Chapter 6
Treatment of Co-Morbid Obsessive-Compulsive Disorder and Substance Use Disorders

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Introduction

Results of recent epidemiological surveys reveal that obsessive compulsive disorder (OCD) and substance use disorders (SUDs) are both among the most prevalent psychiatric conditions in the general population. More specifically, OCD afflicts 2.5% of the population, thus making it the fourth most common psychiatric condition. Yet, this figure is dwarfed in comparison to that of SUDs, which are (collectively) the most common disorders in the general population, with a lifetime prevalence rate exceeding 14% (Grant, 1997; Grant, Peterson, Dawson, & Chou, 1994). When one considers the comparatively high prevalence of OCD and SUDs, respectively, it comes as no surprise that there is a significant subset of individuals who meet criteria for both disorders. Perhaps more importantly, many patients who have both conditions may eventually seek treatment, entering through either the mental health system (to address obsessions and/or compulsions as the primary complaint) or the substance abuse treatment system (to address substance abuse as the primary complaint).

In certain respects, the bifurcation of treatment delivery for mental health problems versus substance abuse heightens and exacerbates the complexities inherent in treating patients with both OCD and substance abuse problems; professionals ensconced in one system (e.g., mental health) often do not have the requisite expertise, by training or experience, to address problems and issues common in the other system (e.g., substance abuse). This is particularly problematic for OCD and SUDs because the most widely used interventions for these disorders in practice, as we will discuss in this chapter, have little in common. Thus, while many have advocated that treatment providers in both systems learn to identify patients with co-morbid OCD and SUDs accurately
and to develop intervention approaches that take into account both disorders (e.g., Fals-Stewart & Lucente, 1994), the practical implementation of this recommendation is far more difficult than it may, at first, appear. Yet, efficacious intervention approaches for patients with OCD and co-morbid SUDs have been developed and tested. Thus, the overarching goal of this chapter is to describe a simultaneous assessment and treatment approach for patients identified as having OCD and an SUD that has proven to be efficacious in a well-controlled randomized clinical trial, followed by a case example to illustrate the assessment and intervention methods outlined.

**Brief Description of OCD**

Once considered a rare and largely intractable condition, OCD is now recognized as among the most prevalent and, in many respects, treatable psychiatric disorders (e.g., Stein, 2002). Generally, OCD is characterized by a reciprocal interrelationship between the presence of intrusive thoughts and images (obsessions), which increase anxiety, and stereotyped ritualistic actions (compulsions), which decrease anxiety. As emphasized in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association [APA], 1994), compulsions can be observable behaviors or mental rituals. Perhaps most poignantly, patients with OCD typically realize that their obsessions and compulsions are irrational or excessive, but are unable to prevent or contain them.

The most frequent symptom presentations of OCD are (a) contamination fears with cleaning rituals and (b) fears of harm to self or others coupled with checking (Leckman, Zhang, Alsobrook, & Paul, 2001). However, OCD assumes a variety of forms; many types of obsessions and compulsions have been identified, including precision and symmetry concerns and arranging rituals, hoarding, scrupulosity, and so forth. Although the symptoms of OCD were once conceptualized and understood as manifestations of deep unconscious conflict, OCD is now more commonly regarded as a neuropsychiatric disorder mediated by neurological pathways and closely related to disorders with well-established neurological underpinnings, such as Tourette’s syndrome and Sydenham’s chorea (e.g., Stein & Stone, 1997).

OCD is equally common among men and women, which is in contrast with most other anxiety disorders, in which the prevalence is usually higher in women than men. Age of onset tends to have a bimodal distribution. Although most patients describe an insidious onset of OCD symptoms prior to age 25 (Eichstedt & Arnold, 2001), there is also a group of patients who report a later onset, for example, after pregnancy, miscarriage, or parturition (Gellar, Klier, & Neugebauer, 2001; Williams & Koran, 1997). Symptoms are usually described as chronic, with some waxing and waning of symptoms, but few spontaneous remissions (e.g. Skoog & Skoog, 1999).