

Neurotic Disorders

Neurosis:

It is a mental disorder in which the predominant disturbance is symptom or group of symptoms that is distressing to the individual and is recognized by him or her as unacceptable and alien, the reality testing is grossly intact.

8.1. Anxiety Disorders

Anxiety: A changing concept:

The cardiologists speak of neurocirculatory asthenia or fatigue syndrome of what the psychiatrist view as a syndrome of physiological manifestations of pathological anxiety states.

In 1892 the concept of Anxiety neurosis was introduced by S. Freud when he described Kathrena case "A girl was climbing the mountains and suddenly developed attack of palpitation, sweating and hyperventilation.

- Now the term Anxiety Neurosis is (abolished), and replaced by acute anxiety state (panic attack) and generalized anxiety state.

Anxiety is differentiated from fear.

Anxiety:- Is the individuals response to a danger that threatens from within in the form of a forbidden instinctual drive that is about to escape from the individuals control.

Fear: Is the reaction to a real external danger that threatens the individual with possible injury or death

Epidemiology and family patterns:

Anxiety as a symptom is a component of almost every psychiatric disorder. Prevalence rates are 2% for panic attack, and 6.4% for generalized anxiety disorder. 6 month prevalence rates are 0.6 - 1% for panic disorder. Anxiety disorders are more common among women than men (2:1).

Etiology:

Any discussion of the etiology of anxiety must therefore deal with both psychological and physiological processes.

I- Psychological theories:

1- Psychoanalytic theories

A- Pierre Janet's theories

In Janet's scheme, the various mental functions were viewed as being held together by nervous energy in a coordinated, working whole. In individual with bad heredity the total energy was less than that of normal people, and in the face of life stresses, it thus was more rapidly lowered in the constitutionally inferior. If the level fell too low. The integration of the mental functions would be impaired, and specific individual functions would be dissociated from the normally integrated totality. The fatigue was explained as a direct conscious awareness of the diminution of nervous energy, other symptoms being a release phenomena secondary to the escape of lower mental functions from secondary to the escape of lower mental functions from central control. In this theory the anxiety was seen as the consequence of the anarchic functioning of lower vegetative nervous centers.

B- Freud's theories

He postulated that ideas, emotions, and impulses unacceptable to the conscious ego were forced by the agency of repression into the unconscious portion of he psychic apparatus. The sexual drive (Libido) was seen as subject to repression, the anxiety was also a psychological reaction of the ego to dangers that threatened it from without and within.

Anxiety is a signal to the ego that unacceptable drive is pressing for conscious representation and discharge, and as a signal it arouses the ego to take defensive action against the pressure from below. If the defensive action against the pressure from

below. If the defenses are successful, the anxiety will be dispelled or safely contained, but depending on the nature of the defenses employed, the individual may develop a variety of psychoneurotic symptoms. It depends on repression, displacement or regression defense mechanisms.

C - Harry Stack Sullivan theory:

He stressed the early relationship between mother and child and the importance of the transmission of the mother's anxiety to her infant.

2- Learning theories

A. Conditioned-reflex theories: It regards anxiety as an unconditional inherent response of the organism to painful or dangerous external stimuli.

B. Cognitive model:

Patients suffering from anxiety disorders tend to over-estimate the degree of danger and the probability of harm in a situation and underestimate their abilities to cope with perceived threats to their physical or psychological well-being, that panic-disordered patients often have thoughts of loss of control and fears of dying that follow in explicable physiological sensations (e.g. palpitations, tachycardia) but precede and then accompany panic attacks. Patients with generalized anxiety disorders are viewed as holding distorted thoughts with regard to events perceived as threatening to their physical or social well-being.

II- Biological theories:

1. Genetic factors:

Five fold greater concordance rate for panic attacks in monozygotic than dizygotic adult same-sexed twins.

- concordance rate for Generalized Anxiety disorder is similar in monozygotic and dizygotic co-twins.

2- Neuroanatomical factors

Panic attacks associated with impulsive behavior can be a major symptom in patients with temporal lobe epileptic foci.

3- Biochemical factors

A. Lactate induced panic

An infusion of sodium lactate produced typical attacks of panic in 70% patients with anxiety neurosis as compared with only 5% normal controls. TCAs, MAOIs block both spontaneous and lactate induced panic attacks.

B. Yohimbine induced panic

Yohimbine an α_2 -adrenergic antagonist increases noradrenergic nucleus locus ceruleus firing in animals. Stimulated locus ceruleus firing is associated with increases in Norepinephrine release and fear behaviors.

Clonidine (Catapres) It is α_2 -adrenergic agonist decreases locus ceruleus firing, decreases norepinephrine release and reduces fear behaviors in animals.

20 mg of Yohimbine commonly produce panic attacks in panic-disorder patients

C. Caffeine- induced panic.

After oral administration of 480 mg of caffeine (4-6 caps of coffee) 40% of Panic disorder patients experience panic attacks.

D. Benzodiazepine inverse agonist

Benzodiazepine antagonist is powerful anxiogenic agent, potential for inducing seizures.

Benzodiazepine agonist (Diazepam) have antianxiety anticonvulsant effect.

F. Mitral valve prolapse was observed in 50% of patients suffering of panic attack compared to 5% of general population.

G. Co₂ inhalation to persons with panic attacks can produce the attack in those patients.

4- Neuroendocrine functions

A. Hypothalamic-pituitary-adrenal functions.

it was observed that there is inhibition of in growth hormone by giving Clonidine, decrease level of prolactin .

B. Hypothalamic-Pituitary-Thyroid functions : T₃-T₄ are higher in panic disorder patients as compared to normal controls.

8.1.A. Panic attack (Acute anxiety state)

The clinical picture of Panic attack

This attack usually started suddenly by feeling of chest discomfort , afraid to have a cardiac attack, fear of going to die. This state usually finished within 10 minutes, sometimes up to one hour. The usual medical history of this attack is that most of those cases are coming to emergency room after the attack started to abolish. They are misdiagnosed as a case of hysteria, Hypochondriasis, with a signs like high blood pressure, increased heart rate, and skin conduction, usually those patient are self medication person. They try to calm down by alcohol or benzodiazepines. Usually this patient is examined thoroughly without any findings ,if he got another attack he will start to be worry , later on he will start waiting for the next attack. He will develop expectancy anxiety. He tried to avoid place in which he experienced the attack for the first time. He will be agoraphobic, depressed and will have family problems.

DSM-IV Criteria for Panic Attack

Note: A panic attack is not a codable disorder. Code the specific diagnosis in which the panic attack occurs (e.g., panic disorder with agoraphobia).

A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:

- (1) palpitations, pounding heart, or accelerated heart rate
- (2) sweating
- (3) trembling or shaking
- (4) sensations of shortness of breath or smothering
- (5) feeling of choking
- (6) chest pain or discomfort
- (7) nausea or abdominal distress
- (8) feeling dizzy, unsteady, lightheaded, or faint
- (9) derealization (feelings of unreality) or depersonalization (being detached from oneself)
- (10) fear of losing control or going crazy
- (11) fear of dying
- (12) paresthesias (numbness or tingling sensations)
- (13) chills or hot flushes

Table 15.6-5. DSM-IV Diagnostic Criteria for Panic Disorder without Agoraphobia

A. Both (1) and (2):

- (1) Recurrent unexpected panic attacks
- (2) At least one of the attacks has been followed by at least 1 month (or more) of the following:
 - (a) Persistent concern about having additional attacks
 - (b) Worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy")
 - (c) A significant change in behavior related to the attacks

B. Absence of agoraphobia.

C. The panic attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).

D. The panic attacks are not better accounted for by another mental disorder, such as social phobia (e.g., occurring on exposure to feared social situations), specific phobia (e.g., on exposure to a specific phobic situation), obsessive-compulsive disorder (e.g., on exposure to dirt in someone with an obsession about contamination), posttraumatic stress disorder (e.g., in response to stimuli associated with a severe stressor), or separation anxiety disorder (e.g., in response to being away from home or close relatives).

DSM-IV Criteria for Agoraphobia

Note: Agoraphobia is not a codable disorder. Code the specific disorder in which the agoraphobia occurs (eg, panic disorder with agoraphobia or agoraphobia without history of panic disorder).

A. Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having an unexpected or situationally predisposed panic attack or panic-like symptoms. Agoraphobic fears typically involve characteristic clusters of situations that include being outside the home alone; being in a crowd or standing in a line; being on a bridge; and traveling in a bus, train, or automobile.

Note: Consider the diagnosis of specific phobia if the avoidance is limited to one or only a few specific situations, or social phobia if the avoidance is limited to social situations.

B. The situations are avoided (e.g., travel is restricted) or else are endured with marked distress or with anxiety about having a panic attack or panic-like symptoms, or require the presence of a companion.

C. The anxiety or phobic avoidance is not better accounted for by another mental disorder, such as social phobia (e.g., avoidance limited to social situations because of fear of

embarrassment), specific phobia (e.g., avoidance limited to a single situation like elevators), obsessive-compulsive disorder (e.g., avoidance of dirt in someone with an obsession about contamination), posttraumatic stress disorder (e.g., avoidance of stimuli associated with a severe stressor), or separation anxiety disorder (e.g., avoidance of leaving home or relatives).

DSM-IV Diagnostic Criteria for Panic Disorder With Agoraphobia

A. Both (1) and (2):

(1) recurrent unexpected panic attacks

(2) at least one of the attacks has been followed by 1 month (or more) of the following:

(a) persistent concern about having additional attacks

(b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy")

(c) a significant change in behavior related to the attacks

B. The presence of agoraphobia.

C. The panic attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication or a general medical condition (e.g., hyperthyroidism).

D. The panic attacks are not better accounted for by another mental disorder, such as social phobia (e.g., occurring on exposure to feared social situations), specific phobia (e.g., on exposure to a specific phobic situation), obsessive-compulsive disorder (e.g., on exposure to dirt in someone with an obsession about contamination), posttraumatic stress disorder (e.g., in response to stimuli associated with a severe stressor), or separation anxiety disorder (e.g., in response to being away from home or close relatives).

DSM-IV Diagnostic Criteria for Agoraphobia Without History of Panic Disorder

A. The presence of agoraphobia related to fear of developing panic-like symptoms (e.g., dizziness or diarrhea).

B. Criteria have never been met for panic disorder.

C. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

D. If an associated general medical condition is present, the fear described in criterion A is clearly in excess of that usually associated with the condition.

Social phobias

A. Either of the following must be present:

(1) marked fear of being the focus of attention, or fear of behaving in a way that will be embarrassing or humiliating;

(2) marked avoidance of being the focus of attention, or of situations in which there is fear of behaving in an embarrassing or humiliating way.

These fears are manifested in social situations, such as eating or speaking in public, encountering known individuals in public, or entering or enduring small group situations (e.g., parties, meetings, classrooms).

B. At least two symptoms of anxiety in the feared situation as defined in agoraphobia, criterion B, must have been manifest at some time since the onset of the disorder, together with at least one of the following symptoms:

(1) blushing or shaking;

(2) fear of vomiting;

(3) urgency or fear of micturition or defecation.

C. Significant emotional distress is caused by the symptoms or by the avoidance, and the individual recognizes that these are excessive or unreasonable.

D. Symptoms are restricted to, or predominate in, the feared situations or contemplation of the feared situations.

E. Most commonly used exclusion clause. The symptoms listed in criteria A and B are not the result of delusions, hallucinations, or other disorders such as organic mental disorders, schizophrenia and related disorders, mood [affective] disorders,

or obsessive-compulsive disorder, and are not secondary to cultural beliefs.

Specific (isolated) phobias

A. Either of the following must be present:

(1) marked fear of a specific object or situation not included in agoraphobia or social phobia;

(2) marked avoidance of a specific object or situation not included in agoraphobia or social phobia.

Among the most common objects and situations are animals, birds, insects, heights, thunder, flying, small enclosed spaces, the sight of blood or injury, injections, dentists, and hospitals.

B. Symptoms of anxiety in the feared situation as defined in agoraphobia, criterion B, must have been manifest at some time since the onset of the disorder.

C. Significant emotional distress is caused by the symptoms or by the avoidance, and the individual recognizes that these are excessive or unreasonable.

D. Symptoms are restricted to the feared situation or contemplation of the feared situation.

If desired the specific phobias may be subdivided as follows:

—animal type (e.g., insects, dogs)

—nature-forces type (e.g., storms, water)

—blood, injection, and injury type

—situational type (e.g., elevators, tunnels)

—other type

Other phobic anxiety disorders

Phobic anxiety disorder, unspecified

Diagnostic Criteria for Other Anxiety Disorders Panic disorder [episodic paroxysmal anxiety]

A. The individual experiences recurrent panic attacks that are not consistently associated with a specific situation or object and that often occur spontaneously (ie, the episodes are unpredictable). The panic attacks are not associated with marked

exertion or with exposure to dangerous or life-threatening situations.

B. A panic attack is characterized by all of the following:

- (1) it is a discrete episode of intense fear or discomfort;
- (2) it starts abruptly;
- (3) it reaches a maximum within a few minutes and lasts at least some minutes;
- (4) at least four of the symptoms listed below must be present, one of which must be from items (a) to (d):

Autonomic arousal symptoms

- (a) palpitations or pounding heart, or accelerated heart rate;
- (b) sweating;
- (c) trembling or shaking;
- (d) dry mouth (not due to medication or dehydration);

Symptoms involving chest and abdomen

- (e) difficulty in breathing;
- (f) feeling of choking;
- (g) chest pain or discomfort;
- (h) nausea or abdominal distress (e.g., churning in stomach);

Symptoms involving mental state

- (i) feeling dizzy, unsteady, faint, or light-headed;
- (j) feelings that objects are unreal (derealization), or that the self is distant or "not really here" (depersonalization);
- (k) fear of losing control, "going crazy," or passing out;
- (l) fear of dying;

General symptoms

- (m) hot flushes or cold chills;
- (n) numbness or tingling sensations.

C. Most commonly used exclusion clause. Panic attacks are not due to a physical disorder, organic mental disorder, or other mental disorders, such as schizophrenia and related disorders, mood [affective] disorders, or somatoform disorders.

The range of individual variation in both content and severity is so great that two grades, moderate and severe, may be specified, if desired, with a fifth character.

Panic disorder, moderate

At least four panic attacks in a 4-week period.

Panic disorder, severe

At least four panic attacks per week over a 4-week period.

DSM-IV Diagnostic Criteria for Generalized Anxiety Disorder

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The person finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). Note: Only one item is required in children.

(1) restlessness or feeling keyed up or on edge

(2) being easily fatigued

(3) difficulty concentrating or mind going blank

(4) irritability

(5) muscle tension

(6) sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a panic attack (as in panic disorder), being embarrassed in public (as in social phobia), being contaminated (as in obsessive-compulsive disorder), being away from home or close relatives (as in separation anxiety disorder), gaining weight (as in anorexia nervosa), having multiple physical complaints (as in somatization disorder), or having a serious illness (as in hypochondriasis), and the anxiety and worry do not occur exclusively during post-traumatic stress disorder.

E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism), and does not occur

exclusively during a mood disorder, psychotic disorder, or a pervasive developmental disorder.

Other mixed anxiety disorders

Other specified anxiety disorders

Anxiety disorder, unspecified

Differential diagnosis panic attack:

1- Psychiatric conditions, like mood disorders, phobia disorder, obsessive-compulsive disorder is easily distinguished by the mental and behavioral phenomena.

2- Medical conditions

1- Acute Myocardial infarction

The chest pain is radiating into their neck.

EEG, cardiac enzymes are characteristics for Myocardial Infarction.

2- Pheochromocytomas

Symptoms like crushing back or abdominal pain, sweating in chest and back regions. We notice increases the catecholamine metabolites like (VMA) in the urine of those patients.

3- Substance abuse:

Cocaine intoxication and withdrawal, but there are severe aching muscles and bones, vomiting, marked rhinorrhea.

4-Hypoglycemia: Sugar level is below 40 mg/1.

5-Caffeine: Excessive consumption.

6- Mitral valve prolapse.

Mitral value prolapse may be more prevalent in panic disorder patient's than in general population ECHO is diagnostic for mitral value prolapse (4 mm of leaflet displacement).

7- Complex partial seizures.

Treatment of panic attacks:

A. Psychotherapy

1- Insight psychotherapy.

2- Supportive psychotherapy.

3- Cognitive Behavioral therapy. Cognitive restructuring :
Make a short provocation of panic symptoms by asking the patient to hyperventilate, show him how to practice relaxation exercise, so he can diminish his panic symptoms (Clark). In panic attack there is inner trigger (Heart rate gone up (Tachycardia),
apprehension (the is alert).

Sensation : The more sensation because of apprehension so the heart beats frequency increased.

introduction feel my heart so I may got Myocardial infarction
Small physiological symptoms and it's interpretation provoke the panic symptoms and you stop that by making the patient physiological complaint, then he feels comfortable so to tell him it's comfortable , so he will say yes okay when we has no hyperventilation , to practice respiration exercise (Deep slow frequent respiration).

4- Meditation

B- Pharmacotherapy.

1. Antidepressant.

1- Tricyclic Antidepressants.

Imipramine (Tofranil) 50-75 mg/ day up to 300 mg/day. can be given. (Drug of first choice)

Chlomipramine (anafranil) can be given.

- Amitriptyline (Elatrol) is effective also.

2-MAOI.

- Phenelzine (Nardil) 45 mg/day.

-Tranlycypromine 10-20 mg/day.

3-Anti hypertensive agents

- Beta Blockers (Propranolol) (inderal) 40-160 mg/day.

- Clonidine 0.1-0.4 mg/day.

4- Benzodiazepine.

- Alprazolam (xanax). 5-6 mg/day.

- Clonazepam 1-5 mg/day.

8.1.B. Generalized anxiety disorder

DSM-IV Diagnostic Criteria for Obsessive-Compulsive Disorder

A. Either obsessions or compulsions:

Obsessions as defined by (1), (2), (3), and (4):

(1) recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress

(2) the thoughts, impulses, or images are not simply excessive worries about real-life problems

(3) the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action

(4) the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

Compulsions as defined by (1) and (2):

(1) repetitive behaviors (e.g., handwashing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.

(2) the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. Note: this does not apply to children.

C. The obsessions or compulsions cause marked distress; are time-consuming (take more than an hour a day); or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.

D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an eating disorder; hair pulling in the presence of trichotillomania; concern with appearance in the presence of body dysmorphic disorder; preoccupation with drugs in the presence of a substance use disorder; preoccupation with having a serious illness in the presence of hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a paraphilia; or guilty ruminations in the presence of major depressive disorder).

E. The disturbance is not due to the direct effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify if:

With poor insight: if, for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable.

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Compulsions are defined as repetitive acts, behaviors, or thoughts that are designed to counteract the anxiety associated with an obsession. A compulsion reduces the anxiety associated with the obsession. While many compulsions are acts associated with specific obsessions, such as hand-washing or checking, other compulsions can be thoughts. For example, patients may have the obsession that they have committed a sin and might relieve the resultant anxiety by repetitively saying a silent prayer to themselves.

Obsessions and compulsions must cause marked distress, consume at least 1 hour a day, or interfere with functioning to be considered above the diagnostic threshold. At least during some point in the illness, symptoms of OCD must be recognized as unreasonable for adults, though this varies greatly both across individuals and in a given individual over time. For example, early in the course of the disorder patients may recognize their hand washing is excessive or irrational but, over a number of years, lose this recognition. DSM-IV recognizes a poor insight subtype of OCD when an individual fails to recognize the irrational or unreasonable nature of the obsessions. This subtype of OCD has been labeled the psychotic subtype in some of the clinical literature, prompting trials of antipsychotic pharmacotherapy. The criterion related to insight does not apply to children, who may either not possess the insight to recognize the unreasonableness of their condition or may be too embarrassed to discuss the condition as unreasonable.

OCD frequently co-occurs with other disorders. The association with major depression is particularly prominent, although comorbidity with panic disorder, phobias, and eating disorders is also not uncommon. Finally, OCD exhibits a particularly interesting association with Tourette's disorder. Approximately half of all patients with Tourette's disorder meet criteria for

OCD, although less than 10 percent of patients with OCD meet criteria for Tourette's disorder. There is also evidence of cotransmission of Tourette's disorder, OCD, and chronic motor tics within families.

History and Comparative Nosology

Descriptions of patients with a syndrome of recurrent obsessions and compulsions are found in the nineteenth century, when these conditions were viewed as a form of "depressive state."

Descriptions of OCD also played a prominent role in Freud's writings, as captured in the case history of the Rat Man, and in early learning-based theories that attempted to apply treatments developed among patients with phobias to patients with OCD. Research on OCD changed with the ECA study in the early 1980s. Prior to this study, OCD was recognized as a discrete but rare entity, stimulating a modest degree of research. The Epidemiologic Catchment Area (ECA) Study noted that OCD had a prevalence in excess of 1 percent in the population and was associated with marked impairment. This stimulated extensive research on all aspects of OCD, including its phenomenology.

The major change in OCD from DSM-III to DSM-IV involved the conceptualization of compulsions. While DSM-III-R viewed compulsions as behaviors, DSM-IV recognized compulsions as either behaviors or mental acts designed to reduce the anxiety-provoking nature of the obsession. The conceptualization of OCD in the ICD and DSM systems is generally similar with a few exceptions in the emphasis on specific features of the condition. For example, ICD-10 emphasizes that a compulsive act must not be pleasurable. ICD-10 also stipulates that obsessions or compulsions must be present most days for 2 weeks, a requirement not included in DSM-IV, and ICD-10 does not stipulate the amount of time a patient must spend on compulsions. Perhaps the major difference between the DSM-IV and ICD-10 view of the disorder relates to the categorization of the disorder with respect to other anxiety disorders. DSM-IV recognizes OCD as one of the nine anxiety disorders discussed in the current chapter. There has been some debate in the United

States and Europe about whether OCD is more properly classified in a distinct category. ICD-10 has adopted such a scheme, using OCD to designate a group of syndromes considered distinct from anxiety disorders (Table 15.6–11).

Table 15.6-11. ICD-10 Diagnostic Criteria for Obsessive-Compulsive Disorder

A. Either obsessions or compulsions (or both) are present on most days for a period of at least 2 weeks.

B. Obsessions (thoughts, ideas, or images) and compulsions (acts) share the following features, all of which must be present:

(1) They are acknowledged as originating in the mind of the patient and are not imposed by outside persons or influences.

(2) They are repetitive and unpleasant, and at least one obsession or compulsion that is acknowledged as excessive or unreasonable must be present.

(3) The patient tries to resist them (but resistance to very long-standing obsessions or compulsions may be minimal). At least one obsession or compulsion that is unsuccessfully resisted must be present.

(4) Experiencing the obsessive thought or carrying out the compulsive act is not in itself pleasurable. (This should be distinguished from the temporary relief of tension or anxiety.)

C. The obsessions or compulsions cause distress or interfere with the patient's social or individual functioning, usually by wasting time.

D. Most commonly used exclusion clause. The obsessions or compulsions are not the result of other mental disorders, such as schizophrenia and related disorders or mood [affective] disorders.

The diagnosis may be further specified by the following four-character codes:

Predominantly obsessional thoughts and ruminations

Predominantly compulsive acts [obsessional rituals]

Mixed obsessional thoughts and acts

Other obsessive-compulsive disorders

Obsessive-compulsive disorder, unspecified