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PSY 240

We are presented with the case of Pat Montgomery who had been diagnosed with obsessive-compulsive disorder (OCD). After her initial diagnosis, Pat participated in two studies that examined effectiveness of medications in the treatment of OCD before being referred to a clinic specializing in psychological treatments for anxiety disorders. A structured clinical interview at the clinic established the nature of Pat's OCD symptoms in addition to revealing a few other problem areas including symptoms of depression and fear of snakes.

The case doesn't describe Pat's symptoms at the time when she was first diagnosed with OCD; examining her reports during the interview at the clinic against the backdrop of description of OCD presented in the *Diagnostic and Statistical Manual Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013), however, confirms that the symptoms she had at the time of the interview do warrant an OCD diagnosis.

DSM-5 specifies 4 criteria for diagnosis of OCD (American Psychiatric Association, 2013). Criterion A is stated as "Presence of obsessions, compulsions, or both". In her interview, Pat reported that "for the past 6 years, she had been intensely fearful of becoming contaminated by germs that would cause her to come down with some deadly disease". She also feared that "she could be contaminated by her food" and that "her husband and children could contaminate her food". Hence Pat's behaviour displayed an obsession, namely thoughts about and fear of contamination. Pat's aforementioned thoughts were clearly recurrent and persistent (as she had experienced them for at least 6 years), and they were almost always followed by execution of a compulsive action (i.e. trying to get rid of the contamination). Pat's repetitive attempts to get rid of contamination display compulsive behaviour, since such attempts were usually aimed at reducing anxiety induced by her fear of contamination.

The case states that Pat would usually wash her hands 40 times a day and spend 60 to 90 minutes taking a shower. Thus her obsessions and compulsions can be characterized as time-consuming. Moreover, these obsessions and compulsion had caused her substantial physical harm ("hands were red and skin around her fingernails had receded") and significant impairment in social (distrust of family members and friends) and occupational damage ("Pat had to quit this position out of fear of coming into contact with persons who had been to a funeral", "her in ability to work outside home"). Thus, Pat's behaviour satisfies the second criterion of DSM-5 specification for OCD (American Psychiatric Association, 2013).

Apart from suggesting that antidepressants Pat took during her participation in the two clinical trials might have caused Pat's depression, the study doesn't mention Pat's relation to other medical conditions and substances listed in the criterion of DSM-5 OCD specification (e.g. alcohol) (American Psychiatric Association, 2013). Since the antidepressants didn't create her obsessions and compulsions (she was diagnosed with OCD before taking the antidepressants) we can conclude that this criterion is also met.

In addition to the criteria described above, DSM-5 also requires the disturbance not to be better explained by other disorders (American Psychiatric Association, 2013). These include generalized anxiety disorder (GAD), body dysmorphic disorder etc. None of these, however, account for obsessions and compulsions prominent in Pat's behaviour, and each of these disorders have at least one criterion in their DSM-5 specification that is not met by Pat's symptoms. As an example, consider GAD: Pat's behaviour doesn't display frequent uncontrollable worries about a variety of subjects which is the most distinct symptom of GAD. The list of candidate disorders given in criterion D of DSM-5 specification of OCD that can potentially better explain symptoms listed in criteria A-C isn't exhaustive, but it is unlikely

that some other mental disorder that isn't classified by DSM-5 as an anxiety or obsessive-compulsive disorder will explain Pat's symptoms better than OCD does. Hence, we can conclude that criterion D is met by Pat's behaviour.

All of the points mentioned above warrant diagnosis of OCD both as primary (since OCD was the reason Pat was admitted to the clinic) and principal (since OCD was arguably the most important of all conditions Pat was concluded to have after the examination) diagnosis. It is also the case that Pat seems to have at least fair insight ("Pat could sometimes hold an objective view that her chances of being contaminated were low") into her condition.

Pat has symptoms that are not well explained by OCD as described in DSM-5, or better explained by presence of other disorders. The most notable of these are symptoms traditionally associated with depression (sleep disruption, feeling down for long periods of time etc.). However, the case study isn't detailed enough to conclude that Pat has a particular depressive disorder. For example, DSM-5 entry on major depressive disorder (MDD) states that "Five or more of the following nine symptoms should be present for at least two weeks" (American Association, 2013), but the description of Pat's symptoms presented in the case study only refer to symptoms observed over much longer time periods. Since there is no other clear secondary diagnosis among anxiety and obsessive-compulsive disorders described in DSM-5, we can conclude that no secondary diagnosis can be reasonably made (American Psychiatric Association, 2013).

Although the study doesn't offer explicit explanations regarding origins of Pat's condition, several biological causes can be suggested for Pat's primary diagnosis (OCD). One such cause of OCD has been studied through functional brain imaging. In brains of patients with OCD increased levels of activity have been found in parts of basal ganglia which in turn caused

an increased activity in orbitofrontal cortex. It has also been shown that people with OCD have dysfunction in the dorsolateral PFC, insula, temporal and parietal lobes of the brain (Nakao, Okada & Kanba, 2014).

Inheritance can also explain presence of OCD symptoms in certain individuals. It has been shown that anxiety disorders and OCD have common biological causes such as neuroticism that correspond to inheritable traits. (Goodwin, 2015, p.249). In Pat's case, this explanation might be relevant, since her father and two sisters have suffered from anxiety disorders.

Psychological factors too can play a role in formation of OCD. During times of high external stress, people can start to associate objects with certain "negative" emotions (e.g. fear). This can facilitate creation of an obsession with the object and a compulsive desire to avoid it (camh-reference).

It has also been suggested that thought-action fusions (TAF) too may play a role in development of OCD in some cases. TAF has two main components: The first is a belief that simply thinking about an unwanted event increases the chances of the event actually happening. The second is a conviction that imagining thoughts related to an immoral or unwanted action is, as far as morals go, equivalent to performing that action. The latter belief causes the person to accept visions and thoughts they regard as unacceptable as real and feel responsible for them (Shafran, Thordarson & Rachman, 1996).

OCD, like many other behavioral disorders, might be influenced by social factors. Establishing such cause-and-effect relations between social factors and progression of OCD, however, is quite hard due to inherent difficulty of identifying and controlling other variables relevant to development of OCD. In Pat's case, the fact that she had to become unemployed due to her condition might have aggravated her symptoms and played a role in formation of her

regular feelings of guilt later on. In general, it is not inconceivable that an individual's employment status and relationship with other close individuals might be linked to onset or progression of OCD.

Anxiety and obsessive-compulsive disorders are closely related - in fact, DSM-4, unlike DSM-5, didn't classify them into two distinct groups. Disorders of these two kinds can have a common cause (e.g. neurocity), can comorbid with one another or with depression, and can have similar symptoms. In particular, excessive worries (a symptom of GAD) and obsessions (a symptom of OCD) can look similar. However, these two symptoms are intrinsically different. The most prominent difference is that obsessions have an obvious counterpart (compulsions), while excessive worries don't (Abramowitz & Foa, 1998, p. 695-700). Excessive worries are uncontrollable, whereas people with OCD perform compulsive actions in order to address the obsession (DSM-5; American Association, 2013). In Pat's case, this corresponds to her urge to wash her hands to cleanse herself from the germs and the relief she feels after doing so.

It has also been suggested that the contents of obsessions and persistent worrying thoughts are different. Worrying thoughts are usually associated with aspects of daily life which aren't completely unreasonable to worry about (Abramowitz & Foa, 1998, p. 695-700). Objects of obsession, however, can be highly unlikely events. Pat's worry about death caused by germs, which she admits to be probably irrational, exemplifies this.

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