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Obsessive-compulsive Disorder

Obsessive-compulsive disorder (OCD) is one of the more common of the serious psychiatric conditions. OCD has varying degrees of severity and it is characterised by obsessions or compulsions but commonly both. Obsessions are unwanted intrusive thoughts, images or urges that occur repeatedly and the person cannot get out of their mind. Compulsions are repetitive behaviours or mental acts that the person feels driven to carry out. They can be overt (noticeable to others), eg. Constantly washing their hands; or they can be covert, eg. A mental act that cannot be observed, such as repeating a certain phrase in one's mind.

Body Dysmorphic Disorder (BDD), a condition related to OCD characterised by severe preoccupation with a perceived physical defect. Body image problems can cause significant distress and can lead to further problems such as anxiety, eating disorders and social phobia. It has long been recognised that negative body image problems are a factor in the onset and maintenance of many eating disorders. In many ways, BDD is quite similar to OCD; BDD also has obsessive characteristics, in the case of BDD the person is obsessed with an imagined defect in his/her appearance. The treatment of BDD is very similar to OCD. For the purpose of this article I will concentrate on OCD.

How common is OCD?

1 to 2% of the population are thought to suffer from OCD, although some studies suggest it is as high as 2 to 3%. Studies suggest that OCD is more common in women than men. There is indications that there is a genetic link with evidence in runs in some families. Obsessive-compulsive disorder can occur at any age but most often presents for the first time in adolescence. It can even occur in children as young as 6 or 7. The World Health Organisation rates obsessive-compulsive disorder as one of the top 20 most disabling diseases.

Symptoms

The most common symptoms of obsessive-compulsive disorder are:

Obsessions
Examples of obsessions include fear of causing harm to someone else; fear of harm coming to self; fear of contamination; need for symmetry or exactness; sexual and religious obsessions; fear of behaving unacceptably and fear of making a mistake

Compulsions
Compulsions can include *behaviours* such as cleaning, hand washing, checking, ordering and arranging, hoarding and asking for reassurance. Compulsions can also include *mental acts* such as counting, repeating words silently and constant worries about past events.

Most people acknowledge the senselessness of these thoughts and behaviours, as well as the wish to be rid of them. Most people with obsessive-compulsive disorder experience both obsessions and compulsions.

Common obsessions include unrealistic distressing worries about harm, such as being responsible for an accident or the fear of contamination, accompanied by avoidance of situations in which harm or contamination may occur. These obsessions are linked with compulsive behaviours, which may temporarily reduce the associated anxiety, such as excessive checking or cleaning rituals.

Conditions which co-exist with OCD

A number of psychiatric conditions can also be present in those suffering from OCD. These include depression (50-60% of OCD sufferers have this), specific phobias (22% of OCD sufferers), social phobia (18% of OCD sufferers), eating disorder (17% of OCD sufferers), schizophrenia (14% of OCD sufferers), alcohol dependence (14% of OCD sufferers), panic disorder (12% of OCD sufferers) and tourette's syndrome (7% of OCD sufferers)

Management of obsessive-compulsive disorder

The Yale-Brown obsessive compulsive scale (Y-BOCS) is considered the best test for assessing the severity of OCD which exists in an adult and a child version. It is best to be referred by your GP to a psychiatrist who has a speciality in OCD.

The following questions can be asked to help determine if someone is suffering from OCD:

- Do you wash or clean a lot?
- Do you check things a lot?
- Is there any thought that keeps bothering you that you would like to get rid of but cannot?
- Do your daily activities take a long time to finish?
- Are you concerned about orderliness or symmetry?
- Do you get very annoyed if you cannot get a task completed?
- Are you concerned about putting things in a special order?
- Do you get very annoyed or upset by mess?

Severity of the condition can vary and medical professionals must determine how much it is affecting the person's ability to function in everyday life.

Management in adults

Those with a milder form of OCD can be managed with low-intensity psychological treatment. International guidelines reckon that psychological therapy called Cognitive Behavioural Therapy (CBT) is the most effective for OCD.

The two prominent features of OCD, overestimations of danger and inflated beliefs of personal responsibility, benefited equally from CBT. Studies show that cognitive

behaviour therapy can give improvement rates of up to 85% for OCD. Cognitive behavioural therapy (CBT) is a form of therapy that emphasises the important role of thinking in how we feel and what we do. CBT challenges the automatic thoughts and assumptions behind behaviour in anorexia.

In relation to obsessive-compulsive disorder, CBT aims to remedy faulty reasoning that may have developed with the disorder. CBT encourages people to re-evaluate overestimated beliefs about risk or personal responsibility, to regain a more realistic perspective

Inference-based treatment (IBT) is a method of psychological treatment sometimes used by psychologists in addition to CBT in OCD with obsessional doubt.

ERP is a technique in which the person is repeatedly exposed to the situation causing anxiety (eg, exposure to dirt) or are prevented from performing repetitive actions, which lessens that anxiety (eg, washing their hands). This method is only undertaken with a professional therapist and is only used after extensive counselling and discussion with the person who understands fully what to expect and is ready to embrace his/her fears. After an initial increase in anxiety, the level gradually decreases. When ERP is done effectively, the person finds that once they confront their worst fears, nothing terrible actually happens, meaning the person can be "weaned off" their obsession or compulsion.

In the case of mild OCD, if low-intensity psychological treatment fails or the person opts not to have more intensive psychological treatment, medication such as an antidepressant called a selective serotonin reuptake inhibitor (SSRI) may be tried as the next step in therapy.

For people with more severe symptoms that are greatly affecting their quality of life (especially where low-intensity psychological treatment has failed), the next step in treatment is high-intensity CBT and ERP (more than 10 hours per person) or an SSRI. People with severe symptoms should always be offered high-intensity psychological therapy plus an SSRI.

Psychological treatment in children

For children, the steps taken and the use of psychological treatments like CBT and ERP is similar to those explained above for adults; it is important to involve family or carers depending on the preference of the child. Children should only be treated by a specialist in OCD.

If psychological treatment fails, other factors that may be looked into by health professionals including the co-existence of other psychiatric conditions (such as depression), learning disorders, family problems such as a marriage breakup of parents and presence of mental health problems in the child's parents.

In children over the age of 8, adding medication such as an SSRI might be appropriate in more severe cases, but only under specialist supervision as there are risks as well as benefits.

Medication

SSRIs in adults:
Antidepressants called Serotonin Selective Reuptake inhibitors (SSRIs) appear to be more effective for OCD than for body dysmorphic disorder (BDD). SSRIs can cause an increased risk of suicidal thoughts and self-harm in people suffering from depression, therefore close monitoring (especially initially) must be performed by the person's GP and other health professionals involved in the person's care. However, there is no current evidence linking the use of SSRIs for OCD *per se* with increased risk of suicide.

When a person is initially prescribed an SSRI, your doctor and pharmacist should inform you of the benefits and risks of SSRIs. Antidepressants are not habit forming and craving and tolerance do not occur. There is a risk of withdrawal symptoms on stopping the drug, missing doses, or reducing the dose; therefore SSRIs should only be discontinued in consultation with your GP and should be reduced slowly (eg) the dose reduced over a few days or weeks and then stopped. Potential side-effects of SSRIs include nausea, worsening anxiety, suicidal thoughts, self-harm, akathisia (restlessness and the urge to move) and agitation; these side effects more commonly occur in the first few weeks of treatment. Side effects like nausea and agitation usually subside after a few weeks. SSRIs normally only take about 2 weeks to start relieving depression, however they take longer to relieve OCD symptoms. There is commonly a delay in onset of up to 12 weeks, although depressive symptoms improve more quickly.

SSRIs which are effective for OCD include fluoxetine, fluvoxamine, paroxetine, sertraline or citalopram. There are no significant differences in efficacy between the different SSRIs for OCD. Higher doses of SSRIs than those used for depression may be needed to effectively treat obsessive-compulsive disorder. For example, fluoxetine dose may be increased to up to 60mg for OCD. If there is no response to a standard dose, the maximum dose should be considered. SSRIs should be continued for at least twelve months; they may then be withdrawn gradually on consultation with the doctor, however many people need to use them longer term.

Other drug options
Another drug option if SSRI therapy fails is the tricyclic antidepressant clomipramine (Anafranil®). Clomipramine was the most prescribed drug therapy for OCD in the past, however nowadays it is only prescribed in severe and resistant cases (since SSRIs were launched over 20 years ago) as SSRIs have less side effects and are safer in overdose. Studies show that the efficacy of clomipramine is similar to SSRIs for relieving OCD. There is little evidence to show that medication such as SSRIs are more or less effective than CBT for treating OCD, however a combination of the two is thought to increase treatment success.

Drugs called antipsychotics are sometimes added to SSRIs in cases where SSRIs are not working adequately on their own. Obsessive-compulsive disorder does not respond to antipsychotic drugs given on their own. However, studies have shown that for children and adults, adding first generation (eg. haloperidol) or second

generation antipsychotics (eg. Olanzapine, risperidone) in low dose to SSRIs may benefit resistant cases of OCD. Antipsychotics have been shown to be particularly beneficial for people with OCD who also suffer from Tourette's syndrome and tics. Tourette's and tics appear to be more common in people suffering from OCD. Tourette's is a neurological disorder characterised by the urge to perform repetitive movements or vocal sounds or sayings. These repetitive movements or sounds are called "tics" and examples include twitches, eye blinking, coughing, throat clearing, sniffing, and facial movements.

Antipsychotics in combination with SSRIs should only be prescribed by a specialist and the person must be closely monitored for side effects.

Other drugs are sometimes combined with on-going SSRIs if the treatments described above have failed. Drugs that have commonly been used include the following: buspirone (Buspar®), lithium carbonate, clonazepam (Rivotril®), methylphenidate (Ritalin®) and other antidepressants e.g., trazodone (Molipaxin®), Duloxetine (Cymbalta®), Venlafaxine (Efexor®). None of these are licenced for OCD and studies have suggested their effectiveness is questionable. They should only be prescribed in resistant cases by a specialist experienced in OCD.

SSRIs in children and young people (8-18 years):
Caution is advised when prescribing SSRIs for younger people as the risk of self-harm or suicide is greater in younger people. CBT therapy is the recommended first treatment choice for under 18s, and SSRIs should only be prescribed if CBT is ineffective. SSRIs should only be prescribed for young people in conjunction with psychological therapy following assessment by a child and adolescent psychiatrist who should also be involved in dosage changes and discontinuation. Sertraline and fluoxetine are the only SSRIs licensed for OCD in under 18s, unless significant coexisting depression is evident, in which case only fluoxetine should be used.

If an SSRI does not work another SSRI may be tried. Intensive CBT can be effective for under 18s even in cases resistant to other psychological therapies. If the young person is still resistant to treatment, Clomipramine (Anafranil®) is an option but can only be prescribed by a specialist. Clomipramine has a greater tendency to produce adverse effects than SSRIs. Because of the risk of cardiac side effects, ECG and BP must be closely monitored. A low dose of clomipramine should be started and increased slowly according to response and the young person must be monitored regularly. Antipsychotics are sometimes used to in addition to antidepressant for young people if an SSRI is not affective alone even though they are not licenced for OCD. Hospital treatment should always be a 'last resort' and only if community based treatment fails.

Treatment failure

Up to 40% of people who present to psychiatrists fail to respond adequately to cognitive behaviour therapy, drugs, or a combination of the two. Neurosurgery may be considered for severely ill people who do not respond to CBT and medication. Risks, benefits and long-term postoperative management should all be carefully considered before embarking on this treatment option. Patient selection can be

improved by the use of neuroimaging. Stereotactic ablation and deep brain stimulation are currently being explored and have shown promise.

OCD Ireland

OCD Ireland is a national organisation for people with Obsessive Compulsive Disorder (OCD) and the related disorders of Body Dysmorphic Disorder (BDD) and Trichotillomania. OCD Ireland provide information and support for people with these disorders and for their family, friends and carers, as well as interested professionals. They also promote awareness of the condition. They provide support, but not treatment of the condition. Their website is www.ocdireland.org and it provides great information and advice on OCD. The website also lists psychiatrists in Ireland who provide treatment of OCD.

References

References for this article are available on request. The article was written and researched by pharmacist Eamonn Brady and Eamonn will forward references upon request.

Disclaimer: Information given is general; please ensure you consult with your healthcare professional before making any changes recommended

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