OBSESSIVE COMPULSIVE DISORDERS

1. Description

Obsessive-compulsive disorder (OCD) is a relatively common disabling mental health condition.

OCD has the characteristics of an anxiety disorder, in which the anxiety is neutralised or reduced by behavioural or mental rituals. The anxiety is generated by either thoughts or behaviours, to which the sufferer responds by anxiety relieving rituals, which again may be thoughts or behaviours.

1.1 Definition

Both ICD10[1] and DSM - IV[2] define OCD in a similar way.

The main difference in classification is that the ICD10 classifies OCD as a distinct separate condition under the general heading of neurotic, stress-related and somatoform disorders, whereas the DSM – IV classifies it as part of the spectrum of anxiety disorders that includes phobias, PTSD etc.

Both classifications use the criteria of obsessions and compulsions as the defining constructs of the condition.

Obsessions are recurrent **thoughts**, ideas, or impulses, which are experienced as unwanted and distressing. Attempts not to have the thoughts increase their frequency and intensity. The patient recognises the thought as being a senseless product of their mind, and not imposed from the outside. The patient tries to resist, suppress or neutralise them with some other thought or action.

Obsessional doubts are common in OCD. These are the subjective feelings of doubt that a person has performed an action, even though he or she has done it. This is not due to any memory deficits, but due to a decrease in memory confidence.[3] Repeating the action provides a temporary anxiety-reducing effect.

The commonest obsessions concern:

- Contamination. (45% of sufferers)
- Pathological doubt. (42%)
- Somatic concerns. (36%)
- Need for symmetry. (31%)
- Aggressive impulse. (28%)
- Sexual impulse. (26%)
- Other. (13%)
- Multiple obsessions. (60%)[4]

Compulsions are repetitive, purposeful and intentional **behaviours**, which are performed in response to an obsession. Compulsions may be either overt actions or covert 'neutralising' thoughts, which are designed to reduce the anxiety caused by the obsessional thought. The patient recognises the behaviour as excessive or unreasonable.

The commonest compulsions are:

- Checking. (60% of sufferers)
- Washing. (50%)
- Counting. (36%)
- Need to ask or confess. (31%)
- Arranging objects with symmetry/precision. (28%)
- Hoarding. (18%)
- Multiple compulsions. (48%)[4]

Compulsions without obsessions have been described. Many of these patients have had OCD for many years and it appears that the original obsessional thought or reason for performing the compulsion has been forgotten, but the compulsion persists as a form of habit.

Compulsive slowness[5] is recognised as a form of OCD where patients may take several hours to do a task but who deny any obsessional thoughts. The motivation for the slowness is often an effort to ensure that everything is performed perfectly. These individuals have many obsessions about perfection. By aiming at perfection they constantly fail and so try harder which takes increasingly longer.

2. Aetiology

2.1 Aetiology

Numerous theories about the aetiology of OCD have been proposed, and these have been summarised in the Table in Appendix A.

Twin studies show that concordance in monozygotic twins is more likely than in dizygotic twins. There appears to be a genetic element, as a third of all sufferers have a first degree relative with the same diagnosis.

The effectiveness of psychoactive medication indicates that there is an abnormality of the serotonergic system.

A multi-factorial aetiology is likely.[6] Current theories involve interaction between an underlying biological vulnerability and social learning.

3. Epidemiology

Epidemiological surveys in the USA have shown a 6 month prevalence of 1.3 - 2%[7] and a lifetime prevalence of 1.9 - 3.3%.[8]

Prior to these studies it had been thought that OCD was a rare condition (based on hospital statistics), affecting 0.05% of the population.

The large difference between these rates could be due to:

1. Hidden morbidity (i.e. sufferers in the general population not seeking medical help), or
2. Inclusion of normal people with obsessional symptoms (rather than the clinical syndrome) in the population surveys.

A survey of 419 individuals with OCD in the USA showed a 10-year lag between the onset of symptoms (mean age 14.5 years) and the seeking of professional help (mean age 24 years). This is followed by a delay in diagnosis of 6 years and a further 18 months before the patients get appropriate treatment. Thus there is an average delay of 17 years between the onset of symptoms and the start of appropriate treatment.[9] These factors of delayed treatment may also be likely in the UK.

Most epidemiological studies have found an equal sex ratio in the incidence of OCD. Women are more likely to suffer from compulsive washing and avoidance, whilst checking rituals are more common in men.

OCD usually starts in early adulthood. Although rituals are a normal developmental feature of children aged 7-8 years, OCD is rare in childhood. Washing rituals generally have a later age of onset, which may account for a younger age of onset in men than women. There is a preponderance of unmarried people who present for treatment with OCD.[6]

Studies in Western, Indian, Korean, and Hong Kong Chinese societies have identified OCD as a worldwide condition. The prevalence of the condition seems to be similar in all these societies. (USA approx. 2.5%, Germany 2.1%, Korea 1.9%, Puerto Rico 2.5%)

There is remarkable cross-cultural concordance in the prevalence of the different types of OCD obsessions in different societies.

	USA	**India**	**UK**	**Japan**	**Denmark**	**Israel**
Dirt, contamination	38%	32%	47%	39%	34%	50%
Harm, aggression	24%	20%	47%	12%	23%	20%
Somatic	7%	24%		13%	18%	3%
Religious	6%	5%	5%		8%	9%
Sexual	6%	6%	10%	5%	6%	6%

It is interesting that somatic obsessions do not seem to be recognised in the UK, and religious obsessions not recognised in Japan.

Religion has been implicated in the development of OCD. However OCD appears to be unrelated to any particular religion, denomination, or cultural background, but it is more common in those individuals who have had a rigid, strictly religious upbringing.[10]

4. Diagnosis

Patients with OCD often attempt to disguise their symptoms because of the shame and embarrassment associated with the disorder and will not reveal their OCD symptoms unless asked about them directly.[11]

The patient is often referred by a concerned parent or partner rather than presenting him or herself directly.

To identify a patient with OCD it has been recommended that five specific questions should be asked as part of every mental state diagnostic examination.[6]

1. Do you wash or clean a lot?
2. Do you check things a lot?
3. Is there any thought that keeps bothering you that you would like to get rid of but can't?
4. Do your daily activities take a long time to finish?
5. Are you concerned about orderliness or symmetry?

In the context of disability assessment these direct questions are not asked, but the functional effect of the symptoms can be assessed during the Typical Day history.

4.1 Differential Diagnoses

Phobias are the main diagnosis that may be confused with OCD. OCD and phobias are both associated with anxiety and avoidance of situations that provoke anxiety. In OCD the fear is not of the situation itself but of the consequences of the situation, and elaborate belief systems develop around the rituals. To cause further confusion, phobias and panic disorders commonly co-exist with OCD.

Anankastic or Obsessional Personality Disorder leads to excessive conscientiousness; checking; stubbornness and caution, combined with perfection, pedantry and meticulous accuracy. These traits are often common in high achievers and over represented in certain careers (medicine, law, accountancy, insurance and the media). They are also common in the pre-morbid personality of patients with OCD. Obsessional personality traits lie on a spectrum from normal healthy to socially incapacitating. The differential diagnosis between a severe obsessive personality disorder and OCD is made by the distinction that OCD sufferers are distressed by their condition, whereas people with obsessive personality disorder are not.

A diagnosis of OCD is made when the traits are out of the individual's control leading to:

- Distressing and persistent obsessional thoughts and compulsive rituals
- Impaired functioning at home or work.

4.2 Co-Morbidity

4.2.1 Depression

There is a strong association between OCD and depression, with a lifetime prevalence of depression in OCD suffers of 70%.[12] Depression may co-exist with OCD in three ways:

1. Depression precedes OCD. Patients suffering from depressive disorders commonly (20%) have obsessive and compulsive symptoms and traits.[13] The obsessions and compulsions begin at the same time or after the onset of depression. Treatment of the depression improves the compulsions.
2. OCD precedes depression. OCD makes patients unhappy by restricting home, work and social life with 92% of patients reporting lowered self-esteem.[9] The unhappiness (dysphoria) may be severe enough to be diagnosed as depression and 13% of sufferers made suicide attempts secondary to OCD symptoms. Depression may cause patients with longstanding OCD to present for treatment. Treatment of the OCD leads to improvement of the depression.
3. Depression is a common disorder; severe OCD is a rare disorder, however both conditions can occur independently of each other in the same person.

4.2.2 Anxiety

Approximately 20% of patients with OCD also meet diagnostic criteria for generalised anxiety disorder (GAD).[14] The presence of GAD is associated with excessive worries, indecisiveness and pathological concerns of responsibility. Some sufferers of OCD exhibit excessive health concerns. This subgroup tends to have poorer insight into the irrationality of their obsessions and a higher prevalence of GAD.[15]

4.2.3 Schizophrenia and other Psychoses

Patients with OCD maintain contact with reality and have insight into their condition. However, clinical observations indicate that at least some obsessive-compulsives do not regard their symptoms as unreasonable or excessive, and their ideas have been characterized as overvalued or delusional.[16] Patients may have difficulty in admitting to professionals that their worries are senseless or, if the obsession has been held for some time, resistance to the thought may disappear. Obsessions may be misdiagnosed as overvalued ideas and delusions, resulting in the misdiagnosis of schizophrenia or other psychosis.

OCD symptoms may also represent a defence against the anxiety symptoms of an acute psychotic breakdown and a small number of patients presenting with OCD later develop schizophrenia.

4.2.4 Obsessive Compulsive Spectrum Disorders

This group of conditions is characterised by intrusive thoughts or repetitive behaviour and shares a similar neurobiological model with OCD[17] (see Table in Appendix B).

Obsessive-compulsive traits or symptoms have been reported in a large number of anorexia nervosa patients.[6] Many anorectics have obsessions and compulsions unrelated to weight and food intake, and the obsessions and compulsions may be more disabling than the anorexia itself.

4.2.5 Tics and Gilles de la Tourette Syndrome

Tics are sudden *involuntary* twitching of muscle groups that can be difficult to distinguish from compulsive rituals. Severe tics associated with grunts, obscene vocalisation or gestures form the Gilles de la Tourette syndrome.

Compulsive rituals are performed to reduce anxiety associated with an obsessional idea. Tics are often worsened by anxiety but they occur spontaneously and do not develop as anxiety reducing behaviours.

4.2.6 Brain Damage

OCD was reported following encephalitis lethargica after the epidemic in 1918 - 1925. OCD may be precipitated by head injury, and has been reported following relatively minor injury.[18]

5. Treatment

If symptoms of OCD have been present for over 1 year then spontaneous recovery is unusual.[12] Most sufferers do not present for treatment for many years and so there is a high level of morbidity from OCD within the community. It is important that all professionals make patients aware that there are effective treatments available for OCD.

Behavioural therapy and drug treatments are both effective in treating OCD.[19]

5.1 Behavioural therapy

The principles of behavioural therapy are:

1. *Exposure* to the anxiety generating cue (e.g. dirt)
2. *Self-imposed Response Prevention*, which involves resisting the anxiety relieving behaviour (compulsions), e.g. hand washing.

The treatment generates anxiety, which the patient learns to tolerate in the absence of the undoing ritual (habituation).

In the past, graduated exposure treatment was very therapist intensive. Recently there has been a move towards more self help exposure work.[6]

Pure obsessional ruminations are a subset of OCD that in the past showed a poor response to the behavioural therapy techniques of thought stopping and distraction. Treatment of obsessive ruminations with the behavioural techniques of exposure and response prevention has a better outcome.[20]

If practised systematically then behavioural therapy (exposure and self imposed response prevention) has been shown by controlled trials to be effective in symptom reduction. Long term outcome studies show success rates between 50 - 80%.[21]
Treatment failure may arise from:

a) Treatment refusal (5-25%)
b) Treatment drop-outs (10%)
c) True treatment failures (10%)
d) Treatment relapses (20%)

Successful treatment outcome is very dependent on habituation. Failure to habituate can occur for a number of reasons:

1. Inadequate homework self – therapy, or continuing covert neutralisation
2. Concurrent major depression (more severe OCD, poor motivation and learning)
3. Covert consumption of anxiolytic drugs (benzodiazepines) or alcohol
4. Physiological non-habituation i.e. anxiety response does not decrease with

repeated exposure. Unfortunately, identification of this group of patients prior to therapy is not possible.

Predictors of treatment failure in OCD include:

1. Initial severe depression
2. Late age of symptom onset
3. Pre-treatment anxiety
4. The obsession having the characteristics of an over valued idea.

Relapses may be precipitated by adverse life events, and so some relapses may be predictable. Short booster behavioural therapy courses to re-establish the previous programme may be helpful in preventing relapse.[22]

5.2 Cognitive Behavioural Therapy

There is debate as to whether cognitive behavioural therapy (CBT) has any advantage over behavioural therapy in the treatment of OCD.

Recent developments in cognitive theory suggest that the key to understanding obsessional problems lies in the way in which intrusive thoughts, images, impulses and doubts are interpreted. The responsibility belief is the idea that the person's action (or choice not to act) can result in harm to oneself or others.[23] There is evidence of an association between responsibility cognitions and obsessional symptoms. The aim of CBT is to change responsibility beliefs and eliminate covert neutralising responses.[24]

CBT may be useful if the obsession has the quality of an overvalued idea.

5.3 Drug Treatment

First Line	**Selective serotonin reuptake inhibitors (SSRIs)**	Paroxetine, fluoxetine, sertraline, citalopram and fluvoxamine.
	Serotonin reuptake inhibitors (SRIs)	Clomipramine.

Multi-centre placebo controlled trials have found the SSRIs, fluoxetine, fluvoxamine, sertraline and paroxetine effective in OCD.[25] [26] Pilot studies of citalopram show promising results.

Most of the work done comparing the effect of various SSRIs to clomipramine has been done with small population studies. Several meta-analyses comparing different subsets of SSRIs have been published. These found clomipramine more effective than SSRIs,[27] [28] and, despite clomipramine having more side effects than SSRIs, dropouts because of side effects are no greater.[26] However, **critical analysis of these meta-analyses reveals significant sources of bias and any conclusions are tentative.**

Clomipramine is the only tricyclic antidepressant that has been shown to be useful, with a 40% reduction in the severity of obsessions and compulsions.

40-60% of patients with OCD do not respond to drug therapy with SRIs, hence other agents have been added to augment the effect.

Buspirone, tryptophan, lithium, clonazepam, trazodone, dopamine antagonists and gabapentin have been reported to have various successes. Therefore other neurotransmitter systems may have a role in the pharmacology of OCD.

Onset of improvement with drug therapy is often delayed many weeks and a 10-week trial of a potent serotonin reuptake inhibitor is the minimum needed to confirm failure to respond. Once response is detected, it may increase for 5 months or longer. Failure to respond to one drug does not predict failure to respond to another; hence a further 10-week trial of a different serotonin reuptake inhibitor is reasonable.[26]

Medication should be considered indefinitely, as discontinuation of drug treatment is associated with relapse rates of 80-90%.[29]

Although SRIs provide statistically significant relief from the symptoms of OCD, patients may remain significantly functionally impaired.

5.4 Surgery for OCD

A few patients do not respond to behavioural or drug treatments and are severely disabled by their OCD and it is this group which may be helped by neurosurgical techniques.

There is a lack of controlled data for each neurosurgical procedure, with each neurosurgical centre favouring one type of intervention based on local tradition rather than evidence.[30] Hence it is unclear which procedure is best and which produces the most side effects.

Progressive improvement in OCD has been reported following some of these procedures. There is some evidence that behaviour therapy and drug therapy may be more successful following neurosurgery.[30]

5.5 Summary

The combination of pharmacological treatment with behavioural therapy is likely to give the best chance of achieving a good response.[31]

Medication should be considered indefinitely due to the high risk of relapse. Booster courses of behavioural therapy may be necessary.

6. Prognosis

With adequate treatment there is likely to be a considerable reduction in symptoms, although the improvement may take more than five months to reach its maximum.

Resistant cases that require different types of treatment may take a year to achieve functional improvement.

For the purposes of disability assessment it would therefore be reasonable to review a case 6 to 12 months following the initiation of treatment.

Chronic cases resistant to treatment and with functional limitations are likely to have the condition long term.

7. Main Disabling Effects

Obsessions and compulsions are distressing, time consuming and have a negative impact on the sufferers' interpersonal relationships and careers.

Social isolation occurs in individuals with moderate to severe OCD, partly because they spend most of their day performing rituals and partly because others interpret their behaviour as peculiar. 62% of OCD sufferers report having fewer friends or difficulty in maintaining friendships and 73% report interference with family relationships.

Obsessional thoughts interfere with concentration on study and work. Two thirds of sufferers reported lowered career aspirations; 47% experienced work interference and 40% were unable to work for an average of 2 years.[32] OCD frequently manifests itself in childhood and adolescence; hence the potential lifetime loss of income is significant.

7.1 Assessing the Claimant

Many sufferers of OCD have severely restricted social functioning, although this may not be apparent from the documentary evidence available to the medical examiner.

It may become apparent during the 'typical day history' that the claimant spends so much time performing rituals, such as cleaning or checking that their social functioning is severely restricted. Obsessive ruminations may occupy the claimant to such an extent that their awareness may be affected.

Co-morbid depression may worsen the disabling effects of OCD. There may be reduced concentration, increased anxiety, increased irritability and social reclusivity.

7.2 IB-PCA Considerations

In the IB-PCA, it may be appropriate to advise exemption under the category of "**severe mental illness**". This is defined as…"**the presence of mental disease which severely and adversely affects a person's mood or behaviour, and which severely restricts his social functioning, or his awareness of his immediate environment**."

If the condition is not so severe as to warrant exemption advice then the examiner will find that the functional limitations caused by OCD may affect all four psychological functional areas; Completion of Tasks (CT); Daily Living (DL); Coping with Pressure (CP); and Interaction with Other People (OP). These effects will be detected by the Mental Health Assessment using the history, the typical day history, and the mental state examination.

Common reductions in reported function are: Decrease in self-esteem (92.1%) – DL effects, Change of career or job or laid off from work (70.3%) – CP effects, Negative relationship with spouse (64.4%) and Fewer friends (62.1%) – OP effects.[9]

Appendix A - OCD: Aetiological Theories

BIOLOGICAL	
Genetic	Higher rates of OCD in relatives of OCD patients than in the general population. Monozygotic twins more likely to be concordant for OCD or obsessional personality traits than dizygotic twins (but no studies of twins reared apart). Obsessional symptoms may be advantageous during evolution and may have been selectively maintained in our genetic makeup.
Neurotransmitter	Drug studies show a differential response when patients are treated with agents acting on different neurotransmitter functions. 5-hydroxytryptamine (5HT) and dopaminergic systems implicated. Variable effects of agents acting on 5HT system suggest heterogeneous pathophysiology.
Gross Brain Pathology	OCD is a rare complication of head injury. It has been postulated that in OCD there is a hyperactive circuit in the brain involving the orbito-frontal cortex, cingulate cortex and caudate nucleus. This is supported by modern brain imaging techniques.
PSYCHOLOGICAL	
Psychoanalytical Theories	Freud proposed that OCD arose out of compromise between conflicting forces of the mind, and symptoms were a *reaction formation* to incompletely repressed forbidden sexual impulses. He introduced the idea of *Undoing* by which the motor activity of compulsions seeks to undo, not only the consequence of the obsession, but the obsession itself. Klien developed Freud's theory of conflicting instinctual forces in the mind: libidinal and destructive.
Behavioural and Cognitive Theories	Obsessions can be viewed as learned responses to specific situations. Compulsive behaviours are introduced as an anxiety reducing activity. Compulsions are inefficient as they only produce a small amount of temporary relief before the anxiety increases again, leading to repetition of the ritual. Individuals use five different techniques of thought control including: distraction, punishment, re-appraisal, social control, and worry. OCD patients use punishment, worry, reappraisal, and social control more often than non-patients. Conversely, distraction is used more often by non-patients than OCD sufferers.[33]
SOCIOLOGICAL	
Sociological	Individuals with OCD report more life events in the year preceding onset of OCD than controls. Life events may increase arousal, which if aversive could be linked with a previously neutral stimulus (e.g. electrical plugs). In a classic conditioning model, the patient would become conditioned to respond with fear and high arousal to electric plugs.

Appendix B - Obsessive Compulsive Spectrum Disorders[9]

Somatoform Disorders	Hypochondriasis Body dysmorphic disorder
Eating Disorders	Binge eating Anorexia nervosa
Impulsive Personality Disorders	Antisocial personality disorder Borderline personality disorder
Impulse Control Disorders	Intermittent explosive disorder Pathological gambling Trichotillomania Sexual compulsions Kleptomania Compulsive buying

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