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Narrative Review: Obsessive-Compulsive and Related Disorders

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ABSTRACT :

Obsessive-Compulsive and Related Disorders (OCRDs) encompass a group of psychiatric conditions characterized by repetitive thoughts, urges, or behaviors causing significant distress and impairment. Recognized as a distinct category in the DSM-5, OCRDs include Obsessive-Compulsive Disorder (OCD), Body Dysmorphic Disorder (BDD), Hoarding Disorder, Trichotillomania, and Excoriation Disorder. This narrative review synthesizes current literature on the epidemiology, etiology, clinical presentation, diagnosis, treatment, and future research directions for OCRDs. OCRDs affect 1-6% of the population, with multifactorial origins involving genetic, neurobiological, and environmental factors. Cognitive-Behavioral Therapy (CBT) and Selective Serotonin Reuptake Inhibitors (SSRIs) are primary treatments, though challenges like treatment resistance persist. Emerging research into biomarkers, digital interventions, and transdiagnostic approaches offers promise for improving outcomes. This review underscores the need for personalized, culturally sensitive approaches to address the burden of OCRDs.

Introduction

Obsessive-Compulsive and Related Disorders (OCRDs) are psychiatric conditions defined by repetitive thoughts or behaviors that significantly impair functioning. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) established OCRDs as a separate diagnostic category, distinct from anxiety disorders, due to their unique clinical and neurobiological features. This category includes Obsessive-Compulsive Disorder (OCD), Body Dysmorphic Disorder (BDD), Hoarding Disorder, Trichotillomania (Hair-Pulling Disorder), Excoriation (Skin-Picking) Disorder, and other specified/unspecified disorders. This review integrates findings from peer-reviewed literature to provide an overview of OCRDs' epidemiology, etiology, clinical characteristics, diagnosis, treatment, and future directions.

Epidemiology

OCRDs are prevalent worldwide, with varying rates across disorders. OCD has a lifetime prevalence of 2-3%, affecting males and females equally, though males often show earlier onset (Stein et al., 2019). BDD affects 1.7-2.4% of the population, with higher rates in cosmetic or dermatological settings (Veale et al., 2016). Hoarding Disorder's prevalence ranges from 2-6%, increasing with age (Cath et al., 2017). Trichotillomania and Excoriation Disorder have estimated prevalences of 1-2% and 1.4-5.4%, respectively, with a female predominance (Grant & Chamberlain, 2016). Cultural factors shape symptom expression, but OCRDs are observed globally, highlighting their significant public health impact.

Etiology

OCRDs arise from a complex interplay of genetic, neurobiological, environmental, and psychological factors. Twin studies indicate heritability of 40-50% for OCD and similar rates for other OCRDs (Pauls et al., 2014). Genes related to serotonin, dopamine, and glutamate systems are implicated, though no single marker is conclusive. Neuroimaging studies show hyperactivity in the cortico-striato-thalamo-cortical (CSTC) circuit in OCD and BDD, with overlapping findings in other OCRDs (Fineberg et al., 2018). Environmental triggers, such as childhood trauma or streptococcal infections (e.g., PANDAS in OCD), may precipitate symptoms. Cognitive models emphasize dysfunctional beliefs, like inflated responsibility or perfectionism, in maintaining symptoms (Salkovskis, 1999).

Clinical Features

OCRDs share repetitive thoughts or behaviors but differ in focus:

- OCD: Involves obsessions (intrusive thoughts, images, or urges) and compulsions (repetitive acts to alleviate distress). Common themes include contamination, harm, symmetry, and forbidden thoughts.
- BDD: Features preoccupation with perceived physical flaws, leading to repetitive behaviors (e.g., mirror checking) or mental comparisons.
- Hoarding Disorder: Characterized by difficulty discarding possessions, resulting in clutter that impairs living spaces.

- Trichotillomania and Excoriation Disorder: Involve recurrent hair-pulling or skin-picking, often triggered by sensory or emotional cues, causing visible damage.

Comorbidity with anxiety disorders, depression, and substance use is common. Insight varies, with poorer insight in BDD and some OCD cases linked to worse outcomes (Phillips et al., 2012).

Diagnosis

Diagnosis relies on clinical interviews using DSM-5 criteria, supported by standardized tools like the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) for OCD or the Body Dysmorphic Disorder Questionnaire (BDDQ). Differential diagnosis is essential to distinguish OCRDs from anxiety disorders, eating disorders, or psychotic disorders. For instance, BDD must be differentiated from normal appearance concerns, and hoarding from OCD-related collecting. Cultural considerations are critical, as symptom presentation (e.g., religious obsessions) varies across contexts (Williams et al., 2017).

Treatment

Treatment for OCRDs includes psychological, pharmacological, and neuromodulatory approaches:

- Psychological Interventions: Cognitive-Behavioral Therapy (CBT) is the first-line treatment. Exposure and Response Prevention (ERP) is highly effective for OCD, reducing symptoms in 60-70% of patients (Foa et al., 2012). Tailored CBT for BDD, hoarding, or body-focused repetitive behaviors (e.g., Habit Reversal Training) shows moderate to strong efficacy. Group or family therapies may enhance outcomes, especially for hoarding.
- Pharmacological Interventions: Selective Serotonin Reuptake Inhibitors (SSRIs) are first-line for OCD and BDD, with 40-60% response rates (Soomro et al., 2008). Higher doses and longer trials (8-12 weeks) are often needed. Clomipramine is an alternative for OCD. Evidence for SSRIs in hoarding, trichotillomania, and excoriation is limited, though N-acetylcysteine shows promise for body-focused repetitive behaviors (Grant et al., 2016).
- Neuromodulation: For treatment-resistant cases, Transcranial Magnetic Stimulation (TMS) or Deep Brain Stimulation (DBS) are emerging options, particularly for OCD, with 30-50% response rates in open-label trials (Carmi et al., 2019).

Treatment resistance, especially in BDD and hoarding, necessitates personalized strategies.

Future Directions

Research is advancing in several areas:

- Neurobiological Insights: Neuroimaging and genetic studies may yield biomarkers for tailored treatments. Glutamate-modulating drugs (e.g., ketamine) are being explored for OCD.
- Digital Interventions: Mobile apps and teletherapy are improving access to CBT, particularly for underserved groups.
- Transdiagnostic Approaches: Treatments targeting shared mechanisms (e.g., emotion regulation) are gaining interest due to overlapping features across OCRDs.
- Early Intervention: Identifying prodromal symptoms could prevent chronicity, especially in children.

Conclusion

OCRDs are a diverse group of disorders with significant personal and societal impact. Advances in neurobiological and psychological research have improved diagnosis and treatment, with CBT and SSRIs as mainstays. However, challenges like treatment resistance, stigma, and access to care remain. Future research into biomarkers, novel therapies, and digital interventions offers hope for better outcomes. Clinicians must adopt culturally sensitive, individualized approaches to address the burden of OCRDs.

REFERENCES

1. Carmi, L., et al. (2019). Efficacy and safety of deep transcranial magnetic stimulation for obsessive-compulsive disorder: A prospective multicenter randomized double-blind placebo-controlled trial. American Journal of Psychiatry, 176(11), 931-938.
2. Cath, D. C., et al. (2017). Hoarding disorder: A new diagnostic category in DSM-5. Comprehensive Psychiatry, 73, 147-154.
3. Fineberg, N. A., et al. (2018). The neurobiology of obsessive-compulsive disorder: New findings from functional neuroimaging. Current Opinion in Psychiatry, 31(2), 108-114.
4. Foa, E. B., et al. (2012). Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences. Oxford University Press.
5. Grant, J. E., & Chamberlain, S. R. (2016). Trichotillomania and skin-picking disorder: Different kinds of OCD. Harvard Review of Psychiatry, 24(6), 441-449.
6. Grant, J. E., et al. (2016). N-acetylcysteine in the treatment of excoriation disorder: A randomized clinical trial. JAMA Psychiatry, 73(5), 490-496.
7. Pauls, D. L., et al. (2014). The inheritance of obsessive-compulsive disorder. Journal of Clinical Psychiatry, 75(6), 678-685.
8. Phillips, K. A., et al. (2012). Body dysmorphic disorder: Some key issues for DSM-V. Depression and Anxiety, 27(6), 573-591.
9. Salkovskis, P. M. (1999). Understanding and treating obsessive-compulsive disorder. Behaviour Research and Therapy, 37(Suppl 1), S29-S52.

10. Soomro, G. M., et al. (2008). Selective serotonin re-uptake inhibitors (SSRIs) versus placebo for obsessive compulsive disorder (OCD). Cochrane Database of Systematic Reviews, (1), CD001765.
11. Stein, D. J., et al. (2019). The global burden of obsessive-compulsive disorder. Lancet Psychiatry, 6(8), 695-704.
12. Veale, D., et al. (2016). Body dysmorphic disorder in different settings: A systematic review and estimated weighted prevalence. Body Image, 18, 168-186.
13. Williams, M. T., et al. (2017). Cultural influences on the presentation and treatment of OCD. Current Psychiatry Reviews, 13(4), 238-245.