



Obsessive Compulsive Disorder What you need to know to help your patients

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Obsessive compulsive disorder (OCD) is a condition that affects millions of adults, adolescents, and children. It is estimated that one in 50 adults and one in 100 children in the United States suffers from this disorder.

OCD includes obsessions, compulsions, and distress or impairment caused by these behaviors. The disorder can take a number of different forms, many of which most people would not identify as OCD. This leads to misconceptions and difficulties with diagnosis and treatment. Fortunately for Minnesotans, there have been recent advances in services, through the Obsessive Compulsive Foundation (OCF) conference held in the Twin Cities this year and the development of a local affiliate of the OCF.

Diagnosis

To accurately diagnose OCD, it is necessary to be able to identify the obsessions that are producing distressing emotions and the compulsions that serve as attempts to rid the individual of his or her uncomfortable feelings (see Table 1).

The onset of OCD is often gradual, but there may also be a subtype with a more sudden onset that likely is related to strep antibodies. Whether OCD develops gradually or rapidly, people find that their symptoms are overpowering and cause them much distress. Patients often notice changes in their mood, physical state, and behavior. The disorder can be private or can involve rules that control not only the individual, but also the family.

Diagnostic challenges

Although OCD appears to be fairly common, it is often missed by clinicians. Sufferers on average spend nine years seeking treatment before they are accurately diagnosed; research indicates that, on average, patients wait 17 years from onset of symptoms to participating in effective treatment.

Even if patients are asked about OCD, they may be reluctant to reveal their OCD issues because of embarrassment and shame. Undiagnosed OCD is problematic because the patient may feel misunderstood and then may not receive appropriate information and treatment. In addition, OCD does not necessarily improve when comorbid disorders improve unless the OCD is a focus of treatment.

In addition to being underdiagnosed, OCD is often misdiagnosed as something else (see Table 2).

Treatment for OCD

OCD was once viewed as a disorder that was very difficult to treat, but when it is accurately diagnosed and treated, most individuals experience significant symptom relief.

Evidence supports the efficacy of serotonin reuptake inhibitors (SRIs) and cognitive behavioral therapy (CBT) in reducing OCD symptoms. Clinical practice guidelines recommend that initial treatment be based on five factors: 1) nature and severity of patient symptoms; 2) comorbid psychiatric and medical conditions; 3) past treatment history; 4) current medications; and 5) patient preferences. Level of impairment, concomitant medications, and availability of treatments also need to be considered when selecting treatment strategies. Both the tricyclic agent clomipramine and the selective SRIs (SSRIs) are effective in reducing OCD symptoms. The SSRIs are recommended as the first-line pharmacological treatment for OCD because they have a better adverse event profile.

Evidence has documented the effectiveness of pharmacological and CBT treatments as monotherapies and as a combined treatment strategy. Although the optimal sequence of treatments has not yet been identified, the American Psychological Association guidelines recommend exposure and response prevention (E/RP) monotherapy for individuals who are motivated to cooperate with E/RP demands, do not have severe depressive symptoms, or prefer not to take medications. E/RP involves exposing a patient to the thoughts or situations that trigger OCD anxiety and not doing anything to escape from, or “fix,” the anxiety. For example, a patient might be encouraged to touch a door handle that he believes is contaminated and will then be asked to resist washing his hands. As he repeats these exercises, the intensity of the fear decreases and it becomes easier to break OCD patterns. This process, called habituation, can be done very gradually or all at once in fullest intensity (“flooding”).

SSRI monotherapy is recommended for individuals who are not able to engage in E/RP, report a previous response to an SSRI, or prefer medication treatments over CBT. A combination of SSRI treatment and CBT is recommended for individuals who have other comorbid conditions that could benefit from SSRI treatment (e.g., major depression) or for those who show an unsatisfactory response to monotherapy.

Treatment challenges

Heterogeneity of OCD. The variety of symptoms in OCD presents a substantial treatment challenge to clinicians. Research has demonstrated four robust and temporally stable symptom dimensions in OCD: contamination obsessions, with cleaning compulsions; harm-related aggressive, sexual, and religious obsessions, with

checking compulsions; symmetry obsessions, with arranging and repeating compulsions; and hoarding/saving symptoms. Individuals with various OCD subtypes vary in their response to both psychosocial and pharmacological treatments, and certain subtypes of OCD may necessitate different treatment strategies.

OCD with poor insight. In relation to OCD, the term “poor insight” is generally used to describe a patient’s relative lack of understanding of the degree to which his or her obsessions and compulsions are unreasonable or excessive. Poor insight has been associated with more severe OCD, co-occurring depression, and somatic obsessions. OCD patients with poor insight appear to respond less robustly to E/RP.

Comorbid conditions. Comorbid psychiatric disorders present a treatment challenge for clinicians caring for patients with OCD.

Depression. Major depressive disorder occurs in about 25 percent to 30 percent of patients with OCD. In fact, many OCD sufferers seek treatment for depression. When present co-morbidly, these disorders seem inseparable, with one worsening or improving in synchrony with the other. Comorbid depression is a strong predictor of occupational disability in OCD. Though several categories of antidepressants are effective for treating depression, only SRIs have shown consistent efficacy in decreasing OCD symptoms.

Obsessive compulsive personality disorder. Obsessive compulsive personality disorder (OCPD) is a chronic maladaptive pattern of excessive perfectionism and the need for control over the environment that affects all domains of an individual’s life. The rate of OCPD among patients with OCD may be as high as 28 percent. OCD patients with OCPD lack motivation to seek or continue in treatment because of the egosyntonic nature of their symptoms (i.e., they feel their thoughts, impulses, attitudes, and behavior to be acceptable and consistent with their self-conception). There is no empirical evidence to support the use of pharmacological interventions for OCPD. Given these factors, a clinician treating a patient with OCD and OCPD needs to understand this comorbidity, as motivation techniques may be needed to keep the patient in treatment.

Body dysmorphic disorder. Body dysmorphic disorder (BDD), a preoccupation with a slight or imagined defect in appearance, co-occurs with OCD at a rate of about 15 percent. BDD comorbidity has been associated with greater depressive symptoms and more illicit drug use. Although BDD is not associated with more severe OCD, patients with both disorders have more severe depressive symptoms and are more likely to use drugs, so treatment needs to focus on both disorders.

Substance use disorders. Research suggests that 25 percent of OCD patients may have a lifetime substance use disorder (SUD). Recognizing this comorbidity is important, as treating the SUD may significantly improve the OCD prognosis

Research and resources

Although obsessive compulsive disorder has received increased research attention over the past decade, much more remains to be done. Recent studies on OCD have investigated comorbid conditions and the impact on treatment, and family factors that may contribute to OCD. Current research on treatment is examining the efficacy of group treatment and of certain drugs (numerous studies), and the potential benefits of deep brain stimulation.

In this past year there have been exciting developments in the Twin Cities for OCD sufferers. The Obsessive Compulsive Foundation (OCF) held its annual conference in Minneapolis August 7–9 and brought in leading providers and researchers to offer workshops. August also marked the launch of the local affiliate of OCF (named “OCD Twin Cities”). This nonprofit organization is designed to improve services locally by providing information about support groups and treatment for people with OCD and their families. It also aims to educate the public about OCD and offer resources to mental health providers. The sidebar lists a number of local and national OCD resources.

Sidebar: OCD Resources

Obsessive Compulsive Foundation. National resource on OCD and related conditions. www.ocfoundation.org
OCD Twin Cities. Local non-profit affiliated with OCF to provide education, resources and assistance to treatment providers, individuals with OCD and family members. www.ocdtc.org
Trichotillomania Learning Center. National resource for individuals who experience compulsive hair pulling and skin picking. www.trich.org
Lakeside Center for Behavioral Change. Offering treatment and training on OCD, hoarding and related conditions. www.lakesidecenter.org
University of Minnesota–Fairview Hospital. Treatment and Research in OCD and related conditions. 612-273-9800
Madison Institute of Medicine. Journal articles and abstracts on OCD and related conditions. www.miminc.org

OCD Awareness Week: Oct. 13-19. Check the Web sites above for event listings.

Table 1. Examples of obsessions and compulsions

Obsessions	Unwanted, involuntary thoughts, impulses, or images that repeatedly enter one's mind. Common obsessions include fears of contamination, harm coming to loved ones, losing control and doing something violent or sexually inappropriate, religious or moral scrupulosity, and fears of hitting someone when driving.
Compulsions	Actions performed deliberately and repeatedly in order to decrease anxiety that is experienced due to the obsessions. Examples include hand washing, cleaning, tapping, checking, praying, repeating, rereading, achieving symmetry, and avoidance behaviors.

Table 2. Frequent misdiagnoses in patients with OCD

Misdiagnosis	Reason for Misdiagnosis
Depression	Depression often coexists with OCD (25%–30%).
Social phobia	Because social anxiety is a common consequence of OCD (40%), OCD is often misdiagnosed as social phobia or avoidant personality disorder.
Agoraphobia	Some patients with OCD are housebound and can be misdiagnosed with agoraphobia.
Psychotic disorder	Beliefs associated with OCD can be of

	delusional intensity.
Compulsive sexual behavior or pedophilia	OCD patients who suffer from sexual obsessions will describe intrusive thoughts about sexual activities, sometimes with children. Most clinicians are unfamiliar with the "taboo" obsessive subtype.
Substance use disorder	Chemical dependency is often a response to untreated OCD.
Obsessive compulsive personality disorder	Focusing on the behavior, such as perfectionism or list-making, without assessing whether it is egosyntonic or dystonic or whether it involves the need for order, symmetry, and arranging may result in misdiagnosis.
Attention deficit hyperactivity disorder	OCD patients with "incompleteness" or "just right" symptoms often display low motivation, repeating rituals, and these often look like procrastination and difficulties with attention and focus.

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