

OCD in Adults

CLINICAL PRACTICE GUIDELINE *for the* TREATMENT of Obsessive-Compulsive Disorder in Adults (Summary)

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OCD in Adults

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OCD in Adults & Children

SUMMARY CARD *for* DIAGNOSING & TREATING OBSESSIVE-COMPULSIVE DISORDER *in* ADULTS & CHILDREN

DIAGNOSIS*

- Either obsessions and/or compulsions are present.

Obsessions are:

- Recurrent thoughts, impulses, or images experienced as intrusive and distressing, often causing anxiety.
- These are recognized by the patient as deriving from his/her own mind.
- The obsessions are not simply excessive worries about real-life problems.

Compulsions are:

- Repetitive behaviors (hand washing, ordering, checking) or mental acts (praying, counting, repeating words/phrases) that the person performs to neutralize the obsessions, i.e., to reduce distress or prevent a dreaded event from happening.
- The compulsions are not realistically connected to the obsessions.
- These symptoms usually never produce pleasure, to be distinguished from compulsions that do (gambling, substance abuse, sexual compulsions).
- The person has at some time recognized that these are excessive/unreasonable (does not apply to children).
- The obsessions or compulsions cause marked distress, consume over 1 hr/day, or interfere with the person's functioning.
- The disturbance is not due to another psychiatric, substance abuse, or medical condition.

ONSET

80% of patients with OCD may have onset of symptoms in childhood and adolescence, so it is crucial to do routine screening, especially with youngsters, even outside of Psychiatry. Average age of onset in children is 9 years for boys and 13 years for girls. Onset after age 40 is rare, in which case a medical and/or neurological exam is appropriate. When unrecognized, years may elapse before appropriate treatment, making the disorder often more difficult to treat.

Helpful screening questions for providers in Primary Care and Psychiatry are:

For Adults:

- Do you have ideas, images, or impulses that seem silly, weird, nasty, or horrible?
- Are you overly concerned with cleanliness or fearful of contamination?
- Do you have to wash your hands repeatedly?
- Do you need to check locks, switches, or calculations repeatedly?
- Do you need to do things in a ritualized way or need to have things exactly symmetrical?
- Do you need to repeat certain actions over and over until it feels just right?
- Do you fear doing something impulsively that might cause embarrassment or harm?

For Children:

- Are you thinking things and doing things that you would like to stop but can't?
- Are there worries you can't kick out of your mind even though they may seem silly to other people?
- Do you have certain actions or routines that aren't really necessary/seem foolish or make you feel crazy, but you do them anyway?

For Parents:

- Does your child show an unusual tendency to keep things in order?
- Does your child wash himself or herself much more than other children?

REFERRAL *for* SPECIALIZED TREATMENT

A thorough evaluation in Psychiatry is strongly recommended.

Evaluation should include questions about substance abuse and suicidal/homicidal ideation.

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TREATMENT

The two treatments effective for OCD are OCD-specific cognitive-behavior therapy (CBT) and pharmacotherapy. CBT alone is at least as effective as medication alone in mild-to-moderate OCD.

BEHAVIORAL MEDICINE & PRIMARY CARE

- Patients should be informed that their condition requires specialized treatment, CBT and/or pharmacotherapy
- Patients should be informed of the efficacy of CBT
- Primary Care providers should not automatically prescribe medications unless:
 - The patient refuses to be treated in Psychiatry
 - The case is urgent and/or severe
 - The patient requests medication treatment alone
 - The patient is receiving maintenance pharmacotherapy

PSYCHIATRY/MENTAL HEALTH

- CBT is recommended for all patients, regardless of OCD severity
- Choosing CBT alone, pharmacotherapy alone, or combined CBT + medications
 - CBT alone is recommended:
 - For mild-to-moderate OCD
 - If patient prefers CBT alone
 - When compulsions predominate and the case is not severe
- Combined treatments are recommended:
 - For moderate-to-severe range of OCD and/or significant functional impairment
 - Refractory cases
 - Presence of moderate-to-severe depression
 - CBT added to withdraw from medications
- Medications alone are recommended:
 - If patient prefers medications alone
 - If patient does not comply or improve with CBT

Pharmacotherapy

ADULTS: An SSRI is usually indicated as first choice, followed by another SSRI or clomipramine if needed. An adequate drug trial is usually 8-13 weeks. If the patient does not respond, consider augmenting agents. Neuroleptics should be used with caution. With elderly patients, start with lower doses and increase very gradually.

Average Doses of SSRIs in the Treatment of OCD in Adults

MEDICATION	AVERAGE DOSE	MAXIMUM DOSE
Fluoxetine (Prozac)	40-60 mg	80 mg
Paroxetine (Paxil)	50 mg	60 mg
Sertraline (Zoloft)	150 mg	200 mg
Fluvoxamine (Luvox)	200 mg	300 mg
Citalopram (Celexa)	40-60 mg	60 mg
Clomipramine (Anafranil)	100-250 mg	300 mg

CHILDREN: In prepubertal children, CBT is the first choice of treatment, even in more severe cases; medications can be added as needed. In adolescents, CBT should be the first choice in mild-to-moderate cases, CBT + SSRI in moderate-to-severe cases. SSRIs are the medication treatment of choice. Consider clomipramine only in refractory cases. Usually, it is not advisable to add clonazepam to augment.

Average Doses of SSRIs in the Treatment of OCD in Children & Adolescents

MEDICATION	TYPICAL DOSE RANGE
Fluoxetine (Prozac)	3-50 mg
Paroxetine (Paxil)	10-40 mg
Sertraline (Zoloft)	50-200 mg
Fluvoxamine (Luvox)	50-200 mg
Citalopram (Celexa)	10-40 mg
Clomipramine (Anafranil)	50-200 mg

INTRODUCTION

- This guideline is a summary version of the longer, comprehensive *Clinical Practice Guideline for the Treatment of Obsessive-Compulsive Disorder in Adults and Children*. The long version is available via Lotus Notes in the Kaiser Permanente Clinical Library (*cl.kp.org*) and on hard copy. Those interested in learning more about the disorder and the research behind the treatment recommendations therein are strongly encouraged to access and read it. *The longer version has all the references substantiating the findings.*
- The summary version you are holding was prepared in a "user-friendly" format for every clinician.
- The "road maps" for clinicians, administrators, and patients are designed to help us deliver a uniform message and up-to-date treatment package.

Y-BOCS

The Yale-Brown Obsessive Compulsive Scale (Y-BOCS) is used widely to assess severity and treatment outcome (Goodman, Rasmussen, Price, et al., 1989c). We have obtained permission to use it within Northern California Kaiser Psychiatry.

The Clinician's Card

This quick reference summarizes the recommended steps in the assessment and treatment of OCD in adults and children.

The Administrator's Card

This information is intended for key administrators in each clinic. It outlines the necessary resources and programs required to implement the services needed for those who suffer from OCD.

Obsessive-Compulsive Disorder (OCD): Information and Treatment Choices (for patients)

This tip sheet, edited and distributed by Health Education, describes briefly the nature of OCD and treatment options. It is important that clinicians do *not* give patients information inconsistent with that on the tip sheet.

THE NATURE of OCD

Obsessive-Compulsive Disorder (OCD) is characterized by *obsessions*, i.e., persistent ideas, thoughts, images, or impulses, which are experienced as intrusive, unacceptable, and cause marked anxiety and distress. *Compulsions* are behaviors or mental acts designed to neutralize the feared obsessions. Many patients resort to *avoidance* of stimuli and situations that may trigger the obsessions or compulsions. The OCD can be severe enough to significantly interfere with the person's normal life, either in occupational or social spheres.

Anxiety is a significant factor, which means that people with OCD readily perceive themselves as being in danger. However, individuals

with OCD also express feelings of tension, guilt, irritability, as well as frustration about being "stuck." Some rituals often seem to serve more a function of being tension-reducing than harm-avoidant. A number of individuals seem unable to identify an anticipated threat or why a special ritual is being performed. They may follow rigid and stereotyped rituals following idiosyncratic rules and gain a strong sense of relief upon the satisfactory completion of the act, i.e., they repeat a ritual until a "just so" feeling state is achieved.

Once fear is acquired, avoidance and compulsions develop to reduce the fear. While obsessions are perceived as involuntary and give rise to anxiety and distress, ritualizing (both overt and covert) is voluntary, controlled behavior, often following very strict idiosyncratic rules, and it is often associated with anxiety relief. Neutralizing attains major proportions in the disorder. The individual sees the ritual as a means to prevent harm from occurring; it has a reparative, corrective function.

There are two peak *modal* ages of onset, in early adolescence and early adulthood. The average ages in the first group are nine years for boys and thirteen for girls; 30-50% of adults reported remembering having OCD before the age of fifteen. The average ages of onset in the adult group are 20 for men and 25 for women. Hence, males show OCD at earlier ages, but more women have it overall.

DIAGNOSIS

The formal criteria for the diagnosis of OCD from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, are listed in Table 1.

RELATED OCD SPECTRUM DISORDERS & DIFFERENTIAL DIAGNOSIS

Two to three percent of the U. S. population has OCD in the strict sense, while up to 10% may have an OCD spectrum disorder. Spectrum disorders are characterized by some degree of compulsive or impulsive behavior. In this Guideline, we will keep to the narrow definition of OCD. Many disorders involving impulsivity are not OCD and do not respond to OCD-specific treatment, e.g., trichotillomania, sexual compulsions, pathological gambling, kleptomania, and self-injurious behaviors.

Whereas OCD is a DSM-IV Axis I disorder, Obsessive-Compulsive Personality Disorder (OCPD) is an Axis II DSM-IV disorder. OCPD involves a pervasive preoccupation with orderliness, perfectionism and control, excessive devotion to work and productivity; rigidity about ethical, moral, and other issues; and inability to discard useless items. Hoarding is defined as an OCPD symptom, but extreme hoarding (when a fire hazard exists or it is difficult for people to walk through the house) is seen as OCD.

COMORBIDITY

A number of comorbid conditions tend to occur with OCD: Major Depressive Disorder, other anxiety disorders such as Specific Phobia, Social Phobia, and Panic Disorder. As a result of the high level of anxiety associated with OCD, patients are more susceptible to excessive use of alcohol and anxiolytic medications. When the obsession reaches delusional proportions, the additional diagnosis of Delusional Disorder or Psychotic Disorder Not Otherwise Specified may apply. The specifier *With Poor Insight* applies to cases on the boundary between obsessions and delusions.

Of particular interest is the close association between Tic Disorders, especially Tourette's syndrome, and OCD. Tourette's syndrome consists of behaviors that seem more to be provoked by physical sensations and involve grunting, blinking, or repeating words and gestures; there are often concurrent OCD rituals.

TABLE 1. DSM-IV CRITERIA FOR OBSESSIVE-COMPULSIVE DISORDER, 300.3

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 (but 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 PRESENTATION & OCD SUBGROUPS

OCD is a heterogeneous disorder. Some of the most common subgroups are:

- **CONTAMINATION:** Obsessive fear of contamination by dirt, germs, or toxic substances (the most common obsession), coupled with avoidance of the feared substances and compulsive washing when these objects have been touched.
- **PATHOLOGICAL REPEATED DOUBT:** Obsessive worry that he or she forgot to do something that will result in a terrible event. The paired compulsion involves constant checking to be sure, such as checking the oven for fear that the house may burn down.
- **AGGRESSIVE OR SEXUAL IMAGERY:** Obsessive fear of performing horrific aggressive or sexual acts, or intrusive thoughts of an aggressive or sexual nature. Compulsions related to these thoughts may involve confessing and/or needing to be reassured that he or she will not do it (or did not do it), avoidance of objects such as knives, or mental counting or praying rituals.
- **HYPOCHONDRIACAL CONCERNS:** Obsessive fear of ill health and the compulsion to repeatedly obtain medical reassurance.
- **FEAR OF DISASTERS:** Obsessive fear of imagined disasters, with the compulsion to perform rituals, such as keeping objects or events in a certain order or place, to ward off the imagined disasters.
- **OBSESSIONAL SLOWNESS:** Extreme slowness in behavior due to counting or ordering.

Some additional obsessions not included above are: concern/disgust with bodily wastes and secretions, fear of embarrassing acts, worry that a task has been done poorly even when the person knows this not to be true, scrupulosity, and experiencing intrusive nonsense sounds, words or music. Additional compulsions include: repetitive touching, hoarding and collecting (often useless items), needing to say certain things or to apologize, and miscellaneous rituals such as licking, spitting, writing, reading, and speaking.

A WORD about ETIOLOGY

Genetic and nongenetic factors in the form of structural damage (neuroanatomy) with its accompanying functional changes (pathophysiology), and/or neurochemical (neurotransmitter) abnormalities exist in OCD. Functional neuroimaging studies have shown regional blood flow abnormalities that suggest dysfunction in the fronto-striatal-thalamic-cortical network. A number of other areas are implicated as well. Metabolic abnormalities in specific regions have been shown to normalize following successful treatment with selective serotonergic reuptake inhibitors as well as with behavior therapy. OCD can develop secondary to some systemic conditions or neurologic illnesses such as brain traumas, toxins, and infections (e.g., Sydenham's Chorea).

In spite of the many studies done, current techniques do not allow the determination of whether abnormal activity in a specific region is (a) primarily defective and responsible for OCD, (b) constitutes a functional region attempting to compensate for a defect, (c) is secondarily defective and caused by upstream fronto-striatal-cortical dysfunction, or (d) represents a nonspecific anxiety response to OCD-produced distress.

Neuropsychologic function can be seen as an intermediate step between brain dysfunction and clinical phenomenology. A number of studies show that people with OCD have impairment in visuospatial ability, nonverbal memory, and executive function.

Early learning experiences that may contribute to the etiology of OCD are: religious scrupulosity, excessive sense of responsibility instilled in the child, and critical or near-critical incidents (e.g., a child's wishing his or her mother were dead coinciding with the mother's actual or near death).

Cognitive belief domains that may contribute to the *maintenance* of the disorder are:

- *Inflated responsibility*, i.e., the person feels powerful enough to bring about or prevent harm.
- *Overestimation of the importance of thoughts*, i.e., the obsessive thoughts reflect the person's true nature, and thoughts equal action (thought-action fusion).
- *The importance of controlling one's thoughts*. The unacceptable thoughts must be controlled.
- *Overestimation of danger/threat*, i.e., an exaggerated belief that a bad event will occur. Overestimation of probability and/or severity of an event.
- *Intolerance of uncertainty*, i.e., worries about making the wrong decision.
- *Perfectionism/a perfect state*. There is a perfect state that must be achieved. Beyond perfectionism, the striving for a "just right" feeling is related to a strong sense of *sensory incompleteness*.
- The domains of beliefs in *boarders* center primarily on *perfectionism, intolerance of uncertainty, and overestimation of danger and threat*. The hallmarks of hoarding are: an over-emotional attachment to possessions, indecisiveness, perfectionistic concern over mistakes, judgments about their need to save.

EVALUATION

IDENTIFICATION of OCD

Since many patients with OCD first seek help in Primary Care and Dermatology, providers there can play a significant role in ensuring proper referral. This requires often great sensitivity and involves:

- Building trust so that the patient can get over his or her embarrassment and accept the diagnosis.
- Dispelling the patient's false beliefs about the symptoms.
- Making a diagnosis and sharing how it was determined.
- Contracting for specialized treatment if the patient is prepared to commit to it. (*Note: This is likely to require referral to Psychiatry/Mental Health Departments.*)

Some *general screening* questions that providers in Primary Care and Psychiatry can ask adults to flush out the potential for an OCD diagnosis are:

- Do you have ideas, images, or impulses that seem silly, weird, nasty, or horrible?
- Are you overly concerned with cleanliness or fearful of contamination?
- Do you have to wash your hands repeatedly?
- Do you need to check locks, switches, or calculations repeatedly?
- Do you need to do things in a ritualized way or need to have things exactly symmetrical?
- Do you need to repeat certain actions over and over until it feels just right?
- Do you fear doing something impulsive that might cause embarrassment or harm?

ASSESSMENT

A thorough assessment of OCD is likely to span two regular therapy-hour sessions. The first session focuses on the presenting problem, the patient's history, family history, past treatments and their outcome, the use of substances, relevant medical history and current medications, comorbid symptoms, and a mental status exam with assessment of risk factors (e.g., suicidality). In the case of comorbidity, the *primary* problem should be identified, which then becomes the first area of intervention. Some OCD patients are obsessed with fears of harming someone, often a child or adult family member; for a differential diagnosis, questions on actual violent acting out is then important. (But note that absent this, OCD patients never act on their violent obsessions.) The second session could focus on specific OCD-related information (including an inventory of specific obsessive and compulsive symptoms), which is needed to form a good treatment plan. Note that gathering information on *current* symptoms, fears, and functioning is much more important for treatment than extensive history of past symptoms.

While adult individuals with OCD may be very willing to describe their compulsions and some obsessions at the time they seek help, they may also be vague about obsessions because of lack of awareness or avoidance. Shame may also prevent patients from revealing some magical thought-behavior connections because they seem so irrational, or from revealing uncomfortable compulsions, e.g., seemingly peculiar and aversive toilet rituals. Important to keep in mind here is that many such details, important for treatment, will not be divulged unless asked.

Of the various rating scales used, we recommend the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS, Goodman, Price, Rasmussen, et al., 1989a, 1989b, 1989c). The standard Y-BOCS includes a symptom checklist and measures of the amount of time obsessions and compulsions consume, level of distress, interference, degree of resistance, and perceived control over them. It can be filled out between the two evaluation sessions and be used to clarify core OCD symptoms as well as severity. The assessment should include level of occupational and social functioning, and the impact the OCD person's symptoms have on other family members. The Y-BOCS, if given also at the end of treatment, can help assess treatment response. The Y-BOCS score ranges from 0 to 40; 0 to 10 indicates very mild symptoms, 10 to 15 mild symptoms, 16 to 25 moderate symptoms, and over 25 severe symptoms (Baer, 1991).

TREATMENT

The two treatment modalities that have been studied systematically, and have been shown empirically to have specific efficacy in the treatment of OCD in adults, adolescents, and children are cognitive-behavior therapy (CBT), particularly exposure and response prevention (ERP), and pharmacotherapy, specifically serotonin reuptake inhibitors (SRIs). While complete elimination of OCD symptoms is uncommon, both treatment modalities can be seen as effective in improving obsessions and compulsions. Both treatments, ERP and SRIs, when effective, have been shown on positron emission tomography (PET) scans to correct the abnormalities in cerebral glucose metabolism.

COGNITIVE-BEHAVIOR THERAPY (CBT)

Exposure & Response Prevention

ERP has shown efficacy in the treatment of OCD in children, adolescents, adults, and the elderly. However, in spite of its success rate, not all patients follow through with ERP: Up to 25-30% of patients do not comply with the treatment, i.e., do not accept it, drop out, or do not complete it. Therapist and patient must be aware that no current treatment is perfect and that OCD tends to be a chronic condition. While total cure may be hoped for, a significant increase in functioning and decrease in distress is a much more likely outcome.

The therapist starts by helping the patient create a hierarchy of 1 to most feared stimuli using a Subjective Units of Distress Scale

(SUDS), where 0 denotes no fear and 100 maximum fear. Although graded exposure starts low on the hierarchy and flooding starts with the most difficult items, many clinicians find it most helpful to start with mid-range items of a SUDS of 40 to 60.

Exposure involves deliberately seeking contact with the feared stimulus. This is combined with *response prevention*, which means that the patient refrains from performing the compulsion. The exposure trial works best if it arouses a great deal of anxiety and is prolonged until the anxiety diminishes or subsides. This is then likely to lead to habituation, a neurobehavioral response, i.e., decrease of physical and emotional reactions to fear. Exposure without response prevention or exposure followed by escape do not allow habituation to occur. For example, a patient with contamination fears is asked to touch a public toilet seat as exposure without washing his or her hands afterwards. If the patient *refrains from using his or her hands* until there is an opportunity to wash, the exposure does not work. Rather, the task is to "contaminate" his or her body, face, and many items in the house with the hands. If an exposure task is too difficult for a patient, an intermediate step consists of postponement of the ritual for a determined amount of time, e.g., 15 minutes, 1 hour, etc. In the example above, the person postpones washing his or her hands (but still using them) for 1/2 hour or 1 hour.

ERP When Comorbidities Exist

Response to ERP is not consistently predicted by duration or severity of OCD, type of OCD symptom, age of symptom onset, age at treatment, level of education, marital status, marital dysfunction, pretreatment level of social and family support, pretreatment level of anxiety, comorbid Axis I disorders, including mild-to-moderate depression, additional anxiety disorders, and/or comorbid personality disorders.

Depression does not contraindicate ERP for OCD, and mild-to-moderate depression may improve after ERP. However, there is some evidence that *severe* depression may negatively impact treatment. (For the treatment of depression, consult the *Clinical Practice Guideline for the Treatment of Depression in Psychiatry*, 2000.)

Patients who are actively abusing substances should be assessed by a chemical dependency specialist before beginning OCD treatment. Usually, they should get treatment for the substance abuse first. In cases where the patient is clearly using substances to medicate their OCD, they can begin OCD treatment early on, but only after some period of sobriety. They may need continued and parallel chemical dependency services.

ERP is *not* the treatment of choice for: Obsessive-Compulsive Personality Disorder (when OCD is not present), Delusional Disorder, Schizophrenia, angry or depressive ruminating, compulsive eating, gambling, stealing, substance abuse, other impulse control disorders, or mental or behavioral/physical habits which reflect general tension and are not associated with fear. However, many of these problems can be treated with related cognitive and behavioral interventions.

Other Techniques Used in Conjunction with ERP

Imaginal Exposure/Flooding

In imaginal exposure and flooding the exposure is done covertly, often following a hierarchy and using relaxation. It is *not effective as a sole treatment* but can be used as rehearsal for or as an adjunct to in vivo exposure. Some evidence supports the use of imaginal exposure to obsessions, feared consequences, long-term consequences (e.g., developing cancer in 20 years, going to hell), or triggers which are difficult to create in vivo. There is some evidence that adding imaginal flooding to ERP results in better long-term outcome than ERP alone. As with in vivo exposure, this type of exposure can follow a hierarchy from less to more anxiety-provoking stimuli.

Cognitive Therapy

ERP as currently practiced contains a number of educational-cognitive elements, such as discussing relevant facts and the necessity of risk-taking, realistic estimates of safety, the impossibility of perfectionism, etc. Cognitive restructuring à la Beck is very different and involves addressing in a systematic way the three levels of cognitions (intrusions, appraisals, and assumptions or beliefs) and the *specific* belief domains that help maintain the distorted thinking. These are worked on via Socratic dialogue and thought records. In other words, the patient needs to reduce the catastrophic thinking and faulty assumptions and beliefs. Cognitive therapy is particularly helpful in addressing scrupulosity, moral guilt, and pathological doubt.

Thought Stopping

One can stop a thought by saying emphatically "Stop!", envisioning a Stop sign, clapping hands, etc.; this often requires repetition. Thought stopping is *contraindicated in the treatment of obsessive fears*. While it may briefly reduce obsessions, it precludes habituation and has a paradoxical effect, increasing both frequency of intrusive obsessive thoughts and discomfort over the thoughts. *Anything that interferes with exposure to the obsessive trigger (e.g., an intrusive thought) is contraindicated in the treatment of OCD.*

The one possible use for thought stopping is to disrupt mental rituals. The goal is to *prevent the mental ritual (response prevention)*. Additional techniques used specifically to prevent mental rituals include distraction, planned neutral thoughts, and/or immediately rethinking the obsessive thought (deliberate exposure).

Hoarding: Treatment Outline

Hoarding may respond to ERP, but treatment is more difficult since hoarding may be ego-syntonic and distresses others more than the patient, i.e., motivation for change is often low. While often uninterested in changing their behavior, patients may respond to a treatment plan where the stated primary goal is to create uncluttered living space, and the secondary goal is to help the patient develop better decision-making and organizational skills. Once the work begins, it becomes clear that discarding objects is unavoidable in order to reach the goals. Hence, discarding becomes increasingly more prominent as the work proceeds. In other programs, discarding is emphasized early, as is throwing things away without ritualized perfectionistic sorting.

Work is also aimed at reducing the accumulation of new possessions. If new possessions had been acquired in a particular place, e.g., a dumpster, the therapist may accompany the patient there. The patient identifies the desired items, and they stay there until the feeling of need subsides.

Variables to Consider in CBT

The literature suggests *effective therapists* know ERP, empathize with the patient's distress while providing optimism and motivation, inspire trust, insist on treatment compliance, and avoid antagonism and power struggles.

Recommendations on *treatment intensity and duration* vary, but most range from 13 to 20 sessions over 4-16 weeks. No firm conclusions can be drawn regarding the optimal *duration of exposure sessions*. Prolonged, continuous exposure is generally regarded as being more effective than short, interrupted exposure. The length of time recommended (for exposures) has varied from 30 minutes to 2 hours. Sessions that are too short to allow anxiety to diminish may leave the patient demoralized and more sensitized to the anxiety triggers. *Distraction during imaginal or in vivo exposure interferes with treatment.*

The overall trend has moved toward decreasing frequency and/or intensity of direct patient-therapist contact hours and focusing more on patient self-exposure and response prevention. Treatment has moved from inpatient to outpatient, from daily to twice weekly to weekly or less frequency, from individual to group, and still the majority of patients reach significant gains. The literature suggests, however, that the trend toward fewer and shorter sessions, longer time between sessions, and client self-exposure yields diminished treatment gains. Self-help approaches, whether with the aid of books or computers, also show less improvement and higher dropout rates compared with the therapist-led treatment.

Clinical practice has often emphasized and recommended individual over group treatment, but this is often based more on anecdotal experience than research, and group CBT has received far less. However, there have been studies showing that *group and individual ERP result in similar improvement.*

Adjunctive Bibliotherapy

Research comparing ERP with and without adjunctive bibliotherapy has not been conducted, but many expert researchers and therapists include bibliotherapy. Recommended books include: Baer's *Getting Control: Overcoming Your Obsessions and Compulsions* (1991), Foa and Kozak's *Mastery of Obsessive-Compulsive Disorder: Client Workbook* (1997), Foa and Wilson's *Stop Obsessing* (1991), Hyman and Pedrick's *The OCD Workbook* (1999), Mark's *Fears, Phobias, and Rituals: Panic, Anxiety and Their Disorders* (1987), Schwartz's *Brain Lock: Free Yourself From Obsessive-Compulsive Behavior* (1996), Steketee's *Overcoming Obsessive-Compulsive Disorder: Client Manual* (1999a), and Steketee and White's *When Once Is Not Enough* (1990). For scrupulosity and religious obsessions, Ciarrocchi's *The Doubting Disease* (1995) is recommended.

Elements of Cognitive-Behavior Therapy for OCD in Adults

Patient Motivation and Cooperation: Treating OCD requires that patients deliberately evoke and endure emotional distress in the short-term in order to obtain long-term benefit. Compliance with treatment is essential for improvement, and lack of compliance is the most common reason for lack of improvement. Patients need to understand that their treatment gains are directly related to the time and effort expended. Patients do less well who only confront some feared situations instead of all (including their most feared situation or thought), and who substitute a more subtle ritual or avoidance or otherwise avoid experiencing anxiety during exposures. Table 2 summarizes the key treatment elements.

TABLE 2. ELEMENTS of COGNITIVE-BEHAVIORAL TREATMENT for OCD in ADULTS

■ Psychoeducation

Patients need to learn about the interaction between behavior and biology, the treatment rationale, and what results can be expected with appropriate treatment. They benefit from having a good understanding about why ERP works. Patients are encouraged to label their obsessions as "OCD."

■ In Vivo and/or Imaginal Exposure to Obsessions

Patients must actively expose themselves to their obsessions and the situations that trigger their urge to ritualize. This applies whether the triggers and rituals are behavioral or mental.

Imaginal exposure is used when:

- The distressing trigger occurs infrequently or would be hard to create in vivo (e.g., contamination by dead raccoons, 13 minutes before or after the hour).
- The distressing trigger is a thought or image, not an external situation (e.g., blasphemous or violent images).
- The feared consequence is hard to confront in vivo because it is unlikely, far in the future, or truly catastrophic (e.g., getting AIDS due to being contaminated by touching doorknobs, the house burning down).

The patient deliberately focuses on his/her fears during extended, scheduled written, recorded, and/or read-out loud practices which after many repetitions foster desensitization. Catastrophic flooding tapes are powerful. The therapist should read in advance the text being taped to assure the absence of "safety" statements in between.

■ Response Prevention for Behavioral & Mental Compulsions

Both exposure and response prevention are essential for best treatment response. Each appears to target different symptoms and either alone results in markedly less improvement. *Strict elimination of rituals leads to best results.* Ten to twenty hours of treatment may be required. Self-exposure and response prevention must take place outside of therapy in addition to what is done in the sessions. Ideally, exposure should occur daily and ritualizing avoided for at least one hour or until the discomfort subsides.

■ Cognitive Therapy

A good adjunct to ERP, cognitive therapy should aim at *changing underlying faulty beliefs and accepting the obsessive triggers.* This goes far beyond a simple psychoeducational approach. The style is Beckian, using Socratic dialogue, thought records, and other cognitive techniques.

■ Relapse Prevention

Adding relapse prevention strategies helps patients maintain treatment gains in the long term. Patients are warned that OCD symptoms may fluctuate with stress and encouraged to continue practicing the treatment techniques on a weekly maintenance basis and to resume more intensive practice sessions when symptoms increase. On the positive side, patients can improve further after discontinuing therapy sessions, especially if they continue to apply the treatment skills in their daily lives. Booster sessions may help with long-term recovery and additional treatment should be available.

Psychotherapeutic Treatments and Techniques Not Useful with OCD

A large number of therapeutic approaches are not recommended because they are either not effective or are significantly less effective than ERP. These are: relaxation training, anxiety reduction/general stress reduction, stress inoculation training, aversion therapy/relief, covert sensitization, systematic desensitization, paradoxical intention, satiation, nondirective psychotherapy, insight-oriented psychotherapy, psychodynamic psychotherapy, and psychoanalytic psychotherapy. However, some of these interventions may be useful for problems that might accompany OCD.

PHARMACOTHERAPY

The physician treating an OCD patient with pharmacotherapy should be guided by information from two main sources:

- *Clinical experience and judgment*
- *Information about an extensive body of research*

While clinical judgment should remain the basis of decision-making, research findings are paramount in helping to determine the best treatment for the patient. Specifically, the prescribing physician should be aware of the findings on CBT and on pharmacotherapy.

Important Considerations in the Pharmacological Treatment of OCD

Four main considerations should be taken into account prior to initiating pharmacotherapy:

■ DEGREE OF OCD SEVERITY & FUNCTIONAL IMPAIRMENT

The treatment approach may vary markedly if a patient presents with a mild versus a severe condition. Those with mild-to-moderate range OCD can be offered CBT alone, which might have a good chance of success. On the other hand, the more severe the symptomatology and the more it interferes with the person's functioning, the clearer the indication for pharmacotherapy. Also, in cases where there is acute and severe anxiety at time of presentation, added medications might be considered.

■ PRESENCE OF COMORBID PSYCHIATRIC CONDITIONS

OCD is often accompanied by depression; in fact 85% of OCD patients have depression secondary to their OCD. If the depression truly is secondary to the OCD, it may remit as the OCD improves. Changes in OCD and depression often occur independently. Medications are likely to have a faster and more complete effect on the depression than on the OCD. If tics or extreme lack of insight are present, augmentation strategies may be needed in addition to an SRI.*

■ MEDICATION SIDE EFFECTS & EXPECTED RESPONSE

Noncompliance, either taking too low of a dose or discontinuing medication, is often due to side effects. While some physicians downplay these effects, it usually does not serve the patient well.

Patients should be told about available agents, dosages, side effects; when and what kinds of effects are likely to be noticed; and how long they can be expected to be taking the drug. They also need to be counseled about the importance of compliance, and the plan that will be followed if the initial drug/dose does not work. When it comes to expected effects, they need to understand that cures are rare but improvement common. This will help protect against unrealistic expectations.

■ QUALITY OF INTERACTION BETWEEN PHYSICIAN & PATIENT

Patients may be hesitant to try pharmacotherapy because they fear drug treatment, the side effects, or lack of efficacy. About one-fifth of patients do not respond to the first drug prescribed, and dose must often be adjusted. Changes in medication or dose can be trying to the patient.

When a patient seems highly resistant, it often behooves the physician to place more emphasis on the quality of the interaction and developing an alliance than having the patient walk out with a prescription, which they may not fill or take. Giving the patient the alternative of CBT and leaving the door open for future consultation is more likely to lead to positive results. If the patient is severely incapacitated or distressed by the OCD, a gentle yet more directive approach might be in order. It is helpful to explicitly weigh the cost/benefit ratio with the patient.

A number of experts recommend that CBT alone or the combination of CBT and medication be introduced first, depending on severity. If the initial treatment consists of CBT alone or medications alone and the results do not prove satisfactory, the other component can be added. If one treatment is initiated first, it is easier to help distinguish which effect is due to which treatment. Although it is true that medications may show some increasing benefits over the long term, most effects are usually observed during the acute phase.

First-Line Pharmacological Agents for Adults

The efficacy of serotonin reuptake inhibitors (SRIs*) in treating OCD has been established in many controlled research studies. They are the most studied and effective pharmacological agents for this disorder. As with CBT, poor compliance with pharmacotherapy occurs in at least 25% of patients.

SSRIs are usually the first-line agents for OCD, mainly due to their side effect profile. Clomipramine, at least as effective, is a more problematic drug. SRI side effects are often dose and time dependent. Higher doses and faster dosage increases are associated with more severe side effects. Tolerance to some side effects such as nausea often develops in 6-8 weeks, but not in regards to others, such as akathisia (from SSRIs), or anticholinergic reactions and postural hypotension (from TCAs).

* The term SRIs includes clomipramine and SSRIs.

SSRIs

Efficacy ratings of the various SSRIs appear indistinguishable. Of the currently used SSRIs, fluoxetine has the longest half-life, fluvoxamine the shortest, whereas paroxetine, sertraline, and citalopram are intermediate.

The effect of fluoxetine is reached in about two months, slower than in depression, and higher doses (up to 60 mg/day) are associated with a higher effect size as well as more side effects. If the patient is severely depressed, an SSRI may be less effective than a broader spectrum TCA, such as amitriptyline (*Elavil*). Citalopram has shown efficacy at 40-60 mg/day. Venlafaxine (*Effexor*) may possibly be effective according to small, uncontrolled studies.

If there is no response to the initial drug/dose trial, barring problems with side effects, it is usually best to increase the dose before switching medications or augmenting with another agent. Some researchers consider 12 weeks at full dose to be an adequate length of trial before a medication is considered a failure. If one SSRI is not effective after the adequate trial, trying another SSRI or switching to clomipramine may be the next alternative. It is not unusual to have to try a few medications before a patient responds.

Side Effects of SSRIs

The most common side effects associated with the SSRIs are gastrointestinal (nausea, diarrhea, vomiting), central nervous system (restless/anxious feelings, jitteriness), further headache, dizziness, tremor, dry mouth, sexual dysfunction, and insomnia. Some of these, such as nervousness, nausea, insomnia, headache, and diarrhea, tend to subside with time. Nausea can sometimes be decreased by taking the medication after the evening meal, and upward titration can be suspended until it abates. For insomnia, 25-50 mg/day trazodone at bedtime can be helpful. The most common side effects reported with citalopram are nausea, vomiting, sexual dysfunction, and insomnia.

SSRI Withdrawal Syndrome

Withdrawal symptoms after five weeks or more of treatment consist of dizziness, headache, vertigo, nausea, fatigue, flu-like symptoms,

insomnia, nervousness, paresthesiae, electric shock feelings. However, the effects seem less common with fluoxetine withdrawal, probably because of the drug's slower metabolism.

SSRI Drug Interactions

The "serotonin syndrome" consisting of agitation, myoclonus, choreiform twitching, autonomic instability, hyperthermia, and coma, can arise when SSRIs are combined with other drugs that augment serotonin (5-hydroxytryptamine, 5-HT) transmission. This can occur in conjunction with monoamine oxidase inhibitors (MAOIs).

Clomipramine (SRI)

Clomipramine shows similar side effects to those of other TCAs and carries the same risks for mortality in overdose. It is possible that individuals taking the same amount of the medication metabolize it differently.

Side Effects of Clomipramine

The most common side effects associated with clomipramine are anticholinergic (dry mouth, constipation), antihistaminic (sedation), and antiadrenergic (orthostatic hypotension). Further side effects are dizziness, fatigue, tremors, headaches, blurred vision, tachycardia, sexual dysfunction, and insomnia. Practical recommendations regarding some of the side effects: for sedation, the entire dose is best taken at bedtime; for postural hypotension, increased fluid and salt intake can be helpful; and in patients at risk for heart disease, an electrocardiogram (ECG) should be obtained before initiating therapy.

■ DOSING

Table 3 shows the average daily doses of SRIs in the treatment of OCD in adults (Goodman, 1999; Jenike, 1997; Koponen, Lepola, Leinonen, et al., 1997; Treatment of Obsessive-Compulsive Disorder, 1997). (Venlafaxine should be given at a maximum dose of 375 mg/day, according to Jenike, 1997).

TABLE 3. AVERAGE DOSES of SRIs in the TREATMENT of OCD in ADULTS

MEDICATION	AVERAGE DOSE	MAXIMUM DOSE
Fluoxetine (Prozac)	40-60 mg	80 mg
Paroxetine (Paxil)	50 mg	60 mg
Sertraline (Zoloft)	150 mg	200 mg
Fluvoxamine (Luvox)	200 mg	300 mg
Citalopram (Celexa)	40-60 mg	60 mg
Clomipramine (Anafranil)	100-250 mg	300 mg

* With elderly patients, it is advisable to start with lower doses and increase very gradually.

Other Pharmacological Agents

Intravenous Clomipramine

Clomipramine via an intravenous route has been shown to have a quick positive response, about five days, when compared to patients given oral clomipramine.

Monoamine Oxidase Inhibitors

Monoamine oxidase inhibitors (MAOIs) were used for OCD before the introduction of the serotonergic reuptake inhibitors. MAOIs used are phenelzine (*Nardil*) and tranylcypromine (*Parnate*). Few case reports and controlled studies have suggested that MAOIs may be very effective when used *alone* in patients with other comorbid anxiety disorders. MAOIs should *not* be combined with SRIs or buspirone to avoid a hypertensive crisis or what is known as serotonergic syndrome. It is further recommended that MAOIs not be started until there is at least a two-week wash-out period with buspirone, clomipramine, fluvoxamine, sertraline, and paroxetine, and at least a five-week wash-out period with fluoxetine.

Treatment-Refractory Patients: Augmenting Strategies

Treatment-refractory patients are considered to be those who have not responded to adequate trials of either SRIs or CBT. In this case, an adequate trial of ERP is considered to be at least 20-30 hours. An adequate trial of pharmacotherapy ranges from 8-13 weeks (but preferably 10-13) per drug without showing adequate improvement.

Data on augmentation are largely based on case studies and open trials and these uncontrolled trials have been contradicted by subsequent more definitive controlled studies. Hence, clinical judgment should always be used when choosing augmenting strategies. Most medication augmenting strategies (such as lithium and buspirone) are based on enhancing the release of the neurotransmitter serotonin in regions of the brain believed to mediate OCD symptoms.

SSRIs + Clomipramine

Clomipramine might be combined with an SSRI in an attempt at achieving a better response to the combination. Interestingly, even if a patient is intolerant to the side effects of either drug, the combination may be better tolerated in addition to providing a better treatment outcome.

Clonazepam

Clonazepam (*Klonopin*) has been shown to affect the serotonin system and can help in controlling OCD when added to an SSRI. It may be a helpful augmenting agent for patients with another comorbid anxiety disorder. The starting dose of clonazepam should be 0.5 mg daily up to 5 mg daily in divided doses. The prescribing physician should be alert and cautious about the possibility of dependence and tolerance.

Buspirone

There are conflicting reports regarding the efficacy of buspirone (*BuSpar*) as an augmenting agent for SSRIs or clomipramine. Buspirone may even worsen OCD symptoms when added as an augmenting agent. However, if used as an augmenting agent, the starting dose is 5 mg three times a day with a slow increase to a therapeutic dose of 30-60 mg per day.

Lithium

Case reports of augmenting effects of lithium to SSRIs appear promising, but some controlled studies have not been able to replicate its initial success.

Tricyclic Antidepressants

The addition of tricyclic antidepressants to ongoing SSRI treatment of OCD has been studied and appears to offer some benefit when patients are also suffering from depression. Caution should be exercised, however, as combination therapy of this kind may elevate serum levels of the tricyclic antidepressant and cause seizures.

Neuroleptics

Neuroleptics as augmenting agents should be considered particularly when there are coexisting tic disorders or schizophrenia-spectrum disorders. In cases of refractory OCD patients with and without comorbid tic disorders, haloperidol (*Haldol*) can be effective when added to fluvoxamine compared to fluvoxamine alone. Of the neuroleptics, risperidone (*Risperdal*) may be the better choice. It causes mild, transient sedation and a lower tendency for extrapyramidal effects compared with typical neuroleptics, though long-term effects are not known as well yet. Olanzapine (*Zyprexa*) is associated with rather significant weight gain. When augmentation with haloperidol or risperidone is considered, a low dose of 1-2 mg/day is usually recommended.

Pharmacological Agents of Questionable Effectiveness in OCD

Pharmacological agents that have not proven effective compared to clomipramine and the SSRIs are: imipramine (*Tofranil*), amitriptyline (*Elavil*), nortriptyline (*Pamelor*), desipramine (*Norpramin*), doxepin (*Sinequan*), Trazodone (*Desyrel*), cloglyline (an MAOI), and beta blockers. Agents that need to be tested further for efficacy are: zimelidine, venlafaxine, mirtazapine (*Remeron*), and nefazodone (*Serzone*).

Nonpharmacological Biological Treatments

Electroconvulsive therapy (ECT) has not been found to be effective. Surgeries and other biological procedures have been used rather extensively in treatment-refractory cases and becoming increasingly sophisticated.

PHASES of PHARMACOTHERAPY

INITIAL PHASE

- The initial phase is the period of time it takes to establish a good or adequate response in the patient with OCD.
- Treatment goals consist of: (a) significantly reducing the obsessions and compulsions to much more manageable levels, and (b) decreasing the patient's distress and increasing his or her functioning.

It is usually indicated to increase the medication dose to an average level, waiting 2-4 weeks between dose increases to observe its effects. If the patient does not respond, assuming side effects are tolerable, we recommend increasing the dose to its maximum within 4-8 weeks from the start of the treatment, and for partial responders within 5-9 weeks from the start of treatment. The initial phase may last anywhere from 3 to 6 months and up, depending on whether the goals have been reached.

MAINTENANCE PHASE

- The maintenance phase may last from six months to a year after the patient is stabilized on the medication(s).
- Treatment goals consist of consolidating treatment gains, while minimizing adverse side effects.

Responders often continue to improve for many months, even if very modestly. There are unfortunately no adequate control studies showing efficacy and safety of the SSRIs in the long-term treatment of OCD patients. In long-term maintenance of clomipramine and fluvoxamine, it is recommended that plasma drug levels be monitored.

Long-term maintenance doses should be considered at doses lower than the initially prescribed level; reductions of 1/3 to 2/3 have been reported as effective as the full dose. A significant dose reduction has the advantage of less exposure to the drug and lower cost. Because of the high rate of relapse, it is sometimes better to keep them at the lower doses than discontinue medications altogether. In general, medications are continued longer if the patient does not receive CBT as well or does not improve sufficiently with CBT.

DISCONTINUATION PHASE

- Patients who have remission of symptoms for at least 6 months are candidates for discontinuation of medications. It is recommended that they not be discontinued within less than 6 months to 1 year, or 1-2 years from the initiation of the medication treatment.
- The goals are discontinuation of medications after tapering dosage and relapse prevention.

Relapse is not uncommon even when patients have done well during maintenance, and symptoms often recur within a few weeks of discontinuation. Because of the high relapse rate in this population, many patients remain on medications.

Discontinuation should be gradual to assess relapse and to avert withdrawal symptoms associated with abrupt discontinuation. Patients should be encouraged to undergo CBT if they have not yet done so. Rapid discontinuation of medications is considered unacceptable, in part because of withdrawal effects. Gradual discontinuation implies a decrease of medications by 25% every 2 months, depending on patient response. If discontinuation is unsuccessful, the patient should be given the option of continued treatment.

CBT, PHARMACOTHERAPY, OR BOTH?

Most experts view behavior therapy (specifically ERP) as a critical and effective first-line treatment for OCD, yet this brand of treatment is all too often overlooked or unavailable. CBT is recommended for all patients. Other clinicians have concluded that the combination may be the most acceptable and successful approach for the majority of OCD patients.

The best available data suggest that behavior therapy is at least as effective as medication in some instances and may be superior with respect to risks, costs, and enduring benefits. Medications alone are rarely curative and are second-best to behavior therapy. Adding ERP to medications often results in increased improvement compared to medications alone. Several studies have found that the combination of ERP and medication is more effective than ERP alone; others have not found this. Clearly, making comparisons between studies is difficult because of differences in population size, subject variability, measures used, etc. Meta-analyses therefore often employ "effect size" statistics that allow comparisons to be made in spite of these differences. The larger the number, the larger the effect size, i.e., greater improvement. Table 4 provides a rough summary of the findings of effect size across a number of studies.

The majority of patients treated behaviorally maintain or improve their gains on follow-up after cessation of treatment. Nonetheless, symptoms fluctuate over time and some patients may need booster sessions.

To summarize, the combination of pharmacotherapy and CBT is only moderately supported in some published research and not in others. However, while combined treatment is frequently practiced and recommended, research evidence for that conclusion is lacking. Many studies on adults and children contain shortcomings, thus leaving unresolved several issues critical to the recommendation of combining the two treatments.

At this time there is sufficient support for the recommendation that all patients be offered CBT and that CBT be the sole treatment in mild to moderate OCD, provided that this is acceptable to the patient. Until and unless shown otherwise, most patients with a moderate to severe range of OCD are likely to benefit from combined treatments.

TABLE 4. TREATMENT EFFICACY: SUMMARY of RESEARCH FINDINGS

TREATMENT	% OF PATIENTS IMPROVED (AVERAGE RANGE)	% OF SYMPTOM REDUCTION (AVERAGE RANGE)	EFFECT SIZE (RANGE)
CBT	75-85%	50-100%	Indiv. 1.47-2.10 Group: .29-2.69
Pharmacotherapy	22-65%	20-40%	.35-1.53

PROS & CONS of EACH TREATMENT MODALITY

Cognitive-Behavior Therapy

The pros of CBT are:

- Current data support CBT as a sole treatment for mild to moderate OCD.
- Regardless of severity, CBT is recommended for every OCD patient, if the patient accepts and is able to comply with it.
- Medications add little to ERP when ERP works.
- CBT shows more durable effect after treatment is stopped as compared to medications.
- ERP may be especially helpful when compulsions predominate.
- ERP can work even with long-standing and relatively severe conditions.
- CBT is more cost-effective in the long-term, particularly when delivered mainly in group format.

The cons of CBT are:

- From 25-30% of patients refuse, drop out, or do not respond to ERP. This can at times be ameliorated by adding more pure cognitive therapy, possibly as a lead-in to ERP.
- Current expertise at Kaiser in the CBT-delivery of OCD treatment is limited compared to the highly trained and experienced professionals involved in the research that has produced such good results. This points to the need for continued high-quality training for Kaiser psychotherapists.

Pharmacotherapy

The pros of pharmacotherapy are:

- If the patient's condition is severe and there is functional impairment, medications are often indicated.
- Patients with moderate to severe depression should be offered medications, and they may need medications alone until the depression lifts enough that they can concentrate on the CBT work.
- If the patient believes in medications and requests this treatment modality, it should be offered.
- If the patient is severely plagued by obsessions, medications are likely to be helpful.
- Pharmacotherapy should be offered if the patient does not comply or improve with CBT.
- There are several medications to choose from, especially if the patient is bothered by a particular set of side effects or there is no significant improvement. The response might be better to a different drug.

The cons of pharmacotherapy are:

- Roughly the same numbers of patients drop out compared to CBT, either because they do not accept this treatment modality, or more commonly, due to side effects.
- Research has shown that when patients attribute their gains to drug treatment, even placebo, they do less well upon discontinuation.
- Relapse rates upon discontinuation are high, regardless of slowness of taper, when pharmacotherapy is the sole treatment.

CULTURAL CONSIDERATIONS

The presentation, conceptualization, and treatment of mental disorders vary across cultures. There are no apparent major cultural differences regarding OCD symptoms (Thomsen, 2000). Yet differences in ethnic and cultural norms between patients and providers can result in erroneous diagnoses and inappropriate treatments. Potential problems stem from language barriers, differences in nonverbal communication, difference in perceptions of medical roles and responsibilities, and differences in how the disorder is explained.

Providers are encouraged to consult with informed colleagues, including champions of the Psychiatry Best Practices Cultural Competence Workgroup, and the *Cultural Diversity Resource Manual* issued in 1999. The latter includes four valuable booklets: *A Provider's Handbook on Culturally Competent Care for African American Population* (1999), *Latino Population* (1996), *Asian and Pacific Island American Populations* (1999), and *Lesbian, Gay, Bisexual and Transgendered Population* (2000). Yet as much as information about cultures can guide us, there is danger in stereotyping people. When a patient presents to us, we are balancing racial and cultural background with the uniqueness of the individual. There are a few booklets and information sheets on anxiety available in various languages. It is hoped that more will become available in the future.

African Americans tend to drop out of treatment prematurely, probably for the following reasons:

1. They do not seek help as readily
2. There is greater use of informal services (prayer, family, clergy)
3. Stigma and social embarrassment prevent them from seeking psychiatric help
4. Physicians may refer them less to specialty service
5. They may not trust the medical establishment as readily due to past history of mistreatment and may be less open to use medications

As with African Americans, we do not know the rate of OCD in the Latino population. Particularly in the case of OCD, with its potentially close association with religious beliefs, norms, and superstitions, and with its utterly inexplicable nature to people unfamiliar with mental disorders, a number of Latinos may consult folk healers, or "curanderos." They may believe they are possessed, or cast under a spell and seek healing.

Asians tend to under-utilize mental health services. Depending on the individual, seeking treatment may have been put off until symptoms have become acute. The fear of shame and being stigmatized is particularly strong in some Asian cultures, which place high value on saving face and thereby maintaining social status. There is evidence that people from Asian cultures have increased sensitivity to

psychotropic medications. CBT is often a more acceptable form of treatment than insight-oriented psychotherapy.

Much of the psychological treatment of OCD occurs in group therapy. Bisexual and transgendered individuals may be very hesitant to be in group therapy, and groups vary in their composition and acceptance of others. Here, the therapist's modeling and leadership can play a large role.

OCD is a disorder of magical thinking and ritualistic behavior par excellence, and as such it touches closely and intimately on religion (scrupulosity), superstition, and rigid norms centered around conformity, "right," and "wrong." In patients with OCD very deep negative core beliefs stand close to the surface.

SPECIFIC RECOMMENDATIONS

HIGHLIGHTS of EVALUATION

- Consider asking every patient one to three screening questions to assess for OCD.
- The OCD assessment involves obtaining detailed information in a number of areas, including type, extent, and interference of symptoms. This may take two sessions.
- For diagnosis, the DSM-IV (American Psychiatric Association, 1994) should be consulted. Not everyone with rituals has OCD, e.g., the person who checks the stove and the door 3-4 times assuming there are no other symptoms. The OCD diagnosis requires that the obsessions or compulsions cause significant distress, consume one hour or more a day, or significantly interfere with the person's normal routine or functioning.
- Differential diagnosis is important here, e.g., distinguishing OCD from Obsessive Compulsive Personality Disorder, Body Dysmorphic Disorder, Hypochondriasis, Delusional Disorder, Trichotillomania, Tic Disorders. It should be also distinguished from angry or depressive ruminating, and from compulsive behaviors such as sexual urges and fantasies, overeating, gambling, substance abuse, etc. One of the main distinguishing characteristics of the latter is that they produce pleasure/gratification/secondary gains. OCD symptoms as a rule never do.
- The Y-BOCS for adults is an instrument that provides reliable outcome measures. It is exceedingly helpful in measuring baseline (at assessment, preferably between the evaluation sessions) and at the end of treatment, whether CBT or pharmacotherapy, to track treatment response.
- The presence of substance abuse and suicidal ideation must be assessed.

HIGHLIGHTS of TREATMENT

- Specialized treatment for OCD is essential and should be offered to every patient. The treatment consists of OCD-specific CBT or medications or a combination of both.

Psychoeducational Classes

Behavioral Health Education anxiety classes where members learn self-care skills, while helpful in many instances, do not constitute "treatment" for OCD.

- Research has demonstrated that CBT has greater efficacy in mild-to-moderate cases. However, there are a number of instances where pharmacotherapy is recommended in combination with CBT. Patients who refuse or are not accessible for CBT may be treated with pharmacotherapy alone. CBT and medications could be considered in moderate-to-severe cases and when there is functional impairment. As prevention, group CBT for subthreshold OCD cases (adults and children) could be offered, even if not quite medically indicated. These patients are not candidates for pharmacotherapy.
- **COGNITIVE-BEHAVIOR THERAPY**
 - CBT for OCD includes these elements:
 - Education about OCD
 - In vivo and/or imaginal exposure to obsessions
 - Response prevention for behavioral and mental compulsions
 - Cognitive therapy
 - Relapse prevention
 - Extensive self-exposure outside of therapy sessions by the client is crucial. Every patient should be strongly encouraged to actively comply with all aspects of ERP treatment. The therapist may choose to conduct some ERP trials with the patient, even in group therapy.
 - Research is unclear re: optimal duration and frequency of sessions, or modality of treatment (individual vs. group vs. with family).
 - *ERP should be the main treatment focus.* However, research supports the addition of pure cognitive therapy (à la Beck, i.e., aimed at altering maladaptive automatic thoughts and underlying beliefs).
 - OCD is considered a chronic, fluctuating condition. The option of booster sessions or repeat treatment should be available.

■ PHARMACOTHERAPY

- Consider medications for clients with moderate-to-severe of OCD, and for those in severe distress, and/or who show functional impairment.
- Offer medications to those with concurrent moderate-to-severe depression, or those with other significant comorbidities.
- Offer medications to patients who wish medications, refuse CBT, do not comply with CBT, or do not benefit from CBT.
- Consider the SSRIs the first line of medication treatment: fluoxetine, fluvoxamine, paroxetine, sertraline, or citalopram. Clomipramine, while at least as effective, has a more difficult side effect profile.
- Consideration must be given to racial/cultural differences in response to medications, e.g., being mindful of historical considerations when medicating African Americans, and taking care not to overmedicate members of Asian populations, who are often highly sensitive to medications.

■ TREATMENT REFRACTORY PATIENTS

- Strongly consider combined pharmacotherapy and CBT treatment for these patients.
- Consider augmenting medications.
- Consider more intensive or different CBT (individual versus group, more frequent sessions, adding imaginal exposure, cognitive therapy, etc.).
- Some patients may benefit from more intensive treatment. For patients who are quite dysfunctional and/or suicidal, weekly, even biweekly, individual sessions should be made available. A case manager may also need to be assigned to these patients.

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