Medicine for Managers

Dr Paul Lambden BSc MB BS BDS FDSRCS MRCS LRCP DRCOG MHSM

Obsessive Compulsive Disorder

What connects Leonardo Di Caprio and Florence Nightingale, Charles Darwin and Howard Hughes or John Bunyan and David Beckham? Answer; they all suffer or suffered from *Obsessive Compulsive Disorder* (*OCD*).

The condition has been known since the fourteenth century and for hundreds of years it was held to be the manifestation of being possessed by the devil. Treatment was by exorcism.

More recently Freud associated the condition with subconscious emotional conflicts and saw the characteristics as a manifestation of phobia.

Many of us feel that we are obsessive in some aspects of our lives and that we indulge in repetitive activities such as checking whether the gas is off or pursue rituals such as checking twice or three times whether the car door is locked after arriving at a destination.

So how might this differ from true obsessive-compulsive disorder? OCD is an **anxiety disorder,** the symptoms of which can be mild or severe. Obsession is a situation in which the mind is overwhelmed by unwelcome constant fear or concern about things such as the possibility of contamination by germs or the prospect of burglary. It leads to intense anxiety. Compulsions are the consequence of the anxiety and result in repetitive actions that are felt to be essential to minimise the obsessions such as repeatedly washing or showering to eliminate the perceived germs or checking and rechecking door and window locks when leaving the house.

Although the compulsive behaviour temporarily relieves the anxiety of obsessions, the symptoms soon recur.

People with obsessions may have forbidden thoughts, sexual impulses, fear of contamination or causing gratuitous harm. They may respond with compulsions involving specific placing or organising of objects, washing, repeated checking or any other repetitive actions. Patients with OCD

are not psychotic; they fully understand the thoughts that they have and the actions that they adopt. They do not understand the reasons for the compulsions but only that they must do them.

At their worst the compulsions will disrupt life because of repeated ritualistic actions which may take hours to complete and can make regular employment or a satisfactory family life impossible.

OCD affects about 1 in 50 adults. Men and women appear equally affected. The condition does run in some families raising the possibility of a genetic trait. Acute stress or sudden changes in activity may precipitate the onset.

Brain imaging has revealed that patients with OCD do show particular neurological activity and altered blood flow in some parts of the brain. It is also known that brain serotonin activity is disturbed in sufferers. People who are intelligent, neat, meticulous and thorough are more likely to exhibit OCD.

There are a number of approaches to the management of OCD. However many patients do not feel able to discuss the problems with their GPs and therefore to get access to support. Indeed not only does telling a healthcare professional make them feel self-conscious to the point of embarrassment but the symptoms cause discomfort and may result in them feeling humiliated such that they avoid telling friends and even their closest family members.

The first stage in management is to gather the courage to tell the GP who would make the initial diagnosis and would probably refer to a consultant for more detailed assessment and treatment planning. Self-help may be valuable.

Simple advice like the avoidance of alcohol as a means of controlling anxiety may be valuable. Using techniques of confronting troubling thoughts to help manage the resulting compulsive behaviour may reduce the feelings of anxiety.

Cognitive Behavioural Therapy (CBT) can be very successful. The person can expose themselves to their fears and reduce the compulsive responses, meeting the challenges one by one and gradually. The treatment is directed, not at ‘curing’ the problem, but at making it manageable, less unpleasant and not harmful until it ceases to occupy a significant place in day-to-day living.

Rather than trying to eliminate problems the approach is to modify the individual’s reaction to them. Developing the techniques is undertaken at the pace of the

person and can be done on a face-to-face basis with a psychotherapist or by telephone consultation or by the use of guided self-help using written or recorded media.

Medication using a Selective Serotonin Reuptake Inhibitor (SSRI) may help to reduce obsessions and compulsions and is used in the treatment of more moderate or severe OCD usually combined with some form of CBT. It is effective for the majority of patients but symptoms may not be controlled, in which case a different medication can be used.

Most patients obtain good results using self-help or support from a psychotherapist with or without medication. However, for between 25 and 50 percent of patients there may be some recurrence during the months or years following completion of treatment. In such circumstances a further course of treatment is provided.

In many cases a big problem can be for the family of the OCD sufferer because their activities may be irritating or frankly frustrating.

It is important to help the family to understand that the individual is not being difficult and is trying to cope with their obsessions in the best way they can. It is helpful to encourage family members to understand OCD in order to help them to tackle their challenges, avoid becoming part of their rituals and accompanying them when necessary to see the GP or other health professional.

paullambden@compuserve.com