PSYCHIATRY

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Summarise OCD and discuss the pattern and prevalence in relation to the population of the East End of London:

Obsessive compulsive disorder (OCD) is relatively common, with an estimated prevalence of 1-2%. As the name would suggest, OCD is characterised by obsessions and compulsions. Obsessions are recurrent unwanted thoughts, images or impulses that cause a great deal of distress to the patient. Common focuses for these obsessions are:

- fear of contamination
- doubts about actions or harm occurring
- perfectionism
- religious beliefs
- violence or aggression
- sexual thoughts

Compulsions are repetitive behaviours carried out in response to an obsession. The goal of these acts is to reduce the distress and anxiety caused by intrusive thoughts by preventing or neutralising the feared obsession. Compulsions can be a physical act, such as hand washing in response to thoughts of contamination, or they can be a mental act, such as saying a particular word or phrase.

Up to 80% of the general population experience obsessions without any consequence but in patients with OCD these obsessions cause anxiety. It is thought that this happens because they have a distorted interpretation of the obsession by ascribing special meaning to these obsessions. For example, a patient may believe that having a thought is like the thought happening and by not neutralising it they have responsibility over the outcome of the thought, or there may be a belief that intrusive thoughts lead to their real life occurrence (known as thought-action fusion). Anxiety and rumination as a result of these distorted interpretations increases the likelihood of further obsessions via preoccupation with them or attempts to suppress them. Compulsions reinforce the distorted thought process regarding the intrusive thoughts due to perceived avoidance or prevention of harm achieved by carrying them out. OCD is commonly associated with avoidance of situations that cause distress, with reinforcement of this behaviour due to prevention of distress or harm. OCD behaviours are thus perpetuated.

OCD results in considerable negative impact on quality of life and comorbidity with depression is relatively common. The exact cause of OCD is unknown, but it is thought to be a combination of psychological, social and genetic factors, making each patient's individual form of obsessions and compulsions quite unique. Most patients have a degree of recognition that their OCD behaviours are irrational, but some hold their obsessions with complete conviction, making it much harder to treat.

In the context of the East End of London, the prevalence of OCD is much the same as the general population. There is however an increase in the levels of comorbidity with other

psychiatric conditions, given the lower socioeconomic status of people living in East London and the link between mental illness and lower socioeconomic status. The ethnic diversity of East London also has an impact on the presentation of patients with OCD, and particular forms of obsessions and compulsions can be wholly underpinned by cultural or religious beliefs. These can range from feelings of being a 'sinner' to paranormal beliefs and superstitions. This can present difficulties to those treating these patients as the wider community can reinforce their OCD.

Discuss principles of OCD management and current guidelines for recommended NHS treatment:

Principles of therapy for OCD involve behavioural and cognitive approaches.

Cognitive approaches aim to change the patients distorted thought processes, helping them understand the reason behind their obsessions and challenging beliefs and values they currently hold that perpetuate their OCD.

Behavioural approaches involve a technique called exposure response therapy (ERP). The principle of ERP is based on the idea that engaging in compulsions is what drives and maintains OCD. Intrusive thoughts cause the patient anxiety so they engage in compulsions and their anxiety reduces but doesn't eliminate it. Each subsequent exposure causes increased anxiety and compulsions only bring down anxiety temporarily and only to a certain degree. ERP involves deliberate exposure to distressing situations or thoughts. This causes a temporary increase in anxiety. Response prevention, i.e. resisting the urge to engage in compulsions is followed by a gradual reduction in anxiety levels, termed habituation. For example, therapy for a patient with a fear of contamination would deliberately contaminate themselves but not wash their hands or clean themselves after. Repeated exposure with response prevention leads to a decrease in anxiety in each subsequent exposure.

In the UK, NICE guidelines for the management of OCD recommend treatment based on degrees of functional impairment, indicated by a stepped care model:

- Mild impairment - low intensity approach with individual or group CBT and ERP for up to 10 therapist hours
- Moderate impairment – SSRI/clomipramine and longer duration of intensive CBT and ERP
- Severe impairment – inpatient care with intensive therapy and SSRI/clomipramine

The guidelines also places emphasis on the involvement of the MDT and family members in the approach to caring for patients with OCD.

Case Summary

(The following is a case summary of a patient with OCD seen during the elective to illustrate OCD and its management.)

NJ is a 26 year old lady with OCD, which mainly takes the form of compulsions based on perfectionism, obsessive slowness and fears of contamination.

Her OCD started in her teens, beginning with very specific washing rituals that had to be carried out perfectly and symmetrically. She has a poor academic record due to the time consuming and perfectionist nature of these rituals.

NJ believes that her OCD is genetic in origin. Her father has OCD (which similarly takes the form of perfectionism) and she describes her mother as 'super clean and tidy'. NJ also acknowledges other factors that have contributed to her OCD, specifically an incident at age 7 involving sexual abuse by a relative. She feels that she had no control over the situation, and relates control to safety. She transfers the idea of being in control to safety in unrelated everyday tasks. She also describes thoughts of being inherently unclean and so feels she must compensate for this by excessive washing.

Her OCD has been the subject of much family and marital discord. She has self harmed twice in the past, both following family arguments.

NJ has had CBT twice before, making much progress during her second course of therapy that took place before her marriage. She was under the care of the Perinatal Mental Health Team after giving birth and was admitted to the Mother and Baby Unit a few months after giving birth due to concerns over her ability to care for her child. She would become engrossed in her rituals and ignore the needs of her baby for long periods or she would involve her baby in her OCD, e.g. taking 50 minutes to change her nappy and wiping excessively.

She now lives with her husband and 1 year old daughter. Social services are involved in her case due to continuing concerns about child safety and domestic violence. She is currently a few months into another course of psychotherapy, involving intensive ERP via weekly therapy sessions and home visits, and has made definite steps towards fighting her OCD.

Describe your involvement in this patient's therapy and discuss any difficulties:

I became involved in NJs care four months into her course of therapy. I was chosen to help her as she came from a similar background as me, a British born South Asian Muslim, and it was felt that my contribution to her therapy in her home would firstly be acceptable to her family (where it would be inappropriate for the male consultant) and would also help her engage in her therapy more than she had been so far. I feel that coming from a similar background helped me relate to NJ a great deal and I could understand the cultural aspects of her feelings and frustrations about her family and married life. I built a good working relationship with her very quickly and found that she confided certain aspects of her OCD she had kept hidden for months to me, which made a real impact in her progress.

My role in her therapy was to visit NJ in her home on a regular basis and to observe her completing her household tasks and to do ERP therapy with her. I would establish what her OCD was telling her to do, and then trying to facilitate her therapy by getting her to do things in the opposite way, which in her case was performing everything imperfectly and asymmetrically. The aim of my presence was to help her recognise areas being affected by her OCD and work towards finding ways to approach them in a non-OCD manner, with an ultimate goal of her becoming her own therapist and not needing the presence of a co-therapist. At first I felt I made real progress with NJ in this regard, but it soon became clear that she was very good at pretending to do her therapy, hiding her rituals and changing the subject. I found I often had to ask my more experienced seniors for strategies to tackle these problems. It was very difficult to keep patient with NJ as I felt both of our time was being wasted by these actions and because I knew that the future of her daughter was in the middle of all of this. My supervising consultant gave me some very good techniques to use with her, including the 'Stuck Record Technique'. These were invaluable in helping me during our sessions and I have no doubt I will use these in my general practise of medicine with difficult patients.

Her Obsessive Compulsive Inventory (OCI) scores are shown in the graph below. The improvement from week 17 (when I started the elective) to week 24 (when I finished) is objective evidence of NJs progress with her therapy through regular home visits.