Obsessive compulsive disorder is a disabling condition that affects 100,000 adult Australians each year. Only rarely does it recover spontaneously. Treatment usually works well, but many sufferers are too embarrassed to seek help.

Guidelines for recognition and treatment of Obsessive compulsive

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Obsessive compulsive disorder is an anxiety disorder characterised by intrusive thoughts, images or impulses (obsessions) and behavioural or mental rituals (compulsions). Recent data from the Australian National Survey of Mental Health and Well-Being reveal obsessive compulsive disorder (OCD) has a 12 month prevalence of 0.7%, indicating that approximately 100,000 Australian adults suffer from this disorder each year.[1] Symptoms often cause significant disruption to work and family life; untreated, the disorder persists with very low rates of spontaneous remission. There is frequently a long delay between symptom onset and access to treatment. While this situation is gradually improving, some people remain too embarrassed or ashamed to discuss their symptoms unless clinicians ask appropriate questions.

IN SUMMARY

- **Obsessions are intrusive thoughts, images or impulses which generate anxiety or distress.**
- **Compulsions are performed in response to obsessions in an attempt to alleviate anxiety or prevent a feared consequence.**
- **Obsessions and compulsions significantly interfere with the person's everyday activities or take more than one hour a day.**
- **Obsessive compulsive disorder can be successfully treated in the majority of cases with behaviour therapy alone or in combination with an SSRI.**
- **Referral to a clinical psychologist or psychiatrist for behaviour therapy is recommended.**

disorder

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Obsessions

Obsessions may take the form of thoughts or doubts regarding potential danger, e.g. 'Did I turn off the stove?' (the house may burn down), or 'My hands are contaminated' (I may become ill). They may be images (e.g. stabbing a loved one, running someone over), or they may be urges or impulses (e.g. to harm someone, to shout something inappropriate). They are certainly unwanted, often persistent, and intrusive in the sense that they keep coming into the person's mind no matter how hard they try to block them out. In all cases, the person finds the obsessions disturbing and unpleasant, and their occurrence causes marked anxiety or distress.

Although the majority of individuals with OCD also describe their obsessions as ridiculous or senseless, such insight is coupled with fear and distress in case the obsessive thought is true. Most obsessions centre on themes of harm to oneself, harm to others, blasphemy, sexual outrage or violence. Invariably, the individuals

recognise that the thoughts are their own and not imposed on them by some external force.

Compulsions

Compulsions can be overt behaviours (such as checking and washing), or covert mental acts (such as praying, counting, or repeating words silently). They are usually performed in response to an obsession, in order to prevent some feared consequence from occurring or to reduce the distress associated with intrusive thoughts.

As the name itself suggests, there is a compulsion to these rituals such that the person feels driven to perform them and is unable to rest until they have been completed satisfactorily. Consequently, rather than perform compulsions just once, individuals with OCD repeat these behaviours over and over until they are satisfied that danger has been averted, or until the anxiety and distress is reduced.

Who is affected?

OCD can occur in both adults and children, with most people developing their first symptoms before the age of 30 years. OCD is twice as common in male children than in female children simply because the age of onset is younger in boys. By adulthood the sex ratio is equal.

The diagnosis of OCD requires that the obsessions and compulsions significantly interfere with everyday life or take more than one hour a day.

Common obsession and compulsion pairings

In some cases there may be a logical connection between the obsession and the compulsion (e.g. contamination and washing). However, in other cases there may be no apparent connection between the thought and the compulsion used to counteract the thought (e.g. counting to a certain number to avoid harm befalling a loved one).

Contamination obsessions and washing rituals

Intrusive thoughts of contamination typically arise in situations where the OCD sufferer comes into contact with objects that may have been touched by other people (e.g. toilets, phones, money, groceries, letters).

The particular concern varies from person to person but may involve a fear of contamination with germs, dirt, dust mites, faeces, saliva, asbestos or HIV, to name a few. Contact with potentially 'contaminated' items is generally avoided as it causes anxiety.

When contact with 'contaminants' occurs, the anxiety associated with thoughts of contamination is usually alleviated by excessive washing or decontamination rituals. Washing rituals can also be associated with obsessional thoughts that pieces of glass or poisons may have contaminated crockery or food. In some cases people with OCD may fear that they could inadvertently poison or harm their loved ones. In order to reduce the fear associated with these thoughts, these people are likely to rewash any items they touch, and to avoid handling food that will be eaten by others.

Pathological doubts and 'checking compulsions'

'Checking compulsions' most commonly arise in the context of leaving the house when no-one else is home, or when going to bed for the night. At these times the individual is tormented with recurring and intrusive doubts that doors and windows may not be locked and that appliances may not be switched off. As a consequence, the person fears that there may be a burglary or a fire. This is often referred to as 'pathological doubt' since, unlike others who are satisfied by one quick glance, the OCD sufferer will have to check over and over again to be satisfied that everything is safe.

Other obsessions about harm frequently linked to checking rituals include:

- doubts that the sound of the car hitting a pothole in the road was instead the sound of the car hitting a pedestrian, resulting in the patient going back repeatedly to check that no-one has been hurt
- doubts that twigs, cracks or shadows on the ground might be syringes or other potentially dangerous objects, resulting in the patient going back repeatedly to check that the ground was safe to walk on.

Magical thoughts and neutralising rituals

Neutralising rituals typically involve an intrusive thought or image of a loved one being harmed. If this thought intrudes into the person's mind while he or she is performing some activity (e.g. walking through a door), then the person may have a compulsion to repeat the activity (e.g. to go back through the door again) while thinking to him- or herself that the loved one will be safe. This ritual is called mental 'neutralising' or 'undoing', because the original unpleasant thought is reversed and then replaced with a good thought. These symptoms may be associated with a wide variety of everyday activities, including dressing, eating, drinking, reading, sitting and walking.

Violent thoughts and associated rituals

People with OCD may experience unwanted images or thoughts of harming themselves or others. Common examples include images of stabbing one's partner or children, verbal thoughts (e.g. 'kill him'), or impulses to poke oneself in the eye with sharp objects.

These obsessions are terrifying and result in a variety of complex avoidance and reassurance rituals. Sharp objects are usually locked away out of sight and there is often a compulsion to repeatedly reassure oneself that one could never do such a thing. Since the thoughts are completely inconsistent with the

individual's true values and beliefs, often there is also self-criticism about why such thoughts occur and what they might mean.

Sexual outrage and associated rituals

In order to be diagnosed as OCD, sexual obsessions must be unwanted, unpleasant and associated with anxiety or distress. The thoughts, images or impulses are completely inconsistent with the person's true values and desires. As a result, they are often associated with high levels of shame and embarrassment, in addition to anxiety or fear. Common examples include thoughts of molesting children, unwanted homosexual images, and impulses to inappropriately touch or stare at breasts or genital areas.

People are often too embarrassed to volunteer these obsessions as presenting complaints. It may be necessary to probe for such obsessions and to reframe them within the context of typical OCD symptoms.

How and why do OCD patients present?

Individuals with OCD usually present for treatment when their obsessions and compulsions are taking up too much time (more than one hour a day) or causing so much distress that they are having difficulty performing their usual daily activities. In most cases, people recognise that their thoughts and behaviours are unreasonable or at least excessive, even though during times of great fear they may perceive their concerns as being somewhat realistic.

What investigations should be ordered?

There is no laboratory test or neuro - imaging procedure for the diagnosis of OCD. A thorough psychological assessment with a clinical psychologist or psychiatrist may be necessary to confirm the diagnosis, particularly in more complex cases of OCD where there is significant comorbidity or other complicating factors.

What treatments have proven efficacy?

The treatments of choice for OCD are behaviour therapy, or a combination of behaviour therapy with clomipramine (Anafranil, Placil) or a serotonin selective re-uptake inhibitor (SSRI). Medication alone may be of great benefit to some patients but of little benefit to others, and on average is less effective than a combined approach or behaviour therapy alone. Those who benefit from medication typically report that the obsessions and compulsions persist but are less frequent and distressing.

What is behaviour therapy?

Behaviour therapy for OCD consists of graded exposure to obsessional thoughts with self-directed prevention of compulsive responses. Emphasis is placed on the role of compulsions in providing short term relief but no long term benefit, since obsessions usually return soon after, generating more anxiety and prompting further compulsive rituals. In this way, compulsions actually prevent individuals from confronting their fears and breaking the cycle of OCD.

Education is provided about the gradual reduction in anxiety that eventually follows when obsessions are confronted with self-directed prevention of compulsive responses. With repeated practice of these techniques, the obsessions generate less anxiety and there is a gradual reduction in the frequency of intrusive thoughts.

For most people, some compulsions will be easier to resist than others, so each compulsion is rated in terms of how anxious people believe they will be when they try to resist (e.g. a rating from 0 to 10). A hierarchy is developed in which compulsions are ranked from least to most distressing, and people encouraged to begin resisting easier compulsions on the hierarchy. Once this step is mastered they resist slightly harder compulsions, and so on, until all compulsions are resisted and the anxious cycle is broken.

An interactive program complete with details on the recognition and management of 20 of the most common psychiatric disorders including OCD can be downloaded from the internet at http://www.crufad.unsw.edu.au. Other resources are listed in further reading at the end of the article.

Does the patient require referral to a specialist?

The majority of cases require specialist referral either to a clinical psychologist or to a psychiatrist with experience in the use of behaviour therapy techniques for OCD.

Will care be shared between the specialist and the GP?

Medication for OCD is frequently managed by the GP. If patients have no access to or refuse behaviour therapy, they will require ongoing medication with an SSRI that has been shown to be effective in clinical trials (e.g. fluoxetine [Auscap 20 mg Capsules, Erocap, Fluo-

hexal, Lovan, Prozac, Zactin], fluvoxamine [Luvox], paroxetine [Aropax], sertraline [Zoloft]), or with clomipramine (Anafranil, Placil).

Medication for OCD is not a cure, and up to 80% of responders will relapse within weeks of ceasing drug therapy.[2] If SSRIs are commenced prior to behaviour therapy, it is usually recommended that patients remain on a constant dose for at least six months following treatment. As the primary caregiver, the GP also has an important role in providing ongoing support and encouragement regarding the continued application of exposure and response prevention techniques following behaviour therapy.

How successful are the standard treatments?

Treatment outcome trials have consistently shown that approximately 70% of OCD patients report clinically significant improvements in symptoms following treatment with behaviour therapy. Medication trials reveal an average improvement of 50%.[3]

What causes OCD?

As yet, little is known about the exact causes of OCD but it is unlikely that any one cause will be deemed both necessary and sufficient. There is now evidence from a number of sources that multiple factors may be involved. Attempts to identify a causal connection between serotonin and OCD have met with little success, despite the efficacy of SSRIs in reducing OCD symptoms.[2] Functional neuroimaging studies have revealed an association between OCD symptoms and increased activity in the orbitofrontal cortex and caudate nucleus. However, this activity normalises following treatment with either drug or behavioural therapies,[4] suggesting that the connection may be associative rather than causal.

Both OCD sufferers and their first degree relatives have been shown to have a higher incidence of obsessional and perfectionistic personality traits, suggesting that vulnerability to OCD may be associated with particular personality styles.[5] There is also evidence that up to 80% of the population experiences unwanted intrusive thoughts with a content similar to obsessional thoughts. This has initiated speculation as to whether these thoughts become more frequent in OCD because the person responds to them differently (e.g. with more analysis and self-criticism) than does someone not vulnerable to OCD.[6]

Conclusions

While OCD seems relatively straightforward to diagnose, cases are missed as a result of individuals being too embarrassed to discuss their symptoms and

clinicians not asking the right questions. Fortunately, this situation is gradually changing with increased media attention and public interest in OCD. The major impact has been on individuals who engage in overt compulsive behaviours, because they are more likely to be recognised or to recognise the symptoms in themselves following newspaper and television coverage. Not so fortunate are the individuals who experience intrusive unpleasant thoughts with covert mental rituals, because their disorder is hidden. The intrusive thoughts are often of such an embarrassing or personally unpleasant nature that it is difficult for them to talk about the symptoms and seek appropriate treatment. Consequently, it is important for GP's to be familiar with the highly distressing and potentially embarrassing nature of symptoms which can be present in OCD, so that they can respond to patients' enquiries and provide appropriate information. Although specialist referral to a behaviour therapist is required in the majority of cases, there is an important role for GPs in the recognition of OCD and in the management of drug therapy. MT

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Further reading

1. Useful resources can be downloaded from http://www.crufad.unsw.edu.au
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3. Treatment Protocol Project. Management of mental disorders (second edition). Sydney: World Health Organization Collaborating Centre for Mental Health and Substance Abuse, 1997.
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