Diagnosis and Treatment of Obsessive-Compulsive Disorder

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Obsessive-compulsive disorder (OCD) is a syndrome characterized by persistent, unwanted thoughts or impulses (obessions), and repetitive, ritualistic behaviors which the person feels driven to perform (compulsions). A cardinal feature of this syndrome is that it is ego-dystonic; the individual attempts (at least initially) to ignore or suppress the obsessions and compulsions and recognizes that his or her preoccupations are excessive or unreasonable. This internal struggle is called resistance, and it is present in all but the most severe cases of OCD. A further hallmark of OCD is that the obsessions or compulsions cause significant interference in functioning. According to DSM-III-R criteria, another Axis I disorder may be present; however, the content of the obsession should be unrelated to it (ie, guilty thoughts in the presence of major depressive disorder or thoughts about food in the presence of eating disorder should not be considered symptoms of OCD).

SYMPTOM CLUSTERS

- Washers

Washers, who represent about 50% of most OCD samples, are obsessed with dirt, contamination, germs, or bugs. These patients may spend several hours each day washing their hands or showering. Typically, they try to avoid sources of "contamination," like public restrooms, door knobs, etc. Although the patient states, "I know I am not really going to transmit cancer if I don’t wash," the patient may refuse to shake hands or to touch public phones. Occasionally, washers are not even certain why they are washing, expressing a vague sentiment that "something terrible will happen if I don’t."

- Checkers

A second presentation for OCD involves pathologic doubt with compulsive checking. Some patients have an incessant need for symmetry or matching objects, but typically the "checker" is concerned about hurting others. Checking, which is enough to resolve normal uncertainty, often only contributes to the obsessional's doubt. For instance, a fear of driving over a child leads to repetitive checking after hitting bumps in the road. A fear of causing a fire leads to checking the stove, even to the extent that the patient cannot leave home. Ultimately, by some inescrutable means, the patient resolves a particular doubt, only to have it replaced by a new obsessional preoccupation. Resistance, which in this case is the attempt to refrain from checking, leads to difficulty in concentrating and exhaustion from the never-ending assault of nagging uncertainties.
Pure Obsessions

A third clinical picture is that of the pure obsessional. Approximately 25% of OCD patients are in this category. Repetitive, intrusive thoughts, usually sexual or aggressive and always reprehensible, may be associated with impulses (which have been called horrific temptations) or fearful images. When the obsession is an aggressive impulse, it is most often directed at the one person most valuable to the patient.

Resistance, which may involve cognitive (e.g., counting or counter-thoughts) rather than behavioral rituals is common. A patient who was afraid that he would decapitate his younger brother struggled with this impulse by avoiding sharp objects, then avoiding his family, and ultimately avoiding letters of the alphabet with his brother's name. However, each time he would encounter the word "ax" or his brother's initials, he went through an extensive internal "counter-ritual" to undo the image of deception.

Primary Obsessional Slowness

Finally, there is the rare and disabling syndrome of primary obsessional slowness. Although slowness results from most rituals, occasionally it becomes the predominant symptom. These patients feel that everything needs to be "just right" and so it may take them an hour or more to brush teeth or two hours to prepare breakfast.

In many cases, washing and checking coexist. In addition, one may see adult patients with pure obsessional complaints who give a history of compulsive handwashing or compulsive checking during young adulthood. Thus, within individuals these different symptom clusters may overlap or may develop sequentially.

Diagnostic Considerations

Obsessive-compulsive disorder is frequently confused with obsessive-compulsive personality or, as it is now called, compulsive-character disorder. Both disorders reveal a preoccupation with aggression and control; both utilize the defenses of reaction formation, undoing, intellectualization, denial, and isolation of affect. The psychoanalytic formulation suggests that OCD develops when these defenses fail to contain the obsessional character's anxiety. In this view, OCD is on a continuum with obsessive-compulsive character pathology. Epidemiologic evidence, however, reveals that compulsive-character pathology is neither necessary nor sufficient for the development of OCD and that a substantial number of patients with OCD do not exhibit premorbid compulsive traits. Diagnostic confusion can be avoided if one remembers that OCD patients have ego-dystonic symptoms, whereas compulsive character traits are ego-syntonic, rarely provoke resistance, and are not usually associated with a sense of compulsion.

A further diagnostic dilemma arises in very severe cases of obsessive-compulsive disorder when patients may briefly relinquish the struggle against their symptoms. At such times, the obsession appears to shift from an ego-dystonic intrusion to a psychotic delusion. It may be tempting to label such a patient schizophrenic, but follow-up data reveal that psychotic decompensations occur in many true obsessives who never develop schizophrenia. For such patients, the term obsessive-compulsive psychosis has been suggested.

Prevalence

The prevalence of OCD in the general population, although traditionally thought to be 0.05%, has been reported to be more than 2.0%.

TREATMENT

Of all psychiatric conditions, OCD has generally been considered one of the most refractory to treatment. Patients with this disorder frequently present with symptoms seemingly laden with unconscious symbolism and dynamic meaning. Yet psychodynamic treatments, particularly if loosely structured and
nondirective, often fail to reduce the symptoms. Two relatively new forms of treatment seem to fare better than the traditional psychodynamic approach.

First, a particular form of behavior therapy—namely, exposure coupled with response prevention—has been developed to treat those patients with rituals and avoidant behavior. Briefly, this treatment involves gradually exposing the patient to the feared object (e.g., urine, glass, feces) or feared situation (e.g., driving without checking) for increasing periods to permit habituation. An essential component of the behavior treatment is “response prevention,” that is, not permitting washing or other ritualizing following exposure.

In some cases, when exposure to the feared stimulus is not possible, the stimulus is experienced for increasing periods using “imaginal flooding.” The therapist instructs the patient to imagine and to mentally experience the worst consequence of his or her fear (e.g., that the patient would actually cause a disaster). This combined use of exposure and response prevention helps to reduce rituals: the patients do not usually develop new compulsive symptoms, and long-term follow-up confirms that the original symptoms do not return.

OCD patients without rituals (i.e., pure obsessonals) provide very little that can be approached with behavior therapy. Also, many patients with OCD may have secondary depressions, and these patients may be less responsive to behavior therapy. Finally, many patients who might be excellent candidates for behavior therapy refuse the treatment. Given the unproven efficacy of psychodynamic treatments and the restricted applicability of behavior therapy, the pharmacologic approach has recently become a second focus for clinical researchers interested in treating this disorder.

As might be expected with such a chronic and refractory condition, a wide variety of medications have been given to OCD patients. There have been case reports documenting responses to lithium, phenelzine, tranylcypromine, clonidine, and trazodone. All of these reports are limited to only one or two patients and the treatments are not placebo-controlled, so the most we can conclude is that more study is needed. Reports of several more extensive uncontrolled medication trials have been published. Jenike and coworkers described a series of OCD patients treated with MAO inhibitors. Curiously, they report improvement only in those patients with a history of panic attacks. A novel suggestion that neuroleptics are useful during acute exacerbations of OCD. Benzodiazepines have not been adequately investigated for obsessive patients, although obsessive symptoms in other anxiety disorders appear refractory to benzodiazepines.

The most promising developments, however, have been with the tricyclic antidepressant clomipramine (Anafranil, CIBA-Geigy). Although clomipramine (CMI) is not yet available for general clinical use in the United States, it has been widely used elsewhere for over 20 years. Since 1980, eight double-blind studies using clomipramine have been published. In all of these studies, clomipramine appears more effective than placebo or a comparison drug for reducing OCD symptoms. Perhaps most surprising is that several other excellent antidepressants studied, including nortriptyline, desipramine, and clorgyline, do not appear better than placebo, and in this disorder, placebo treatment is consistently without beneficial effects. When the data from all these double-blind studies of clomipramine in OCD are combined, of 116 patients treated with clomipramine, approximately two thirds reported significant improvement.

Our experience with more than 40 patients has been that most of the patients who responded to clomipramine felt that it was easier for them to resist the obsessive-compulsive symptoms. Consequently, they would spend significantly less time being engaged with OCD symptoms; however, most of them are not symptom-free. Moreover, the majority of patients relapse after discontinuation of clomipramine even following a year of treatment (Pato et al, personal communication, 1987).

Although it once was suggested that clomipramine was effective in treating the obsessive-compulsive symptoms by an antidepressant mechanism, the majority of controlled studies found that its antipsychotic effects occurred whether the patient was depressed or not. Benzodiazepines resemble other nonaffective disorders such as panic disorder, anxiety disorder, bulimia, enuresis, migraine, and chronic pain syndrome, in which several tricyclics are also found to be effective in the absence of initial (either primary or secondary) depression. Unlike these other disorders (and in striking contrast to depression), in OCD only clomipramine among the tricyclics has been demonstrated to be effective.

THE SEROTONIN HYPOTHESIS

The serotonin hypothesis for OCD was put forward mainly due to the specific antipsychotic effects of clomipramine, because this drug is distinguished by its high potency for serotonin reuptake blockade. Recently, other nontricyclic selective serotonin reuptake blockers such as fluoxetine and fluvoxamine have also been reported to be effective in OCD. Further support for the
serotonin hypothesis is derived from a recent report that single dose oral administration of the serotonin agonist methchlorphenylpiperazine (mCPP), which has very limited behavioral effects in normal volunteers, profoundly increases obsessive-compulsive symptoms in patients with OCD. Additional studies directed to other neurotransmitters are certainly warranted.

CONCLUSION AND IMPLICATIONS

OCD has been considered a rare, treatment refractory disorder, entirely of psychological origin. Recent research has demonstrated that the lifetime prevalence of OCD in the general population is more than 1% and that both behavioral techniques and the tricyclic clomipramine are effective treatments. Unfortunately, clomipramine is not yet available in the United States. Aside from sending OCD patients to Canada to obtain clomipramine, what can psychiatrist in the United States offer these patients pharmacologically?

Preliminary data from studies with two new nontricyclic serotonin reuptake blockers (fluvoxamine and fluoxetine) are promising; however, both remain investigational. Lithium augmentation of imipramine is believed to increase the tricyclic's serotoninergic effects, and thus might be useful in treating OCD. MAO inhibitors, other than clorgyline, also seem promising, although controlled studies remain to be done. A combined approach—using both behavioral and pharmacologic interventions—is not yet proven, but ultimately may be the most effective treatment.

Finally, it should be noted that the availability of effective behavioral and pharmacological treatment is essential, but not sufficient, for the comprehensive treatment of OCD. The context in which the symptoms of OCD have persisted needs careful evaluation. Providing a therapeutic role for the family and encouraging the patients to take risks and to push themselves into work or school may be critical to the ultimate outcome.

REFERENCES


