

key points

SELECTED BY

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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.