



OBSESSIVE COMPULSIVE DISORDER: A REVIEW

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ABSTRACT

Obsessive Compulsive Disorder (OCD) is an anxiety disorder, characterized by repetitive unwanted obsessions and compulsions. The exact pathogenesis of OCD remains uncertain but multiple components such as hereditary/genetic, cognitive, biological, environmental and behavioral factors have been implicated. The aim of this review is to highlight the pathogenesis of OCD in differentiate it from adult onset OCD and outline its assessment and management.

INTRODUCTION

Obsessive-compulsive disorder (OCD) is characterized by the presence of obsessions and/or compulsions. The obsession is an idea or impulse characterized by persistence, recurrence and forcefulness that the patient perceives as intrusive and inappropriate, which creates discomfort and does not disappear in spite of attempts to ignore or suppress it. The compulsion is a repetitive behaviour or mental act carried out in response to the obsession according to precise rules. Many of these behaviours have the aim of reducing or neutralizing the anxiety, or avoiding the feared event, which is frequently excessive or unrealistic.¹

EPIDEMIOLOGY

Obsessive-compulsive disorder is a common anxiety disorder that can be chronic and disabling. Considering that psychiatric disorders occur in at least 20 percent of medical outpatients.² An epidemiological study demonstrated that the time between the appearance of symptoms and correct diagnosis is about 17 years.³ There are many reasons why the disorder goes unrecognized: patients tend to hide their symptoms, fearing that they will appear 'crazy', and only seek specialist help when the clinical picture is complicated with anxiety and depression.^{4,5}

Although many OCD sufferers recognize that their obsessional fears and rituals are senseless and excessive, others strongly believe that their rituals serve to prevent the occurrence of disastrous consequences; in other words, they have poor insight.⁶

DEFINITION

According to DSM-IV - TR - Obsessions are defined by the following features

1. Recurrent or Persistent thoughts, impulses or images that are experienced at some time during the disturbance as intrusive and inappropriate and that causes marked anxiety and distress.
2. Thoughts impulses or images that are not simply excessive worries about real life problem.

3. Attempt to ignore or suppress such thoughts or impulses or to neutralize them with some other thought or action.
4. Recognition that the obsessional thoughts, impulses or images are a product of one's own mind, not imposed from without as in thought insertion.

Compulsions are defined as follows (2):

1. Repetitive behaviours or mental act that the person feels driven to perform in response to an obsession or according to rules that must be rigidly applied.
2. Behaviours or mental act aimed at preventing & reducing distress or preventing some dreaded events or situations. Those behaviours or mental acts are either unconnected realistically with what they are designed to neutralize or prevent or clearly excessive.

Obsessions are usually anxiety provoking whereas compulsions are usually anxiety relieving. Most common obsession are repetitive thoughts of violence, contamination & doubt. Typical compulsions are hand washing, counting & checking.

Obsessive-Compulsive Disorder (OCD) is a common neuropsychiatric disorder characterized by the presence of obsessions and/or compulsions that are time consuming and cause distress or interference in the patient's life.⁷

EPIDEMIOLOGY

OCD is the fourth most common psychiatric diagnosis after phobias, substance related Disorders and major depressive Disorder. The life time prevalence of OCD in the general population is estimated at 2 to 3 percent. The prevalence of OCD among children & adolescent appears to be as high as among adults. Both men and women are equally likely to be affected with slight female preponderance. During adolescence, boys are more commonly affected than girls. The mean age of onset is about 20 year although men have a slightly earlier age of onset (mean about 19 years) than woman.⁸

ETIOLOGY

Biological factors likely play an important role in the development of OCD. In fact, researchers have started to identify specific genes and chromosomes associated with increased vulnerability.⁹ Some studies have also found that a small subset of children develop the disorder following streptococcal infections. Still, given the complexity of causal pathways for mental disorders, more research is needed to help refine intervention efforts, especially for OCD given that no effective prevention programs exist.¹⁰

FACTORS THAT INCREASE THE RISK OF OCD

1. Genetic

Family members with obsessive compulsive symptoms, OCD or tics

- Promising candidate genes: SLC1A1 and SAPAP.¹¹

2. Family

- Family history of OCD or OCD spectrum disorders (e.g., tic disorders, tricotillomania, body dysmorphic disorder)
- High familial accommodation to obsessive-compulsive symptoms.¹²

3. Individual

- Presence of obsessive-compulsive symptoms and subclinical OCD
- Neuropsychological abnormalities (global cognitive deficits, mental inflexibility, visual spatial deficits, impaired motor skills)

- Comorbid psychiatric disorders (e.g., Tourette’s syndrome).¹³

4. Environmental

- Prenatal, perinatal and postnatal factors, e.g., excessive weight gain during gestation; prolonged labor; preterm birth; jaundice emotional stress, traumatic brain injury, exposure to substances (alcohol, cocaine, stimulants, and hormones) in early pregnancy.
- Streptococcal infections and rheumatic fever.¹⁴

CLINICAL FEATURES

The following table explaining the clinical features of Obsessive Compulsive Disorder.¹⁵

| Obsession | Examples | Associated compulsive behavior |
|------------------------|--|--|
| Symmetry and exactness | Recurrent thoughts of needing to do things in a balanced or exact fashion. | Ordering and arranging |
| Sexual | Recurrent thought of being a pedophile or sexual deviant | Performing mental rituals to counteract the thoughts |
| Superstition | Fears of certain bad numbers or colors | Counting excessively |
| Religious | Thoughts about being immoral | Asking forgiveness and praying |
| Self control | Fear of inappropriate comments in public | Avoiding being around others |
| Pathological doubt | Recurrent worries about doing things incorrectly or incompletely | Checking excessively |
| Contamination | Fear of being contaminated or contaminating others | Washing and cleaning rituals |
| Aggressive | Fear of harming others, recurrent violent images | Monitoring the news for reports of violence. |

Obsessive-Compulsive Related Disorder

1. Body dysmorphic disorder
2. Excoriation(Skin picking disorder)
3. Trichotillomania(hair pulling disorder)
4. Hoarding disorder

Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington, DC: American Psychiatric Association; 2013.

COMORBIDITY

Similar to adults with OCD, 60% to 80% of affected children and adolescents have one or more comorbid psychiatric disorders. Some of the most common are tic disorders, attention deficit hyperactivity disorder (ADHD), other anxiety disorders, mood and eating disorders .¹⁶

DIAGNOSIS

Obsessive-compulsive disorder is a common problem that will undoubtedly afflict a number of patients in a family medicine practice. Prompt recognition and treatment, especially when it combines pharmacologic and behavioral interventions, as in this case, can lead to rapid

resolution of symptoms. There are, however, a number of impediments to diagnosis and treatment.¹⁷

Patients with obsessive-compulsive disorder might conceal their symptoms for fear of being thought crazy. Additionally they often have co-existing symptoms of depression, anxiety, or panic.¹⁸

Acc to DSM 5, Diagnostic Criteria for Obsessive-Compulsive Disorder

A. Presence of obsessions, compulsions, or both:

B. Obsessions are defined by (1) and (2):

1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.

2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

Compulsions are defined by (1) and (2):

1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.

2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

Note: Young children may not be able to articulate the aims of these behaviors or mental acts.

B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalized anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin-picking] disorder; stereotypies, as in stereotypic movement disorder; ritualized eating behavior, as in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behavior, as in autism spectrum disorder.¹⁹

OCD is a complex, heterogeneous disorder, and some presentations are under recognized. For example, taboo thoughts may be attributed to other causes or may not appear to be associated with overt compulsions. Even when compulsions are not easily observable, patients with OCD usually have mental rituals. Patients are often reluctant to report symptoms of OCD for a variety of reasons, including embarrassment, stigma, and the fear of what the obsession might mean or the consequences of revealing it.²⁰

TREATMENT

Once OCD is diagnosed, it is important to provide the patient with information and support. Patients and family members should be educated about the chronic nature of OCD and the importance of self-management skills. Evidence-based medical and behavior therapies can reduce the severity and frequency of obsessions and compulsions, and can induce remission in some patients. Because it may take weeks to months for these therapies to become effective, physicians should inform patients about this delay in treatment response and encourage adherence during the early phase of treatment.²¹

Pharmacological

Selective serotonin reuptake inhibitors (SSRIs) are the first-line medication for OCD in children, adolescents and adults.²² Clomipramine, a serotonergic tricyclic agent, was the first medication proven to be effective in the treatment of OCD.²³

Despite the effectiveness of SSRIs, about half of the patients do not respond or have significant residual symptoms, even with adequate duration of treatment and maximum recommended or tolerated dosages. For these patients, some strategies have been suggested and are described below. Unfortunately, there are no systematic studies that compare switching medications with adding an augmenting agent to the initial medication AACAP, 2012.²²

Non pharmacological treatment

CBT is the only psychological therapy shown to be effective in the treatment of childhood OCD.²⁴ Cognitive restructuring helps patients realize the influence of thoughts and beliefs on behavior (rituals and avoidance), the functional relationship between obsessions and rituals, and strategies to neutralize them while causing relief. The behavioral model uses exposure and response prevention techniques based on the relationship between obsessions and compulsions, with the purpose of weakening the association and the distress caused by them. It exposes the sufferers to the objects, people or situations they fear, and prevents them from performing the compulsion, in order to gradually reduce the anxiety level.²⁵ Cognitive and behavioral techniques complement each other and the power of one lies in its correct combination with the other.²⁶

Most CBT treatment manuals for OCD recommend twelve to twenty five sessions. The manuals usually suggest that therapists use the first one or two sessions to collect detailed information about the patient's symptoms, how the patient and the family deal with them, family environment, school performance and other relevant issues on the patient's functioning. As much psychoeducation as possible is also to be provided; this will involve detailed information about all aspects of the illness, including possible clinical symptoms, impact of comorbidity, treatment options, duration of illness and duration of treatment, the risks of family accommodation and how best to deal with a family member with OCD. Usually, a 50 minute CBT session includes a review of the goals, review of the previous week, provision of new information, therapist-assisted practice, homework for the coming week, and monitoring.^{27,28,29}

Patients should be assessed for suicide risk and presence of comorbidities throughout the course of their illness. Treatment is indicated when OCD symptoms impair the patient's functioning or cause significant distress. Reasonable treatment goals are spending less than one hour per day on obsessive-compulsive behaviors and achieving minimal interference with daily tasks.²⁸

CONCLUSION

Obsessions are recurrent, persistent thoughts, impulses or images that enter the mind despite the person's efforts to exclude them. The characteristic feature is the subjective sense of a struggle the patient experiences while resisting the obsession which nevertheless intrudes into his awareness. Obsessions are recognized by the person as his own and not implanted from elsewhere. They are often regarded by him as untrue or senseless. They are generally about matter which the patient finds distressing or otherwise unpleasant. The presence of resistance is important because together with the lack of conviction about the truth of the idea, it distinguishes from delusions.

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