INVITED ARTICLE

MANAGEMENT OF OBSESSIVE COMPULSIVE DISORDER

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ABSTRACT

The treatment of obsessive compulsive disorder was characterised by therapeutic pessimism until 25 years ago when effective treatments using behaviour therapy and the serotonin reuptake inhibitors were developed. At present the best available treatment is a combination of behaviour therapy and pharmacotherapy with a serotonin reuptake inhibitor. Psychosurgery is only indicated for patients who fail to respond to pharmacologic and behavioural treatments and who suffer from disabling symptoms.

Keywords: obsessive compulsive disorder, serotonin reuptake inhibitors, behaviour therapy, obsessions, compulsions

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INTRODUCTION

Until 25 years ago obsessive compulsive disorder (OCD) was considered to be a chronic illness with a poor prognosis and its treatment was characterised by therapeutic pessimism. Since then effective behavioural strategies and effective drug treatments with the serotonin reuptake inhibitors such as clomipramine have led to the successful treatment of many OCD patients.

OCD was once thought to be a relatively rare disorder. However data from the National Institute of Mental Health Epidemiologic Catchment Area (ECA) survey estimate the lifetime prevalence to be 1.2% to 2.4% in the U.S. population[1]. This suggests that it is as common as schizophrenia which has a lifetime prevalence of about 1%. A cross national study on the epidemiology of obsessive compulsive disorder[2] in seven international communities (USA, Canada, Puerto Rico, Germany, Taiwan, Korea and New Zealand), with the exception of Taiwan which has a low prevalence of the disorder, confirm the ECA findings.

OCD affects males and females equally[3]. It has an early age of onset, with over 65% of patients reporting first symptoms before the age of 25 while less than 15% develop the illness after age 35[4].

The cause of OCD is unclear[5]. In the last decade a great deal of research has gone into elucidating the cause of OCD. Presently the most common theories of aetiology involve a combination of biological and behavioural theories.

DIAGNOSIS

OCD is characterised by the presence of recurrent obsessions or compulsions that are severe enough to cause marked distress or interfere with a person's functioning[6]. Obsessions are recurrent, persistent thoughts, impulses or images that intrude on the mind despite the person's efforts to exclude them. Many common obsessions involve fears of contamination and concerns over something happening to oneself or others. Compulsions are repetitive and seemingly purposeful behaviours that are performed according to certain rules or in a stereotyped manner. Common compulsions involve cleaning or washing rituals and repeatedly checking an item. Patients with OCD realise the senselessness of their obsessions and compulsions.

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Phenomenologic subtypes of OCD

The clinical presentation of OCD can be conveniently divided into the following subtypes[7]:

1. those with washing/cleaning compulsions as the major problem;
2. those with checking compulsions as the major problem;
3. those with other covert compulsions (mental compulsive rituals) as the major problem;
4. those with obsessions unaccompanied by overt compulsive behaviour;
5. those with primary obsessional slowness. This is an uncommon problem in which patients require an extraordinary amount of time to complete a task.

TREATMENT

Studies[8] have shown that between two-thirds and three-quarters of patients will respond to behaviour therapy. Christensen et al[9] found that only behaviour therapy, clomipramine and psychosurgery were effective treatments for OCD. Behaviour therapy was also the only treatment whose gains were long maintained[10]. Patients on drug therapy tend to relapse when treatment is stopped[11] and may need medication indefinitely.

1. Education

All patients seeking help for OCD benefit from explanation of their disorder and its treatment. I have found books such as The Boy Who Couldn't Stop Washing[12] and Living With Fear[13] helpful in educating the patient. Family members of patients with OCD often engage in compulsive behaviour with the patient. They also have to be educated on the illness and treatment as part of the behaviour programme since they need to help the patients by not engaging in compulsive behaviour.

2. Behaviour therapy

Behaviour therapy is indicated for patients who have rituals, who dislike drugs, or who have not responded to drug therapy.

(a) *Inpatient vs outpatient behaviour therapy*
OCD patients are treated as outpatients as there is no general advantage to inpatient treatment. Outpatient treatment is also

cost effective and allows for better generalisation of improvements from behaviour therapy. Megens and Vandereycken[14] reviewed the literature on inpatient vs outpatient behavioural treatment of OCD. They concluded that both methods of treatment were highly effective but that in the presence of severe depression, nearly psychotic-obsessions, social isolation, or severely disturbed relationships, inpatient treatment may be indicated. A recent article by Baer[15] provides guidance for clinicians treating patients with OCD in the office-based practice.

(b) *Exposure and response prevention for those with overt rituals*
Exposure and response prevention[16] is an established technique for patients with washing/cleaning compulsions, checking compulsions and other overt compulsive behaviour. Exposure entails deliberately facing the feared or avoided object, thought, situation or place. Response prevention involves delaying, diminishing or preventing the performance of anxiety-reducing rituals.

In OCD the following chain of events occur:

Obsession (or feared stimuli) → Increasing tension → Avoidance → Reducing tension. (Chain of avoidance)
Obsession (or feared stimulus) → Increasing tension → Yield to compulsion → Reducing tension. (Chain of compulsive behaviour)

Avoidance behaviour is self-reinforcing as it provides a way to partially reduce the anxiety and thus contribute to the chronicity of OCD. Exposure is the key to breaking this chain of avoidance. Exposure in vivo is the preferred form of treatment as it entails an actual confrontation with the feared stimulus. On exposure to the evoking stimulus patients with OCD carry out compulsions that reduce tension. The compulsion is thus self-reinforcing. The key to breaking this chain of compulsive behaviour is response prevention.

(c) *Behavioural techniques for those without overt rituals*
The treatment of patients without overt rituals are not as well developed. Several behavioural techniques have been found to be useful[7,16]. Imaginal flooding and thought stopping have been used to help OCD patients who do not have overt rituals. In imaginal flooding the patient is asked to elaborate on his anxiety-provoking obsession (for example a patient who fears that harm will come to his family if he is careless is asked to think or imagine the worst that could happen whenever the obsession occurs) or by recording and repeatedly playing back thoughts on a tape recorder. In thought stopping the patient is taught to use the stop command to control his obsessions. Other behavioural techniques[7] such as thought substitution and distraction are also useful. For patients with covert compulsions, distraction and thought stopping techniques are helpful in preventing them.

(d) *Behaviour therapy of primary obsessional slowness*
Primary obsessional slowness is a disabling variant of OCD. The treatment of primary obsessional slowness involves pacing, prompting and shaping procedures[17].

Predictors of failure in behaviour therapy are: non-compliance with treatment, concomitant severe depression, absence of rituals, presence of overvalued ideas, and concomitant severe personality disorder[18].

3. Pharmacotherapy
Serotonin reuptake inhibitors
Drug treatment is indicated for patients who have purely obsessional symptoms, who are depressed or for whom behaviour therapy has been ineffective or unavailable.

The serotonin reuptake inhibitors (SRIs) - clomipramine, fluvoxamine, fluoxetine, sertraline - are the drugs of choice in the treatment of OCD as they have antiobsessional effects. The choice of medication will depend on the drug's side effect profile and availability. Rasmussen et al[19] recommend the starting doses of 25mg for clomipramine, for fluoxetine, 10mg and for fluvoxamine, 50mg respectively. Some patients respond well to the starting dose while others require more than the recommended dose. The dose should be increased to the maximum tolerated level and then reduced in the maintenance phase of treatment once a response has been obtained. The trial of drug treatment should be continued for 10 to 12 weeks at adequate doses before being considered as treatment resistant. Responders are maintained on the drug for at least one year before discontinuing treatment. About 40% to 60% of patients show a clinically meaningful response to drug treatment with SRIs. For responders who want to stop treatment, the medication should be reduced slowly over several months and they should consider behaviour therapy as symptoms tend to recur when the SRI is stopped.

For patients who do not respond, alternative pharmacologic strategies can be used. These include augmentation of SRI's with clonazepam, using non-SRI monotherapies such as clonazepam and using intravenous clomipramine[20].

4. Psychosurgery
Psychosurgery[21] is indicated for patients who do not respond to any other therapy and who suffer from disabling symptoms. Various psychosurgical procedures that interrupt the efferent pathways from the frontal cortex to the basal ganglia are effective.

5. Electroconvulsive therapy (ECT)
ECT[22] is generally not useful in reducing obsessive compulsive symptoms. It should be considered in OCD patients who are depressed and at risk of suicide.

6. Psychotherapy
Psychoanalysis and dynamic psychotherapy are unsuccessful in the treatment of OCD. However supportive psychotherapy in the form of advice, empathic understanding of the patient's distress, fostering the patient's strength and minimising his limitations and encouraging him at the same time as he receives other effective treatments for OCD is helpful.

CONCLUSION
The treatment of OCD has been revolutionised by the introduction of effective behavioural therapy and drug treatment with the SRIs. Griest[23] recommends an integrated approach to OCD. The combination of behaviour therapy and pharmacotherapy offers the best available treatment at present.

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