Obsessive-Compulsive Disorder
Treatment Options

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Contents

1. Clinical Features
   1.1 Epidemiology.................................188
   1.2 Diagnosis..................................188
   1.3 Symptomatology............................188
   1.4 Comorbidity...............................189

2. Treatment
   2.1 Pharmacological Treatment..............189
   2.2 Psychotherapeutic Treatment – Behavioural Therapy..............195
   2.3 Electroconvulsive Therapy..............196
   2.4 Neurosurgery..............................196

3. Integrated Approach to Treatment..............196

4. Conclusions................................198

Summary

Obsessions, compulsions and rituals have been recognised as abnormal cognitions and behaviours for several centuries. These symptoms and signs, which have been variously referred to in different ages and cultures, are encompassed under the present diagnosis of obsessive-compulsive disorder (OCD).

OCD has been an elusive nosological entity, resistant to treatment until the last 30 years. In 1966, two distinct treatment modalities, a potent serotonin (5-hydroxytryptamine; 5-HT) reuptake inhibitor (SRI) and behavioural therapy, were introduced. Today, SRIs and behavioural therapy remain important interventions in modern OCD management, underscoring the fact that more effective modes of treatment have not been developed. Despite recent advances in understanding the underlying neurobiology of OCD, its treatment remains a challenge.

At present, the mainstay of treatment is a combination of pharmacotherapy and behavioural therapy. In terms of pharmacotherapy, the most effective class of medication remains the SRIs. Clomipramine and the selective SRIs fluoxetine, fluvoxamine, paroxetine and sertraline have all demonstrated efficacy and are regarded as first-line agents for monotherapy. If multiple trials of SRIs do not result in improvement, alternative monotherapy may be attempted with monoamine oxidase inhibitors, buspirone or clonazepam. If monotherapy achieves partial response, augmentation of SRIs or combinations of agents may be considered. Only haloperidol has demonstrated efficacy as an augmentation of an SRI in a controlled trial and only in patients with comorbid tic disorders. There is support from noncontrolled trials for some other augmenting agents.
Of the psychotherapeutic techniques, only behavioural therapy in the form of exposure and response prevention (ERP) has demonstrated significant effectiveness. Optimal results in the management of OCD are often realised through a combination of ERP and pharmacological therapy, although the availability of behavioural therapy is limited.

For the small proportion of patients who are severely disabled by prolonged treatment-resistant OCD, neurosurgery may be an effective treatment option.

### 1. Clinical Features

#### 1.1 Epidemiology

Until recently, it was believed that obsessive-compulsive disorder (OCD) was a rare psychiatric disorder. Previous estimates suggested that the lifetime prevalence was about 0.05%. What Freud has described as the ‘hidden nature of the disorder’ helps to explain why OCD has been under-reported, and even in recent times Jenike has described OCD as a ‘hidden epidemic.’ This characterisation is supported by the recent Epidemiologic Catchment Area community study in the US. It found a lifetime prevalence of 2.5% and a 1-year prevalence of 1.5 to 2.1%. These higher prevalence rates are not restricted to the US. In a 7-country sample, 1-year prevalence ranged from 1.1 to 1.8%. With the exception of Taiwan (where annual prevalence was a low 0.4%), no statistical difference was demonstrated among the prevalence rates of the other countries. There has been some criticism, based on methodology, that these studies overestimated prevalence. However, it is generally accepted that the lifetime prevalence of OCD is 1 to 2%.

OCD is slightly more common in women than men. There does not appear to be any relation to marital or socio-economic status. While the age of onset is usually adolescence or early adulthood, childhood presentation is not infrequent. The course of OCD is variable and is most often characterised by a waxing and waning of symptoms. While progressive worsening occurs in no more than 10% of cases, spontaneous remission and complete cure are also infrequent.

#### 1.2 Diagnosis

The essential features of OCD are recurrent obsessions and/or compulsions. According to DSM-IV, obsessions are ‘persistent ideas, thoughts, impulses, or images that are experienced as intrusive and inappropriate and that cause anxiety or distress’, while compulsions are ‘repetitive behaviours (e.g. hand washing, ordering, checking) or mental acts (e.g. praying, counting, repeating words silently) the goal of which is to prevent or reduce anxiety or distress, not to provide pleasure or gratification’.

The DSM-IV diagnosis of OCD requires that the symptoms be severe enough to be time consuming (i.e. they take more than 1 hour per day) or cause marked distress or significant impairment. Because OCD is experienced as intrusive and foreign, it is referred to as ‘ego-dystonic.’

#### 1.3 Symptomatology

OCD symptomatology consists of obsessions, compulsions, or both. Rasmussen and Eisen examined and classified the symptoms of 200 patients who had OCD as they presented on admission to an inpatient unit. The most common type of obsessions involved contamination fears, followed by pathological doubt and somatic concerns. The most common compulsions were checking, followed by washing and counting. Although Rasmussen and Eisen conducted their research exclusively in the US, similar symptoms and symptom subtypes are found internationally.

While the classical description of OCD symptomatology is characterised by a pattern of obsession leading to compulsion, the actual clinical presentation may demonstrate significant variations. For instance, many patients have a combination of