Obsessive compulsive disorder

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Abstract

Obsessive compulsive disorder (OCD) is a frequent, chronic, costly and disabling disorder characterised by recurrent intrusive ideas, images, ruminations, impulses and thoughts (obsessions), which increase anxiety and repetitive patterns of behaviour (compulsions), in an attempt to decrease anxiety. It is one of the most disabling psychiatric conditions, and has a negative impact on the quality of life of both patients and those close to them. When correctly recognised and diagnosed, it can be successfully treated. The World Health Organization ranks OCD as one of the 10 most disabling conditions in terms of lost income and decreased quality of life.

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Introduction

Obsessive compulsive disorder (OCD) is a frequent, chronic, costly and disabling disorder characterised by recurrent intrusive ideas, images, ruminations, impulses and thoughts (obsessions), which increase anxiety and repetitive patterns of behaviour (compulsions), in an attempt to decrease anxiety. It is one of the most disabling psychiatric conditions, and has a negative impact on the quality of life of both patients and those close to them. When correctly recognised and diagnosed, it can be successfully treated. The World Health Organization ranks OCD as one of the 10 most disabling conditions in terms of lost income and decreased quality of life.

Epidemiology

The lifetime prevalence of OCD is 2.5%. Both women and men are equally affected, although the disorder more commonly presents in males in childhood or adolescence, and tends to present in females in their twenties. It has a similar prevalence in different races and ethnicities, although specific pathological preoccupations may vary with culture and religion.

Causes

OCD has a high genetic origin, with a 35% occurrence in first-degree relatives. It can be caused by the interplay of a myriad of factors, including developmental and psychological factors, as well as certain stressors (Table I). Very rarely, symptoms may present in adults as a consequence of a neurological condition.

Prognosis

Without treatment, symptoms will rarely remit spontaneously. Overall, close to 70% of patients entering treatment experience a significant improvement in their symptoms. Fifteen percent demonstrate a progressive worsening of symptoms or deterioration in functioning over time, and 5% undergo complete remission from symptoms between episodes of exacerbation.

Diagnosis

The Diagnostic and statistical manual of mental disorders (DSM), fifth edition, was published in 2013, and includes a new stand-alone chapter on OCD and related disorders. This group of
conditions now includes OCD, body dysmorphic disorder, trichotillomania (hair-pulling disorder), excoriation (skin-picking) disorder, hoarding disorder, substance- or medication-induced OCD, OCD due to another medical condition, and other specified OCDs. Previously, OCD was grouped within the anxiety disorder category.5

The American Psychiatric Association defines OCD as the presence of obsessions, compulsions or both (Table II).

<table>
<thead>
<tr>
<th>Table II: Common obsessions and compulsions</th>
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</thead>
<tbody>
<tr>
<td>Common obsessions</td>
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<tr>
<td>Contamination</td>
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<tr>
<td>Safety</td>
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<tr>
<td>Scrupulosity (needing to do the right thing, fear of committing a transgression)</td>
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<tr>
<td>Doubting one's memory or perception</td>
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<tr>
<td>Common compulsions</td>
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<tr>
<td>Cleaning and washing</td>
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<tr>
<td>Checking</td>
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<tr>
<td>Counting or repeating actions a certain number of times</td>
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<td>Arranging objects</td>
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<tr>
<td>List making</td>
</tr>
</tbody>
</table>

Obsessions are defined as follows:6

- Recurrent and persistent thoughts, urges or images that are experienced at some time during the disturbance as intrusive and unwanted, and which cause marked anxiety and distress
- Attempts by the person to suppress or ignore such thoughts, impulses or images, or to neutralise them with some other thought or action.

Compulsions are defined as follows:

- Repetitive behaviour, e.g. hand-washing, ordering and checking, or mental acts, e.g. praying, counting and repeating words silently, in response to an obsession, or according to rules that must be applied rigidly
- The behaviour or mental acts are aimed at preventing or reducing distress, or preventing some dreaded event or situation from occurring. However, the behaviour or mental acts are either not connected in a way that could realistically neutralise or prevent whatever they are meant to address, or they are clearly excessive.

At some point during the course of the disorder, the person recognises that the obsessions or compulsions are excessive or unreasonable. The obsessions or compulsions caused marked distress, are time-consuming (> 1 hour per day) or significantly interfere with the person's normal routine, occupational or academic functioning, or usual social activities or relationships.6

The changes of greatest significance from previous diagnostic criteria in the DSM-IV-text revision pertain to OCD specifiers, namely the insight specifier and the tic-related specifier, both of which may have significant impact on treatment. Insight has been defined as the individual's degree of conviction that their disorder-related belief is accurate. It is a multidimensional concept, which includes both recognition that the cause of the belief is psychological or psychiatric, and willingness to consider that the belief may be false. Upon making a diagnosis, the clinician must determine whether or not the patient's insight is good or fair, poor or absent, or involves delusional beliefs.54

Some studies have associated poor insight with increased symptom severity, greater co-morbidity with depression, longer duration of illness, and poorer response to psychological and pharmacological treatment. Therefore, determining insight may be important when planning psychological treatment strategies.5

The addition of a tic-related specifier reflects the unique difference between patients with and without co-morbid tics. There is a high degree of co-morbidity between OCD and Tourette's syndrome and tic disorders, with prevalence estimates ranging from 26-59%. It is of clinical relevance that the pharmacological treatment response may be influenced by the presence of tics.5

Co-morbidities

Depression (approximately 33%), social phobia (33%), alcohol misuse (25%) and generalised anxiety disorder (10%) are the most common co-morbid diagnoses in people with OCD.5

Management

The treatment goals of OCD are to reduce symptom frequency and severity, and to improve functioning and quality of life. Treatment goals also include minimising the adverse effects of medication, helping the patient to develop coping strategies for the OCD and related stressors, and educating the patient and family on the disorder and its treatment.7

Pharmacotherapy is more effective than psychotherapy, but is most effective when combined with cognitive behavioural therapy (CBT). Prognosis with therapy is fair, but some cases are intractable.1

Nonpharmacological treatment

Psychological education, as part of the management of OCD, is crucial.2 Since the symptoms of OCD can greatly affect the patient's family, inclusion of the partner or family in the development of a treatment strategy is appropriate.2 Education on the nature and treatment is essential. As with many psychiatric disorders, patients and their families often have misconceptions about the illness and its management. Information should be provided about the neuropsychiatric source of the symptoms, as opposed to having families place unnecessary blame on themselves.4

CBT is an important aspect of OCD treatment, whether used alone or in combination with medication. CBT for OCD can be delivered in an individual, group or family therapy format.7 Treatment is short term and interactive, and focuses on correcting distorted assumptions and cognitions. The emphasis is on confronting
and examining situations that elicit interpersonal anxiety, and focusing on maladaptive thoughts. The number and length of treatment sessions vary across different studies, but some guidelines recommend 13-20 weekly sessions for most patients.

Group therapy can range from only providing support and an increase in social skills, to focusing on specific symptom relief, or to therapy which is specifically insight orientated.

Exposure therapy ensures that patients make contact with the feared stimuli, and that this contact is maintained until the anxiety associated with the contact subsides. The process is termed "habituation", and can only occur if patients are prevented from using their usual escape or avoidance behaviour (extinction). Exposure has been described as the most effective way of treating fear. Efficacy of exposure is optimal when it is graduated, repeated and prolonged, and when the practice tasks are clearly specified.

Pharmacological treatment

Selective serotonin reuptake inhibitors (SSRIs) are considered to be effective first-line medicine for the treatment of OCD. Given the apparent lack of differences in efficacy between the SSRIs, the side-effect profile of these agents may be an important issue when considering which agent to use first. Individual patients may respond well to one medication, and not to another. When choosing an SSRI, it is important that the safety and acceptability of particular side-effects in the patient are considered, as well as potential drug interactions, past treatment response and the presence of co-morbid conditions.

A response to SSRIs for OCD may take longer than that for other disorders. Response times of up to 12 weeks have been reported. Therefore, it is important that the trial of medication is of adequate duration. When there is a poor response to medication, it is important that the dosage and appropriate duration of treatment are optimised. If there has only been a partial response, options include changing to a different SSRI or augmentation with a different agent.

Pharmacotherapy should be maintained for at least a year, and if a decision is taken to discontinue the medication, it should be carried out gradually, over a few months.

Table III details the medications registered for use for obsessive compulsive disorder in South Africa.

Conclusion

OCD is a chronic, disabling condition which adversely affects the quality of life of patients and those around them. It can cause significant impairment in daily functioning, and a great deal of distress. Obsessions, which increase anxiety, are often followed by compulsions, which are a mechanisms used to decrease the anxiety. OCD can be effectively managed using a combination of nonpharmacological and pharmacological treatment. Of the pharmacological treatments, SSRIs are the mainstay of therapy.

References

10. MIMS. 2014;54(2).

Table III: Medications registered for use for obsessive compulsive disorder in South Africa

<table>
<thead>
<tr>
<th>Medication</th>
<th>Adults</th>
<th>Children (aged five and older) and adolescents</th>
<th>Paroxetine</th>
<th>Sertraline</th>
<th>Citalopram</th>
<th>Escitalopram</th>
<th>Fluvoxamine</th>
<th>Clomipramine</th>
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<tbody>
<tr>
<td></td>
<td>20-60 mg daily</td>
<td>Starting dose: 20 mg daily; recommended dose: 40 mg daily; maximum dose: 60 mg daily</td>
<td>20-60 mg daily</td>
<td>50 mg daily</td>
<td>40-60 mg daily</td>
<td>10 mg once daily; recommended dose: 20 mg daily; maximum dose: 60 mg daily</td>
<td>50 mg daily</td>
<td>Minimum dose: 50 mg daily; increments above 100 mg daily have no additional benefit</td>
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<td></td>
<td>300 mg daily</td>
<td>100-200 mg daily</td>
<td>25 mg daily; increased gradually in divided doses, up to daily maximum of 3 mg/kg or 100 mg, whichever is smaller</td>
<td>20-60 mg daily</td>
<td>60 mg daily</td>
<td>20 mg daily; possible increase to 20 mg daily, depending on individual response</td>
<td>250 mg daily</td>
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<td></td>
<td>75 mg tablet once daily, preferably in the evening</td>
<td>75 mg tablet once daily, up to maximum of 3 mg/kg or 100 mg, whichever is smaller</td>
<td>25 mg twice a day or three times a day, or 1 sustained-release 75 mg tablet once daily, preferably in the evening</td>
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Recommended doses:

- Paroxetine: 10-60 mg daily
- Sertraline: 50-200 mg daily
- Citalopram: 20-80 mg daily
- Escitalopram: 10-20 mg daily
- Fluvoxamine: 50-200 mg daily
- Clomipramine: 25-300 mg daily