EXAMINING THE DIFFERENTIAL DIAGNOSIS BETWEEN OCD AND PTSD

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BACKGROUND

Lifetime Prevalence

OCD

(In general US population)

ESTIMATED AT

2.3%

with estimates ranging from

1% to 5%

among U.S. Veterans

PTSD

ESTIMATED AT

6.8%

with estimates of

13.8%

for OIF/OEF Veterans

The co-occurrence of these disorders is common, with nearly **1 IN 4 INDIVIDUALS WITH PTSD ALSO EXPERIENCING OCD.**

DISORDER OVERVIEW

Posttraumatic Stress Disorder (PTSD) criteria, as defined by *DSM-5*:

- Exposure to actual or threatened death, serious injury, or sexual violence
- Presence of reexperiencing symptoms (trauma-related nightmares, recurrent intrusive memories, or flashbacks)
- Persistent avoidance of trauma-related cues
- Negative changes in thoughts or mood associated with traumatic events
- Marked changes in arousal and reactivity, such as irritability, exaggerated startle response, hypervigilance, or difficulty sleeping
- Symptoms that occur for longer than 1 month

Obsessive-compulsive disorder (OCD) criteria, as defined by *DSM-5:*

- Presence of obsessions and/or compulsions
- Presence of obsessions {recurrent, intrusive thoughts or images that are unwanted and the individual attempts to avoid)
- Presence of compulsions (urges to perform mental or behavioral rituals in response to obsessions to neutralize obsessions and reduce anxiety)
- Obsessions and compulsions that are time-consuming (take more than 1 hour per day) and cause clinically significant distress or impairment
- Although not necessary for diagnosis, stress and trauma can be a precipitant

Overlap in symptoms

- Unwanted, intrusive memories or thoughts
- Repetitive behaviors and actions to reduce distress
- Avoidance of stimuli that cause intrusive thoughts to occur

HOW THESE SYMPTOMS DIFFER:

	PTSD	OCD
Intrusive Thoughts	• Focused on past experiences and trauma	• Focused on the future negative outcomes
Repetitive Behaviors	• Done to prevent trauma from recurring • Often completed and not done again unless another threat is perceived • Decreases anxiety because perceived threat is neutralized • Perfectionistic in that doing it correctly further minimizes threat	• Done to prevent imagined threat from occurring • Sense of magical thinking connecting action and what it is preventing • More rigid set of rules and patterns • Strong sense of self doubt and/or not doing it "right" that leads to repeated behaviors
Avoidance	Avoiding triggers of trauma memories that may lead to flashbacks or reexperiencing	• Avoiding scenarios where compulsions may be triggered, or obsessive thoughts brought on
Underlying Function	• Avoiding painful memories and reexperiencing trauma	• Preventing feared consequences

THE CONNECTION BETWEEN TRAUMA AND OCD

The role of trauma in PTSD is well defined, but a new phenomenon called trauma-related OCD, in which a patient develops OCD after experiencing a trauma, has been coined to refer to the link between trauma and OCD. In OCD patients with a diagnosis of PTSD, 10.6% had the OCD diagnosis emerge either concurrently or after PTSD (posttraumatic OCD), and 4.1% had an OCD diagnosis that occurred before PTSD. Studies have suggested that OCD occurring after or near onset of PTSD is associated with distinct clinical features. Namely, patients who developed OCD after PTSD had a later age at onset and greater rates of aggressive, sexual/religious and hoarding obsessions and compulsions, along with a more severe clinical picture.

CASES

Cases below illustrate the role of trauma in symptom development for both OCD and PTSD. They also differentiate between OCD and PTSD symptoms, emphasizing safety-related rituals and avoidance.

CASE 1 • PTSD WITH TRAUMA-RELATED OCD

Mr. K, a 45-year-old Navy officer, suffered a blast-injury during an extensive tour of duty. He survived serious physical injuries and returned home. Over the next 7 months, he developed psychological symptoms, including frequent, unwanted intrusive cognitions about the event; recurrent dreams and nightmares; avoidance of various settings and stimuli; exaggerated startle reactions; and hypervigilance. Mr. K began checking his house to assure himself it was secured and made sure his handgun kept in a safe was always cleaned and worked perfectly. The checking was extensive and ritualistic. Doors and windows had to be checked repetitively in sets of 2s to ensure they were properly secured. He had recurrent doubts about their security, frequently going back immediately after pulling hard on a door to assure it was locked, only to do so again. He also began constantly requiring reassurance from his wife about the safety of the house, himself, and the family.

Discussion:

Mr. K clearly meets criteria for PTSD as defined by the DSM-5. He exhibits hypervigilance in the form of repetitive behaviors and task completions. Initially the behaviors are done to prevent the trauma from reoccurring and to feel safe in his home, with a clear focus on what happened in the past. His checking behavior begins to become more rigid and ritualistic, transitioning his core focus to "how" he must check doors and windows and making sure it is done perfectly. This distinction differentiates between PTSD and OCD. A high sense of doubt compels Mr. K to recheck everything, which is unique to OCD. In this case, Mr. K meets criteria for both PTSD and OCD, with OCD symptoms that are trauma-congruent.

CASE 2 • PTSD WITH NON-TRAUMA-RELATED OCD

Mrs. D served overseas for the Army. She suffered various psychological difficulties following a vehicular accident when she was caught in a tropical storm that overturned her vehicle. She was not in any way responsible but was injured and seriously shocked. On returning home, she developed anxiety about driving and began to avoid leaving the house if rain was forecast. She also had flashbacks of the accident, loss of interest in leisure activities, difficulty in relating to others, poor sleep, impaired concentration, and hypervigilance about the weather. She reported that, within weeks after the accident, she developed extensive rituals of cleaning and tidying the house. She did this several times a day, with great energy. She said that she "had to do it" or she "just wouldn't feel right." She recognized the repetitive cleaning and tidying rituals were unnecessary and irrational, but she could not resist the compulsion to engage in them.

Discussion:

Mrs. D meets diagnostic criteria for both PTSD and OCD. In this case, her obsessions and compulsions begin after her traumatic accident yet are in no way related to her trauma. The performance of her cleaning rituals is not in response to intrusive thoughts regarding the accident. This is an example of comorbid PTSD and OCD that develop following a trauma, yet the obsessions and compulsions are trauma-incongruent.

CASE 3 • TRAUMA-RELATED OCD WITHOUT PTSD

Mrs. A served 10 years overseas for the Air Force and suffered sexual trauma during her service. To distract herself from her trauma-related thoughts while deployed, she often showered upwards of 10 times a day, replacing the sensation and thoughts of the perpetrator's hands on her body with that of hot water and scrubbing. After returning home, she continued her showering habit in the absence of intrusive memories about the trauma. Her showering ritual involved very detailed, specific routines that had to be done for her to "feel clean." Sometimes after showering she felt a sense of not having done it correctly, so she showered for over an hour at a time until she felt she did it perfectly. She also avoided watching sexual content on TV, as doing so elicited the feeling she needed to shower again.

Discussion:

Initially Mrs. A uses showering to distract herself from trauma-related thoughts. However, her showering develops key features of having to be done in a specific, ritualistic manner until she feels she did it correctly. Furthermore, the aim of the action is no longer to distract herself from her thoughts but to reduce anxiety she feels if not done correctly. Similarly, her avoidance of triggers is to prevent herself from feeling the need to complete her showering compulsion. Mrs. A meets criteria for trauma-related OCD but not for PTSD.

CONCLUSION

In summary, in distinguishing PTSD from OCD, it is important to consider the following:

- What is the function of the behavior?
- What triggers the behavior?
- Is the behavior logically connected to the feared harm and done in reasonable frequency to protect oneself, or does the patient have the sense that the behavior or the frequency of it is illogical, or that s/he is unable to be finished with the behavior when s/he would like to?

None of these questions is indicative of PTSD or OCD, but these questions may inform the overall differential diagnosis.

TREATMENT

Currently there are no guidelines for treating comorbid PTSD and OCD. Selective serotonin reuptake inhibitors are first-line pharmacological treatment for both OCD and PTSD, though second-line pharmacological treatments and augmentation differ between the 2 disorders.

First-line psychotherapies for OCD and PTSD are based on principles of cognitive behavioral therapy. For more information regarding specific therapies indicated for each respective disorder, click below.

OCD Exposure and Response Prevention: https://iocdf.org/about-ocd/treatment/erp/

PTSD Cognitive Processing Therapy: https://www.ptsd.va.gov/understand_tx/cognitive_processing.asp

PTSD Prolonged Exposure Therapy: https://www.ptsd.va.gov/understand_tx/prolonged_exposure.asp

For more information visit the OCD and Related Disorders VA SharePoint:
https://dvagov.sharepoint.com/sites/vhaocdandrelateddisorders

WHERE YOU WILL FIND:

Assessment measures • Recommendations for therapist manuals and patient workbooks • Client handouts including self-monitoring forms and exposure hierarchies • Journal articles and other resources

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