

Obsessive-Compulsive Disorder

EPV0652

The Impulsivity-Compulsivity Spectrum: Understanding Brain Mechanisms and Clinical Implications

C. Pinheiro Ramos*, C. Baptista, J. Nogueira, S. Mendes and A. Gamito

Setúbal Hospital Center, Setúbal, Portugal

*Corresponding author.

doi: 10.1192/j.eurpsy.2024.1303

Introduction: Impulsivity and compulsivity are natural behaviors controlled by brain mechanisms that are essential for survival in all species. Understanding these brain mechanisms may lead to targeted treatment strategies for these symptom domains when impulsivity and compulsivity become dysfunctional.

Pathological impulsivity and compulsivity characterise a broad range of mental disorders.

Objectives: This study aimed to synthesise the latest evidence about the conceptualization of the impulsivity-compulsivity spectrum.

Methods: A review was conducted, drawing on reputable sources (PubMed and Web of Science databases).

Results: The concept of impulsivity can be defined as a predisposition toward rapid, unplanned reactions to internal or external stimuli without regard to the negative consequences of these reactions to the impulsive individual or to others. However, impulsivity is not always unplanned. Impulsive behaviours can be conceptualised as the core symptoms of a broad range of psychiatric disorders. In contrast, compulsivity refers to repetitive behaviours that are performed according to certain rules or in a stereotypical fashion. Compulsivity is a tendency to repeat the same, often purposeless acts, which are sometimes associated with undesirable consequences.

Impulsivity and compulsivity may be viewed as diametrically opposed, or alternatively, as similar, in that each implies a dysfunction of impulse control. Each involves alterations within a wide range of neural processes, including attention, perception, and coordination of motor or cognitive responses.

Conclusions: The neurobiology of impulsivity and compulsivity may involve inhibitory neurotransmitters, excitatory neurotransmitters, the prefrontal cortex, and/or limbic dysfunction.

Impulsive and compulsive features may present at the same time or at different times during the same illness. Although both compulsive and impulsive disorders may be related to prefrontal cortex dysfunction, compulsive disorders would be related to hyperactivity and impulsive disorders to hypoactivity of the prefrontal cortex. Compulsiveness appears to be associated with increased frontal lobe activity, while impulsiveness may be associated with reduced frontal lobe activity.

Disclosure of Interest: None Declared

EPV0650

Body dysmorphia in a 23 year old patient with obsessive compulsive disorder: a case report

P. Setién Preciados*, E. Arroyo Sánchez and C. Díaz Mayoral

Servicio de Psiquiatría, Hospital Universitario Príncipe de Asturias, Alcalá de Henares, Spain

*Corresponding author.

doi: 10.1192/j.eurpsy.2024.1304

Introduction: Body dysmorphic disorder (BDD) was considered an anxiety disorder in the DSM-IV, but in the DSM-V was added to the obsessive-compulsive and related disorders category. BDD is a psychiatric disorder characterised by an excessive, persistent, and distressful preoccupation with a perceived defect in appearance. These perceived defects are slight and are unnoticed by others. People with BDD usually have poor insight and are preoccupied with a perceived physical defect which causes them to check on it repeatedly. This leads to an impairment in psychosocial functioning, depression, and an increase in suicide risk.

Objectives: Review how dismorphophobia (BDD) and obsessive compulsive syndrome intersect, the differences they present in symptomatology, prevalence and treatment.

Methods: Presentation of a patient's case and review of existing literature, in regards to body dysmorphic syndrome and its similarities and differences with respect to obsessive compulsive syndrome.

Results: There are common features between both disorders, which are genetic overlap, physical past traumatic events, sex ratio, trait of perfectionism and body image disturbance.

Studies have found the prevalence of BDD in patients with OCD in a large patient sample was 8.7% to 15% compared to 3% in non-OCD.

The risk of comorbidity of OCD-BDD is three times higher in samples with a primary diagnosis of BDD compared to those with a primary diagnosis of OCD with 27.5% and 10.4%, respectively.

BDD as well as OCD must be managed with pharmacological and psychotherapy treatment. A selective serotonin reuptake inhibitor is the recommended first-line medication for BDD, even if appearance beliefs are delusional in nature.

Serotonin reuptake inhibitor (SRI) doses and trial durations are similar to those used for OCD; higher doses and a longer treatment trial are recommended than those typically used for depression and most other disorders. Cognitive-behavioral therapy that is specifically tailored to BDD is the psychosocial treatment of choice. Simply treating BDD as if it were OCD is not recommended.

Conclusions: There are limitations included a restricted number of studies overall, an absence of studies comparing biological parameters, and the frequent inclusion of participants with comorbid body dysmorphic disorder and obsessive-compulsive disorder. The current nosological status of body dysmorphic disorder is somewhat tenuous and requires further investigation, with particular focus on dimensional, biological and aetiological elements.

Disclosure of Interest: None Declared