### Obsessive Compulsive Disorder

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### What is a Psychiatrist?

Physician, from the Greek:
- **physis**: growth, nature, the natural world  
- **-ian**: a person skilled in the art or science

Psychiatrist, from the Greek:
- **psyche**: breath, life; also soul or spirit  
- **-iatreia**: healing, medical treatment  
- **-ist**: a person devoted to an art or method, science, branch of knowledge

### OCD Diagnostic Criteria (1)

- Either obsessions or compulsions  
- The obsessions or compulsions:
  - Cause marked distress  
  - Take > 1 hour/day  
  - Greatly interfere with normal routine, functioning, or relationships

**DSM-IV-TR — Diagnostic and Statistical Manual of Mental Disorders, 4th ed, Revised, 2000**

### OCD Diagnostic Criteria (2)

- The person recognizes the obsessions or compulsions are excessive or unreasonable
  
- Not due to physiologic effects of a substance (e.g., drug abuse) or a general medical condition

### Common OCD Obsessions

- Fear of contamination  
- Fear of causing harm to someone else  
- Fear of harm coming to self  
- Need for symmetry or exactness  
- Sexual and religious obsessions  
- Fear of offending others  
- Fear of making a mistake  
- Pathologic doubt

### Common OCD Compulsions

- Cleaning  
- Hand washing  
- Checking  
- Ordering and arranging  
- Hoarding  
- Asking for reassurance  
- Counting  
- Repeating rituals  
- Neutralizing thoughts
Epidemiology of OCD

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- adults
  - In children, boys > girls

Epidemiology of OCD (Cont’d)

- Usual onset: adolescence or early adulthood
  - Boys (6–15 yrs) < Girls (20–29 yrs)
  - Usually gradual, but can be acute

- Typically chronic and debilitating, with an episodic course that may be triggered by stress

What Causes OCD?

- Genetics
  - Twin/Family studies; Tourette’s
- Neurochemistry
  - Serotonin, DA, Glutamate, GABA
- Neuroanatomy
  - ↑ activity in certain brain areas
- Neuroimmunology
  - PANDAS, Sydenham’s chorea

Commonly Associated Conditions (Lifetime Rates)

- Major Depression (67%)
- Social Anxiety Disorder (28%)
- Panic Disorder (18%)
- Substance Use Disorder (26%)
- Tourette Syndrome (5%)

Treatment of OCD (1)
American Psychiatric Association Guideline

First Line treatments

1. CBT (Exposure/Response Prevention)
   - time intensive, less accessible
2. Medication (an SSRI, e.g., Prozac)
   - side effects, drug interactions
   - higher doses produce better outcomes
3. Combination of CBT + SSRI
**Combined Treatment**

- More effective than monotherapy for some, but not necessary for all.

- Consider for inadequate response to monotherapy; co-occurring psychiatric conditions; and patients wishing to limit drug Rx duration.

- For patients with severe OCD.

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### Treatment of OCD (2)
**American Psychiatric Association Guideline**

**Second Steps**

1. Switch to a different SSRI
2. Switch to clomipramine (an SNRI)
3. Augment with dopamine-blocker
4. Switch to Effexor or Remeron

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### Concerns in Treating OCD in Women

- Pre-menstrual worsening of symptoms
- Effects of meds on birth control
- Safety of meds during pregnancy
- Postpartum onset / worsening of OCD
- Safety of meds during nursing
- Sexual side effects of meds

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### Implementing Pharmacotherapy

- Start low, titrate to max tolerated dose.
- Continue for 8-12 weeks, including 4-6 weeks at max tolerated dose.
- Manage side effects, e.g., insomnia, fatigue, bruxism, sweating, sexual dysfunction.
CBT and Other Psychotherapies

- CBT (exposure & response prevention)
- Cognitive Therapy
- Psychodynamic psychotherapy
- Motivational Interviewing
- Family Therapy

Implementing CBT

- Adequate trial: 13-20 weekly sessions with daily homework (or, 3 weeks of daily Mon-Fri).
- Individual, group or family format, session from <1 hour to 2 hours.
- Booster sessions after response achieved.
- Self-help treatment guides are OK.

Reasons For Med Non-response In "OCD"

- Incorrect diagnosis
- Inadequate medication trial
- Coexisting condition limits efficacy
- Counter-therapeutic influences
- OCD’s biological heterogeneity

Changing Treatment

- 1st Rx rarely abolishes all symptoms.
- Patients may accept residual symptoms. Is depressed mood ↓ hopefulness, or is OCD associated with secondary gain?
- ? problems in therapeutic alliance, co-occurring conditions, poor adherence, psychosocial stressors, family accommodation.

Discontinuing Treatment

- Continue med for 1-2 years, then ? gradual taper (10%-25% q 1-2 months).
- Follow successful CBT with monthly booster sessions for ≥ 3-6 months.
- Relapse rates are high. Most require continued treatment of some form.
- "Relapse" 4-6 months after stop CBT may be less likely than after stop med.

Some Areas for Research

- Pathophysiology of OCD – nature of the genetic risk, and the biochemical lesion(s)?
- Predictors of response or side effects to a given drug (? use gene chips, brain scans)
- Predictors of response to CBT, e.g., brain circuitry maps
- Best means of preventing relapses
- New treatments: meds, TMS, psychotherapies