Obsessive-compulsive disorder

Obsessive-compulsive disorder (OCD) - F42 (Clinical term: Obsessive compulsive disorder Eu42)

Presenting complaints

- Commonly concern avoidance and thoughts of 'contamination' by objects or situations, and repetitive, cleaning and washing rituals to dispel the contamination.
- Also common are intrusive thoughts of doubt and repetitive checking to prevent harm to self or others, or urges to obtain order or precision or follow a strictly personal routine.

Patients often conceal their symptoms (because of their perceived silly or shameful nature) for fear of ridicule or other unpleasant consequences and so seek help only many years after their problem began.

Diagnostic features

- Obsessions: recurrent intrusive, unwanted, non-sensical thoughts, images or impulses that the patient knows are 'silly' but cannot banish. The obsessions relate to the presenting complaint and usually cause anxiety or other discomfort.
- Compulsions: repetitive rituals performed to reduce anxiety from obsessions by warding off the imagined dreaded consequences. Common rituals are repetitive checking, washing or cleaning, or repetitive rearranging and ordering of objects. Other compulsive behaviours include hoarding of objects and extreme slowness in carrying out every day activities.
- Most patients have both obsessive thoughts and compulsive rituals.
- Most patients have or have had insight into their obsessions and compulsions (although this can depend on when you ask them and how anxious they are) and regard them as 'silly' and resist them.

Symptoms should last for at least two weeks and the patient should have insight into at least one of the symptoms (ie obsessions or compulsions) as being excessive or unreasonable.

Differential diagnosis and co-existing conditions

- Phobias -F40 phobics fear phobic objects more directly than the imagined consequences characteristically seen in OCD.
- Hypochondriasis - the fear is of an illness rather than contamination per se.
- Depression - F32# common co-existent condition.
- Generalized anxiety - F41.1 worries are less stereotyped than in obsessions.
- Other conditions in which stereotyped repetitive behaviour may be seen are:

  - Eating disorders - F50
  - Autism spectrum disorders - F84
  - Tourettes syndrome
  - Psychosis - F23, F20

Essential information for patient and family

- Patients and their relatives need to understand (as the symptoms can be bizarre and non-sensical) that OCD is well known and can be overcome by systematic self-help involving exposure and ritual prevention.
- Patients often pressure their families to participate in their rituals (eg cleaning, checking, etc.) and to give reassurance about their doubts.
- Such demands can be very frequent and insistent and can become a source of conflict and stress within the family.

General management and advice to patient and family

(ref 174)

- Patients and their relatives can understand the problem better and how to help it by reading and implementing a self-help manual (see below).
- The doctor should explain to them together that giving reassurance or help with rituals may transiently relieve the patient's anxiety but worsens their problems.
- The doctor can help the patient and family start treatment by agreeing that if the patient seeks reassurance or help with rituals the family will reply 'The doctor says no answer'.
- Exposure to stimuli triggering obsessional thoughts and response prevention (ie prevention of performance of rituals) is effective (ref 175-177) and the improvement lasts longer than that observed with drug treatment (ref 178,179)
- Cognitive therapy involves correcting faulty interpretations and beliefs about thoughts and their consequences (175-177,180) and is as effective as behaviour therapy (ref 181).

References

174 NICE will publish a guideline on the management of Obsessive-compulsive disorder in February 2005.

175 Greist JH, Marks IM, Baer L et al. Behaviour therapy for obsessive compulsive disorder guided by a computer or by a clinician compared with relaxation as a control. J Clin Psychiatry 2002, 63: 138-145 (CII) This is a randomized controlled trial. Computer-guided behaviour therapy was effective for patients with Obsessive compulsive disorder, although clinician-guided behaviour therapy was even more effective. Systematic relaxation was ineffective.

176 Freeston MH, Ladouceur R. The cognitive-behavioural treatment of obsessions. In: Caballo VE (ed) International Handbook of Cognitive and Behavioural Treatment of Psychological Disorders. Oxford: Pergamon, 1998: 127-160.

177 Salkovskis PM, Kirk J. Obsessional disorders. In: Hawton K, Salkovskis PM, Kirk J, Clark M (eds.) Cognitive Behaviour Therapy for Psychiatric Disorders. Oxford: Oxford University Press, 1988: 129-168.

178 Stern R, Drummond L. The Practice of Behavioural and Cognitive Psychotherapy. Cambridge: Cambridge University Press, 1991

179 Marks IM. Fears, Phobias and Rituals. New York: Oxford University Press, 1987.

180 Soomro GM. Obsessive compulsive disorder. Clinical Evidence 2002, 8: 991-1002. (AI) This is a review. Selective serotonin reuptake inhibitors, behaviour therapy, cognitive therapy and

combined treatment (fluvoxamine and behaviour therapy) are beneficial in Obsessive-compulsive disorder.

181 Cottraux J, Note I, Yao SN et al. A randomized controlled trial of cognitive therapy versus intensive behavior therapy in Obsessive-compulsive disorder. Psychother Psychosom 2001, 70(6): 288-297. (BII) This is a randomized controlled trial. Cognitive therapy and behaviour therapy were equally effective for patients with Obsessive-compulsive disorder.

Medication

(ref 174)

- Drug treatment might be indicated where patients are unwilling to engage in behaviour or cognitive therapy, or where expertise to deliver such therapies is not available.
- Clomipramine and SSRIs (eg fluoxetine, fluvoxamine, sertraline and citalopram) are effective in the treatment of OCD. An adequate trial of treatment usually requires moderate to maximum BNF dose and a duration of about 12 weeks (ref 179) (BNF 4.3.1 and 4.3.3).
- Discontinuation of drug after improvement often results in relapse within weeks so long-term maintenance treatment with medication may be required (ref 179).

References

174 NICE will publish a guideline on the management of Obsessive-compulsive disorder in February 2005.

179 Marks IM. Fears, Phobias and Rituals. New York: Oxford University Press, 1987.

Referral

See general referral criteria. These particularly apply where there are co-existing disorders.

Special considerations for children and adolescents

- In children, care needs to be taken to distinguish between normal rituals, which are common up to the age of about 10 years, and OCD.
- Parents are often involved in maintaining the rituals by providing reassurance.
- Children and adolescents may not recognize the excessive or unreasonable nature of their thoughts and rituals and may not wish to engage in therapy.
- Very few drug treatments are licensed for children in the UK.
- In children cognitive behaviour therapy has been shown to be as effective as clomipramine (ref 182).

References

182 de Haan E, Hodgduin KA, Buitecaar JK et al. Behavior therapy versus clomipramine for the treatment of obsessive-compulsive disorder in children and adolescents. J Am Acad Child Adolesc Psychiatry 1998, 37(10): 1022-1029. (CII) This is a randomized controlled trial. Behaviour therapy is shown to be a good alternative to drug treatment.

Resources for patient and families

OCD Action 020 7226 4000 (9.30am–5pm, Tuesday, Wednesday, 11am–5pm, Thursday)
Email: info@ocdaction.org.uk; website: http://www.ocdaction.org.uk
Provides information, advice and support for people with obsessive compulsive disorder and related disorders such as body dysmorphic disorder and trichotillomania

Triumph over Phobia 01225 330 353
Email: triumphoverphobia@compuserve.com; website: http://www.triumphoverphobia.com
Structured self-help groups for sufferers from phobias or obsessive-compulsive disorder. Produces self-help materials.

Living with Fear, 2nd edition, by Isaac M Marks. McGraw-Hill, 2001. Tel 01628 252700; Email: orders@mcgraw-hill.co.uk
Self-help manual.

Getting Control: Overcoming Your Obsessions and Compulsions by Lee Baer. Brown & Co, 1991.
Self-help manual.

The Imp of the Mind: Exploring the Silent Epidemic of Obsessive Bad Thoughts by Lee Baer. Penguin & Dutton Books, 2001.
Self-help manual.

Obsessive-Compulsive Disorder - the Facts, 2nd edition, by Padmal de Silva and Stanley Rachman. Oxford University Press, 1998.

Understanding Obsessions and Compulsions. A Self-Help Manual by F Tallis. Sheldon Press, 1992.

Obsessive Compulsive Disorder by Stuart Montgomery and Joseph Zohar. Martin Dunitz, 1999.