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Obsessive-compulsive disorder (OCD)

This article refers to the International Classification of Diseases 11th edition (ICD-11) which is the official classification system for mental health professionals working in NHS clinical practice. The literature occasionally refers to the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification system which - whilst used in clinical practice in the USA - is primarily used for research purposes elsewhere.

What is obsessive-compulsive disorder?

Obsessive-compulsive disorder (OCD) may be characterised by the presence of obsessions or compulsions but commonly both.

- Obsessions are unwanted intrusive thoughts, images or urges that repeatedly enter the person's mind.
- Compulsions are repetitive behaviours or mental acts that the person feels driven to perform. They can be overt (observable by others) - eg, checking a door is locked; or they can be covert - eg, a mental act that cannot be observed, such as repeating a certain phrase in one's mind.

How common is OCD? (Epidemiology)[1]

Studies vary but the figure for prevalence ranges from 0.8-3% in adults and 0.25-2% in children and adolescents. Onset is most commonly in late adolescence and early twenties but can occur at any age.

What causes OCD? (Aetiology)[2]

Aetiology seems to be multifactorial, involving several possible components:

- Genetic. Twin studies suggest a genetic predisposition.[3]
- Developmental factors. Abuse or neglect, social isolation, teasing or bullying may predispose.
- Psychological factors. Personality characteristics maintain OCD.
- Stressors/triggers. A common stressor is pregnancy or the postnatal period.
- Neurological conditions. Occasionally OCD is a presenting sign of a neurological condition such as a tumour or frontotemporal dementia, or the result of trauma to the brain.

Obsessive-compulsive disorder symptoms (presentation)

Diagnostic criteria

The International Classification of Diseases 11th Edition (ICD-11) definition of OCD applies the following criteria: [4]

- Either obsessions or compulsions (or both) are time-consuming and must be present for at least one hour per day.
- They are acknowledged as originating in the mind of the patient and are not imposed by outside persons or influences.
- They are repetitive and unpleasant and at least one obsession or compulsion must
  be present that is acknowledged as excessive or unreasonable.
- The subject tries to resist them (but if very long-standing, resistance to some obsessions or compulsions may be minimal). At least one obsession or compulsion must be present which is unsuccessfully resisted.
- Carrying out the obsessive thought or compulsive act is not in itself pleasurable.
- The obsessions or compulsions cause distress or interfere with the subject's social or individual functioning, usually by wasting time.

Associated diseases[2]

There are frequently comorbid conditions, namely one of the following:

- Depression.
- Social and other phobias.
- Alcohol misuse.
- General anxiety disorder.
- Body dysmorphic disorder (BDD).
- Eating disorders.
- Schizophrenia.
- Bipolar disorder.
- Tourette's syndrome.
- Autistic spectrum disorder.

Assessment[5]

People with OCD often do not volunteer their symptoms spontaneously and it is likely that there is under-diagnosis of this condition. Assessment should include the following elements:

- Identify cases - for patients at risk of OCD (depression, anxiety, BDD, substance misuse or eating disorder), ask the following questions:
    - 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 putting things in a special order or are you very upset by mess?
    - Do these problems trouble you?

- Assess severity, ie how much it is affecting the patient's ability to function in everyday life. National Institute for Health and Care Excellence (NICE) guidance bases management guidelines on degree of severity but does not specify how this should be assessed. Essentially assess the effect the condition has on quality of life, school or work, relationships and social life. Rating scales such as the Yale-Brown Obsessive Compulsive Scale may be used.[1]
- Assess the risk of self-harm or suicide and the presence of comorbidity such as depression.
- Arrange referral to appropriate secondary care provision.
- Ensure continuity of care to avoid multiple assessments, gaps in service and a smooth transition from child to adult services (many patients have lifelong symptoms).
- Promote understanding - make patients/families aware of the involuntary nature of symptoms. Consider patient information leaflets, contact numbers of self-help groups, etc.
- Consider the bigger picture - cultural, social, emotional and mental health needs.
- If the patient is a parent, consider child protection issues.

OCD treatment and management in adults[1] [5]

NICE recommends referral to a specialist multidisciplinary team offering age-appropriate care.

Mild functional impairment

People with mild functional impairment can be successfully managed with low-intensity psychological treatment. A psychological intervention should be recommended as first-line therapy. This is accessed by referral or self-referral to the Improving Access to Psychological Therapies (IAPT) scheme. Options for therapy include:

- Individual cognitive behavioural therapy (CBT) plus exposure and response prevention (ERP).
- Individual CBT and ERP by telephone or internet.
- Group CBT.

- A couples-based course, which has been developed for patients in long-term relationships.[6]

If the person has been unable to engage in low-intensity CBT (including ERP) or the response is inadequate then offer the choice of a selective serotonin reuptake inhibitor (SSRI) or higher-intensity psychological therapy. (Higher intensity essentially refers to the level of hours of input of therapy.)

Moderate functional impairment

Those with moderate functional impairment should be offered a choice between high-intensity CBT and ERP (more than 10 hours per patient) or an SSRI. Clomipramine may also be used as an alternative to an SSRI.

Severe functional impairment

Those with severe functional impairment should be offered high-intensity psychological therapy plus an SSRI.

Evidence comparing treatment options

- Cochrane reviews have determined psychological therapies to be effective in OCD, although have not been able to recommend one specific technique.[7] Likewise, SSRIs have been shown to have efficacy over placebo but no evidence supports one over another or shows superiority between SSRIs and psychological therapies.[8]
- Studies show psychological therapies such as CBT delivered by phone or internet to be effective.[9] [10]
- One randomised comparative trial concluded that group CBT was an effective treatment but did not exclude the possibility that individual therapy was superior.[11]
- One study found that two prominent features of OCD - overestimations of danger and inflated beliefs of personal responsibility - benefited equally from CBT.[12]
- Inference-based treatment (IBT) is a method of psychological treatment sometimes used as an adjunct to CBT in OCD patients with obsessional doubt.[13]

- ERP is a technique in which patients are repeatedly exposed to the situation causing them anxiety (eg, exposure to dirt) and are prevented from performing repetitive actions, which lessens that anxiety (eg, washing their hands). Efficacy has been demonstrated in studies.[14] [15] This method is only used after extensive counselling and discussion with the patient who knows fully what to expect. After an initial increase in anxiety, the level gradually decreases. The patient feels that they have confronted their worst fears without anything terrible happening. One study found that, providing there was adherence to a standardised treatment manual, the experience (or inexperience) of the therapist did not affect the outcome.

OCD treatment and management in children[1] [5]

- Mild dysfunction : offer guided self-help along with support and information for the family or carers. If this fails, or if it is unavailable locally, refer to Children and Adolescents Mental Health Services (CAMHS).
- Moderate-to-severe: refer to CAMHS. Psychological therapy will be with CBT/ERP as for adults but should involve family/carers. It may be individual or group therapy, depending on the preference of the patient. CBT has been shown to be effective in children for OCD and other associated disorders.[16] [17] Furthermore, CBT may be more effective than SSRI treatment.[18]
- If psychological treatment fails, factors which might require other interventions may be involved - eg, co-existence of comorbid conditions, learning disorders, persisting psychosocial risk factors such as family discord, presence of parental mental health problems.
- Pharmacotherapy: in children over the age of 8, adding an SSRI might be appropriate, following a multidisciplinary review. In children under the age of 18, an SSRI should only be prescribed after assessment by a specialist psychiatrist for this age group (but see below concerning safety issues).

Using selective serotonin reuptake inhibitors[5]

See also the separate Selective Serotonin Reuptake Inhibitors article.

SSRIs in adults[19]

- There is a range of potential side-effects (see individual drugs), including worsening anxiety, suicidal thoughts and self-harm, which need to be carefully monitored, especially in the first few weeks of treatment. **Caution is advised in view of increased risk of suicidal thoughts and self-harm in people with depression**.
- In high-risk patients, prescribe limited quantities, keep in contact especially during the first few weeks and actively monitor for akathisia (restlessness and the urge to move), suicidal ideation, agitation and increased anxiety.
- NICE recommends fluoxetine, fluvoxamine, paroxetine, sertraline or citalopram. There are no significant differences in efficacy.
- There is commonly a delay in onset of up to 12 weeks, although depressive symptoms improve more quickly.
- When prescribing, provide written supporting material.
- If there is no response to a standard dose, check compliance, check interaction with drugs and alcohol, then consider titrating to a maximum dose according to the Product Characteristics.
- Monitor all patients around the time of dosage changes.
- A prolonged course of treatment is required. Continue for at least twelve months from remission and withdraw gradually.
- There is a risk of discontinuation/withdrawal symptoms on stopping the drug, missing doses, or reducing the dose.
- Clomipramine may be used as an alternative if the person is intolerant of SSRIs, if at least one SSRI has been ineffective, or if they have previously responded successfully to clomipramine.

SSRIs in children and young people (8-18 years)

- **Caution is advised, as there is a risk of self-harm or suicide in patients with depression**. Only prescribed by specialists, 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 fluvoxamine are the only SSRIs licensed for this use, unless significant co-existing depression is evident, in which case fluoxetine should be used.
- Discuss adverse effects, dosage, monitoring, etc with the patient/family/carers, as per adults (see above).
- SSRIs should only be prescribed in conjunction with CBT.

Treatment failures[20]

About half of those treated with SSRI medication will have an incomplete response.The following are suggested in conjunction with specialist assessment and multidisciplinary review:

- Optimise dose and trial duration.
- Try a different SSRI.
- Consider change to clomipramine; however, there is a greater tendency to produce adverse effects. Do baseline ECG and check BP. Start with a small dose, titrate according to response and monitor regularly.
- Antipsychotics are sometimes used to augment the effect of an SSRI. There is evidence for haloperidol, risperidone and aripiprazole.
- Intensive inpatient therapy or residential/supportive care may occasionally be needed for people with chronic severe dysfunction.
- Neurosurgery may be considered for severely ill patients who do not respond to CBT and medication. Risks, benefits, long-term postoperative management and patient selection should all be carefully considered before embarking on treatment. Patient selection can be improved by the use of neuroimaging.[21] Anterior capsulotomy is the traditional procedure.
- Transcranial magnetic brain stimulation is only currently recommended by the National Institute for Health and Care Excellence (NICE) in the context of research because evidence of safety and efficacy is inadequate.[22]

Further reading

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