Obsessive-compulsive disorder: Tools for recognizing its many expressions

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).

H as 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 published 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.
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), 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), and rapid symptom-onset may reflect this phenomenon.

**Symptoms may cause no distress...**

Though many pediatric patients report multiple symptoms, some will not recognize that their symptoms are bizarre or excessive. In fact, a subset of pediatric patients may appear undistressed by their symptoms or report that they enjoy engaging in OCD behaviors.

---

**TABLE 1**

**Common obsessions in OCD**

<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>OBSESSIVE CONCERNS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contamination</td>
<td>Dirt; germs; animals/insects; illnesses; bodily waste; contaminants; household cleaners; “sticky” substances; spreading contamination, germs, illnesses, etc</td>
</tr>
<tr>
<td>Aggression</td>
<td>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</td>
</tr>
<tr>
<td>Sexual</td>
<td>Forbidden/perverse sexual thoughts, images; disturbing sexual impulses, desires; homosexuality; molestation; sexual acts toward others</td>
</tr>
<tr>
<td>Hoarding/saving</td>
<td>Losing things; throwing away objects that might be important</td>
</tr>
<tr>
<td>Magical thinking</td>
<td>Lucky/unlucky numbers, colors, names, etc</td>
</tr>
<tr>
<td>Health/body</td>
<td>Contracting illness (especially if fatal or rare); appearance; physical abnormalities (real or imagined)</td>
</tr>
<tr>
<td>Mortality/religion</td>
<td>Dying and not going to Heaven; offending God; being sinful; morality/perfection; right/wrong</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>Knowing/remembering certain things; saying things exactly right; not saying certain words/phrases; intrusive images sounds, words, music, numbers, etc</td>
</tr>
</tbody>
</table>

Adapted from the Yale-Brown Obsessive-Compulsive Scale and the Children’s Yale-Brown Obsessive-Compulsive Scale.
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 (e.g., 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 (e.g., 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 (e.g., general anxiety, psychosis, and mood, pervasive-development...
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...
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 Compulsive 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.
Four assessment methods for pediatric OCD yield varying kinds of information.


