential OCD programs benefit patients who fail two adequate outpatient medication trials.
- **Deep TMS** targeting medial prefrontal and anterior cingulate cortex is FDA-cleared as an adjunct for treatment-resistant adult OCD.
- **Deep brain stimulation** of the ventral capsule and ventral striatum carries an FDA humanitarian device exemption for severe refractory illness.
- Sleep regulation, aerobic exercise, and abstinence from alcohol and cannabis reduce symptom amplification and improve exposure tolerance.

CLINICAL PEARLS

- OCD needs higher SSRI doses and longer trials than depression: 10-12 weeks before calling it a failure.
- Ask directly about mental rituals and reassurance seeking; patients rarely volunteer either one.
- Cutting family accommodation often moves severity more than another dose increase.

References

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NOTE

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