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# Obsessive-compulsive disorder

## The role of the GP

### Background

Obsessive-compulsive disorder (OCD) is a mental illness that causes high levels of morbidity and is commonly associated with long delays between onset of symptoms and access to diagnosis and treatment.

### Objective

To address some of the key clinical questions about detecting and managing OCD from the general practice perspective.

### Discussion

General practitioners play a crucial role in recognising OCD, in facilitating timely access to evidence-based therapies and providing ongoing follow-up and support. Exposure and response prevention, and selective serotonin re-uptake inhibitors have the strongest evidence for efficacy in patients with OCD.

### Keywords

obsessive-compulsive disorder; anxiety disorders; general practice



The prevalence of obsessive-compulsive disorder (OCD) in a 12-month period is estimated at 1.9% of the Australian adult population.<sup>1</sup> While symptoms commonly originate in childhood, the main time for presentation is in late adolescence or adulthood. Neurobiological, developmental and cognitive behavioural models have been proposed to account for the disorder, which consists of a highly heterogeneous group of symptoms, comprising obsessional thoughts, compulsive behaviours and related avoidance.<sup>2</sup> The general practitioner (GP) has a crucial role in recognition of this condition, in arranging access to the most effective treatments and in following up patients over time, given the tendency for OCD to be a relapsing, remitting condition with a high rate of psychiatric comorbidity. These three issues (recognition, referral and follow-up) are the main focus of this article.

### Recognition

*'Our patients all believe that their thoughts are odd or crazy; they are embarrassed by their habits and teased by their friends. They keep their ideas and actions secret; indeed some become brilliant actors at hiding their thoughts or rituals.'* (Dr Judith Rapoport, *The Boy Who Couldn't Stop Washing*)<sup>3</sup>

Obsessive-compulsive disorder (OCD) has been classified by the World Health Organization as one of the top 10 most disabling diseases with respect to loss of income and quality of life.<sup>4</sup> Yet it is a condition that is well known for long delays between symptom onset and access to appropriate treatment.<sup>5</sup> This requires the GP to be alert to the possibility in patients known to be at higher risk of OCD, including those with anxiety, depression, alcohol or substance misuse, eating disorders, body dysmorphic disorders and some chronic physical health problems (the classic example being dermatological problems due to excessive hand washing).<sup>4</sup> In the authors' experience, patients with chronic depression that has failed to respond to several medications and talking therapies are a group in which OCD is frequently present and often concealed.

As the very act of consulting a doctor can be anxiety provoking or potentially stigmatising for people when they are unwell, it can be challenging to detect the more intrusive symptoms experienced by those with true OCD. The detection of OCD is also challenging because



obsessional personalities are common across the population (including, of course, in the medical profession). Key features that define OCD are listed in *Table 1*. While most GPs will be familiar with the common OCD complaints of repetitive checking or washing, it is often the other dimensions of OCD that are particularly difficult to recognise in the primary care setting. In fact, research has shown that there are at least five dimensions within which obsessions and compulsions frequently co-occur<sup>6</sup> as outlined in *Table 2*. However, a range of more idiosyncratic thoughts, images and even urges, together with related compulsive actions are also properly diagnosed as OCD. Any recurrent, anxiety-provoking thoughts that are seen as intrusive and involuntary and are recognised as exaggerated, excessive or against the person's own belief system should be reviewed as possible OCD symptoms.<sup>7</sup>

Alongside heightened awareness, the GP may need to ask fairly direct questions that explore both thoughts and behaviours across all five dimensions. *Table 3* provides some suggested questions to support disclosure of these symptoms, identified in the literature and based on conversations with our own patients. It is recommended that GPs try a selection of these questions until they find a combination that feels comfortable for them. Most experienced GPs will be able to recall encounters with patients who reveal obsessional thoughts that are so unusual they can lead one to misdiagnose a psychotic illness. In such instances, taking the time to enquire about specific OCD symptoms and the patient's insight into these symptoms can make a major difference to the treatment path one might follow in such cases.

*The very first thing the dietician said to me was "you can tell me the thoughts, I assure you I have heard everything". I'm not sure that she said she wouldn't judge me, but that's how I felt – that I wouldn't be judged and I was safe.* (Female patient with OCD, who had been seeing a psychologist for help with an eating disorder for several years before she was correctly diagnosed and treated)

Clearly, to facilitate patients talking about symptoms that they may feel ashamed or embarrassed about requires considerable skill. Non-judgemental language and the willingness to establish rapport over time can increase disclosure. This may have a therapeutic advantage via the mechanism of gradual exposure to the cognitive and physiological stresses that can accompany disclosure. In turn, this may lead to a desensitisation and allow the opportunity to challenge the individual's private interpretations of their thought processes.<sup>8</sup> A caring GP, by gently exploring the patient's thoughts and behaviours, can prepare the way for a referral for specific psychological interventions by reassuring the patient that disclosure in a safe environment will not lead to ridicule and that their symptoms are not a sign of impending insanity, but are a specific mental disorder that has the potential to improve with appropriate treatment.

## Treatment and referral

The treatment options with the strongest evidence in OCD are cognitive-behavioural therapy (CBT) and prescription of selective serotonin re-uptake inhibitors (SSRIs).<sup>7</sup>

**Table 1. ICD-10 definition of OCD<sup>12</sup>**

- Recurrent obsessional thoughts OR compulsive acts.
- Obsessional thoughts are ideas, images or impulses that are repetitive, stereotypical and usually distressing. Patients recognise them as their own thoughts, but they are involuntary, often repugnant, and the patient often tries to resist them.
- Compulsive acts are repetitive, stereotypical behaviours that the patient does not find pleasurable. Their function is to prevent some objectively unlikely event, yet the patient recognises the behaviour as pointless or ineffectual. Repeated attempts to resist invariably leads to anxiety.

**Table 2. Five dimensions of OCD<sup>6</sup>**

Obsessions about causing or failing to prevent harm; checking compulsion
Symmetry obsessions; ordering and counting rituals
Contamination obsessions; washing and cleaning rituals
Repugnant obsessions related to sex, violence, religion
Hoarding obsessions; compulsions to collect and retain objects

With respect to CBT, the only psychological therapy with a substantial evidence base for OCD is exposure and response prevention (ERP), with a cited response rate of 83%.<sup>9</sup> ERP is designed to teach patients to confront fears and stop rituals and avoidance, whilst also improving their capacity to tolerate uncertainty. As outlined in *Table 4*, the patient (with the help of their therapist) creates a list of their obsessions and compulsions. The patient lists a hierarchy of situations that trigger obsessions and therefore compulsions, and situations that they avoid, ordered from the least to most anxiety provoking. The patient is then supported to confront the actual stimulus for anxiety (exposure in vivo) or the specific intrusive thoughts, images or doubts in their thinking (imaginal exposure). This confrontation is accompanied by practise at restricting and eventually ceasing compulsive rituals.<sup>6</sup>

With respect to pharmacotherapy, the tricyclic antidepressant clomipramine was the first medication that demonstrated efficacy in the treatment of OCD.<sup>3</sup> In more recent years, SSRIs have tended to supplant clomipramine due to their lesser side effects and greater safety profile.<sup>10</sup> Despite similar efficacy of the different SSRIs<sup>11</sup> not all SSRIs are subsidised on the Pharmaceutical Benefit Scheme for treatment of OCD (see [www.pbs.gov.au](http://www.pbs.gov.au) for further information).

In choosing which intervention to recommend, GPs should be aware that the response rate for ERP is equal (if not superior) to medication<sup>2</sup> and the relapse rate is lower.<sup>6</sup> Some caveats to consider include access to a psychiatrist or psychologist experienced in ERP, patient preference (ERP can provoke anxiety and drop-out rates of 25% have been noted<sup>5</sup>) and affordability. This final issue is important in the Australian context,



**Table 3. Suggested questions (compiled from the literature,<sup>4</sup> patient suggestions and our own clinical practice)**

Do you check things a lot?  
 Do you wash or clean a lot?  
 Do your daily activities take a long time to finish?  
 Do you have to do things over and over, even though you don't want to?  
 Are you concerned about putting things in a special order or are you very upset by mess?  
 Is there any thought that keeps bothering you that you would like to get rid of, but cannot?  
 Do you have any rituals or routines that you have to follow every day?  
 Troubling thoughts can really affect our mood and way of life; do you think this could be the cause of your anxiety?  
 Do other people often tell you that your home is cluttered or that you have problems with throwing things out?  
 (NB: it is not uncommon for hoarders to deny that it is a problem for them)  
 Do these problems trouble you?

where Medicare currently provides rebates for up to 10 sessions with a psychologist for patients with a GP Mental Health Treatment Plan (under the Better Access to Mental Health Care initiative), yet evidence from OCD studies suggest between 13 and 20 treatment sessions are optimal.<sup>5</sup>

Certainly, if a patient is going to embark on psychological treatment for OCD, it is prudent for the GP to ensure they are referring to a therapist with specific experience in ERP. While the websites of the Royal Australian and New Zealand College of Psychiatrists and the Australian Psychological Society have search directories to assist in finding psychiatrists and psychologists who will treat OCD, it is the authors' experience that not all of these providers offer ERP. Therefore more informal referral networks may need to be established to link up with therapists who are able to offer ERP. One option is to make contact with mental health professionals in your region via the Mental Health Professional Network ([www.mhpn.org.au](http://www.mhpn.org.au)) and/or enquire directly about the provider's familiarity with ERP. Regardless of the time needed to find the right therapist for a patient with OCD, we recommend avoiding a rushed referral process. Nothing is more frustrating for anxious or ambivalent patients than to be referred to a second or third therapist. Furthermore, it is evidently unhelpful to continue with inappropriate or ineffective treatment.

*'One of the worst things about OCD is the intrusive thoughts. The intrusions are usually always the reason behind my obsessional behaviour such as excessive hand washing and checking. These thoughts can pop in at any time and cause a great deal of annoyance in my day. When I was un-medicated, the thoughts were debilitating.'* (Female patient with OCD who commenced medication after symptoms increased in the post-natal period)

Approximately 40–60% of patients are expected to have a response to SSRIs, whether they are used as first-line or add-on therapy to ERP.<sup>5</sup>

**Table 4. Exposure and response prevention (ERP) therapy**

- Exposure involves confronting what you fear, usually using graduated, specific and prolonged tasks
- Response or ritual prevention is the complete cessation of all rituals, both behavioural and/or mental
- It does not involve addressing underlying issues

ERP process

1. Identification of the different types of obsessional fears (eg. contamination, harm, loss) and associated avoidances in interview with therapist or via checklist.
2. Initial treatment focuses on fears at lower or moderate levels in many cases.
3. Development of a list of all situations feared or avoided.
4. Creation of an exposure hierarchy – a ranked order of situations that cause anxiety using Subjective Units of Distress (SUDS) scale from 0–100.
5. Review of items on hierarchy to ensure that a range of situations that are not dangerous but are perceived as such are included and not avoided, eg. touching hands to floor then to clothes and skin.
6. Deliberate exposure to feared situations with patient accepting anxiety and uncertainty without performing rituals at the time or later.
7. Patient instructed to stay with anxiety and not distract or neutralise until anxiety drops substantially.
8. Immersion in feared situation encouraged such that escape, avoidance or rituals impossible or unsuccessful in reducing anxiety, eg. spreading contamination to self, items within home, other family members, the world.
9. Best to start at lower levels of anxiety and slowly move up to more difficult tasks.
10. Proceed to next task after body 'gets used to' fear and the process of habituation occurs.
11. ERP work proceeds upwards until all tasks complete.
12. Development of maintenance plan to prevent lapse or relapse.

Most patients have a partial response to SSRIs, with an expected mean improvement in symptoms of 20–40%.<sup>5</sup> The estimated number of patients needed to treat for SSRIs in OCD has been calculated at 6–12.<sup>11</sup> If a patient does not respond to one SSRI, it is reasonable to try a different one in the same class, but note that the doses required are usually higher than those commonly used for treating major depression, and an adequate therapeutic trial is usually longer, of the order of 8–12 weeks.<sup>5</sup> Once response is achieved, maintenance of treatment is advised for 6–12 months for first presentations.<sup>10</sup> More intensive inpatient ERP therapies, augmentation with other medications and neurosurgery are reserved for more severe cases<sup>5</sup> and require consultation with a psychiatrist with specific expertise in this field.

**Follow-up**

While treatment for OCD is effective in many patients, it is also true that many patients receive only partial remission of their symptoms and the course of the illness can fluctuate over time, often with no clear



reason for a relapse of symptoms. Alongside the GP's important role in case detection is the requirement to support people with OCD in the longer term. Being familiar with the obsessions and compulsions of individual patients and asking if these have altered over time can facilitate pro-active attention to new issues as they arise, and foster a culture against concealment. One strategy is to record a relapse-prevention plan tailored to the individual patient, which highlights potential stressors, triggers and exposure tasks that the patient and their family should be aware of. Similarly, the GP can play a role in steering people away from interventions that probably won't work, like benzodiazepines or psychoanalytic psychotherapy.<sup>7</sup> Interestingly, relaxation strategies, which GPs might commonly suggest to other anxious patients, are not effective in OCD, and in fact are often used as a control treatment in research trials.<sup>5</sup> The GP can certainly play a vital role in encouraging patients to stay on medication and persist with therapy.

In the long-term, the GP can offer patients with OCD and their families ongoing psycho-education about the condition. A number of useful online resources and support groups can facilitate this process,<sup>7</sup> including [www.arcvic.org.au](http://www.arcvic.org.au), [ocfoundation.org](http://ocfoundation.org), [www.ocdaction.org.uk](http://www.ocdaction.org.uk) and [www.ocduk.org](http://www.ocduk.org)

Additional simple fact sheets about the condition can be found on Australian websites such as [au.reachout.com](http://au.reachout.com) and [www.sane.org](http://www.sane.org)

## Key points

- Obsessional thoughts and compulsive behaviours are key to the diagnosis of obsessive-compulsive disorder (OCD).
- Patients will often conceal these symptoms, which are recognised as illogical or irrational by the patient, leading to resistance and anxiety.
- GPs need to pro-actively ask about OCD symptoms in patients presenting with anxiety, depression, alcohol or substance misuse, eating disorders and some physical conditions (eg. chronic dermatitis).
- Exposure and response prevention is the psychological therapy with the best evidence for efficacy in OCD.

## Summary

In conclusion, the GP has a key role to play in the recognition and appropriate referral of patients with OCD. Because of the patient's tendency to conceal symptoms, the GP needs to take extra steps to explore anxiety symptoms in all patients at higher risk of OCD. Providing accurate advice about treatment options and ensuring interventions are based on the best available evidence are crucial, if optimal outcomes are to be achieved in this patient group.

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