OBSESSIVE COMPULSIVE DISORDER

COURSE: PSYCHOPATHOLOGY
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ANXIETY

Anxiety is a "normal" phenomenon, which is characterized by a state of apprehension or unease arising out of anticipation of danger. Anxiety is often differentiated from fear, as fear is an apprehension in response to an external danger while in anxiety the danger is largely unknown (or internal).

TYPES OF ANXIETY DISORDERS

In ICD-10, “neurotic, stress-related and somatoform disorders have been classified into the following types:

Generalized Anxiety Disorder

Panic Disorder

Obsessive-Compulsive Disorder

Post-Traumatic Stress Disorder

Specific Phobias

OBSESSIVE-COMPULSIVE DISORDER

An *obsession is defined as:*

1. An idea, impulse or image which intrudes into the conscious awareness repeatedly.
2. It is recognised as one's own idea, impulse or image but is perceived as *ego-alien (foreign to* one's personality).
3. It is recognised as irrational and absurd (insight is present).
4. Patient tries to resist against it but is unable to.
5. Failure to resist, leads to marked distress.

COMPULSION

An obsession is usually associated with compulsion(s)

A *compulsion is defined as:*

1. A form of behaviour which usually follows obsessions.
2. It is aimed at either preventing or neutralising the distress or fear arising out of obsession.
3. The behaviour is not realistic and is either irrational or excessive.
4. Insight is present, so the patient realises the irrationality of compulsion.
5. The behaviour is performed with a sense of subjective compulsion (urge or impulse to act). Compulsions may diminish the anxiety associated with obsessions.

Epidemiology, Course and Outcome

In India, obsessive compulsive disorder (OCD) is more common in unmarried males, while in other countries, no gender differences are reported. This disorder is commoner in persons from upper social strata and with high intelligence.

The average age of onset is late third decade (i.e. late 20s) in India, while in the Western countries the onset is usually earlier in life.

Recent studies show the life-time prevalence of OCD to be as high as 2-3%, though the Indian data shows a lower prevalence rate. Although classically thought to have a steady *chronic course, the longitudinal* profile of this disorder can also be *episodic.*

A summary of long-term follow-up studies shows that about 25% remained unimproved over time, 50% had moderate to marked improvement while 25% had recovered completely.

Clinical Syndromes

ICD-10 classifies OCD into three clinical sub types:

1. Predominantly obsessive thoughts or ruminations,
2. Predominantly compulsive acts (compulsive rituals),and
3. Mixed obsessional thoughts and acts. *Depression is very commonly associated with* obsessive compulsive disorder. It is estimated that at least half the patients of OCD have major depressive episodes while many other have mild depression. *Premorbidly obsessional or anankastic personality* disorder or ‘traits’ may be commoner than in rest of the population. Four clinical syndromes have been described in literature, although admixtures are commoner than pure syndromes.

Washers

This is the commonest type. Here the *obsession is of contamination with dirt, germs, body excretions and* the like. The *compulsion is washing of hands or the* whole body, repeatedly many times a day. It usually spreads on to washing of clothes, washing of bathroom, bedroom, door knobs and personal articles, gradually. The person tries to avoid contamination but is
unable to, so washing becomes a ritual.

Checkers

In this type, the person has multiple *doubts, e.g. The* door has not been locked, kitchen gas has been left open, counting of money was not exact, etc. The *compulsion,* of course, is *checking repeatedly to 'remove'* the doubt. Any attempt to stop the checking leads to mounting anxiety. Before one doubt has been cleared, other doubts may creep in.

Pure Obsessions

This syndrome is characterised by repetitive intrusive thoughts, impulses or images which are *not associated* with compulsive acts. The content is usually sexual or aggressive in nature. The distress associated with these obsessions is dealt usually by *counter-thoughts (such* as counting) and not by behavioural rituals.

A variant is *obsessive rumination, which is a preoccupation* with thoughts. Here, the person repetitively ruminates in his mind about the pros and cons of the thought concerned.

Primary Obsessive Slowness

A relatively rare syndrome, it is characterised by severe obsessive ideas and/or extensive compulsive rituals, in the relative absence of manifested anxiety.

This leads to marked slowness in daily activities. This subtype is quite difficult to diagnose in the routine clinical practice, unless the possibility of this subtype is kept in mind.

In clinical practice, one of the most useful scales is the Y-BOCS (Yale-Brown Obsessive Compulsive Scale). It can be used to elicit the symptomatology and rate the severity of OCD. The Y-BOCS classifies the symptoms and signs of OCD as follows:

1. Aggressive obsessions
2. Contamination obsessions
3. Sexual obsessions
4. Hoarding/Saving obsessions
5. Religious/Scrupulous obsessions
6. Obsession with need for symmetry or exactness
7. Somatic obsessions
8. Miscellaneous obsessions
9. Cleaning/washing compulsions
10. Checking compulsions
11. Repeating rituals
12. Counting compulsions
13. Ordering/arranging compulsions
14. Hoarding/collecting compulsions
15. Miscellaneous compulsions.

AETIOLOGY

Several causative factors have been explored in the past but no clear aetiology of obsessive compulsive disorder is known yet. Some of the important theories include:

Psychodynamic Theory

Sigmund Freud found obsessions and phobias to be psychogenetically related.

Isolation of Affect: By this defense mechanism, go removes the affect (*isolates the affect) from the* anxiety-causing idea. The idea is thus weakened, but remains still in the consciousness. The affect however becomes free and attaches itself to other *neutral idea(s) by symbolic associations. Thus, these neutral* ideas become anxiety-provoking and turn into *obsessions.* This happens only when *isolation of affect is* not fully successful (incomplete isolation of affect).

When it is fully successful, both the idea and affect are repressed and there are *no obsessions.*

Undoing: This defense mechanism leads to compulsions, which prevent or *undo the feared consequences* of obsessions.

Reaction formation results contributing to obsessive compulsive symptoms, while *displacement leads to formation of phobic* symptoms. *in the formation of* obsessive compulsive personality traits rather than

This mechanism has been explained in slight detail as this theory attempts to describe the probable causation of OCD in a remarkably systematic manner.

However, it must be remembered that this is only a theory and whether it is true or not, is a matter of conjecture.

Thus, the psychodynamic theory explains OCD by a defensive regression to anal-sadistic phase of development with the use of isolation, undoing and displacement to produce obsessive-compulsive symptoms.

Behavioural Theory

The behavioural theory explains *obsessions as conditioned* stimuli to anxiety (similar to *phobias). Compulsions* have been described as learned behaviour which decrease the anxiety associated with obsessions.

This decrease in anxiety positively reinforces the compulsive acts and they become 'stable', learned behaviours. Behavioural or learning theory is *not able to* explain the causation of OCD adequately but is very useful in its treatment.

Biological Theories

1. Obsessive compulsive symptoms can occur secondary to many illnesses such as von Economo's encephalitis, basal ganglia lesions, Gilles de la Tourette syndrome, and hypo thalamic and third ventricle lesions.

2. Obsessive compulsive disorder is found in 5-7% of first degree relatives of the patients with OCD.

3. Psychosurgery has been successfully used for treatment of OCD.

4. Biochemically, the central 5-HT system seems to be involved in OCD, as SSRIs are useful in the treatment of OCD

Treatment

Psychotherapy

1. Psychoanalytic psychotherapy is used in certain selected patients, who are psycho logically oriented.
2. Supportive psychotherapy is an important adjunct to other modes of treatment. Supportive psychotherapy is also needed by the family members.

Behaviour Therapy and Cognitive

Behaviour Therapy

Behaviour modification is an effective mode of therapy, with a success rate as high as 80%, especially for the compulsive acts. It is customary these days to combine CBT with BT at most centres. The techniques used are

i. Thought-stopping (and its modifications).
ii. Response prevention.
iii. Systematic desensitisation.
iv. Modelling.

Drug Treatment

1. Benzodiazepines (e.g. alprazolam, clonazepam) have a limited role in controlling anxiety as adjuncts and should be used very sparingly.

2. *Antidepressants: Some patients may improve* dramatically with specific serotonin reuptake inhibitors (SSRIs). *Clomipramine (75-300 mg/day), a nonspecific* serotonin reuptake inhibitor (SRI), was the first drug used effectively in the treatment of OCD. The response is better in the presence of depressive symptoms, but many patients with pure OCD also improve substantially.

Fluoxetine (20-80 mg/day) is a good alternative to clomipramine and often preferred these days for its better side-effect profile. *Fluvoxamine* (50-200 mg/day) is marketed as a specific anti-obsessional SSRI drug, whilst paroxetine
(20-40 mg/day) and sertraline (50-200 mg/day) are also effective in some patients.

3. *Antipsychotics: These are occasionally used in* low doses (e.g. haloperidol, risperidone, olanzapine, aripiprazole, pimozide) in the treatment of severe, disabling anxiety.

4. Buspirone has also been used beneficially as an adjunct for augmentation of SSRIs, in some patients.

Electroconvulsive Therapy

In presence of severe depression with OCD, ECT may be needed. ECT is particularly indicated when there is a risk of suicide and/or when there is a poor response to the other modes of treatment. However, ECT is not the treatment of first choice in OCD.

Psychosurgery

Psychosurgery can be used in treatment of OCD that has become intractable, and is not responding to other methods of treatment. It is worth mentioning that psychosurgery is only available as a treatment choice at a very few centres throughout the world. The best responders are usually those who have significant associated depression, although pure obsessives also do respond. The main benefit is the marked reduction in associated distress and severe anxiety.