Editorials

Friday the 13th and obsessive compulsive disorder

Better understanding has brought some success in treatment

Most readers of this journal are probably not superstitious. They are unlikely to change their behaviour this Friday the 13th despite a study showing significantly more road traffic accidents on Friday the 13th than Friday the 6th. They might, however, "touch wood" or choose a lucky number in the national lottery. People who are superstitious take it further. They see a causal relation between their own thoughts or actions and events in the world. Superstitions flourish whenever people cannot tolerate uncertainty or believe that they have no control over events; they lead us to believe that we can influence outcomes. Superstitiousness correlates significantly with the obsessional thoughts and compulsive checking experienced by people with obsessive compulsive disorder.

Obsessive compulsive disorder consists of obsessions or compulsions or, most commonly, the two combined. Obsessions are recurrent intrusive thoughts, images, or urges that cause considerable anxiety or disgust. Typical obsessions concern contamination, misfortune, violence, blasphemy, and sex. Compulsions are thoughts or actions that a person feels driven to repeat. They include ritualistic cleaning, checking, counting or touching of objects, hoarding, and superstitious behaviour. According to one cognitive model, people with obsessive compulsive disorder experience fusion of their thoughts and actions. Having a
bad thought (about, for example, abusing a child) becomes morally equivalent to doing the act itself, while failing to prevent a bad event becomes equivalent to being responsible for the harm inflicted.

A recent epidemiological survey in the United States found that obsessive compulsive disorder was the fourth most common psychiatric disorder in the community but that many sufferers did not seek help or took up to 10 years before consulting a health professional. Sufferers typically try to suppress intrusive thoughts. They may also try to neutralise them by using mental rituals such as counting to 10 or reciting simple rhymes to themselves. These attempts to suppress or neutralise intrusive thoughts can, however, make matters worse, since they tend to reinforce the obsessive compulsive behaviour patterns.

Our understanding of the biological correlates of obsessive compulsive disorder has progressed, allowing us to integrate biological and psychological models. Of particular interest have been reports suggesting that people with the disorder have smaller caudate nuclei than healthy controls, leading to inadequate filtering of outputs from the orbitofrontal region of the brain.

The main options for management are behaviour therapy, cognitive therapy, and treatment with drugs. In behaviour therapy the patients are helped to face the situations that they have been avoiding and to resist ritualistic responses to their compulsions. About a quarter of patients, however, either decline such treatment or drop out once it has started. Of those who participate, about three quarters respond well. Some patients may benefit from establishing their own programme of behaviour therapy with the help of lay volunteers. Cognitive therapy entails teaching patients to recognise obsessions simply as thoughts. Patients are encouraged to make realistic estimates of the likelihood of a
bad event actually happening and of the degree of their responsibility for it if it did happen. A recent trial suggests that cognitive and behavioural therapy are equally effective,\textsuperscript{9} and there is growing interest in integrating the two. For those who decline behavioural and cognitive therapy or who do not respond fully, the treatment of choice is antiobsessional drugs, either potent or selective serotonin reuptake inhibitors.\textsuperscript{10} About 60\% of patients will respond, with on average a halving of symptoms even in the absence of depression. Patients may need to be given the highest tolerable dose for up to 12 weeks to achieve the full response. In patients with a comorbid tic disorder the addition of a neuroleptic drug may improve the outcome.\textsuperscript{11} Stopping treatment frequently leads to relapse. To reduce the risk of relapse patients should continue treatment long term or be treated with a combination of drugs, behaviour therapy, and cognitive therapy. Selective serotonin reuptake inhibitors have some troublesome side effects, such as anorgasmia. These may be acceptable in the short term treatment of depression but not when treating a chronic condition such as obsessive compulsive disorder. It is not yet known which patients will respond to which treatments or whether there is a hard core of patients who cannot yet be fully treated. For some patients, obsessive compulsive disorder remains a chronic handicap as severe as schizophrenia.

Dr Veale is a committee member of Obsessive Action. Obsessive Action (PO Box 6097, London W2 1WZ, tel 0181 991 9585) is a new charity set up to educate the public and health professionals about obsessive compulsive disorder, to provide a network of support for sufferers, and to raise funds for research. Triumph over Phobia (PO Box 1831, Bath BA1 3YX, tel 01225 330353) is an established charity of lay volunteers
who teach patients with obsessive compulsive disorder and phobias the principles of self management.
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References


