

TAKE-HOME NOTES:

The assessment and management of obsessive-compulsive disorder: Part 1

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Obsessive-compulsive disorder (OCD) is an illness, which can cause serious social and occupational impairment for chronic sufferers.

OCD is a common underlying reason for seeking medical help, but patients often hide their psychiatric symptoms and eventually present to doctors in non-psychiatric clinics, or when they are depressed.

Healthcare professionals, therefore, need to be vigilant and where appropriate ask direct questions to identify OCD in individuals thought to be at risk.

Most people with OCD can be satisfactorily managed in primary care, however more severe or resistant cases may require specialist input from psychiatric services.

OCD is a common condition and its lifetime and 12-month prevalence rate appear closely similar, emphasising its chronic nature. In many cases, OCD starts in childhood or late adolescence.

Once viewed predominantly as a manifestation of psychodynamic conflict, OCD is now considered to be a model neuropsychiatric disorder. In explaining its aetiology, there has been a shift from a psychoanalytical approach towards a more neuropsychiatric stance.

The pathogenesis of OCD may best be described in anatomical, neurochemical, neurocognitive, genetic and perhaps immunological terms.

Psychological theories relating OCD to abnormal risk assessment, harm avoidance and sense of responsibility still have a place in the understanding of OCD and may reflect the behavioural and emotional effects of disturbances in the underpinning neurobiology.

The main areas of psychopathology of OCD are:

- obsessions
- emotions
- compulsions
- avoidance
- safety-seeking behaviours.

Substantial lifetime comorbidity with other mental disorders has been identified, including:

- depression, which develops in approximately two thirds of cases presenting for treatment
- simple phobia (22%)
- social phobia (18%)
- eating disorder (17%)

- alcohol dependence (14%)
- panic disorder (12%)
- Tourette's syndrome (7%).

OCD shares the greatest comorbidity with depression and it has been estimated that around 12% of cases of depression also suffer from OCD.

There are a number of obsessive-compulsive related (spectrum) disorders including:

- obsessive-compulsive personality disorder (OCPD)
- hypochondriasis
- body dysmorphic disorder (BDD)
- anorexia nervosa
- Gilles de la Tourette's syndrome
- Sydenham's chorea and PANDAS
- autistic spectrum disorders
- paraphilias
- compulsive gambling.

Other disorders may have symptoms similar to those found in OCD, such as the delusions of psychosis or ruminations of mood disorders.

All patients presenting with depression or anxiety as well as those with exaggerated or medically unexplained symptoms should be screened for OCD.

There are scales used to diagnose OCD as well as to assess severity. Both of these can be subjective and observer-rated.

Reflection

(2.4) Serotonin (5-HT) reuptake inhibitor agents (SRIs) have been successful in the treatment of OCD. What might this suggest?

(2.5) What might be the role of dopamine in the pathophysiology of OCD? Can you think of instances where dopamine-blocking agents might be used in the treatment of OCD or any obsessive-compulsive spectrum disorders?

(2.10) What do you know about psychological theories in relation to the origins and development of obsessive-compulsive behaviours? How might the following theories attempt to explain them? Learning theory; Cognitive theory; Behavioural theory.

(3.1) How would you define obsessions? How are they different from schizophrenic delusions?

(3.4) Which specific emotions do you think tend to accompany the following obsessions? An obsession: that you might be responsible for preventing harm; about being touched with a perceived contaminant; of a sexual or aggressive nature; that you are responsible for a catastrophic event in the past.

(3.8) What is your understanding of the differences between compulsions and neutralising behaviours? How are they similar?

(4.4) Can you think of any clinical features you might use as markers to identify the difference between obsessive and depressive ruminations and obsessive thoughts?

(4.5) What is your understanding of the difference between obsessive-compulsive personality disorder (OCPD) and OCD? Can you think of any other differential diagnoses for OCD?

(4.11) Can you think of other areas of secondary care that might attract people with OCD?

Tables and figures

[\(1.4\) Figure 1: Anxiety disorders – epidemiology](#)

[\(3.8\) Figure 2: Common symptoms of obsessive-compulsive disorder](#)

[\(4.5\) Figure 3: Obsessions vs depressive ruminations](#)

[\(4.9\) Figure 4: Obsessive-compulsive disorder related \(spectrum\) disorders](#)

[\(4.12\) Figure 5: Non-psychiatrists likely to see patients with OCD and OC spectrum disorders](#)

[\(5.3\) Figure 6: The Zohar-Fineberg Obsessive Compulsive Screen \(Z-FOCS\)](#)

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Further reading

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Useful links

Link to download the MINI: [\[website\]](#)

Further information on the Symptom Driven Diagnostic System for Primary Care: [\[website\]](#)

Online access to the WB-DAT: [\[website\]](#)

Obsessive-compulsive inventory as a PDF: [\[PDF\]](#)

Y-BOCs as a PDF: [\[PDF\]](#)

CY-BOCs as a PDF: [\[PDF\]](#)

Padua Inventory: [\[PDF\]](#)