FIVE THINGS TO KNOW ABOUT ...

Obsessive–compulsive disorder

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Obsessive thoughts and compulsive behaviours are common in children and adults and do not necessarily signify the presence of obsessive–compulsive disorder

1

Obsessions are recurrent thoughts, images or urges that are generally unwanted (ego-dystonic). Compulsions are repetitive behaviours or mental acts performed to relieve anxiety related to obsessions or according to rigid rules. Typical obsessive–compulsive themes include contamination or cleaning, checking, symmetry, ordering or counting, as well as fears of harm to self or others.[1] Community studies suggest that obsessive–compulsive symptoms occur in over 25% of adults,[1] and developmentally appropriate rituals and superstitions are common in children.

Diagnosis of obsessive–compulsive disorder requires the presence of obsessions or compulsions that are time-consuming (e.g., >1 h/d total) or cause major distress or impairment in functioning for the individual[2]

2

Obsessive–compulsive disorder (OCD) has a lifetime prevalence of 2% and is highly disabling.[1] It is strongly heritable and has a neurobiologic basis, but environmental factors also play a role. It is considered to be on a spectrum that encompasses hoarding disorder, skin-picking disorder, hair-pulling disorder and body dysmorphic disorder.[2] The differential diagnosis includes anxiety disorders, depression, complex tics, eating disorders and psychosis. Patients have varying degrees of insight into the irrationality of their OCD symptoms, and some have no insight.[2]

Controlled studies involving children and adults support the efficacy of cognitive-behavioural therapy that emphasizes exposure and response prevention[1,3]

3

In exposure and response prevention therapy, patients are exposed to situations that trigger obsessions, and they are taught strategies to prevent the compulsive response that would temporarily relieve their anxiety. Patients gradually become desensitized to the feared stimulus, resulting in improved OCD symptoms. Long-term maintenance of improvement has been shown in both children[4] and adults.[3] Information about cognitive-behavioural therapy (CBT) for OCD can be found at www.ocduk.org/cbt-video.

Important differences exist between childhood-onset and adult-onset OCD

4

The mean age of onset of OCD is bimodal, with peaks at 11 years and 23 years.[5] Early-onset OCD is more common among males, is more likely comorbid with tics and is generally more severe.[5] The course of OCD is typically chronic and fluctuating, although studies involving youth suggest that over half experience remission by early adulthood.[6]

If CBT does not improve OCD symptoms sufficiently or is not feasible, treatment with a selective serotonin reuptake inhibitor should be considered

5

The efficacy of selective serotonin reuptake inhibitors (SSRIs) for OCD in children and adults is based on multiple placebo-controlled studies.[1] Longer trials (at least 12 wk) of SSRIs are often required[7] with doses at the higher end of the approved range, leading to increased rates of adverse effects.[8] Relapse is more likely with discontinuation of SSRI therapy than with CBT.[5] Thus, CBT is the preferred first-line treatment, although SSRIs can be used as first-line treatment if CBT is not feasible or acceptable to the patient.

For references, please see Appendix 1, available at www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.131257/-/DC1

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