OBSSESSIVE-COMPULSIVE DISORDERS IN DOGS

BASICS

OVERVIEW

- Repetitious, relatively unchanging sequence of activities or movements that has no obvious purpose or function, usually derived from normal maintenance behaviors (such as grooming, eating, walking); the repetitive behavior interferes with normal behavioral functioning
- Called "OCD" or "Obsessive-Compulsive Disorder"
- Most common obsessive-compulsive signs are spinning; tail chasing; self-mutilation; hallucinating ("fly biting"); circling; fence running; hair/air biting; pica (appetite for non-food substances such as dirt, rocks); pacing; staring and vocalizing; self-directed vocalization; potentially some aggressions

SIGNALMENT/DESCRIPTION of ANIMAL

- No breed, sex or age of dog is more likely to have obsessive-compulsive disorders, although the type of OCD (such as spinning compared to self-mutilation) displayed by the dog may be affected by breed
- Signs begin early (at 12 to 24 months of age) in development of social maturity (generally defined as occurring at 12 to 36 months of age in dogs) like other anxiety disorders; have been seen in younger animals
- Bull terriers—tail chasing not uncommon and seems to run in families
- German shepherd dogs—spinning and tail chasing have been reported to be more common than in other breeds
- Great Danes and German short-haired pointers—some lines display self-mutilation, stereotypic motor behavior (such as fence running), or hallucinations; may be more familial than breed-associated, with incidence varying by region and not well documented
- Breed versus familial association is confusing in dogs; not all family members show the same manifestation (for example, spinning, grooming, or hallucinating) and, in fact, the opposite may be true; if the client sees signs developing in a dog from a line where other dogs are affected, early intervention is critical; treat all nonspecific ritualistic behaviors with increased exercise, behavior modification, and, minimally, nonspecific tricyclic antidepressants (TCAs)
- Obsessive component may be at core of the problem, although it is difficult to verify; only the resulting ritualistic behaviors are recognized easily

SIGNS/OBSERVED CHANGES in the ANIMAL

- May be nonspecific; physical examination findings may be normal or may be abnormal secondary to OCD behavior (for example, signs of self mutilation)
- The behavior may be a manifestation of OCD, if the client cannot interrupt it and if it intensifies over time, increases in frequency or duration, and interferes with normal functioning
- Videotape dogs in all circumstances where the client sees the behavior; a pattern may become clear
- Dog may have begun to chase its tail as part of play, but tail chasing became more frequent and now the tip is missing and even physical restraint does not stop the behavior (however, not all dogs that tail chase will mutilate their tails)
- May be seen in young dogs, but its onset is more common during social maturity; play decreases with age, OCD increases.
- A solitary focus may have seemed to spur the behavior (for example, chasing a mouse that the patient could not catch), but usually no provocative stimulus is noted
- Behavior worsens with time
- May see self-induced injuries and lack of condition that may be associated with increased motor activity and repetitive behaviors; may note self-mutilation with a focus on the tail, forelimbs, and distal extremities

CAUSES

- Illness or painful physical condition may increase a dog's anxieties and contribute to these problems; few of these conditions actually cause OCD
- Kenneling and confinement may be associated with spinning
- Degenerative (for example, aging and related nervous-system changes), anatomic, infectious (primarily central nervous system [CNS] viral conditions), and toxic (for example, lead poisoning) causes may lead to signs, but abnormal behavior likely is rooted in primary or secondary abnormal nervous system chemical activity

RISK FACTORS

- Illness or painful physical condition may increase a dog's anxieties
- Kenneling and confinement

TREATMENT

HEALTH CARE

- Most patients respond to a combination of behavior modification and anti-anxiety medication
- Anti-anxiety medication—implement early; may be a prerequisite to effecting any behavioral therapy

• Usually outpatient
• Inpatient—patients with severe self-mutilation and self-induced injury; patients that must be protected from the environment until the anti-anxiety medications reach effective levels (may require days to weeks of therapy); constant monitoring, stimulation, and care
• Sedation may be necessary in severe cases; only a stop-gap measure, but necessary if serious and acute mutilation involved
• Behavior modification—geared toward teaching the patient to relax in a variety of environmental settings and to substitute a calm, competitive or desired behavior for the obsessive-compulsive one
• Desensitization and counterconditioning—most effective if instituted early; may be coupled to a verbal cue that signals the patient to execute a behavior that is competitive with the abnormal one (for example, instead of circling, the patient is taught to relax and lie down with its head and neck stretched prone on the floor when the client says, "Head down")
• Punishment should be avoided; may make the behavior worse and lead to the patient being more secretive
• The veterinarian should diagnose and control itchy skin diseases and painful conditions, as itchiness (known as "pruritus") and pain are related to anxiety
• Confinement or physical restraint—avoid bandages, collars, braces, and crates; all serve to focus animal more on the center of its distress and will make the dog worse; if these are needed to ensure healing, they should be used for the minimum amount of time

ACTIVITY
• Increase exercise

DIET
• Dietary management to control some forms of itchy skin disease

MEDICATIONS
Medications presented in this section are intended to provide general information about possible treatment. The treatment for a particular condition may evolve as medical advances are made; therefore, the medications should not be considered as all inclusive.

• Tricyclic antidepressants (TCAs) and selective serotonin reuptake inhibitors (SSRIs) increase serotonin levels in the central nervous system
• Mild signs—amitriptyline; imipramine; only useful for nonspecific ritualistic behaviors that may be associated with OCD
• Severe or long-standing signs—clomipramine; fluoxetine; these drugs may take 3–5 weeks to be effective
• May take months to get real effect
• Self-mutilation—narcotic antagonists (such as naltrexone) may be useful, but expensive and have a short effective period in the dog
• Thioridazine—occasionally used as an adjuvant treatment; newer more specific treatments appear more effective; some antipsychotic drugs (such as risperidone, olanzepine, clozapine)
• Treatment is lifelong; any attempt to withdraw medication should be gradual; recurrence is common

FOLLOW-UP CARE

PATIENT MONITORING
• Monitor behaviors via weekly videotaping and written logs; will provide unbiased assessments of change and help with alterations in treatment plans
• Complete blood count, biochemistry profile and urinalysis—semiannually or yearly if the patient is on chronic treatment; adjust dosages accordingly
• Observe for vomiting, gastrointestinal distress, and rapid breathing (tachypnea); if these signs are identified, contact your pet's veterinarian
• Medications may take several weeks to show an effect on the target behavior—the first sign of efficacy may be change in the duration or frequency of bouts rather than total cessation of the undesired behaviors
• Setting realistic expectations for change will help owners manage the pet and the outcome of behavioral and medical intervention
• Relapses can be common during stressful situations

PREVENTIONS AND AVOIDANCE
• Discourage the client from reassuring the patient that it does not have to spin, chew, or perform other repetitive behaviors; this inadvertently rewards the repetitive behavior; have them reward dog only when not engaged in behavior and relaxed

EXPECTED COURSE AND PROGNOSIS
• If left untreated, these conditions almost always progress

KEY POINTS

- Repetitious, relatively unchanging sequence of activities or movements that has no obvious purpose or function, usually derived from normal maintenance behaviors (such as grooming, eating, walking); the repetitive behavior interferes with normal behavioral functioning
- Most patients respond to a combination of behavior modification and anti-anxiety medication
- Monitor behaviors via weekly videotaping and written logs; will provide unbiased assessments of change and help with alterations in treatment plans
- If left untreated, these conditions almost always progress