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Family Practice Recertification®

A peer-reviewed clinical journal for primary care physicians

JANUARY 2000 / VOL. 22, NO. 1

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Obsessive-compulsive disorder: Diagnosis and treatment advances

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ABSTRACT

Obsessive-compulsive disorder (OCD) is an important and still underrecognized public health problem. Many affected individuals fail to seek treatment, preferring to keep their symptoms private. As a result, the marked distress caused by the symptoms may severely impair daily activities, occupational or academic functioning, and social and family relationships. Diagnosis can be enhanced by including direct questions about intrusive thoughts or repetitive rituals during the review of systems. Accumulating evidence indicates that a combination of behavioral therapy and potent serotonergic antidepressants can significantly reduce OCD symptoms. Because the condition is often chronic and the treatment course long-term, an effective physician-patient relationship is essential to a good outcome.

As recently as 15 years ago, obsessive-compulsive disorder (OCD) was thought to be relatively rare.[1] Today we understand that OCD is a severe, chronic psychiatric problem that afflicts about 3.3 million American adults each year.[2] Men and women suffer with equal frequency.[2] OCD also affects an estimated 1% of children and adolescents in the United States.[3] The social and economic losses due to OCD totaled $8.4 billion in 1990 alone.[2]

Among the common manifestations of OCD are repeated hand washing to remove imagined contamination, rechecking activities (such as locking the door or turning off the stove) because of obsessional doubt, and repetitive touching or looking to assure that an object is correctly placed or a person is there.[4] The symptoms, along with the avoidance of situations that incite them, may result in social isolation and impaired social functioning and quality of life.[5]

The ritualized aspect of the compulsive behavior, its startling uniformity, and the fact that children and adults demonstrate identical symptoms, suggest a form of biological preprogramming. But for much of this century, obsessions and compulsions have been considered

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Table 1 DSM-IV criteria for the diagnosis of OCD

A. Either obsessions or compulsions

Obsessions are defined by all of the following:

1. Recurrent and persistent thoughts, impulses, or images experienced at some time during the disturbance as being intrusive and inappropriate and that cause marked anxiety or distress.
2. The thoughts, impulses, or images are not simply excessive worries about real-life problems.
3. The person tries to ignore or suppress such thoughts, impulses, or images, or to use another thought or action to neutralize them.
4. The person recognizes the obsessional thoughts, impulses, or images as a product of his or her own mind (not imposed from without as in thought insertion).

Compulsions are defined by both of the following:

1. The person feels driven to perform repetitive behaviors (such as hand washing, ordering, checking) or mental acts (such as praying, counting, repeating words silently) in response to an obsession or according to rules that must be applied rigidly.
2. Although the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or action, they either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive.

B. The person has recognized, at some point during the course of the disorder, that the obsessions or compulsions are excessive or unreasonable. (Note: This does not apply to children.)

C. The obsessions or compulsions cause marked distress, are time-consuming (take at least 1 hour per day), or significantly interfere with the person's normal routine, occupational (or academic) performance, or usual social activities or relationships.

D. The content of the obsessions or compulsions is not restricted to another Axis I disorder if present.

E. The disturbance is not due to the direct physiological effects of a substance (such as a recreational drug or a medication) or to a general medical condition.

Specify if with poor insight:
For most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable.

Key: OCD = obsessive-compulsive disorder.

Source: American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 4th ed. Washington, DC: American Psychiatric Association; 1994:422-423.

symbolic expressions of underlying wishes and conflicts. Contamination obsessions and handwashing compulsions have been thought to be expressions of unconscious guilt, similar to Lady Macbeth washing her hands over and over after her murderous actions.

The popular press has widely publicized recent advances in treatment, and many patients are well informed about their condition. But some have read older texts that suggest the disorder is rare, untreatable, and of psychogenic origin. OCD is currently regarded as a neuropsychiatric disorder that is mediated by specific neuroanatomical circuits and neurochemical systems. And rather than being a consequence of unconscious guilt, it produces guilt and shame.

OCD is tremendously underreported, in part because affected individuals understand that the symptoms are irrational. The condition can be severely disabling, permeating one's personal, social, and work life, and making even simple tasks of daily living difficult or impossible to perform. In fact, the psychosocial morbidity from OCD is among the highest of any major psychiatric disorder.

Within the past three decades, effective therapies have been proposed and tested, and cog-

nitive behavior therapy and antidepressant medications have substantially improved prognosis.[6-8] Because of the relative frequency of the disorder, primary care physicians must be able to recognize its myriad manifestations, be particularly sensitive to its subtle signs, be able to create an atmosphere in which patients feel comfortable enough to disclose their symptoms, and be familiar with new and effective therapies that may release sufferers from the shackles of their obsessions and compulsions.

Defining the disorder

The term "obsession" derives from the Roman Catholic concept of being possessed by the devil.[9] We now understand that obsessions are persistently recurring thoughts, impulses, or images that are experienced as intrusive, inappropriate, and distressing; they are not simply excessive worries about realistic problems. Obsessions can be created from any object of mental content including simple repetitive words, thoughts, fears, memories, pictures, music, and elaborate dramatic scenes.

Compulsions, on the other hand, are repetitive behaviors or mental acts that one feels driven to perform, according to a rigidly applied rule, to reduce distress or to prevent some dreaded outcome—albeit one not realistically related to the action. The rituals are either in response to obsessions or are carried out in an effort to ward off certain thoughts, impulses, injuries, or events.

Criteria for diagnosis in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) require that the obsessions or compulsions cause impairment in terms of marked distress, time consumed (more than 1 hour per day), or significant interference with daily routines or academic or social functioning[10] (Table 1).

A cardinal feature of the syndrome is that it is ego-dystonic: The symptoms are repugnant or unacceptable to the rest of the individual's personality. The patient attempts (at least initially) to ignore or suppress the obsessions and compulsions and recognizes that the preoccupations are either excessive or unreasonable.

Who is affected and when

According to the National Institute of Mental Health's Epidemiologic Catchment Area study, the lifetime prevalence of OCD is approximately 2.5%.[11] It is thus more common than panic disorder, schizophrenia, anorexia nervosa, and mania. Evidence suggests that the clinical diagnosis of OCD has increased as professional and public awareness has grown.[12] Mild or transient obsessions and compulsions are common in the general population.[13] Prevalence estimates of subclinical OCD range from 4% to 19%.[14] The lifetime prevalence of OCD among a community sample of 861 16-year-olds was only 2.3%, but the rates of various self-reported obsessive-compulsive symptoms were relatively high: 65% had intrusive images; 8%, disturbing thoughts; 29%, hoarding behaviors; 27%, repetitive actions; 30%, urges to repeat; 34%, ritualized routines; 49%, orderliness; and 72%, extreme neatness.[14]

OCD has a bimodal onset: one in late childhood and one in early adulthood.[15] Males predominate in the younger group, but the overall incidence is roughly equal.[16] In children, the mean age at onset is 10 years (range, 7-12 years).[17] The average age of adult onset is 17 for men and 21 for women.[13] Fewer than 5% of patients experience symptom onset after the fourth decade of life. The condition is often chronic, with 47%-70% of patients remaining symptomatic for several years.[18]

A family history of OCD is seen in about 20% of cases.[15] The younger the age at onset, the more likely a positive family history. First-degree relatives of patients with Tourette's disorder also have a higher incidence of OCD.[10]

The proposed origins of the disorder

Several pathogenic hypotheses prevail, but the precise etiology of OCD is uncertain. Proponents of the learning theory believe that obsessions represent a conditioned stimulus to anxiety and that compulsions are used to reduce the anxiety associated with the obsessions. This theory is reinforced by the relief patients feel after performing their rituals.

Recent research suggests that OCD is a

neurobiological disorder caused by an imbalance of serotonin.[19] A key feature of this model is that certain behavioral subroutines related to grooming and territoriality have been programmed in the human brain over the course of evolution. Ordinarily, evidence that one is clean or the stove is turned off is enough to suppress the subroutines. But if higher brain centers malfunction, the subroutines may be replayed continually. Affected individuals feel compelled to continue washing or checking the stove even though they consciously recognize such behavior as "crazy."

Neuroimaging studies have implicated a network of brain regions. Subtle volumetric abnormalities have been seen in the striatum of OCD patients; functional abnormalities have been found in the orbitofrontal cortex, anterior cingulate cortex, and caudate nucleus.[20] (It is worth noting that no clinical indication for neuroimaging has been established in OCD or related disorders except to rule out gross structural abnormalities that reflect general medical etiologies.) In one study, 20 OCD patients were treated for 10-12 weeks with either behavioral therapy or fluoxetine HCl ([Prozac] 20 mg/d, titrated within 2 weeks to 60-80 mg/d as tolerated).[21] Compared with pretreatment positron emission tomography (PET) scans, posttreatment scans showed changes in glucose metabolic rates in the head of the right caudate nucleus of patients successfully treated with either therapy.

Thus, a deficit in caudate nucleus function may lead to inadequate filtering (or repression) of orbital "worry" inputs that drive the relevant fraction of inhibitory caudate nucleus output to the globus pallidus.[21] With effective treatment, adequate filtering activity damps out this self-driving circuitry, allowing patients to limit their symptoms when an obsessive worry is launched from the orbital region.

Reports of symptom improvement following frontal lobe injury[22] or cingulotomy buttress these results. And in one survey, 3 of 23 patients with Sydenham's chorea (which also affects the basal ganglia) had OCD symptoms, compared with none of 13 subjects who had rheumatic fever without chorea.[23]

A wealth of evidence favors abnormalities of the 5-hydroxytryptamine (5-HT) system, particularly hypersensitivity of postsynaptic receptors. This theory is supported by the efficacy of 5-HT reuptake inhibitors in treatment—although it is likely that OCD is related to more than one dysfunction.[24] Selective serotonin reuptake inhibitor (SSRI) therapy has been shown to reverse some of the abnormalities seen on the PET scans of patients with OCD.[21]

Recognizing the OCD patient

OCD appears in virtually identical forms in both children and in adults, making it more consistent in its presentation across the lifespan than disorders such as major depression or schizophrenia. Nevertheless, few patients readily report OCD symptoms, and the diagnosis may require some dogged sleuthing. The medical history may offer important clues since individuals with OCD tend to have significant treatment histories. Many have received psychotherapy, behavior therapy, pharmacotherapy, hypnosis, or biofeedback. Sometimes a seemingly unrelated medical condition makes the diagnosis more obvious; increasing evidence suggests that OCD symptoms are exacerbated in patients infected with group A β-hemolytic streptococci, particularly children.[25,26]

OCD may also be recognized by patterns of symptoms, the most common of which is an obsession of contamination that is followed by washing. Such patients believe that dirt from their hands might contaminate others. Washing rituals may consume 4 hours each day, with an entire bar of soap being dissolved in a single session. Family members may report monthly hot water bills increasing 6-8 times over their baseline as symptoms blossom. Such symptoms can lead to medical complications.[4] Some individuals wash until their hands are worn raw and become macerated. Indeed, when scaly skin is noted on a patient's hands, it is not unreasonable to ask about obsessions or compulsions.

The second most common symptom pattern is an obsession of doubt followed by a compulsion of checking. The obsession often implies some danger or violence (such as forgetting to

turn off the stove). Self-doubt leaves the patient with perpetual feelings of guilt about having forgotten something or having committed some transgression.

In a less common form of OCD, intrusive obsessional thoughts occur without any accompanying compulsion. These thoughts are usually of a sexual or aggressive act that is reprehensible to the patient. One mother in her late 30s was tortured by images of her daughter being hit by a car every time the child left the house. The mental picture of her little girl's body lying broken and bleeding in the gutter was particularly vivid, and the mother was incapable of exorcising the tormenting scene from her mind.

Obsessional slowness is the fourth pattern that may be seen. In this form, the obsession and the compulsion seem to unite to slow the performance of daily behaviors. Such patients may spend hours eating a meal or shaving in the morning.

OCD: Making the diagnosis

Why do primary care physicians so rarely report seeing patients with OCD? The answer lies in the ego-dystonic nature of the disorder. Patients tend to be secretive about their symptoms because of the accompanying introversion and guilt and the lack of public awareness. One study found that accurate diagnosis was delayed an average of 10 years,[27] and during this period patients and their families did not know why they were in such distress. Patients had difficulties with family relationships and involved family members in their rituals.[27] Those who received an incorrect diagnosis or treatment used health care facilities and resources at higher rates than did the general population.[27]

Early detection and aggressive treatment of OCD in children can result in significant long-term improvements.[28] But unless specifically asked, many patients will not reveal their symptoms. To increase recognition, physicians should thus routinely include direct, specific questions about intrusive thoughts or repetitive rituals during the review of systems. A similar inquiry should be used to rule out OCD in patients who complain of anxiety or panic.[29] Several important issues must be kept in mind during the clinical interview: 1) The diagnosis requires functional impairment as a consequence of symptoms; 2) affected individuals feel they are being forced or invaded by the symptoms; and 3) patients always retain their insight—no matter how vivid and compelling the obsession or compulsion, it is recognized as absurd and irrational.

Table 2 OCD: The differential diagnosis

Alcohol dependence or abuse
Anxiety disorder due to a general medical condition
Body dysmorphic disorder
Delusional disorder
Eating disorders
Generalized anxiety disorder
Hypochondriasis
Major depressive episode
Obsessive-compulsive personality disorder
Paraphilias
Pathological gambling
Schizophrenia
Specific or social phobia
Stereotypic movement disorder
Substance-induced anxiety disorder
Tic disorder
Trichotillomania

Key: OCD = obsessive-compulsive disorder.

Source: Adapted from the American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 4th ed. Washington, DC: American Psychiatric Association; 1994:417-423.

• *Excluding other diagnoses* OCD must be distinguished from a variety of other conditions that may share similar features (Table 2). Obsessive-compulsive personality disorder (OCPD) is an important condition with features distinct from those of OCD. The former is characterized by a preoccupation with orderliness, perfectionism, and mental and interpersonal control.[10] Affected persons are cautious, deliberate, thoughtful, and rational in their approach to life and its problems, and they may appear dry and pedantic when those traits are carried to an extreme. Reason and logic is emphasized

at the expense of feeling and intuition; patients do their best to be objective and to avoid being carried away by subjective enthusiasm. Although OCPD may be characterized by rigid routines, a need for orderliness, hoarding behaviors, and indecisiveness, affected individuals usually do not experience them as ego-dystonic. Most patients with OCD neither have nor appear to develop OCPD.

"Fear of AIDS" is a term applied to individuals with obsessional fears and preoccupations about having contracted AIDS, and many of these patients skirt the boundary between subthreshold obsessions and OCD. Other anxiety disorders that are particularly difficult to differentiate from OCD include generalized anxiety disorder (obsessive worries about real-life circumstances) and specific or social phobia (preoccupation with a feared object or situation).[10] In general, a phobic reaction is characterized by anxiety about harm that may come from an external object or situation, and the person avoids the object to control the anxiety. In contrast, patients with OCD fear they will hurt others. Most important, people with phobias are usually symptom free when not being confronted with the feared object, whereas distance does not afford any relief to the patient with OCD.

Major depression may be associated with obsessions, but affected individuals are without hope; the OCD patient retains hope. And in contrast to schizophrenia, no matter how bizarre the content of obsessional thoughts or how strange the compulsive acts, OCD sufferers usually maintain full contact with reality and are painfully aware of the absurdity of their thinking and behavior.

• *Common associated disorders* The condition most often associated with OCD in adults is major depressive disorder. Two thirds of OCD patients will be depressed during their lifetime, and one third will have major depression when first diagnosed with OCD.[30] An estimated 35%-50% of patients with Tourette's disorder have comorbid OCD.[10] Current or past tics are reported in 20%-30% of OCD patients.[10] Other anxiety disorders (specific phobia, social phobia, panic disorder), eating disorders, and OCPD may all be associated with OCD (Table 2, page 33).

OCD may also be a consequence of various neurologic conditions, and has reportedly occurred in patients with carbon monoxide poisoning, tumors, allergic reactions to wasp stings, postviral encephalitis, traumatic brain injury, Sydenham's chorea, and a host of other basal ganglia pathologies.[31]

OCD spectrum disorders that are postulated to have a common pathophysiologic abnormality include body dysmorphic disorder (characterized by recurrent concerns with imagined ugliness) and hypochondriasis.

• *Giving the diagnosis* It is the physician's role to explain the disorder, offer hope for change, and empathize with the distress of patients and family members (see the FYPI, "What is obsessive-compulsive disorder, and can it be treated?" page 47). If the patient is a child or young adult, a family meeting can be useful. The family may best appreciate how much symptoms have interfered with the patient's life and disrupted the lives of those closest to him or her. Physicians should meet with the parents alone to discuss sensitive information. Parents may fear their child is psychotic or untreatable, feel guilty about having caused the condition, or worry that they will be blamed. When talking with the child, it is important to show that you know he or she is not "crazy." Children and adults often respond to the analogy between obsessive thoughts and "hiccups of the brain."

Once the diagnosis has been made, instruments such as the Yale-Brown Obsessive Compulsive Scale (Y-BOCS)[32] or Children's Yale-Brown Obsessive Compulsive Scale[33] can be used to rate and record symptom severity.

Treatment strategies for OCD

Since no treatment is completely effective and many patients will have a chronic course, the physician-patient relationship must be sturdy enough to sustain both parties over a period of years. OCD sufferers are anxious about their symptoms and treatment, and most find it difficult to access appropriate treatment In addition, many are uneasy discussing their

thoughts or rituals, particularly if the content is sexual. Patients must feel that the clinician will understand their distress and can be trusted. The clinician can effectively reassure patients and absorb much of the anxiety, allowing discussion and observation to proceed freely.

Systematic studies have shown that cognitive behavioral therapy and SSRIs are specifically effective for the core symptoms of OCD; a combination of the two is usually recommended. Behavioral therapy can help maintain the gains achieved with pharmacotherapy, while medications enhance compliance with the behavioral therapy. Cognitive behavioral therapy appears to be more effective in treating compulsions than obsessions; medication seems to lessen both. Psychotherapy may also play a role in teaching coping skills, increasing the patient's sense of mastery, treating accompanying anxiety and depressive symptoms, addressing comorbid diagnoses, and improving family relationships.

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Patients with severe symptoms may require brief hospitalization to contain symptoms. In general, however, behavioral therapy is based on patients continuing their ordinary daily routines for as long as possible.

• *Behavioral therapy* has shown efficacy in the treatment of adults as well as children and adolescents with OCD.[34] At first glance, it may seem contradictory to claim simultaneously that OCD has a strong biological basis and that behavioral conditioning is effective in reversing it. Yet ethologists have shown that many fixed action patterns in animals, which in part stem from hardwiring, can be extinguished with repeated training.

The most effective psychological treatment to date uses direct and imaginary exposure to the feared object or event—such as dirt—followed by a period when the person is kept from responding with the symptomatic reaction—such as repeated washing.[4] Patients are first required to confront the things they fear until their anxiety diminishes. Once the anxiety abates, the ritual fades because there is no longer any anxiety to be reduced. In response prevention, the patient learns to reduce and then eliminate ritualistic responses to anxiety-producing stimuli. Several controlled trials using this technique have yielded success rates of 70%-80%.[35]

Unfortunately, one fourth of OCD patients refuse to participate in behavioral therapy.[36] Prognostic indicators of good response include a motivated patient willing to cooperate with treatment, the presence of overt rituals and compulsions, an ability to monitor and report symptoms, and the absence of complicating comorbid conditions.[37] To achieve the best results, behavioral techniques should be applied by an experienced clinician.

• *Pharmacologic treatment* using agents with potent inhibitory effects on the reuptake of serotonin is key to effective therapy. Six serotonergic antidepressants are currently available in the United States: clomipramine HCl (Anafranil), and the SSRIs, fluoxetine, fluvoxamine maleate (Luvox), paroxetine HCl (Paxil), sertraline HCl (Zoloft), and citalopram hydrobromide (Celexa). Recent trials have proved the efficacy and safety of SSRIs in children and adolescents with OCD, and the Food and Drug Administration has approved sertraline, clomipramine, and fluvoxamine for treatment in this age-group.[38-40] The tricyclic antidepressant, clomipramine, is a relatively selective and potent inhibitor of active serotonin uptake that also blocks histamine H_2, cholinergic and α-noradrenergic receptors. Its side-effect profile is

Table 3 Pharmacologic treatment for obsessive-compulsive disorder in adults

Drug	Dosage range (mg)	Average daily dose (mg)	Side effects
SSRIs			
Fluoxetine HCl (Prozac)	10-100	50	Headache, nausea, sexual dysfunction
Fluvoxamine maleate (Luvox)	50-300	200	Sexual dysfunction, fatigue
Paroxetine HCl (Paxil)	10-40	30	Headache, nausea, sexual dysfunction
Sertraline HCl (Zoloft)	25-200	150	Headache, nausea, sexual dysfunction, diarrhea
TCA			
Clomipramine (Anafranil)	100-300	200	Anticholinergic, weight gain

Key: SSRI = selective serotonin reuptake inhibitor; TCA = tricyclic antidepressant.

Note: If the patient does not respond to the average dose, the drug should be pushed to the maximum dose in 4-8 weeks from the start of treatment. If response to the average dose is partial, the drug should be pushed to the maximum dose in 5-9 weeks from the start of treatment.

Sources: The Expert Consensus Panel for obsessive-compulsive disorder. Treatment of obsessive-compulsive disorder. J Clin Psychiatry 1997;58(suppl 4):2-72.
Gedenk M, Nepps P. Obsessive-compulsive disorder: Diagnosis and treatment in the primary care setting. J Am Board Fam Pract 1997;10:349-356.
Koponen H, Lepola U, Leinonen E, et al. Citalopram in the treatment of obsessive-compulsive disorder: An open pilot study. Acta Psychiatr Scand 1997;96:343-346.

thus more complicated than that of the SSRIs, which is why they are the usual first-line therapy. All SSRIs have shown equal efficacy in reducing symptoms in up to 70% of patients using them.[41] Differences in the potency and selectivity of the serotonergic agents appear to be unrelated to their clinical anti-obsessional efficacy.[42]

Symptoms may worsen during the first 10 days of treatment, but patients should be encouraged to continue the trial (perhaps at a reduced dose) as this phenomenon often subsides. Since a clinical response is unlikely in the first 3 weeks, patients should start with a low dosage that is slowly increased to allow the patient to tolerate the medication while avoiding dose-related side effects (Table 3). Clomipramine should be increased to 250 mg and fluoxetine to 80 mg.

Some patients respond to standard doses, but others require much higher doses of SSRIs than are used to treat depression. When it becomes clear that a patient is not responding to the medication after 10-12 weeks, most experts recommend switching to another SSRI.

Patients who have only a partial clinical response after a trial of 10-12 weeks may be helped by augmentation strategies using clomipramine, clonazepam (Klonopin), conventional neuroleptics, buspirone HCl (BuSpar), or risperidone (Risperdal), or by adding a second SSRI.[43] Clonazepam and risperidone have proved superior to placebo in controlled studies in adults.[44] The choice of augmentation medication is generally tailored to the individual.[43] A patient who has not adequately responded to an SSRI may be given clomipramine to boost the response, and those who have not responded to one or more of the SSRIs should be given a trial of clomipramine alone. Neuroleptics may be preferable for those with a comorbid tic disorder, while clonazepam may be best for patients with a comorbid anxiety disorder.[43] Intravenous clomipramine has also shown promise in recent trials.

Response to pharmacotherapy progresses over several months. Patients may find it easier

OCD resources for physicians and patients

Organizations

Anxiety Disorders Association of America
11900 Parklawn Dr., Suite 100
Rockville, MD 20852
Phone: (301) 231-9350
Web site: http://www.adaa.org

Madison Institute of Medicine
Obsessive Compulsive Information Center
7617 Mineral Point Rd., Suite 300
Madison, WI 53717
Phone: (608) 827-2470

National Anxiety Foundation
3135 Custer Dr.
Lexington, KY 40517-4001
http://www.lexington-online.com/naf.ocd.2.html

National Institute of Mental Health
Web site: http://www.nimh.nih.gov/publicat/ocd.htm

Obsessive-Compulsive Foundation, Inc.
3376 Notch Hill Rd.
North Branford, CT 06460
Phone: (203) 315-2190
Web site: http://www.ocfoundation.org

Books

Foster CH. Polly's Magic Games: A Child's View of Obsessive-Compulsive Disorder. Ellsworth, Me: Dilligaf Publishing; 1994.

Greist JH. Obsessive-Compulsive Disorder: A Guide. Madison, Wisc: Obsessive-Compulsive Disorder Information Center. Rev. ed. 1992.

Johnston HF. Obsessive-Compulsive Disorder in Children and Adolescents: A Guide. Madison, Wisc: Child Psychopharmacology Information Center; 1993.

Rapoport, JL. The Boy Who Couldn't Stop Washing: The Experience and Treatment of Obsessive-Compulsive Disorder. New York, NY: EP Dutton; 1989.

VanNoppen BL, Pato MT, Rasmussen S. Learning to Live with OCD. Milford, Conn: OC Foundation; 1993.

to resist the OCD symptoms and spend significantly less time engaged with them. But most will not be symptom free. Patients with hoarding obsessions and compulsions appear to have a poorer response to SSRIs.[45]

All SSRIs should be tapered (by 25% every 2 months) before stopping to prevent the possibility of symptom return and withdrawal reactions. At least 1 year of maintenance pharmacotherapy is reasonable. Behavioral therapy during drug withdrawal may help prevent relapse. For patients who relapse after receiving psychotherapy and being slowly taken off medication, long-term treatment is indicated. Benzodiazepines are helpful when anxiety is significant.

• *Neurosurgical procedures* have shown efficacy and safety in treatment-resistant patients. Newer techniques that use the gamma knife for circumscribed anterior capsulotomy, cingulotomy, and subcaudate tractotomy have shown success in adults with incapacitating OCD.[46] Although electroconvulsive therapy is not considered helpful for most OCD patients, research on transcranial magnetic stimulation may ultimately provide new forms of treatment.

The chances of recovery

The outcome from any episode of OCD may range from complete and permanent remission to complete remission with discrete recurrent episodes, partial remission, or deterioration. Continuous illness with fluctuating severity occurs in 84% of adults, and a deteriorating course develops in 15%.[12] Other studies have reported a 2-year spontaneous remission rate of 65%.[9] A recent study of 144 OCD patients found that almost half had the disorder for

more than 30 years, and only about one fifth had completely recovered at 40 years of follow-up although most showed some improvement in clinical symptoms and social functioning.[47] Effective pharmacologic treatments were not introduced until the end of the study period, however.

Worse outcomes have been associated with early age of onset, especially in men.[47] And patients with comorbid paranoid personality disorder, schizoid personality disorder, or schizotypal personality disorder are much less likely to improve than are those with other personality disorders.[48]

Conclusion

The OCD patient is the ultimate skeptic who cannot credit his sense data or his attempts to refute the obsession by means of logic. He or she cannot accept reassuring information, such as the fact that the door is locked or the light is off. Since the patient understands that his symptoms are irrational, there is tremendous underreporting of symptoms. The clinician must therefore be able to recognize the characteristic features of this handicapping condition and include direct questions about related symptoms during routine patient evaluations.

In the clinical setting, it is extremely important to reassure patients that their symptoms are the result of the disease and that they cannot be held entirely responsible for their obsessive thoughts and compulsive behaviors. A combination of pharmacotherapy and cognitive behavioral therapy can improve symptoms. SSRIs are the usual first-line drug of choice. Augmentation strategies may benefit patients who do not respond adequately to SSRIs. **§**

SELF-EXAMINATION

1. Which of the following symptom patterns is not characteristic of OCD?

   a) obsessional thoughts without compulsions

b) preoccupation with orderliness and mental control that is not ego-dystonic
c) obsessional thoughts that dirt on one's hands may contaminate others
d) obsessional slowness in carrying out daily routines

2. Up to one third of OCD patients have depression during their lifetime.

a) true
b) false

3. Which of the following statements about the occurrence of OCD is false?

a) A positive family history is seen in about 20% of cases.
b) OCD may follow traumatic brain injury.
c) About 35%-50% of Tourette's disorder patients have OCD.
d) Onset in late childhood is more common in girls than in boys.

4. Behavioral therapy appears to be more effective in treating compulsions than in treating obsessions.

a) true
b) false

5. Which of the following statements about the pharmacologic treatment of OCD is not true?

a) All SSRIs are equally effective.
b) Pharmacotherapy successfully treats symptoms in about 50% of patients.
c) At least 1 year of maintenance therapy is generally recommended.
d) Medication enhances compliance with behavioral therapy.

Answers at end of reference list.

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Answers: 1)b, 2)b, 3)d, 4)a, 5)b.