Obsessive Compulsive Disorder And Phobias Affecting Employment: Occupational Medicine Perspective

O Ogundipe

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Abstract

The case of a 28 year old lady with obsessive-compulsive disorder (OCD) and phobias, but striving to maintain gainful employment is presented. A discussion on some of the implications of OCD in relation to employment follows.

CASE REPORT

A 28-year-old female employed within the public sector by a large employer of labour was referred to the occupational health services, in accordance with an existing sickness absence management policy, because of frequent short-term absences from work.

She had been employed in the human resources section for over one year. Her duties included telephone consultations with the public, responding directly to enquiries from the public and other administrative duties.

She was reviewed by the occupational health physician. Enquiries regarding the episodes of absences established that she had a long-standing history of obsessive-compulsive disorder. She also claimed that she suffered from sleep paralysis as well as night terrors. There was also a history of hallucinations (mainly visual) and extreme phobias. She was under the regular review of a psychiatrist and taking 30mg of Citalopram on a daily basis.

The combination of the above problems translated into a disturbed and poor sleep pattern which left her exhausted in the mornings. Due to the OCD, she had to follow a regimented routine each morning. Compulsive actions like going back to recheck that she had locked her front door were common. The repetition of these actions often meant that she was late for work.

At work, it was not uncommon for her to experience phobias that were non-discrete, unpredictable and apparently unpreventable. There was often an associated intense and irrational fear of different objects. These phobic anxiety episodes meant that she often had to leave work and go home. It is worthwhile to note that she did not experience phobia to the ‘workplace' per se, but to objects of fairly common usage within the office-based workplace environment.

She had recently disclosed the extent of her psychological constraints to her line manager and this had prompted the referral to the occupational health department.

She reported being under a great deal of emotional strain due to domestic and family issues.

The initial assessment resulted in the generation of a letter to management confirming the presence of long standing psychological problems. Further information was requested, with her consent, from the hospital specialist as well as her general practitioner (GP).

Her employers were informed that her condition was covered under the remit of the disability discrimination act (DDA) as applicable under United Kingdom (UK) law.

The report from both her GP and Psychiatrist confirmed her history and diagnoses, as well as indicating that the prognosis for her full recovery was unlikely.

FOLLOW UP

She was reviewed about 2 months later to find out how she was getting on at work.

At this review, she confirmed that she was still experiencing difficulty in getting to work on time. She ascribed this to her difficulty in getting up on time in the morning despite the use of an alarm clock, and an early wake-up phone call from a friend on every working day. She however claimed that

she always ensured that she finished her allocated duties before leaving work, and if required she would compensate by staying behind to make up for time lost in the morning.

Her domestic and family problems, though not completely resolved, did not appear as grim as before.

She remained under regular psychiatric follow up although she was unable to derive benefit from cognitive behavioural therapy as she felt unable to explore her phobias with the therapist.

The overall impression from both consultations was that of an individual who definitely had ongoing difficulties, but was willing to make the effort to retain remunerative employment.

She was also aware that her problems were going to be present for the foreseeable future.

The advise given to management was to re-emphasise that her condition was covered by the disability discrimination act and a reasonable adjustment that might be considered in her case would be to tolerate a higher than average frequency of short term absences.

DISCUSSION

Obsessive-compulsive disorder (OCD) is characterized by the presence of obsessions, compulsions, or both, which cause significant personal distress or social dysfunction /disruption. OCD is not an uncommon psychiatric illness with variably quoted prevalence of 1-2.([1]) Prevalence data would depend on the diagnostic criteria applied ([2]). The Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) or the International Classification of Diseases -10 (ICD-10) criteria have been more often used in recent epidemiological studies.

Pharmacological therapy with a variety of serotonin reuptake inhibitors (SRI) and cognitive-behavioural therapy (CBT) are both evidence based options that have been proven to be effective in the management of OCD. ([3], [4]) Our patient was unable to participate fruitfully in CBT. She was however on citalopram. Citalopram is a Selective Serotonin Reuptake Inhibitor (SSRI), which is licensed in the UK for the management of depressive illness and panic disorders. ([5])

Though not licensed specifically for OCD in the UK, evidence exists that citalopram is useful in its management. One double-blind, placebo-controlled study conducted in the UK was described as the first trial to assess the efficacy of the citalopram in the management of OCD. The Sheehan Disability Scale also showed an advantage for citalopram compared with placebo ($P < 0.05$) on all three citalopram groups versus placebo for both work situation, and the family life & home responsibilities. Citalopram was well tolerated with only few patients in each dose group discontinuing the study prematurely on account of medication side-effects.([6])

This client's ability to perform her duties effectively was seriously affected by her underlying psychological condition. It was equally apparent that she was willing to attempt to make certain adjustments, if feasible, with the overall goal of remaining in gainful employment.

The main problems identified were her persistent lateness, and her irregular attendances due the unpredictable attacks of phobia with panic episodes.

As her problems are potentially long-standing, the issue of time scales for improvement in work attendance was virtually unanswerable and there seemed to be no permanent adjustments that could be made to accommodate her phobias, as these were varied and quite random.

OCD and such severe phobias could present genuine and wide-ranging difficulties for both employee and employer.

The fact that her condition was covered by the disability discrimination act - DDA of 1995 (as applicable in the UK) placed her employer in the situation that they had to consider ‘reasonable adjustments.’ An employer and employee may not agree as to what either party would consider to be a reasonable adjustment.

In certain cases, striking the right balance on what can be accepted as a ‘reasonable adjustment' in the workplace may need to be judged by an external tribunal.

Fortunately, most developed countries have legislation in place that safeguards some of the employee rights of individuals considered to have a disability as defined by acts of legislation. The disability discrimination act (DDA) of 1995 (applicable in the UK) is an example of such legislation. ([7])

The main adjustment that could be considered in light of the long-term nature of her condition could involve the employing management tolerating a higher than average frequency of short-term absences. The flexibility of adjusting her ‘time of leaving work' in relation to ‘time of

resuming work' is another option, if practical from both employer and employee points of view. Working from a 'non-threatening environment' such as from home could be an option if the precipitants of the phobias could be reasonably predicted and prevented.

If however, there are no reasonable adjustments possible, and regular and sustained attendance was not achievable, then the final decision rests with her employer. At any stage the client could request a case review by an external tribunal if the employee perceives he/she is being disadvantaged by decisions reached by her employers.

Previous studies have attempted to highlight the negative influence OCD could have on the general quality of life and social functioning of the sufferers.([8], [9], [10],)

A review of the literature revealed a paucity of studies looking directly at the relationship between OCD and employment. One study reported on some outcome predictors in OCD following behavioural psychotherapy. In a series of 178 outpatients with OCD, the 103 women in the study group were shown to have a significant trend towards a better outcome if they were in paid employment at the time of assessment.([11]) The ability to remain at work appeared to suggest a positive effect on the sufferers, as well as improving their quality of life. Further research is required to determine the nature and significance of the relationship (if any) between OCD and employment.

Though only a cautious extrapolation from available evidence, it could be in our client's best interest to be supported as much as feasible and practical, to maintain the paid employment that she now has.

This case demonstrates to an extent, some difficulties a person with mental health or behavioural disorders like OCD and certain phobic anxiety disorders experience in relation to employment. It also demonstrates on another facet, the inherent strengths (e.g. this client's desire to continue working) that many of these individuals possess and which we, as their carers or health care-givers need to be able to detect and support. In certain cases, if deemed appropriate, consideration could be given to referring patients to an occupational health service for further professional advice.

CORRESPONDENCE TO

Dr OO Ogundipe: funbi.ogundipe@ohsas.scot.nhs.uk Tel: +44 0131 672 2911 Fax: +44 0131 672 2905

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Author Information

Oluwafunbi O. Ogundipe, M.R.C.P. (UK)
Specialist Registrar in Occupational Medicine, Occupational Health & Safety Advisory Services (OHSAS)