Everyday Practice

Diagnosis and treatment of obsessive–compulsive disorder

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INTRODUCTION

Obsessive–compulsive disorder (OCD) is characterized by repeated distressing thoughts (obsessions) and/or repetitive behaviours (compulsions). Obsessions occur in the form of thoughts, images or urges, which are often distressing and perceived as unwanted. Compulsions are repetitive voluntary motor or mental acts which are done to reduce distress due to obsessions or according to rigid rules.

OCD is a common condition with a lifetime prevalence of 2%–3% in the community.[1] It is one of the most debilitating neuropsychiatric disorders[2] and is often underdiagnosed and untreated.[2] The prevalence of OCD is around 4% in primary care settings[3] but is often misdiagnosed.[4] With the decreased availability of specialists in many regions of the country, there is a need for increased awareness about the diagnosis and management of OCD amongst general practitioners and primary care physicians.

We discuss the common clinical presentations, diagnosis and management of OCD in the community setting. We also discuss when it would be appropriate to refer the patients for specialist care.

OCD: ONSET, COURSE AND OUTCOME

OCD has a bimodal age-at-onset, with peaks during childhood and early adulthood,[5] with a majority of patients developing symptoms before 20 years of age.[6] Males have an earlier age at onset compared to females. The course of OCD is typically described as a chronic one with waxing and waning. However, an episodic course of the illness is also known.[7,8] It affects people in the crucial developmental stage, causing major morbidity and impairing their quality of life.

AETIOLOGY

Although the aetiopathogenesis of OCD is not completely understood, there is evidence to implicate genetic and specific neuronal circuits. The heritability of OCD is estimated to be 45%–65% in childhood-onset OCD[9] and 27%–47% in adult-onset OCD.[9,10] Studies have pointed to dysfunction in fronto-striatal circuits and specific neurotransmitters (e.g. serotonin, dopamine, glutamate),[11] which have guided the development of effective treatments for OCD.

ASSESSMENT

It is imperative to establish a clinical diagnosis of OCD and its comorbid conditions before formulating a management plan. Assessment of the severity of illness will help in adapting the plan for the needs of the patient.

Establishing diagnosis

As in other psychiatric disorders, the diagnosis is established through detailed clinical evaluation. Structured diagnostic interview schedules such as Structured Clinical Interview for Diagnostic and Statistical Manual 5th edition (DSM-5) (SCID-5 Clinician or Research version)[12] and diagnostic interview for Anxiety, Mood and Obsessive Compulsive and related disorders (DIAMOND) are available for both adults[13] and children.[14] They are time-consuming and not practical to administer in routine clinical settings. A clinical history is often adequate for diagnosis in the majority of cases. The International Classification of Diseases 11th edition and the DSM-5 provide explicit diagnostic criteria for diagnosing all psychiatric disorders, including OCD (Table I).

The obsessive thoughts and compulsive actions are often centred around a few common themes (Table II). Although patients can present with more than one theme, it is generally consistent throughout the illness. There are specific scales, such as the Dimensional Obsessive–Compulsive Scale and Yale–Brown Obsessive–Compulsive Scale (Y-BOCS) checklist for adults and children, which can be used to assess various types of obsessions and compulsions.

Other important terminologies in the context of OCD are:

1. Avoidance: It is a common behaviour where a person engages in avoiding triggers to reduce negative outcomes based on their fears (Table II).[15]
2. Mental compulsions: Compulsions can occur as voluntary mental acts (as opposed to physical behaviours) in some patients, e.g. mental reviewing, checking, self-reassurance, etc., which can be equally distressing and time-consuming.[16]

Comorbid conditions

A meta-analysis found psychiatric co-morbid conditions in 69% of patients of a pooled sample of OCD patients.[17] The most common are mood disorders, followed by anxiety disorders.[17]

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[To cite: Tholasappa V, Arumugham S. Diagnosis and treatment of obsessive–compulsive disorder. *Natl Med J India* 2025;**38:**104–7. DOI: 10.25259/NMJI_511_2024]

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Table I. Diagnostic criteria for obsessive–compulsive disorder (OCD) based on ICD-11

Obsession	*Compulsions*
• Repetitive and persistent thoughts, images, impulses/urges • Experienced as intrusive unwanted • Anxiety provoking • Attempts to reduce anxiety by ignoring/suppressing/neutralising by performing compulsions • Time consuming (>1 hour)	• Repetitive behaviours, either physical or mental acts. • Individual feels driven to perform in response to an obsession • Are performed according to rigid rules or to achieve a sense of completeness
• Not a manifestation of any other health condition, substance use or medication-related and not better explained by any other mental and behavioural condition	
• Results in significant distress or significant impairment in functioning	
Insight Insight refers to a person's ability to recognise OCD-related thoughts are not true and/or excessive Two levels are described in ICD 11 as follows: – Fair to good insight: when a person entertains that their beliefs are mostly untrue – Poor to absent insight: convinced that the OCD beliefs are true and do not accept alternate explanations	

ICD 11 International Classification of Diseases 11th edition

Table II. Common obsessions, compulsions and associated behaviours seen in patients with obsessive–compulsive disorder (OCD)[24]

Obsession	Description	Compulsion	Avoidance
Fear of contamination	Germs, viruses/blood/sticky substances	Cleaning and washing Disinfecting and sterilizing	Avoidance of feared contaminants, e.g. public bathrooms, crowded places
Fear of harm/over the responsibility of harm	Possibility of harming someone or themselves by carelessness/ negligence	Checking This may also include repeating safety prayers, counting, analysing a situation	Avoiding driving in fear of causing an accident, etc.
Unacceptable thoughts: fear of committing acts that violate personal beliefs and moral values	Sexual or blasphemous thoughts/ images/urges	Ritualizing behaviour: praying, mental counting and reassurance seeking	Avoidance of children care facilities, religious practices/places
Need for symmetry and exactness	Need for feeling just right May or may not be associated with fear of causing unrelated events (a/k/a magical thinking)	Ordering and arranging	Avoidance of certain routine activities due to compulsive slowness

Mood disorders: Depressive disorders are more common but bipolar disorder also occurs at increased rates compared to the general population.

Anxiety disorders: Panic disorder, generalized anxiety disorder and social anxiety disorder are common.

Other obsessive–compulsive-related disorders: Body dysmorphic disorder, body-*focussed* repetitive behaviours, hoarding and hypochondriasis can co-exist.

Psychotic disorders: OCD symptoms can occur in patients with schizophrenia or sometimes as an adverse effect of specific antipsychotic medications (e.g. clozapine).

Neurodevelopmental conditions: Attention–deficit hyperactivity disorder, autism spectrum disorder and tic disorders are commonly seen in childhood-onset OCD.

Others: Personality disorders, substance use disorder, etc. are known to co-occur commonly in OCD increasing both treatment complexities and morbidity of illness.

Suicide: Studies report the suicide attempt rate to be between 12% and 27%.[18] Hence, it is always important to look for the risk of suicide in any patient diagnosed with OCD.

Neurological disorders: OCD is also described in neurological disorders involving basal ganglia dysfunction such as Huntington's disease, Sydenham chorea, dementia and ischaemic stroke.

Differential diagnosis

1. Anxious preoccupations in generalized anxiety disorder and depressive rumination in depression might resemble obsessions. However, a patient does not recognize these thoughts as excessive/irrational, and they are not associated with compulsive rituals.[19]
2. A person with an obsessive–compulsive personality disorder may be meticulous in day-to-day activities and have preoccupations about orderliness. These are often not associated with repetitive behaviours and may not be considered irrational.[19]
3. Poor insight in OCD may need to be differentiated from delusions in schizophrenia. Accompanying compulsions to reduce anxiety associated with obsessions suggest a diagnosis of OCD, while the presence of hallucinations, affective blunting and other psychotic symptoms suggests a diagnosis of psychosis.[20]

The Y-BOCS scale for adults and children is the gold standard for assessing the severity of OCD.[21]

TREATMENT

The detailed assessment as described above helps in establishing a therapeutic alliance and in formulating a holistic treatment plan, which involves pharmacological and psychological approaches.

Psychoeducation

It forms an important component of treatment. Emphasizing that their symptoms are a manifestation of a disorder with a label often reassures the patient and decreases stigma. The link between obsessions and compulsions, the course and treatment strategies available and the need for long-term follow-up have to be discussed.[22]

TABLE III. Recommended doses and adverse effects* of serotonin reuptake inhibitors (SSRI) used in obsessive–compulsive disorder (OCD)

Drug	Recommended doses	Side-effects/drug interactions*	Child and adolescent	Elderly population	Perinatal population
Escitalopram	20–40 mg	Dose-dependent QTc prolongation, minimal pharmacokinetic interactions	Treatment-emergent agitation and suicidal thoughts can occur Fluoxetine, fluvoxamine, sertraline and clomipramine are FDA-approved for the treatment of OCD in children and adolescents	Dose-dependent QTc prolongation, hyponatraemia, syndrome of inappropriate antidiuretic hormone secretion, increased risk of bleeding Drug interactions might pose additional risks in the elderly hence prompt monitoring for the same is essential.	Paroxetine is under Category D by the US FDA, while all other SSRIs are under Category C. SSRIs might not significantly affect inability to conceive or increase the risk of malformation. However, increased risk for postpartum haemorrhage, *in utero* neonatal exposure to SSRI can increase the risk for persistent pulmonary hypertension and neonatal behavioural syndromes though absolute risk remains less. Hence, risk associated with mental illness vs SSRI on pregnancy may be considered in decision-making. Regular antenatal and postnatal checkups are warranted
Fluoxetine	60–80 mg	Higher rates of anxiety, agitation and weight loss Inhibits P4502C, P4502D6, P4503A			
Fluvoxamine	200–300 mg	Higher rates of gastrointestinal disturbances Inhibits P4502C, P4502D6, P4503A			
Paroxetine	40–60 mg	Sleep disturbances, discontinuation syndrome and sexual side-effects Inhibits P4502D6, P4503A			
Sertraline	150–200 mg	Gastrointestinal side-effects are common Inhibits P4502C			
Citalopram	40–60 mg	Dose-dependent QTc prolongation			
Venlafaxine	225–300 mg	Dose-dependent blood pressure elevation, more frequent arrhythmia than SSRI			
Clomipramine	150–225 mg	Higher anticholinergic, cardiac and neurological side-effects.			

FDA Food and Drug Administration *All SSRIs can cause adverse effects such as gastrointestinal disturbances, sexual dysfunction, weight gain and sleep disturbances. Individual SSRIs have increased propensity towards particular adverse effects and drug interaction, which are highlighted in the table

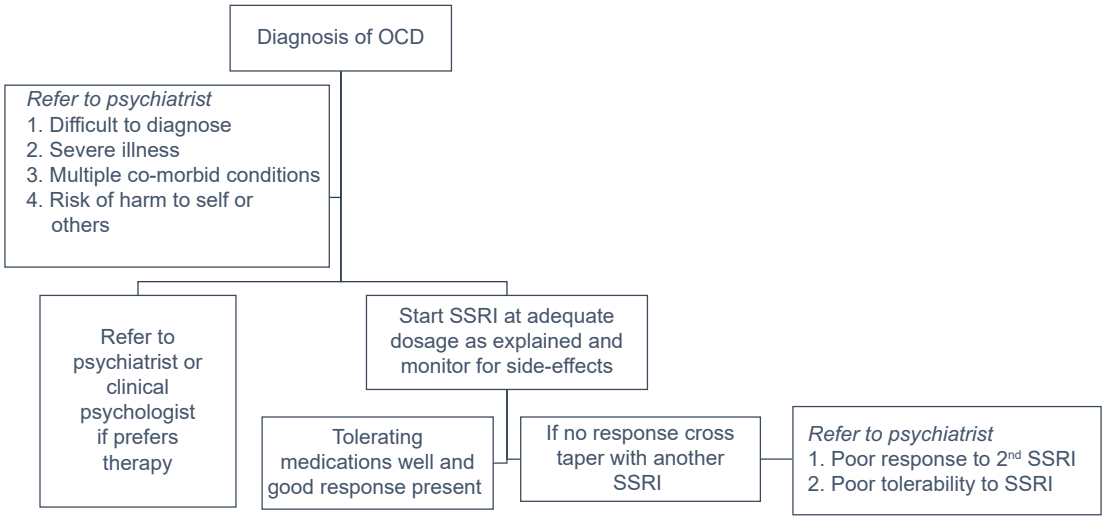

FIG 1. When to refer a patient with obsessive–compulsive disorder (OCD) for specialist care SSRI selective serotonin reuptake inhibitor

Pharmacological treatment

Selective serotonin reuptake inhibitors (SSRIs) are the first-line treatment for OCD and have shown consistent efficacy and better tolerability in multiple randomized controlled trials and meta-analyses.[2,22] No SSRI is found to be superior over others in terms of efficacy. Hence, factors such as cost, adverse effects and previous response are to be considered while choosing between SSRIs (Table III).[23–29] Guidelines recommend upward titration to maximum tolerable doses within 4–6 weeks and further continuation for 6–8 weeks for an adequate trial.[22]

The adverse effects include gastrointestinal disturbances, sexual dysfunction, weight gain, drug interactions and hyponatraemia, which are common amongst all SSRIs. Serotonin syndrome is a rare complication due to overactivation of both central and peripheral serotonergic receptors and can cause a range of severity between triads of altered sensorium, autonomic hyperactivity and neuromuscular abnormalities (rigidity and myoclonus). Hence, caution must be exercised while titrating doses and cross-tapering. Individual differences in side-effects amongst SSRIs and propensity for side-effects/drug interactions pertinent to specific population groups are discussed in Table III. Considering the cost, availability, ease of titration and decreased propensity for drug interactions, escitalopram may be acceptable for many patients.

Around half the patients may respond to their first trial of SSRI. In case of treatment failure, trial of another SSRI can be considered. If there is a partial response to an SSRI,

augmentation with cognitive behaviour therapy (CBT), low-dose anti-psychotics (risperidone 2 mg or aripiprazole 10–15 mg) or glutamatergic agents (memantine 20 mg) can be considered. Due to poor tolerability, clomipramine can be considered if there is a poor response to at least 2 SSRIs.

CBT can be provided as a standalone treatment for mild-to-moderate OCD. It can also be used as an augmentation in partial responders/non-responders to medication. Exposure and response prevention is the recommended therapeutic technique. However, this should be provided by a trained therapist. Hence, referral to a psychiatrist/clinical psychologist may be provided if CBT is preferred.

Referral to specialist care

Referral to specialist care may be required in certain situations (Fig 1). Indications for referral include (i) severe illness, (ii) non-responsive to first-line treatments, (iii) need for CBT, and (iv) presence of severe psychiatric comorbid conditions/suicidal thoughts.

SUMMARY AND CONCLUSION

OCD is a common psychiatric disorder with onset usually during adolescence or early adulthood. Untreated OCD often runs a chronic course. Detailed assessment of the symptoms, severity and comorbid conditions may help plan management strategies. First-line treatments such as SSRIs and CBT are helpful in the majority of patients. Early diagnosis and treatment in primary healthcare settings is a feasible option and helps reduce the overall disease burden.

Conflicts of interest. None declared

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