

# OBSESSIVE-COMPULSIVE DISORDER (OCD) IN GENERAL PRACTICE

*Obsessive-compulsive disorder (OCD) was previously considered rare, psychologically based and with no known treatment. However, we now know that it is common (2% lifetime prevalence), affects both genders and has a well-characterised symptomatology. Furthermore, OCD responds selectively to serotonergic antidepressants and has a clear biological basis.<sup>1</sup>*



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Despite these advances, considerable diagnostic and treatment challenges still face the medical professional. Most patients develop OCD before the age of 25 years and the major challenge is to reduce the time lag between onset of illness and effective treatment — as long as 17 years in some cases.<sup>2</sup>

## DIAGNOSING OCD

Patients seldom volunteer OCD as the presenting complaint. They may not realise that it is an illness, or may worry that the symptoms of OCD are a sign of impending madness or believe that it is something to be ashamed of. Concerns are not helped by the stigma associated with psychiatric disorders. A high index of suspicion is therefore necessary to ensure that the symptoms of OCD are sought during history-taking.

The diagnosis of OCD hinges on three requirements. First, obsessions and/or compulsions should be present; secondly, this should not be due to the use of any substance or the presence of an underlying general medical condition; and thirdly, symptoms should lead to significant impairment in functioning.<sup>3</sup>

### Requirement one: Obsessions and/or compulsions

An obsession is a recurrent, persistent thought, image or impulse causing anxiety or distress. The person realises that it is a product of his/her own mind and tries to ignore, suppress or neutralise it (see Table I for examples).<sup>3</sup>

Table I. **Examples of some common obsessions and compulsions**

| Obsessions   | Compulsions                                    |
|--|--|
| Contamination fears  | Washing or cleaning self or objects repeatedly |
| Pathological doubt   | Checking, counting objects repeatedly          |
| Symmetry concerns  | Lining up objects, grouping objects            |
| Scrupulosity   | Repetitive confession, prayer, etc.            |
| Others include somatic, sexual or aggressive obsessions and/or compulsions |  |

Compulsions serve the purpose of neutralising or reducing this distress or preventing a feared event or situation. Compulsions are repetitive behaviours or mental acts performed according to strict rules. The compulsions often do not seem realistically connected to what they are supposed to prevent or neutralise and can be clearly excessive (see Table I for examples).<sup>3</sup> The compulsions may be linked to another interesting phenomenon called 'magical numbers'. Magical numbers refer to the specific number of times someone has to perform a compulsion before neutralising or preventing the dreaded event.

Given the wide range of obsessions and compulsions, patients may have many different initial presentations such as dermatological complaints (due to repetitive hand washing) or repeated requests for cancer screening (somatic obsessions).

### **Requirement two: No causative substance or medical illness**

Once the diagnosis is suspected, the physician should be guided by the clinical status of the patient in deciding on the appropriateness of special investigations. Streptococcal infection and Sydenham's chorea are classic medical conditions associated with the presence of obsessive-compulsive symptoms. Reports also exist of atypical antipsychotic medications inducing obsessive-compulsive symptoms.<sup>4,5</sup>

### **Requirement three: Functional impairment**

Everyone shows some obsessive or compulsive behaviour, so when does one consider this behaviour an illness? The differentiation between normal or subclinical obsessive-compulsive symptoms and OCD is linked to the threshold of acceptability. The first guideline is that the symptoms must cause marked distress for the individual, which will become apparent during the clinical interview. Patients will experience intense discomfort regarding the content of the intrusive thoughts or images if it is in conflict with their perception of the self or the world. A religious individual may, for example, develop obsessions or compulsions concerning blasphemy or a mother may have intrusive images about killing her baby. The second guideline refers to time spent on obsessions and compulsions. OCD sufferers can sometimes spend more than 8 hours a day on their obsessions and/or compulsions. Thus, the symptoms must significantly interfere with normal daily activities including work, academic or interpersonal situations. For example, a student writing exams may spend 2 of the 3 hours checking the answers repeatedly and not completing the exam paper.

### **OCD spectrum and other co-morbid disorders**

The clinical interview should, in addition, include the spectrum of OCDs.<sup>6</sup> This refers to a group of disorders that may share some underlying pathology and may often co-occur. These include trichotillomania (hair pulling), skin picking, body dysmorphic disorder (imagined defect in appearance), Tourette's disorder (vocal and motor tics), pathological shopping (excessive shopping) and hypochondriasis. In more than half of cases, OCD may further be hidden or obscured by other co-morbid diagnoses. Indeed, depression (the most common co-morbid disorder; 70% lifetime prevalence in OCD), other anxiety disorders, eating disorders, personality disorders and substance abuse often co-occur and can lead to a more complicated presentation.<sup>7,8</sup>

### **TREATMENT PRINCIPLES**

The successful management of OCD requires the establishment of treatment goals, psycho-education, patient and family support, selective serotonergic antidepressants and cognitive-behavioural therapy as part of a holistic approach.

#### **Establish treatment goals**

As a first step, it is useful to identify target symptoms and the degree of illness as a baseline for measuring response. Target symptoms can be identified during the clinical interview or via self-rating questionnaires. The Yale-Brown Obsessive-Compulsive Rating Scale is widely accepted and takes only a few minutes to complete. This scale measures the time spent on obsessions and compulsions, the interference, distress, resistance and control over the symptoms. A score between 20 and 35 out of 40 is a typical initial pre-treatment score. It is useful to complete this scale at regular intervals to measure improvement.

#### **Psycho-educate and support**

Before initiating any form of treatment, all efforts should be made to clearly

inform the patient and family (if permission is granted) of the cause, treatment and course of the disorder. Given the current knowledge base it seems reasonable to ascribe the symptoms of OCD to serotonergic dysfunction (and some dopaminergic influence) and to abnormal activity in the pre-frontal-basal ganglia-thalamic loop. The cause of the dysfunction also seems to be linked to a genetic predisposition.<sup>9</sup> Environmental factors may play a role in triggering the disorder and much work has centred on the interaction between infective agents and immune response. PANDAS (paediatric-onset autoimmune neurodevelopmental disorder associated with streptococcal infection) is a term that refers to a subgroup of children who develop OCD after exposure to streptococcal infection.<sup>10</sup> Pregnancy also seems to influence OCD and may act as a trigger.

Patients should be able to access further information as and when they require this. It is important that the doctor should allow for further psycho-education sessions as part of the treatment programme. The Internet can be of huge benefit in this process, but the doctor and patient may need to compare their understanding of information at regular intervals.

The patient forms part of a larger system that includes the family and workplace. Families often do not know how to react to the obsessions or compulsions, frequently enabling the disorder by, for example, 'taking over' some of the compulsions (cleaning the school uniform three times) in order to 'help' a child with OCD be on time at school. Excellent literature is available for families on how to assist in the recovery of the individual. Consumer groups such as the Obsessive-Compulsive Association of South Africa also offer the patient with OCD support and information that may be helpful in successful recovery and maintenance.

The supportive role of occupational therapists should not be overlooked. Assessment and appropriate work-

place intervention may enhance the ability of patients to maintain employment or fulfil their true potential within the workplace.

**Introduce medication**

OCD responds to selective serotonin re-uptake inhibitors (SSRIs) and the dosing principle is: start low, go slow, and aim high. It is advisable to start at low doses since these patients are already anxious (some have somatic obsessions) and the initial side-effects of SSRIs, namely the increase in anxiety, headaches, gastrointestinal upsets and changes in sleep patterns, may be difficult to tolerate. If tolerability during the initial 2 weeks remains problematic, an additional benzodiazepine could be used to ameliorate the increased anxiety.

Doses between 2 and 3 times the minimum effective dose for depression and/or the highest tolerable dose for the individual should be the general guideline (e.g. 40 - 60 mg fluoxetine). Again, individual response should guide the doctor. Insufficient response after 8 - 12 weeks at a maximum tolerable dose (usually this point is reached at week 10 - 16 of treatment) is an indication for switching to a second antidepressant (either a second SSRI or clomipramine) for another trial of 8 - 12 weeks at the maximum tolerable dose. If there is treatment resistance, one may consider the addition of a dopamine-blocking agent to the antidepressant treatment. Dopamine-blocking agents may cause extrapyramidal side-effects and tardive dyskinesia (although this is less of a concern with newer agents). This requires careful clinical monitoring, and low doses (for example 50 - 200 mg quetiapine or 0.5 - 2.0 mg risperidone) are advisable. Further treatment options should preferably be considered in conjunction with a specialist and can include the addition of mood stabilisers, benzodiazepines, immunosuppressants and very rarely neurosurgery.

Treatment should be continued for at least 1 year from onset of response. The advantages and disadvantages of

discontinuation after this period should be discussed with the patient and the dose could be reduced by 25% every 2 months. Re-emergence of symptoms should be regarded as a sign of a longer-term need for treatment at the lowest effective dose.

The use of alternative therapies, for example St John's wort, often surfaces during the treatment of OCD. At this stage no randomised controlled trials (RCTs) exist on the use of St John's wort for OCD. Nevertheless, requests for the use of this or other non-RCT-tested treatment options should be discussed within the therapeutic context and a risk-benefit assessment done.

**Utilise psychotherapy**

Cognitive-behavioural therapy (CBT) has been the mainstay of psychotherapeutic interventions and can be employed as a single treatment modality. Although a detailed account of the intricacies associated with CBT for OCD is not provided here, it is worth noting that the therapist should be experienced in the exposure and response prevention techniques that underpin this approach. A combination of medication and CBT is generally advised.

**Follow-up**

The role of regular follow-up, even after discontinuation of treatment, cannot be overstated. The chronic wax-

ing and waning course of OCD makes it likely that patients will need longer-term support and treatment. Early detection of relapses or co-morbid psychiatric disorders will help to alleviate the morbidity associated with OCD.

References available on request.

**IN A NUTSHELL**

OCD consists of obsessions and compulsions.

OCD symptoms seem to be mediated by the serotonin system.

There is high co-morbidity with other psychiatric disorders, especially depression.

Treatment should include:

- setting of treatment goals
- psycho-education and support
- medication (higher doses of selective serotonin re-uptake inhibitors may be needed)
- continuation of treatment for at least 1 year from time of improvement
- cognitive behavioural therapy — an effective option
- long-term follow-up.

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