PRIMEVIEW

OBSESSIVE-COMPULSIVE DISORDER

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Obsessive–compulsive disorder (OCD) is characterized by the presence of intrusive and unwanted repetitive thoughts, impulses, images or urges (obsessions) together with repetitive mental acts or behaviours that an individual feels driven to perform (compulsions).

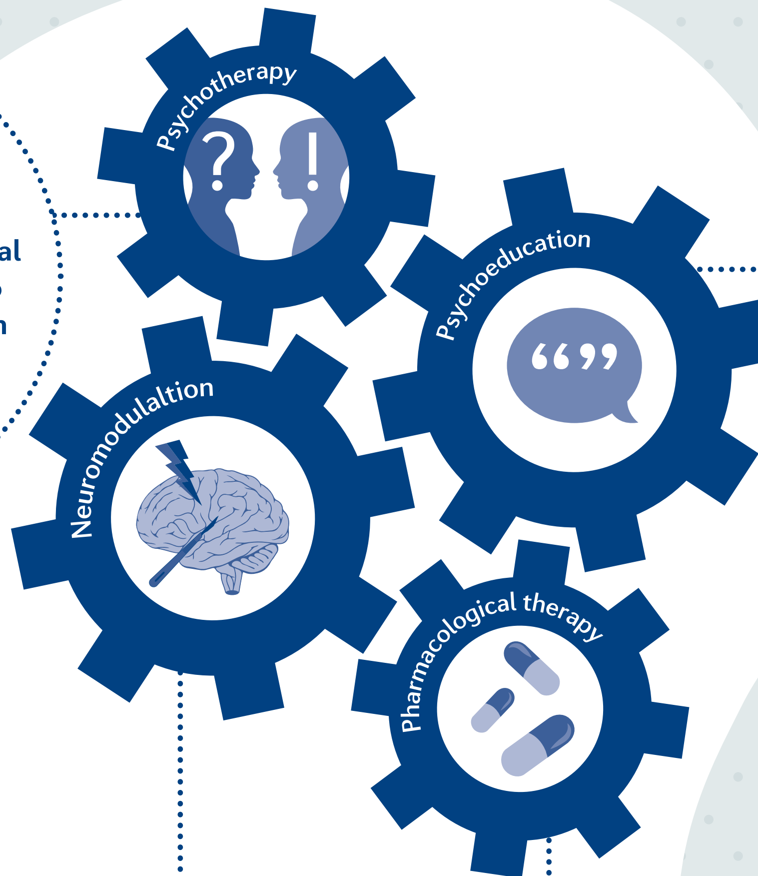
EPIDEMIOLOGY

The lifetime prevalence of OCD is 2–3% although this figure varies geographically. Almost 25% of males with OCD have onset before 10 years of age, whereas females often have onset during adolescence. Most patients with OCD have a co-occuring psychiatric disorder, of which tic disorders, anxiety disorders and mood disorders are very common.

MECHANISMS

Several cortico–striato–thalamo–cortical (CSTC) circuits are believed to have a role in OCD. These circuits are involved in habitual behaviours, executive functions, motivational behaviour and fear extinction — processes that might be dysfunctional in patients with OCD. Variants in genes encoding serotonergic, catecholaminergic and glutamatergic pathway components have been implicated in OCD, although studies have been underpowered and further investigation is required. Environmental risk factors for OCD include birth complications and stress or trauma, although the precise contribution of these factors in the aetiology of OCD requires further study.

MANAGEMENT



Exposure and response prevention is the psychotherapy of choice for OCD and involves gradual and prolonged exposure to fear-provoking stimuli, with instructions to abstain from compulsive behaviours.

Psychoeducation is useful in providing a rationale to OCD patients and their families for treatment. Techniques such as motivation interviewing may be helpful for patients with poor insight.

Neuromodulation (such as deep transcranial magnetic stimulation or deep brain stimulation) may be useful for patients with refractory OCD.

Selective serotonin reuptake inhibitors are the first-line pharmacological therapy for OCD.

QUALITY OF LIFE

In those with OCD, quality of life may be substantially reduced in all domains, including work, family and social activities. Worse illness severity, the presence of comorbid depression and some symptoms (such as hoarding) are associated with worse quality of life. Effective treatment with psychotherapy or pharmacological therapy can improve symptoms and quality of life.

DIAGNOSIS

A diagnosis of OCD requires that the obsessions and compulsions are severe enough to cause substantial distress or functional impairment. In addition, the symptoms must not be attributable to another medical condition or induced by a substance. Diagnostic criteria for OCD include specifiers to denote patients who believe that their obsessions are true (those with poor insight and those with absent insight or delusional beliefs) and those with a co-occuring tic disorder.

! Several symptom dimensions of OCD exist

OBSESSIONS	COMPULSIONS
Concerns about dirt and germs	Washing, showering or cleaning
Thoughts about harm	Checking
Forbidden thoughts	Checking, mental rituals or praying
Symmetry	Ordering, straightening, repeating or counting
Hoarding	Hoarding behaviours

OUTLOOK

OCD is often misdiagnosed and incorrectly treated, or diagnosis is missed altogether in clinical practice. Improved education of the general public and clinicians is required to address this problem. In addition, despite the availability of several effective treatments for OCD, access to these treatments, particularly cognitive-behavioural therapy, is limited in some countries. Improving treatment access is possible using internet-delivered therapy or smartphone applications, but these tools require further study.

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