Current PSYCHIATRY

Treating OCD in patients with psychiatric comorbidity

How to keep anxiety, depression, and other disorders from thwarting interventions

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Psychiatric comorbidities complicate the treatment of obsessive-compulsive disorder (OCD) and are much more the rule than the exception in clinical practice *(Table 1, page 58)*.[1-6] Even so, surprisingly few studies have examined comorbidities' effects on OCD treatment, and results have been mixed.

For the typical patient with obsessive-compulsive symptoms, we discuss our experience and evidence that supports:

- clinically useful tools to differentiate OCD from other obsessive and anxiety disorders

Table 1

Common psychiatric comorbidities with OCD

Comorbidities	Estimated prevalence in OCD patients
Personality disorders	63%
Major depressive disorder	28 to 31%
Simple phobia	7 to 48%
Social phobia	11 to 16%
Bipolar disorder	15%
Eating disorders	8 to 13%
Alcohol abuse	8%
Panic disorder	6 to 12%
Tourette's syndrome or tic disorders	6 to 7%

Source: Data from references 1-6

- how to address comorbidities that pose acute danger or would prevent effective psychotherapy
- how to modify first-line OCD treatments—cognitive behavioral therapy (CBT) and serotonin reuptake inhibitors (SRIs)[7-9]—to also manage most comorbid disorders.

IS OCD PRIMARY?

OCD-like obsessive thoughts or repetitive behaviors may be evident in a number of psychiatric disorders. Distinguishing OCD from masquerading or co-occurring conditions is important because interventions can differ.

Patients with generalized anxiety disorder (GAD), for example, may experience ruminative, anxious thoughts that mimic obsessions. Somatoform conditions such as hypochondriasis or body dysmorphic disorder are characterized by intense preoccupation with illness or appearance, respectively. Repetitive or compulsive behaviors may be seen in impulse control or developmental disorders such as pathologic gambling, trichotillomania, and Asperger's disorder.

To help differentiate OCD from these conditions, consider the function of a patient's symptoms. In OCD, obsessions are experienced as ego-dystonic and generally cause great anxiety. OCD patients perform compulsive rituals to alleviate anxiety but do not gain pleasure from their actions. Contrast this with trichotillomania's repetitive behavior—commonly experienced as pleasurable or gratifying—or with GAD's ruminative thoughts—seen as ego-syntonic worries about real-life situations.

ASSESSING OCD, COMORBID CONDITIONS

When you suspect psychiatric comorbidity with OCD, an accurate and thorough assessment is key to successful treatment *(Table 2, page 61)*.[10-14]

In specialty OCD clinics, the Structured Clinical Interview for DSM-IV (SCID-IV)[15] or Anxiety Disorders Interview Schedule for the DSM-IV (ADIS-IV)[10] are routinely given to assess the most common comorbid conditions. In clinical practice, however, these instruments can take up to several hours to perform, especially for patients who meet criteria for several disorders.

An alternative may be the Mini International Neuropsychiatric Interview (MINI).[11] The MINI is a short, structured, diagnostic interview for DSM-IV and ICD-10 that takes about 15 minutes and screens for most conditions commonly comorbid with OCD. The MINI provides less-detailed information than the SCID-IV or the ADIS-IV but allows for a quick, accurate diagnosis while using a structured format.

OCD severity. After you have diagnosed OCD and

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any co-occurring conditions, numerous symptom measures can help you assess OCD symptoms and severity and plan treatment.

The Yale-Brown Obsessive Compulsive Scale (YBOCS) is widely used.[12,13] It includes a checklist of common obsessions and compulsions plus 10 items measuring interference with daily living, distress, resistance, control, and time spent on symptoms. Each item is scored from 0 to 4, for a total score of 0 to 40.

The YBOCS has good reliability and validity, is available in both clinician-rated and self-rated versions, and can be given repeatedly to measure treatment progress. A Children's Yale-Brown Obsessive-Compulsive Scale (CYBOCS) is useful for patients ages 6 to 17.[16]

Table 2

Common assessment tools for patients with suspected OCD

Structured clinical interviews	Time to administer	Use
Anxiety Disorders Interview Schedule-IV (ADIS-IV)	2+ hrs	Detailed assessment of anxiety disorders
Mini-International Neuropsychiatric Interview (MINI)	15 to 30 min	Brief screen for diagnosis
OCD-specific measures		
Yale-Brown Obsessive Compulsive Scale (YBOCS)	30 min	Severity and OCD symptom types
Obsessive Compulsive Inventory-Revised (OCI-R)	5 to 10 min	Self-report severity of OCD symptoms

Source: Data from references 10-14

TREATING UNCOMPLICATED OCD

CBT. When OCD is not concurrent with another diagnosis, expert consensus guidelines recommend CBT as first-line treatment.[17] Most patients treated with exposure and response prevention (ERP) therapy—the specialized CBT for reducing anxiety that triggers obsessive-compulsive symptoms—report reduced symptoms and often maintain those gains over time.[18]

In specialty clinics, patients frequently engage in intensive ERP (2 hours per day, 3 to 5 times per week for about 3 weeks). Although studies find excellent outcomes with intensive OCD treatment,[18] it is not always practical or indicated (as in patients with moderate symptoms). Less-intensive protocols, such as biweekly sessions, have also shown promise in studies examining how session frequency affects treatment outcome.[19]

Many studies supporting ERP's efficacy in OCD have included relatively homogenous samples under well-controlled conditions. Some investigations have also found good effects for ERP when including patients with complex treatment histories, concomitant pharmacotherapy, and comorbid conditions.[20]

Medication. Functional imaging studies suggest that OCD results from dysregulation in the so-called "OCD circuit"—the orbitofrontal cortex, anterior cingulate, and caudate nucleus. In patients with OCD, metabolic activity in this region is increased at rest relative to controls, increases further with symptoms, and decreases after successful treatment.[21] The serotonin hypothesis—which emerged from observation that OCD symptoms responded to serotonergic medications but not to noradrenergic ones—suggests serotonin system dysregulation in patients with OCD.

High dosages of SRIs—selective serotonin reuptake inhibitors or the tricyclic antidepressant clomipramine—are first-line OCD medications

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(Table 3, page 66). Double-blind clinical trials have found clomipramine, fluoxetine, sertraline, paroxetine, fluvoxamine, and citalopram more effective than placebo, and the first five of these drugs are FDA-approved for treating adult OCD.

Side effects. SRI dosages required to treat OCD may lead to intolerable side effects, including sedation, insomnia, GI side effects, and sexual dysfunction. Clomipramine is rarely used as a first-line agent because of its anticholinergic side effects.

Nonresponse. Patients typically require at least 10 to 12 weeks of treatment at target dosages. Sequential medication trials may be needed to achieve a response. Complete remission is rare, and relapse rates are high when medication is discontinued.[22]

The up to 40% of patients who do not respond to SRI therapy require alternate strategies:

- Augmenting SRI therapy with a low-dose atypical antipsychotic such as risperidone, 1 to 2 mg bid, or olanzapine, 5 to 10 mg/d, may be effective, even in patients without a comorbid psychotic or tic disorder.[23,24] It is worth noting that trials using atypicals as adjunctive therapy for OCD have been brief (12 weeks), and long-term use of these medications carries a risk of metabolic side effects such as weight gain, diabetes, and hyperlipidemia.
- The serotonin-norepinephrine reuptake inhibitor venlafaxine, $\geq$225 mg/d, showed efficacy in a naturalistic study of patients who did not respond to SRIs.[25]
- Augmentation with pindolol, lithium, buspirone, trazodone, tryptophan, or thyroid hormone has shown mixed results.[24]

FACTORING IN COMORBIDITIES

Acute risk? Conditions that endanger the patient take precedence over OCD treatment. Suicidal risk and self-mutilating behaviors, for instance, must be addressed before a patient can engage in ERP therapy. Active psychosis also would exclude ERP and may be best handled by augmenting SRI therapy with an antipsychotic.[17]

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Table 3

Serotonin reuptake inhibitors indicated for treating OCD*

Drug	Starting dosage	Target dosage (adults)
Clomipramine	25 mg/d	150 to 200 mg/d
Fluoxetine	20 mg/d	60 to 80 mg/d
Fluvoxamine	50 mg/d	150 to 300 mg/d
Paroxetine	20 mg/d	40 to 60 mg/d
Sertraline	50 mg/d	150 to 200 mg/d

* 10- to 12-week medication trials at target doses; sequential trials may be required to achieve treatment response.

Interfere with CBT? Exposure therapy can exacerbate symptoms in patients who self-medicate their anxiety with alcohol or other substances. In turn, alcohol or other substance abuse may interfere with habituation by ameliorating the anxiety necessary for effective exposure therapy. Thus, we recommend delaying OCD behavioral treatment until you treat or stabilize these conditions.

Many OCD patients report comorbid depression, which may be secondary to their OCD symptoms and may spontaneously decrease with successful OCD treatment. Patients with mild to moderate depression can usually engage in and benefit from ERP without depression-specific interventions.

Patients with comorbid depression may not respond to OCD interventions as well as nondepressed OCD patients do.[26] For concurrent OCD and major depression, expert consensus guidelines suggest combining CBT with an SRI.[17]

Less is known about how other comorbidities affect OCD treatment. In one study, patients with comorbid OCD and posttraumatic stress disorder (PTSD) responded poorly to ERP. Exposure therapy reduced OCD symptoms but increased PTSD symptoms in some patients.[27] Some Axis II disorders—such as schizotypal, avoidant, paranoid, and borderline personality disorder—have also been found to predict poorer outcome in patients treated with clomipramine.[3]

Concurrent treatment? In some concomitant conditions, such as PTSD with OCD, preliminary evidence suggests that treatment can or should be simultaneous rather than sequential.[27] Likewise, CBT can be used to treat OCD concurrent with other anxiety disorders with only slight modifications, such as:

- constructing exposures for social anxiety disorder patients that, at least initially, minimize extraneous social contact and evaluative fears
- instructing panic disorder patients in anxiety management skills so that exposures do not trigger anxiety attacks and reinforce their fears.

The same medications are appropriate for some overlapping conditions such as depression and anxiety disorders, which simplifies simultaneous drug therapy. Treatment is more complicated in OCD patients with bipolar disorder, however, as the antidepressants used to treat OCD can induce

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Bottom Line

Treating OCD successfully may depend on identifying comorbid psychiatric conditions. Address comorbidities that pose acute danger or may thwart psychotherapy before you try exposure and response prevention (ERP). Otherwise, ERP and SRIs are first-line treatments, requiring only slight modification with most comorbidities.

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mania or hypomania and worsen the mood disorder.[28] In these patients, stabilize mood before starting an antidepressant.

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DRUG BRAND NAMES

Buspirone • Buspar
Citalopram • Celexa
Clomipramine • Anafranil
Fluoxetine • Prozac
Fluvoxamine • Luvox
Olanzapine • Zyprexa
Paroxetine • Paxil
Risperidone • Risperdal
Sertraline • Zoloft
Trazodone • Desyrel
Venlafaxine • Effexor

DISCLOSURE

The authors report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

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