

Diagnosis and treatment of obsessive compulsive disorder

Grant N, Stobie B. Diagnosis and treatment of obsessive compulsive disorder.
Practitioner May 2020;264(1837):17-21

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Practitioner
Medical Publishing Ltd

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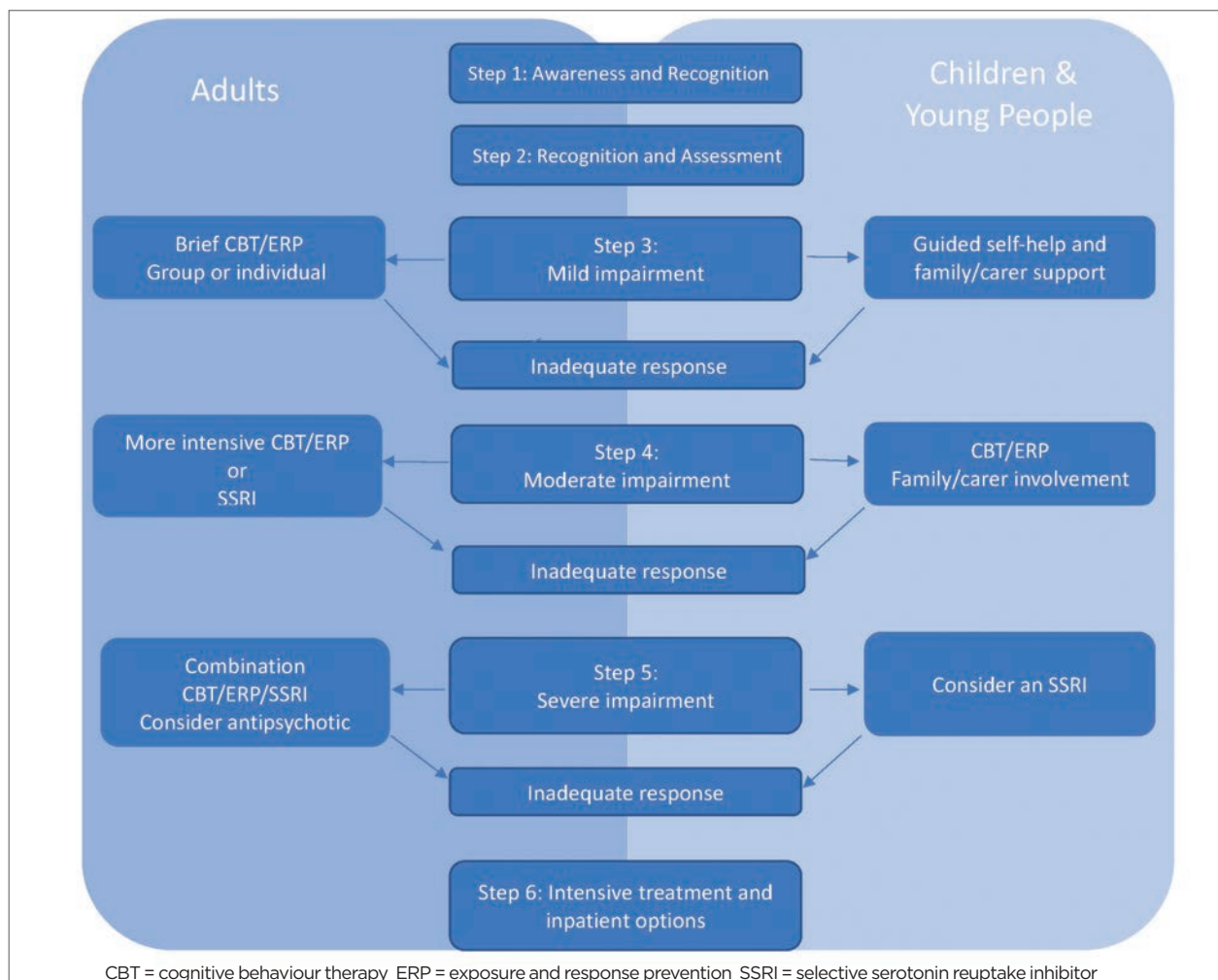


FIGURE 1

Stepped care model
for the management
of obsessive
compulsive disorder
based on NICE CG31¹⁷

How do patients
present in
primary care?



**OBSESSIVE COMPULSIVE
DISORDER (OCD) IS A
RELATIVELY COMMON
SYNDROME, WHICH CAN**

be chronic and disabling.¹

It consists of obsessions (repetitive, intrusive thoughts, urges, impulses or doubts) and compulsions (ritualistic, deliberate behaviours performed in response to obsessions). Obsessions are thoughts, whereas compulsions can be overt (e.g. checking) or covert behaviours (e.g. ruminating).

As well as contamination and safety

How should
patients be
assessed?

fears, many patients experience distressing thoughts of causing harm. Sexual obsessions are common, including thoughts regarding sexual orientation, aggressive sexual behaviour or child molestation.² Typical compulsions include checking, washing, ruminating, and counting, among others.

The point prevalence of OCD in the UK was 1.3% in the most recent National Psychiatric Morbidity Survey.³ However, many people will experience both obsessive thoughts and/or compulsive behaviours without meeting diagnostic

Where should
patients
be referred?

criteria for OCD or any other mental health disorder.⁴ Age of onset differs between the sexes, with men typically experiencing first symptoms in late adolescence, and women in their early twenties.⁵

OCD is associated with a particularly high degree of impairment, relative to both healthy individuals and other anxiety disorders.⁶ It affects social and occupational functioning, is associated with higher rates of unemployment, lower income, and negatively impacts on work and relationships.⁶

PRESENTATION

Accurate recognition in primary care can be difficult because of significant symptom heterogeneity: e.g. fear of harming self or others (which may manifest in checking, reassurance-seeking or avoidance) among other compulsions, symmetry obsessions (ordering and counting compulsions), fear of contamination (washing, cleaning and avoidance), distressing violent or sexual thoughts (avoidance and rumination).⁷ OCD may be best explained as a dimensional disorder which has a cluster of symptoms across broad areas including: order and symmetry, causing harm, and contamination.⁸

Many patients present with shame or fear regarding their intrusive thoughts.⁹ Secondary symptoms, such as dermatological complaints, may be reported as the primary problem.

Patients often delay seeking help, and only a small percentage of primary care patients may report the problem as OCD.¹⁰ A treatment delay of more than two years is associated with poorer treatment outcomes.¹¹

OCD symptom patterns are similar in children, adolescents, and adults. Childhood prevalence rates are estimated at 1-2%.¹² However, boys are more likely than girls to develop OCD in childhood,¹³ and younger age is associated with less insight.¹² Young children often present with intrusive thoughts about their caregivers dying, and adolescents with sexual or religious

intrusions. Children with OCD may present with school avoidance and disrupted social relationships.¹⁴

Perinatal OCD can present in the absence of a previous OCD diagnosis.¹⁵ It is very common for new parents to have intrusive thoughts, including thoughts about harming their baby. These are rarely indicative of either OCD or postpartum psychosis. However, some new parents will experience a new onset, or a relapse, of OCD.

Distinguishing intrusive thoughts indicative of OCD (generally characterised by doubts about distressing intrusions), and delusional beliefs (generally held with conviction) which might be a sign of postpartum psychosis, has important consequences for parental and infant wellbeing.¹⁵

ASSESSMENT

The screening questions in box 1, below, can prompt assessment of patients presenting with possible OCD. Time constraints within GP consultations may preclude routinely asking every anxious or depressed patient who does not self-report OCD all the screening questions. In these cases, the first question 'do you currently spend a significant amount of time compulsively repeating actions or worrying that something bad might happen?' can be asked before deciding whether to ask the remaining screening questions.

Box 2, below, shows the DSM-5 diagnostic criteria, which includes reference to the level of impairment

experienced by the patient.¹⁶ Although most people experience intrusions, the key to an OCD diagnosis is the frequency, distress and time taken up by intrusions, and responses to them.

Patients can often be fearful of acting on intrusions, particularly those involving antisocial, sexual or violent thoughts. Careful assessment of these thoughts is necessary to identify whether they are unwanted intrusions, or an indication of risk to others i.e. not OCD. In most cases, patients will be clear that they have never acted, and never will act, on the thoughts. It is only in very severe cases that patients may express serious doubts about this.

Patients with suspected OCD may be at increased risk of deliberate self-harm and suicidal thoughts, and therefore a risk assessment should be carried out.¹⁷ Patients with OCD are extremely unlikely to act on their intrusive thoughts.¹⁴

Of greater relevance is risk of harm to self, and secondary risk to others due to the compulsions. For example, a new mother with intrusive thoughts of harming her baby may respond by avoiding the baby.

COMMON COMORBIDITIES

Up to 90% of patients with OCD will meet criteria for another psychiatric disorder in their lifetime, with the most common being other anxiety disorders, major depressive disorder and substance use disorders.¹⁸ Patients with comorbidities tend to have more severe OCD symptoms, and lower quality of life.¹ Patients with depression, anxiety disorders, alcohol or substance misuse, body dysmorphic disorder and eating disorders are at higher risk of OCD.¹⁷

Some patients with other mental health diagnoses may present with symptoms similar to OCD, such as eating disorders (preoccupation with thoughts about eating, shape and weight as well as altered eating behaviours); generalised anxiety disorder (broader, excessive and uncontrollable worrying), and autistic spectrum disorders.

Those with addictive gambling behaviours may also demonstrate obsessive thoughts and behaviours, along with distress. People with a diagnosis of obsessive compulsive personality disorder may report a preference for performing tasks in a particular way, which may cause conflict with others e.g. excessive perfectionism.

OCD is distinct from, but related to, three other disorders, namely hoarding disorder, body dysmorphic disorder and trichotillomania. While these disorders

Box 1

Screening questions¹⁵

Do you currently spend a significant amount of time compulsively repeating actions or worrying that something bad might happen? If so, what are the main things that you worry about or repeat?

- 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?

Box 2

DSM-5 diagnostic criteria (simplified)¹⁴

- A Presence of obsessions or compulsions, or both
- B These are time-consuming (i.e. more than one hour per day) OR cause clinically significant distress or impairment
- C Not attributable to physiological effects (e.g. from medication)
- D Not better explained by another mental disorder

Box 3

National treatment centres

- Centre for Anxiety Disorders and Trauma, South London & Maudsley NHS Foundation Trust *
- Anxiety Disorders Residential Unit, South London & Maudsley NHS Foundation Trust *
- National OCD/BDD Service, Springfield Hospital, South West London & St Georges Mental Health NHS Trust *
- OCD/BDD Specialist Service; Hertfordshire Partnership University NHS Foundation Trust *
- OCD/BDD Service, Priory Hospital North London *
- Oxford Health Specialist Psychological Intervention Centre, Oxford Health Foundations Trust

*Top tier treatment available

may appear similar by virtue of the repetitive behaviours they entail, the underlying motivation behind these behaviours differentiate them from each other. For example, someone with trichotillomania may compulsively remove body hairs, in the absence of a feared consequence if they fail to do so.

Patients with body dysmorphic disorder may engage in repeated or extreme checking behaviours and reassurance seeking, fearing negative evaluation by self or others. A perceived responsibility for causing or failing to prevent harm is the motivating factor which differentiates OCD from the repetitive behaviours evidenced in these other conditions mentioned above.

MANAGEMENT

The two evidence-based treatments for OCD are cognitive behaviour therapy (CBT) and medication.

Stepped care treatment

Treatment for OCD following a stepped care model is shown in figure 1, p17. Step 1 (awareness and recognition) and step 2 (recognition and assessment) in primary care inform decisions about when to refer patients. Steps 3-5 will usually be provided in primary care by the GP, and via an Increasing Access to Psychological Therapies (IAPT) service.

Patients will begin treatment at the step most appropriate for them, so that if their presentation is severe they can begin at step 5, or if they do not respond they can be stepped-up. Where patients have not responded at steps 3-5, and the OCD is severe and having a significant impact, patients may be referred for outpatient, residential or inpatient treatment at specialist treatment clinics (see box 3, above).

Referrals to these specialist centres will usually be made by local mental health teams. Should the OCD persist, NHS England commissions a nationally

funded treatment service for patients with treatment resistant OCD. To be eligible for treatment under this service, patients will have to have failed to maintain gains from at least two past courses of CBT, as well as two trials of SSRIs at adequate dosage, including augmentation of at least one of the SSRI trials (see box 3, above; clinics marked * offer this top tier treatment).

The British Association for Psychopharmacology guideline¹⁹ states that drug and psychological approaches have broadly similar efficacy in acute treatment i.e. patients should be offered a choice. For those with more severe OCD e.g. at step 5, NICE suggests combination treatment i.e. CBT including exposure and response prevention (ERP) which involves facing the feared stimulus while resisting compulsions, plus an SSRI.¹⁷

Cognitive behaviour therapy

The most effective psychological therapy for OCD is CBT, which incorporates ERP. Step 3 usually consists of up to 10 hours with a psychological therapist, and patients with mild functional impairment who do not respond to this initial treatment may then need to receive more intensive psychological therapies.

Therapist-assisted exposure (vs exposure prescribed as homework), imaginal exposure paired with actual exposure (i.e. picturing the contamination on a door handle while touching it), and home-based treatment (where indicated), are all associated with better outcomes.⁷

Medication

SSRIs should be considered for patients with OCD with moderate or severe impairment.¹⁷ Although individual patients may respond better to one SSRI than to another, there is no convincing evidence that any one SSRI is more effective in comparison with others.^{20,21} Higher SSRI doses may be associated

with better outcomes²² although this needs to be weighed against the risk of side effects.

If the patient does not show significant improvement, consider switching SSRIs¹⁷ and if that is ineffective, clomipramine may be considered. The relative efficacy of clomipramine for OCD must be weighed against its side-effect profile and the potential effect on cardiac function.²⁰ There is good evidence for the efficacy of SSRIs in children and young people¹² but the increased risk of suicidal ideation, and deliberate self-harm must be closely monitored. Pharmacotherapy can also be of benefit with perinatal OCD, but the risk profile, as well as potential implications for breastfeeding, will also need to be considered.²³

Where two different SSRI trials have not led to treatment response, augmentation with a low-dose antipsychotic medication may be considered, and there is some evidence that this may be effective.²² However, these medications are associated with side effects such as endocrine and metabolic dysregulation, and weight gain, even with second-generation antipsychotics, and high relapse rates on discontinuation.²⁴

NICE recommends that benzodiazepines are not prescribed for those with anxiety disorders, including OCD, because of reduced tolerance over time and the potential for dependence.²⁵

It is common for patients with OCD to worry that taking medication may cause them to act on their intrusions.²⁶ Patients may therefore agree to a medication trial but may avoid initiating it; they may also not take medications as prescribed for fear of side effects. Awareness of these issues, along with empathetic reassurance, monitoring and follow-up may improve compliance.

REFERRAL

Decisions about urgency and referral pathways can be guided by: previous treatment, severity, and risk assessment. For patients who have not benefited from previous treatments but are stable, consider a non-urgent referral to a specialist clinic, which may offer inpatient or residential care (see box 3, above).

Referrals for treatment may be urgent where the patient is actively suicidal or displaying other potentially self-injurious behaviours e.g. disordered eating or food or liquid restriction because of concerns about contamination, poor insight or overvalued ideation.

Some of the specialist clinics in box 3, above, prioritise perinatal parents »

key points

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Obsessive compulsive disorder (OCD) consists of

obsessions (repetitive, intrusive thoughts, urges, impulses or doubts) and compulsions (ritualistic, deliberate behaviours performed in response to obsessions). As well as contamination and safety fears, many patients experience distressing thoughts of causing harm. Sexual obsessions are common, including thoughts regarding sexual orientation, aggressive sexual behaviour or child molestation. Typical compulsions include checking, washing, ruminating, and counting. The point prevalence of OCD in the UK is 1.3%. The age of onset differs between the sexes, with men typically experiencing first symptoms in late adolescence, and women in their early twenties.

Childhood prevalence rates are estimated at 1-2%. Boys

are more likely than girls to develop OCD in childhood, and younger age is associated with less insight. Young children often present with intrusive thoughts about their caregivers dying, and adolescents with sexual or religious intrusions. Children with OCD may present with school avoidance and disrupted social relationships. Perinatal OCD can present in the absence of a previous OCD diagnosis and often involves thoughts about harming the baby. It is important to distinguish intrusive thoughts indicative of OCD from delusional beliefs (generally held with conviction) which might be a sign of postpartum psychosis.

Up to 90% of patients with OCD will meet criteria for

another psychiatric disorder in their lifetime, with the most common being other anxiety disorders, major depressive disorder and substance use disorders. Patients with OCD are at increased risk of suicidal thoughts, and therefore a risk assessment should be carried out. Patients with OCD are extremely unlikely to act on their intrusive thoughts but there may be secondary risk to others due to the compulsions.

The most effective psychological therapy for OCD is CBT

incorporating exposure and response prevention (ERP) i.e. facing the feared stimulus while resisting compulsions. Those with mild functional impairment should be offered up to 10 hours with a psychological therapist, but those who do not respond may need more intensive psychological therapy. NICE recommends that those with moderate impairment should be offered a choice of intensive CBT incorporating ERP, or an SSRI; those with severe impairment should be offered combination treatment.

Approximately 20% of patients treated with SSRIs or CBT

achieve a full recovery, and a further 20-40% of patients will have a significant reduction in symptoms but remain symptomatic. Discontinuation of medication is associated with high rates of relapse and if medication is then restarted, its effectiveness may be reduced. NICE recommends that when a patient has improved with medication this should be continued for at least 12 months, and in some cases for an even longer period.

with OCD. If patients are housebound by their OCD or unable to travel, residential or inpatient treatment may be required. In urgent cases, GPs should also consider referral to local mental health teams, particularly as there may be a waiting list for treatment, if the patient is in crisis or requires additional support, and as the referral to tertiary services may need to be made by the patient's mental health team.

TREATMENT RESPONSE AND FOLLOW-UP

Approximately 20% of patients treated with SSRIs or CBT recover completely, and a further 20-40% of patients will have a significant reduction in symptoms but remain symptomatic.²⁷ However, not all patients will be offered or accept treatment, and of those that do, a subset of approximately 30-40% will report small, minimal or no improvement at follow-up.²¹ These patients are likely to present with chronic symptoms that fluctuate but seldom remit completely.²⁸

Discontinuation of medication is associated with high rates of relapse.^{22,24} Where drug treatment is reintroduced, the effectiveness of the medication may be reduced.²⁴ NICE guidelines recommend that when a patient has improved with medication this should be continued for at least 12 months, and in some cases an even longer period.¹⁷

GPs are well placed to provide reassurance about how common intrusive thoughts are and can signpost patients to relevant third sector organisations. Ongoing GP follow-up can also help patients to access services, address medication issues, and improve overall levels of functioning.

NEW TREATMENT APPROACHES

Current research is investigating the potential effectiveness of novel treatments including deep brain stimulation,²⁹ use of smartphone technology²³ and alternative medication strategies.³⁰

Increasing the intensity of psychological treatments, such as longer appointment times over consecutive days, has been shown to be effective in both adolescent and perinatal OCD.^{31,32} More intensively delivered psychological treatments may be better for patients with comorbid depression, but this type of treatment delivery is not routinely available outside specialist clinics.

Treatment fidelity is important in both pharmacotherapy and psychological therapies. Some treatment resistant

patients may be showing a lack of response to psychological therapies which did not contain core components of CBT/ERP.³³ Of particular relevance is the implicit need for both patient and therapist to tolerate high levels of distress caused by exposure to feared stimuli: psychological treatment which lacks exposure will generally be less effective.

Competing interests: None

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