Obsessive Compulsive Disorder

Chronic disorder characterised by a pattern of **obsessions** (intrusive thoughts, images, urges) which may lead to **compulsions** (routines involving repetitive, compulsive behaviours, or mental rituals)

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Epidemiology

- Affects ~2% of the Australian adult population
- M > F in childhood, F > M in adulthood
- Onset peaks in pre-adolescence and early adulthood with males having earlier age of onset than females

Risk Factors

- Family History
- Postpartum period
- Stress
- Adverse childhod events
- Other mental health conditions
- Greater internalising symptoms
- Higher negative emotionality
- Behavioural inhibition in childhood

Aetiology

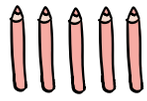
- Unknown
- Complex interplay between environment and biological/ genetic factors:
  - Serotonergic system abnormalities and other abnormal brain neurocircuitry
  - Orbitofrontal cortex, caudate and thalamus correlated by neuroimaging

- Autoimmune-related syndromes (Group A Streptococcal infections implicated in cases of rapid onset OCD associated with Childhood Acute Neuropsychiatric Symptoms (CANs) in children/ adolescents)

Types of Obsessions/ Examples of Compulsions:

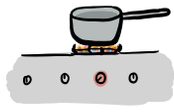
5 general dimensions:

Contamination obsessions
(e.g. excessive handwashing or cleaning rituals)



Symmetry obsessions
(e.g. repeated counting and ordering of objects)

Repugnant obsessions related to sex, violence, religion
(e.g. avoidance of trigger situations, asking for reassurance about being a good person, monitoring the news for reports for violent crimes, praying)



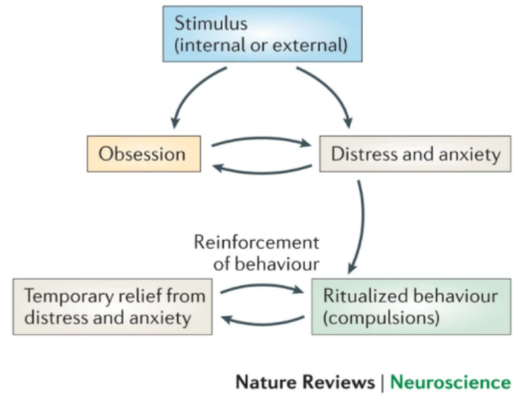
Obsessions about **causing or failing to cause harm**
(e.g. excessive checking of locks, electrical appliances, gas stoves, etc.)

Hoarding obsessions
(e.g. collection of objects)

Postpartum OCD
Intrusive thoughts and images related to harming baby, obsessions with contamination and perfectionism related to baby

Clinical Features

- Chronic, often episodic/ relapsing-remitting course
- Egodystonic (vs. ego**syn**tonic in OCPD)
- Comorbidities:
  - Anxiety disorders
  - MDD
  - Bipolar disorder
  - Tic disorders
  - Other OCD- related disorders: Body dysmorphic disorder, Trichotillomania, Excoriation disorder, Hoarding disorder
  - Alcohol and substance use disorder
  - Eating disorders



DSM-5 Criteria

A. Presence of **either** obessions, compulsions, or **both:**

Obsessions:
Defined by **1 and 2**
1. Recurrent and persistent thoughts, urges or images that are intrusive and unwanted, and cause marked anxiety or distress
2. Attempts to ignore, suppress, or to neutralise them with some other thought or action (e.g. performing a compulsion)

Compulsions: defined by **1 and 2**
1. Repetitive behaviours or mental acts that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly
2. The behaviours or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however are not connected in a realistic way

B. The obessions or compulsions are **time-consuming (>1 hour/day)** or cause **clinically significant distress or functional impairment**

C. Not attributable to a substance or another medical condition

D. Not better explained by another mental disorder

Specify if:
- With good or fair insight- individual recognises beliefs are not true, or may not be true
- With poor insight- individual thinks beliefs are probably true
- With absent insight/ delusional beliefs- individual is completely convinced beliefs are true
- Tic-related- individual has current/ past history of a tic disorder (up to 30%)

Differentials

• Generalised Anxiety Disorder: worry and anxiety may mimic obsessive thinking
• Major Depressive Disorder: ruminations may mimic obsessive thinking but in MDD are of a depressed theme
• Tic disorders: tics are involuntary whereas OCD compulsions have cognitive source
• Eating disorders: disordered eating and ritualised behaviours around food may be a component of OCD
• ADHD
• Obsessive Compulsive Personality Disorder (OCPD): pervasive pattern of behaviours which arise out of a desire for organisation, perfectionism and sense of control, without intrusive thoughts or compulsive behaviours
• Peripartum depression and psychosis: intrusive thoughts arise out of anxiety and fear of causing harm to baby in postpartum OCD

Assessment

History	Examination	Investigation
Assess functional impairment • Time spent on compulsions • Avoidance behaviours which impact social and occupational functioning • Risks to health due to avoidance of help-seeking • Dermatological conditions Check for presence of comorbidities and other OCD-related conditions Psychometric scales (e.g. Yale-Brown Obsessive Compulsive Scale)	• Vitals & BMI • Signs of self-harm • Signs of excessive hand-washing (e.g. contact dermatitis) • Signs of thyroid dysfunction (hyper or hypo) • Signs of anaemia • Signs of infectious mononucleosis • Signs of PCOS • Signs of physical abuse	• FBC,UEC,LFT • CRP, ESR • Iron, folate, B12, Vitamin D → depressive Sx • TFTs → anxiety and depressive Sx • Hormone levels • ECG • BhCG in women of child-bearing age • Urine Drug Screen

Management

Biological therapy
• Pharmacotherapy:
  - High dose SSRIs
  - 2nd line: Clomipramine (TCA with serotongergic action)
ECG recommended after dose escalation of SSRIs/ Clomipramine due to cardiac side effects
• Brain stimulation techniques (deep brain stimulation, TMS)

Psychological therapy
• Risk assessments: high rates of comorbidity and suicidality
• Psychoeducation for patient and family
• Psychotherapy
  - CBT with exposure response prevention
  - Family therapy

Social therapy
• Support groups
• Encourage aademic and occupational attainment

Lifestyle
• Encourage healthy diet and exercise
• Cessation of substance use and avoidance of substances detrimental to mental/physical health

Quiz Time!

Q: What are the predictors of good prognosis for patients with OCD?
A: Later age of onset, shorter duration of symptoms, good insight and response to initial treatment

Q: Is OCD egosynotic or egodystonic?
A: Egodystonic- people with OCD are generally aware of their behaviours and that they are not rational, and it causes significant distress

Q: What are the 3 main risks of hoarding disorder?
A: The 3F's: Food, Fires and Falls!

Q: What is trichotillomania?
A: Compulsive hair pulling in the absense of obsessions

Prognosis
• Delay in help seeking: 5-10 years
• 1/3 will develop MDD
• 1/2 experience suicidal thoughts, 1/4 attempt suicide