CURRENT TREATMENTS OF OBSESSIVE-COMPULSIVE DISORDER

Second Edition

Edited by
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Joseph Zohar, M.D.
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Preface to the Second Edition

It has been more than 10 years since the first medication for obsessive-compulsive disorder (OCD), clomipramine, received U.S. Food and Drug Administration approval and since the first edition of this book was published. It seems an appropriate time to stop and summarize the data that have accumulated regarding current treatment approaches to OCD. Progress in neuroscience has had direct and immediate clinical implications not only in the pharmacologic arena but also in the psychologic arena. This second edition reflects this progress in many ways. Instead of three chapters devoted to pharmacotherapy (clomipramine, fluoxetine, and fluvoxamine), there are now six (sertraline, paroxetine, and citalopram have been added). Chapter 8, on the diagnosis and treatment of OCD in children and adolescents, has been expanded to include the newest findings in immunology, namely pediatric autoimmune neurologic disorders associated with streptococcal infection (PANDAS). The behavioral therapy chapter (Chapter 9) now includes not only detailed treatment schedules for both individual and group treatments but also up-to-date empirical data to support their use. Finally, all of the chapters have been updated to include the most current data on the use of these treatments in special populations such as the elderly, children and adolescents, and pregnant women.

We still feel that the best way to understand and treat OCD is through the clinical examples provided by our patients, and our intention is for this book to be a practical but comprehensive “how-to” manual for treating OCD. Thus, this second edition—as was true in the first—maintains a strong emphasis on describing OCD by sharing the stories of patients whom we have treated. The case histories presented in each chapter have been carefully selected to highlight specific treatments and diagnostic issues involved in treatment. Several of these case histories are new, and others have been reproduced or updated from the first edition. The authors of these chapters have extensive clinical and research experience in treating OCD.

Not only has the number of compounds now available for treatment
of OCD doubled, but knowledge of the pharmacokinetics, receptor profiles, interactions, and comparative efficacy has also greatly increased. Thus, in this edition we hope to provide the clinician with the most current available data to better match treatment approaches with the patient’s unique needs.

In the area of psychology, a vast amount of clinical experience and some research in behavioral and cognitive therapy have accumulated. As a reflection of the changes in our health economy, the use of more economic and probably even more effective strategies such as group therapy or multifamily therapy have been implemented; these strategies are described in Chapter 9.

Increased public awareness of OCD has in turn raised expectations for its treatment. Patients expect to be cured; however, about 30% of patients do not respond or respond only partially to treatment. We often must combine all of our current knowledge and focus it on the treatment of one individual, and the chapter on treatment resistance (Chapter 12) addresses this challenge in a multidisciplinary way.

Reaffirmation of the OCD diagnosis is the first step when managing treatment-resistant cases. In addition to raising treatment expectations, increased awareness of OCD has raised its profile, and we have started to expand the boundaries of the disorder to include a spectrum of other disorders, such as body dysmorphic disorder, trichotillomania, pathologic gambling, and Tourette’s syndrome. The clinical implications of this new, broader definition are discussed in Chapter 11. Recognition that obsessive-compulsive symptoms can present in different disorders has led to an intriguing finding in schizophrenia. The prevalence of OCD among schizophrenic patients is approximately 15%; these patients require innovative treatment approaches such as those discussed briefly in Chapter 1. The intimate relationship between OCD and schizophrenia also raises intriguing questions about the relationship between obsession, delusions, religiosity, and OCD. These complicated diagnostic and management issues are discussed in Chapter 10.

Because early detection of OCD may help minimize its devastating effects, a considerable effort has been made to identify and treat childhood OCD. Moreover, meticulous research has opened the door to a new entity, PANDAS, that bridges immunologic, neurologic, and psychiatric boundaries. All of these issues are discussed in Chapter 8.

Editing and updating of this kind of book requires significant attention and effort. We would like to thank our contributors for their scholarly chapters as well as our patients for all that we have learned from them and for pushing us to better understand this fascinating but frustrating disor-
der. Our pursuits in this field have only been possible with the continuous support and understanding of our families. Our love and thanks go to our spouses, Carlos Pato and Rachel Zohar-Kadouch, and our children, Michael and Eric Pato and Karmit, Zeev, and Mishael Zohar.

Michele Tortora Pato, M.D.
Joseph Zohar, M.D.
The past 15 years have seen a threefold increase in publications about obsessive-compulsive disorder (OCD), which reflects the growing interest in this disorder. Currently, research ranges across a spectrum of approaches such as brain imaging, genetics, epidemiology, immunology, neuropsychology, and treatment interventions including biologic and behavioral modalities. Each area represents an important piece in the complex jigsaw puzzle of OCD (see Sasson and Zohar 1996 for a review).

Epidemiologic studies during the 1980s found a prevalence of 2%–3% for OCD in five communities in the United States. This finding indicated that OCD was not a rare disorder—the prevailing perception at the time—but was, in fact, more prevalent than schizophrenia (Karno et al. 1988; Robins et al. 1984). Since this seminal work, other studies within general population samples have established a rather consistent worldwide prevalence of OCD. For example, the cross-national collaborative study that surveyed community samples in Canada, the United Kingdom, Puerto Rico, Germany, Taiwan, Korea, and the Netherlands suggested a prevalence of 1.9%–2.5% (Weissman et al. 1994), although later reports by Nelson and Rice (1997) and Stein et al. (1997) reexamined the epidemiologic data and proposed lower prevalence rates of 1%–2%. Epidemiologic research focused on children and adolescents reported prevalence ranges of 2%–3.6% (Flament et al. 1988; Zohar et al. 1992), and the same range was...
found among a cohort of older adults (age greater than 65 years) in the United Kingdom and Spain (Saz et al. 1995). Based on this figure, the number of patients with OCD worldwide is estimated to be 50 million, making OCD a global problem (see Sasson et al. 1997a for a review).

In this chapter, we provide the therapist with an overview of OCD symptom clusters, differential diagnoses, clinical courses, and general treatment guidelines that we believe to be essential before specific treatments can be considered.

The diagnostic criteria for OCD on Axis I of DSM-IV-TR (American Psychiatric Association 2000), the new text revision of DSM-IV (American Psychiatric Association 1994), include the presence of recurrent, persistent, and unwanted thoughts, impulses, or images (obsessions) and/or the performance of repetitive, often seemingly purposeful, ritualistic behaviors (compulsions) (Table 1–1). These obsessions and compulsions are often ego-dystonic, are often resisted by the patient at some point in the illness, and interfere with patients’ daily function—characteristics that are clinically important in differentiating OCD from other diagnoses such as obsessive-compulsive personality disorder, schizophrenia, and phobic disorders.

Despite these straightforward criteria, in actual clinical practice the diagnosis of OCD is not always easy or obvious. For example, Rasmussen (1985) noted that patients often were referred to dermatologists for treatment of dermatitis caused by excessive hand washing, but these patients were not referred for psychiatric evaluation for this symptom. In addition, many patients do not seek psychiatric care for specific complaints of obsessive-compulsive symptoms but rather for complaints of depression, phobic disorders, and panic disorder, all of which can occur concurrently with OCD (Goodwin et al. 1969; Jenike et al. 1986; Mellman and Uhde 1987).

Increased awareness and better treatment of OCD has not reduced the lag time for patients seeking treatment, which is reported to be 7 years both in recent studies (Hollander et al. 1997; Rasmussen and Tsuang 1986) and in studies dating back to 1957 (Pollitt 1957). It may be postulated that this lag reflects the severe embarrassment and consequent secretiveness that many patients with OCD experience in relation to their symptoms.

In a study of discharge diagnoses, an increased incidence of OCD but not other psychiatric disorders (e.g., paranoid disorder) was observed (Stoll et al. 1992). This increase was associated with an increasing number of publications on the treatment of OCD, which suggests a positive sequence of increased interest, more clinical research, better treatment, and increased diagnosis.
### Table 1–1. Diagnostic criteria for 300.3 Obsessive-Compulsive Disorder

A. Either obsessions or compulsions:

   **Obsessions as defined by (1), (2), (3), and (4):**
   - (1) recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as 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 attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action
   - (4) the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

   **Compulsions as defined by (1) and (2):**
   - (1) repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly
   - (2) the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

B. At some point during the course of the disorder, the person has recognized 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 more than 1 hour a day), or significantly interfere with the person’s normal routine, occupational (or academic) functioning, or usual social activities or relationships.

D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder).

E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

**Specify if:**

**With Poor Insight:** if, for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable

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Symptom Clusters

Although initially the diversity of the clinical presentations of OCD is striking, it become evident over time that the number and types of obsessions and compulsions are limited and stereotypical (Rasmussen and Tsuang 1986). Patients with OCD are often relieved when they learn that other patients engage in the same behaviors. Furthermore, cross-cultural analysis of OCD symptoms reveals that the content of obsessions and compulsions is relatively similar across geographic locations (see Sasson et al. 1997a for review).

Many subclassifications of OCD symptoms have been proposed. One possible approach is to cluster OCD into four groups based on the factor analysis by Leckman et al. (1997) and Summerfeldt et al. (1999). These proposed clusters are presented in Table 1–2.

Table 1–2. Four clusters of obsessive-compulsive symptoms

<table>
<thead>
<tr>
<th>Obsessions</th>
<th>Compulsions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Contamination</td>
<td>Cleaning</td>
</tr>
<tr>
<td>2) Aggressive, sexual, religious, somatic</td>
<td>Checking</td>
</tr>
<tr>
<td>3) Symmetry</td>
<td>Ordering and arranging, counting, repeating rituals</td>
</tr>
<tr>
<td>4) Hoarding</td>
<td>Hoarding and collecting</td>
</tr>
</tbody>
</table>

Source. Adapted from Leckman et al. 1997.

Cleaning

Patients who are obsessed with dirt, contamination, germs, or bugs may spend several hours each day washing their hands, showering, or cleaning. Typically, they try to avoid sources of “contamination” such as door knobs, electric switches, and newspapers. Paradoxically, some of these patients are quite slovenly (see, for instance, the description of Howard Hughes [Bartlett and Steele 1979]). Although these patients are cognizant that nothing will happen if they resist washing, they may refuse to touch even their own bodies, knowing that if they do, they will not be at ease until they execute extensive washing rituals.

Checking

Patients in the “checking” symptom cluster are obsessed with doubt, usually tinged with guilt. Frequently, they are concerned that if they do not check something carefully enough they will hurt others. However, rather
than resolving uncertainty, their checking often contributes to even greater doubt, which leads to further checking. “Checkers” often enlist the help of family and friends, seeking reassurance that they have checked enough or correctly. Ultimately, by some inscrutable means, the patient resolves a particular doubt only to have it replaced by another. Resistance, which in this case is the attempt to refrain from checking, leads to difficulty in concentrating and to exhaustion from the never-ending assault of nagging uncertainties.

Common examples of these concerns and doubts are related to fundamental life themes such as aggression, sex, religion, and health. When the obsession is an aggressive impulse, it is most often directed at the person most valuable to the patient. In addition, the obsession might be a fear that the patient will act on other impulses (e.g., to kill somebody, rob a bank, steal) or that he or she will be held responsible for something terrible (e.g., fire, plague). For example, a fear of hurting somebody while driving may lead a patient to drive back and forth over the same spot for hours after hitting a bump in the road. These checking rituals may be combined with avoidance and may expand over time. In one such case, a mother who was afraid that she would stab her daughter struggled with this impulse by avoiding sharp objects and then by avoiding touching her daughter until she ultimately left the house altogether. Occasionally, checkers are not even certain why they are checking, expressing a vague feeling that they “just have the urge to do it until it feels right.”

Sexual obsessions include forbidden or perverse sexual thoughts, images, or impulses that might involve children, animals, incest, and homosexuality. Patients with aggressive and sexual obsessions might not reveal them, even if asked directly, because they fear being “locked up.” Clinicians should make a special effort to create an atmosphere that enables patients to disclose these types of obsessions. One approach is for clinicians to explicitly mention these types of obsessions as ones already heard many times and to reassure patients that these obsessions are part of OCD.

Obsessional thoughts can often carry a religious rather than a sexual or violent theme. These thoughts might lead to repetitive silent prayer or confession or may result in more obvious rituals such as repeated bowing or never-ending trips to church to make confessions. Such behavior presents a particular problem to both clinicians and clergy as they try to draw the line between disorder and devotion (see Chapter 10). At times, obsessional thoughts may take on a more nondescript quality. Examples include a need to know or remember what was eaten for breakfast, a need to say or not say a particular word or phrase, or a need to keep a certain musical phrase in one’s head.