



*Imprisoned in Rituals:
Unlocking the Gates of
OCD*

Imprisoned in Rituals: Unlocking the Gates of OCD

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About the Authors

Cherlene S.M. Pedrick, RN, graduated from Emmanuel Hospital School of Nursing in Portland, Oregon, in 1975. Her most recent experience is in home health nursing. She has also worked as a medical-surgical nurse and as a school nurse. She was diagnosed with obsessive-compulsive disorder (OCD) in 1994. Since then, she has researched the information available about the disorder. She has written articles about OCD for nurses, teachers, and Sunday school teachers.

With Excerpts By **Diana Harland, BS, CCRC**, received her degree in microbiology from the University of Texas at El Paso. She worked in preclinical research in retrovirology while in undergraduate school and again after graduation at the Texas Biomedical Research Institute (formerly Southwest Foundation for Biomedical Research) in San Antonio, Texas. While at the Southwest Foundation, she worked in the Department of Virology and Immunology.

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Cheryl Duksta, RN, ADN, M.Ed., A master's prepared teacher and former public school teacher, she frequently serves as a continuing education facilitator. She has 15 years of experience in education and medical publishing, including writer and editor at the National Center of Continuing Education.

Instructional Objectives

Upon completion of this course, the learner will be able to:

1. Name the essential features of OCD, and define obsessions and compulsions.
2. Analyze the most recent theories about the causes of OCD.
3. List the symptoms of OCD the nurse is likely to see in patients.
4. Identify the therapies most often used for treating OCD.
5. Compare the thought pattern of a person with OCD to the same thought in a person who does not have OCD.
6. Explain side effects and contraindications medications used to treat OCD.
7. Identify the side effects of monoamine oxidase inhibitors (MAOIs), and the food and medication precautions needed during treatment with MAOIs.
8. Relate information about behavior and cognitive therapies in a way patients can understand.

9. Identify areas where supportive psychotherapy may be helpful in treating OCD.
10. Distinguish between the symptoms of OCD in children and normal childhood rituals.
11. Outline the risks of taking anti-obsessional medications during pregnancy and while breast feeding.
12. Identify comorbid diagnoses that can complicate OCD treatment.
13. State ways the family may assist with the OCD patient in recovery.
14. Summarize the nurse's role in caring for the patient with OCD.

Purpose and Goals

The goal of this course is to increase awareness of healthcare professionals in the psychiatric/behavioral area of global change: obsessive-compulsive disorder to obsessive-compulsive disorder (OCD). You will learn psychological, pharmacological, and environmental treatment approaches, and how to apply crisis theory and intervention techniques to clinical situations.

My Experience with OCD

At the age of 40, I developed obsessive-compulsive disorder. It started with vague doubts when I left the house. I questioned if I had locked the door and turned off the coffee pot, stove, and lights. I developed a ritual of checking everything in a certain order. If I was interrupted, I "had" to start over. Often I would return home after leaving the house, to check something. When the frequent trips back home began to interfere with my job, I sought psychiatric treatment.

The checking rituals improved, but I developed other symptoms. As I was driving, I would suddenly feel like I had hit someone. I would retrace my path, looking for something or someone. Often, this triggered a cycle. I would drive back and forth until I was satisfied there was no dead body by the road. I discovered later that acting on the first obsessive thought often triggers a cycle of repeated compulsive behaviors.

I worried about the car door and brakes, and made frequent trips back to the car to make sure the door was locked and the brake was set. I had a fear of contaminating food, so I only cooked for my immediate family. I washed my hands frequently during food preparation. I worked as a home health nurse, and when

I was asked to help with quality assurance, my symptoms escalated at work. Seeing the mistakes of others made me more conscious of my own. I became fearful of making even small mistakes and spent increasing amounts of time at the office and in patients' homes. I reviewed my paperwork and patient teaching repeatedly, fearful that I had left something out. I called patients to repeat my instructions or add details to my teaching, and I called doctors to clarify phone orders I had received. Voice mail was a problem. After leaving a message, I questioned if I had said the right thing. Maybe I mixed up patients' names, left something out, or left the message on the wrong voice mail. I called back frequently to add small details or repeat the entire message.

In patients' homes I questioned my sterile technique, worried that I had made a mistake in measurements and assessments, and became overly concerned about minor complaints or symptoms. At home, I worried about the patients I had seen, fearful that I had missed something important or unintentionally hurt someone. Calling my patients relieved my anxiety only briefly. After hanging up, I would begin worrying about another detail. One especially difficult day, I saw five patients and called each of them back three times! The next work day, my supervisor called me to her office. I had told her about my illness, and she had been patient with me, but now it was affecting patient care. She asked me to take a leave of absence. I was depressed for days, but I was also relieved. I gave myself permission to be honest with my supervisor, my therapist, and myself. My supervisor knew me when I was a good nurse, and she believed in my ability to be a good nurse again. Medication and therapy put me on the road to recovery, and 4 months later, I returned to work with a reduced workload. I hope that sharing my story will help others to understand obsessive-compulsive disorder and its treatment. If therapy is sought early, treatment is less painful and recovery is faster. In their concern for me, my supervisor and co-workers tried to overlook my behavior. When I returned to work my supervisor refused to enable my constant checking, worrying, repeated behaviors, and demand for perfection. It was much more difficult for both of us, but it was what I needed.

Definitions

An obsession can be a thought, an idea, or an image that occurs over and over again, and will not leave the mind. Obsessions can cause a great amount of anguish and suffering. Examples of obsessions are:

1. Worrying about catching a contagious disease or contaminating others
2. Fearing you will accidentally hit or injure someone with your car
3. Thoughts of murdering someone or harming someone
4. Unacceptable thoughts that are sexual or religious
5. Superstitions about lucky or unlucky numbers, colors, days of the week
6. Being overly even or exact

A compulsion is a behavior that is repeated over and over to relieve the anxiety brought about by an obsession. Examples of compulsions are:

1. Constantly cleaning
2. Continually washing your hands, or excessive bathing, showering, or teeth brushing
3. Repetitively counting, tapping, blinking
4. Checking something repeatedly
5. Repeating a routine behavior, such as walking in and out of a room
6. Hoarding

(Source: http://ocd.about.com/od/causes/a/OCD_Thought.htm; <http://psychcentral.com/disorders/ocd/>)

What Is OCD?

OCD is the fourth most common psychiatric diagnosis, with a lifetime prevalence rate of up to 2.0%. It is considered by the World Health Organization to be one of the 10 most disabling illnesses of all medical and psychiatric conditions in terms of lost wages and reduction of quality of life. Estimates from the National Institute of Mental Health show that 1 in 100 adults (2 to 3 million people in the United States) have OCD. The onset of symptoms is usually gradual, although some patients report a sudden onset. Some patients recall a precipitating event, while others do not. Precipitating events can include emotional stress at work or at home, increased levels of responsibility, health problems, and bereavement. Pregnancy, the birth of a child, and termination of pregnancy may be linked to the onset or worsening of OCD symptoms.

The French have called OCD *la folie de doute*, which means “the doubting disease” because the person with OCD cannot live with doubt or uncertainty. These are the emotions

that feed their obsessive-compulsive behavior. Persons with OCD need to have life’s answers in black and white and are unable to handle shades of gray.

The DSM-IV-R (*Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition Revised) states that “the essential features of obsessive-compulsive disorder are recurrent obsessions or compulsions ... that are severe enough to be time consuming (i.e., they take more than 1 hour a day) or cause marked distress or significant impairment. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable.” Adults usually realize their obsessions and compulsions are unreasonable or excessive, but children are not as likely to recognize this.

Obsessions are persistent ideas, impulses, images, or thoughts that are experienced as inappropriate and intrusive and cause marked anxiety. The person has the sense that the thought is not within his or her control and not the kind of thought that he or she would expect to have. The person is able to understand that the obsessions are the product of his or her own mind and are not imposed from without.

Trying to ignore the thoughts or impulses, or to neutralize them with other thoughts or actions, leads people to develop compulsions. Compulsions are mental acts, such as repeating words silently or counting, or repetitive behaviors, such as ordering, checking, or hand washing. The goal is to reduce or prevent anxiety, not to provide gratification or pleasure. The person usually feels driven to perform the compulsion to prevent some dreaded situation, or to reduce the distress accompanying an obsession. Compulsions are either not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

Superstition, Rituals, Prayer: What OCD Is Not

The DSM-IV-R goes on to state, “Culturally prescribed ritual behavior is not in itself indicative of obsessive-compulsive disorder unless it exceeds cultural norms, occurs at times and places judged inappropriate by others of the same culture, and interferes with social role functioning. Important life transitions and mourning may lead to an intensification of ritual behavior that may appear to be an obsession to a clinician who is not familiar with the cultural context.

“Superstitions and repetitive checking behaviors are commonly encountered in everyday life. A diagnosis of obsessive-compulsive

disorder should be considered only if they are particularly time-consuming or result in clinically significant impairment or distress.”

It is important to recognize that certain behaviors may be due to cultural or religious differences, not OCD. Most people perform some rituals and repetitive behaviors, and many people are superstitious. Many people depend on prayer in their daily lives. OCD is diagnosed only when these behaviors result in significant impairment, distress, or anxiety, or are too time-consuming.

Almost everyone worries, at times excessively. OCD is considered as a diagnosis if it interferes with one’s life or causes distress. The worries of OCD are usually senseless and irrational. Ignoring them makes one feel anxious and nervous. Excessive worrying that is rational, but excessive, may be a symptom of depression. Many people are compulsive, but do not have OCD. They give careful attention to details and procedure. The compulsions of the OCD patient are useless, repetitive behaviors, and are performed to dispel the anxiety that accompanies an obsession.

People with obsessive thoughts or compulsive rituals that are not distressing or particularly time-consuming may have subclinical OCD. They have OCD symptoms that are of concern, but are too mild to diagnose OCD. If therapy is needed, the same treatments used for OCD may be helpful for subclinical OCD.

Etiology and Diagnosis

In the past decades, both basic and clinical research into the causes of OCD have focused on dysfunctions in the neurocircuitry of the central nervous system. Brain imaging studies have demonstrated increased activity at rest in the frontal lobes, the basal ganglia, and the cingulum of OCD patients. Activity in these brain regions increases even more with provocation of the symptoms of OCD, and is reduced by successful treatment. Researchers have suggested that this hyperactivity may be the result of abnormal development of these structures, or a failure of the normal pruning of neuronal connections between them that occurs both prenatally and in the first few years of life. Decreased size of the caudate nucleus has also been noted in some cases.

Research has found that certain autoimmune diseases, such as rheumatic fever and lupus, may cause some cases of OCD. In some studies, an association of OCD with Economo’s encephalitis, hypothalamic lesions, head trauma, brain tumors, and long-term use of central nervous system drugs has been demonstrated. Support has also been growing

for the hypothesis that obsessive compulsive symptoms as well as tics may develop in a subgroup of children who have been infected with group A beta-hemolytic streptococci. These disorders, called PANDAS (Pediatric Auto-immune Neuropsychiatric Disorders Associated with Streptococcus), may result from cross-reaction of antibacterial antibodies with specific brain structures.

Serotonergic mechanisms are also of clear importance in the pathophysiology of OCD. Serotonin plays a role in many biological processes, including mood and anxiety regulation, aggression, impulse control, sleep, appetite, body temperature, and pain. Serotonin dysregulation has also been implicated in depression, panic disorder, eating disorders, autism, and schizophrenia.

The onset of OCD is usually in the second or third decade of life. Onset after the age of 50 is rare and usually is a result of organic impairment. Although women are more likely to develop OCD, men generally have an earlier age of onset. There is evidence that there may be different types of OCD, and that some types are inherited. Patients with childhood-onset OCD seem to be more likely to have blood relatives with OCD. Early onset OCD is associated with symptom onset prior to puberty, a relatively aggressive course, and a greater number of obsessions and compulsions. Patients with later onset OCD report symptoms beginning in puberty and a static course with fewer obsessions and compulsions overall. The course of OCD is usually chronic, but there is evidence of a subtype characterized by an episodic course.

Diagnosis of OCD is made on the basis of the psychiatric examination and history. The Yale-Brown Obsessive-Compulsive Scale (Y-Bocs) is a questionnaire that can be used to help target obsessive compulsive symptoms and assess their severity. There is also a children's version of the scale. Other assessment tools include the Obsessive-Compulsive Checklist, the Leyton Obsessional Inventory (LOI), the Maudsley Obsessive-Compulsive Inventory (MOCI), the Padua Inventory (PI), and the NIMH Global Obsessive-Compulsive Scale (NIMH-GOCS).

Can Bacteria Cause OCD?

The National Institute of Mental Health (NIMH) is currently studying the possible link between streptococci bacteria and OCD-type symptoms in children. The study is focusing on the streptococci being the cause of Pediatric Acute-onset Neuropsychiatric Syndrome (PANS). In this syndrome, children and teens

seem to suddenly develop abnormal eating behaviors, along with what parents describe as a "ferocious" onset of obsessive thoughts, compulsive rituals, and overwhelming fears. The abrupt onset usually occurs after the child has had a strep throat infection. The attack on the body by the bacteria appears to target cells of the basal ganglia in the brain, and this pathology is thought to bring on the sudden symptoms of OCD and anorexia. Other symptoms that have been noted include extreme separation anxiety, motor or vocal tics, a regression to "baby talking," bedwetting, temper tantrums, other problems such as sensory and motor problems, and decreases in school performance.

PANS is an extension of Pediatric Auto-immune Neuropsychiatric Disorders Associated with Streptococcus (PANDAS) in which certain cases of streptococcal infection are linked to an autoimmune process. PANDAS describes a group of children with OCD and/or tic disorders, such as Tourette syndrome, whose symptoms worsen following strep infections, such as strep throat and scarlet fever. The diagnosis of PANDAS is a pediatric-only diagnosis that is based on clinical presentation; there are no diagnostic lab tests available. The National Institute of Mental Health (NIMH) has defined the diagnostic criteria as follows:

1. Presence of obsessive-compulsive disorder or tic disorder
2. Pediatric onset of symptoms (age 3 to puberty)
3. Episodic course of symptom severity (Episodic means dramatic ups and downs in OCD or tic severity that is different from the child's usual "ups and downs" of good and bad days, and appears with very sudden onset or worsening of symptoms followed by slow and gradual improvement. Increased symptoms may last several weeks to several months or longer. Tics and OCD symptoms may fade, and weeks to months may pass without problems. If another strep infection should occur, the same pattern follows with tics and OCD symptoms returning suddenly and dramatically as the previous time.)
4. Association with group A beta-hemolytic streptococcal infection (a positive throat culture for strep or history of scarlet fever)
5. Association with neurological abnormalities [motoric hyperactivity, or adventitious movements such as choreiform (involuntary spasmodic) movements]

Physicians are encouraged to look for hidden

cases of strep in sinusitis or middle ear infections or atypical presentations of strep (e.g., abdominal pain and vomiting). Other diseases, such as Lyme disease, mononucleosis, and mycoplasma, may also trigger the sudden onset of OCD symptoms.

Strep bacteria have evolved to evade the immune system by displaying molecules on the cell wall that look almost identical to molecules on the cells of different body tissues, including brain tissue. This gives the strep bacteria a type of "camouflage" from the body's immune system. In time, the immune system recognizes the strep as foreign and makes antibodies against it. These antibodies react with the strep and also inadvertently react with the body's identical molecules in human tissues. These "anti-brain" antibodies can cause OCD and the symptoms of PANDAS. Immunoglobulin known as IVIG that has been used to treat other autoimmune illnesses is known to neutralize these harmful antibodies so that normal immune function can be restored. Researchers currently studying PANS are predicting that children with high levels of "anti-brain" antibodies will greatly benefit from IVIG in the areas of OCD as well as other psychiatric symptoms.

PANDAS is treated with cognitive behavioral therapy or anti-obsessional medications. Since antibodies produced by the immune system are the causative problem, any antibiotics given will kill the strep bacteria but will not help the problems in the immune system, and therefore will not help with the symptoms of PANDAS. Although IVIG has been shown to benefit severe strep-induced OCD, there have been adverse side effects, such as nausea, vomiting, dizziness, and headaches. The procedure also carries risk of infection due to invasiveness. For these reasons, IVIG is recommended only for severely ill patients, and only when it can be carried out by a qualified team of healthcare professionals.

OCD and Thought-Action Fusion

Thought action fusion (TAF) is when a person believes that thinking a particular thought is the same as actually carrying out that thought. In TAF, a person becomes convinced that his or her thoughts will actually make something a reality. In other words, the person believes, "if I think it, then it will come true." This brings about a very intense fear as sufferers attempt to do whatever is in their power to prevent this unwanted thing from happening. For example, if a person with OCD that is complicated by TAF has a

thought that a burglary will occur at home, then in the person's mind, it is just a matter of time until it happens. The person may decline to go out and socialize or leave the house for fear that the burglary will occur while he or she is gone. The person becomes the "guard" who must protect loved ones from harm. Not only must the person protect him- or herself from the burglary, but the person must be ready at all times to protect loved ones from the potential threat of a burglary. Another aspect of TAF is that thinking the thought (e.g., "I want to kill my spouse") is just as terrible as following through with that thought. It is not the thought that differentiates the person with OCD and TAF from the person without OCD; it's what the person does with that thought. The extent to which a person with OCD is susceptible to TAF is a good predictor of the severity of their OCD symptoms.

TAF is different from the effects that prayer can have on people's lives. TAF is more of a "magical" belief in which people believe that their thoughts can actually influence or change the circumstances and events of everyday life. In TAF, the unwanted thought stays in the person's mind for too long. A person without an obsessive-compulsive disorder may have a passing thought, such as "I am afraid I will stab someone with a knife," but the thought is very short lived and the person moves on to other thoughts. The person with OCD and TAF becomes stuck with that thought, and the longer the person dwells on it, the more important the brain thinks that thought is. As the person focuses on the thought and tries to solve it with other thoughts, or tries to get rid of it with other thoughts, the thought can become fused with reality. For example, the thought "I am afraid I will stab someone with a knife" becomes linked to events, and the person loses the ability to distinguish between the thought and real events.

Treatment for OCD complicated by TAF consists of a number of steps that are designed to help the person confront obsessive thought patterns and resulting behaviors. Cognitive behavioral therapy (CBT) teaches the person to recognize the unfounded thought, confront it, and replace it with thoughts based on fact. The thought "I am afraid I will stab someone with a knife" is replaced with "although I have had the thought that I might stab someone with a knife, I have never on any occasion gone out and stabbed anyone." If a person does well with CBT, he or she can move forward with mindfulness-based CBT, in which the person is taught to accept, without judgment, his or her thoughts and feelings. In mindfulness-based

CBT, the person is helped to learn that just because unwanted thoughts may be there does not indicate that they have meaning. When this is realized, the person can work to change his or her reactions and behaviors to the thoughts. After mindfulness-based CBT is mastered, the next step is exposure and response prevention (ERP), in which the person is exposed to the thought or situation without the person reacting with the compulsive or avoidant response. Although this process may be difficult for the person undergoing therapy, it is possible for the person to come away knowing that he or she can tolerate unwanted thoughts or feelings. With successful therapy, the person realizes that when he or she purposely thinks about the unwanted thought, the feared event almost never occurs, thus considerably decreasing the person's anxiety. The person also realizes that should the feared event occur, it is not likely to be as terrible as the person previously thought.

Symptoms of OCD

The most common symptoms of OCD are checking compulsions and washing or cleaning compulsions. Other symptoms are a need for symmetry, unwanted aggressive thoughts, unwanted sexual thoughts, counting, the need to ask or confess, order rituals, and hoarding. Patients often have multiple obsessions and compulsions. A "checker" may also be a "washer," for example. Some patients are "purely obsessional" with no compulsions. These patients are likely to have repetitious thoughts of an aggressive or sexual act that are reprehensible to the patient. Many patients, once labeled as pure obsessionals, do have mental rituals. Some believe that only about 1% of OCD patients have obsessions without compulsions. Other patients exhibit primary obsessional slowness. In these patients, slowness is the primary symptom. They may spend hours every day getting washed, dressed, and eating.

People with OCD are very secretive about their obsessive thoughts and compulsive behaviors. Many are successful in hiding their illness for years. Unlike many mental illnesses, patients with OCD are aware of their inappropriate behaviors and thoughts; however patients are often unaware that their symptoms are part of a recognizable clinical condition that can be treated. Or they may be fearful that they will be "locked up" if they reveal their obsessions and compulsions.

One or more of these symptoms is not sufficient to diagnose a person with OCD. Remember that OCD is diagnosed only when these behaviors result in significant impair-

ment, distress, or anxiety, or are too time-consuming. Look for symptoms of depression also. Approximately one-third of OCD patients suffer from depression when they seek treatment. Signs of depression include weight loss, sleep changes, loss of appetite, lack of energy, sadness, crying, suicidal thoughts, feelings of hopelessness or helplessness, lack of interest in things that were of interest before, and lack of enjoyment of life, especially without knowing why. Suicide is a risk for all patients with OCD.

A Closer Look

OCD is difficult for people without the disorder to understand. Why can't people with OCD just turn off the thoughts or stop the compulsive behaviors? What is going on in their heads? The easiest way to explain it is to describe the progression of my thoughts and actions when my OCD was at its worst.

Before leaving the house, I would check the appliances, lights, toilets, and doors. I checked these things in a certain order, and if I was interrupted, I started over. Often I would stop and wonder if I really had checked to make certain the stove was off, so I began touching the knobs to make certain. Then I began to question if, while touching the knobs, I had actually turned the stove on. This thought would cause me to check the stove again. Sometimes I would obsess about the stove (or coffee pot or door lock or...) after I had already left the house. Often, I called my neighbor and asked her to check it. I had a need for certainty. "Probably" was not good enough.

If I were nervous about something or had my mind on other things, it took longer to complete my checking rituals. At first checking was enough to relieve my anxiety and fear, but soon checking once did not produce the same relief. The continuing anxiety would cause me to want to check again. Before I knew there was a problem: I was checking over and over, with only minimal relief of anxiety.

Frequent hand washing started in the same way. I washed my hands before meal preparation. When I touched the refrigerator, my hands were now "dirty" again. So I washed again. Soon, meal preparation involved washing my hands a dozen times. I did not prepare food for anyone outside my family to avoid the possibility of harming others.

I worried about everything. Not the kind of worrying that everyone does at times. Constant, continuous worrying-obsessing. When the day was over, and I sat down to relax, I worried. I would go over the events of the day, my mind searching for a mistake, a potential problem, or something to "fix." Something

would stand out: a teaching left out, something left undone, or something done imperfectly. A phone call might solve the problem. At first this was enough, but soon it was followed by more phone calls because it took more to satisfy my need for certainty. Maybe I said the wrong thing or left something out in the first phone call. Often the worrying went on into the night and into the next day. Entire days off were filled with worrying and phone calls.

I think my strangest obsession was a fear that I had run over someone. The first time it happened, I was driving on a busy city street in the dark. A man stood by the side of the road and ran behind my car as I passed by. "What if I hit him" turned into "Maybe I did hit him." I turned the car around and went back to make certain I had not hit him. I didn't see anyone in the street or any emergency vehicles, so I drove on. But it was dark. Maybe I didn't look well enough. I went back two more times before it "felt right," and I was certain no one was hurt. After that night, this fear would pop into my head often. Going back to check the road once was sometimes enough. At other times, I went back several times. The progression of my checking rituals increased my anxiety, rather than alleviating it. This is because the rituals only produce short-term anxiety relief. My obsessions and compulsions usually started with a somewhat reasonable worry. Many people with OCD have obsessions that are completely out of character for the person to have, such as thoughts of harming a parent or child. The compulsion is meant to relieve the distress that accompanies an obsession. Often it is a ritual unrelated to the obsession, such as tapping, counting, saying certain words, or praying.

Treatment of OCD

OCD is most effectively treated with a combination of behavior therapy and medications. Studies have shown that a combination of behavior therapy and medication therapy produce better results than either treatment used alone. Although more difficult and time-consuming, behavior therapy has demonstrated more lasting results. Relapse is frequent when medication is withdrawn.

Medication Therapy

Serotonin is one of the neurotransmitter chemicals that nerve cells in the brain use to communicate with each other. These neurotransmitters are active when they are present in the synaptic cleft between nerve cells. Transmission is ended when the chemicals are taken back up into the transmitting cell. Classes of antidepressants known as serotonin reuptake

inhibitors (SRIs) and selective serotonin reuptake inhibitors (SSRIs) act to slow the reuptake of serotonin, making it more available to the receiving cell and thus prolonging its effect on the brain.

The medications most commonly used in treating OCD are antidepressants, and only antidepressants that effectively inhibit the presynaptic reuptake of serotonin have been useful in treatment. Clomipramine (Anafranil) is an older tricyclic antidepressant used to treat OCD. It is a SRI, but it is not selective for serotonin; as a result it has effects on other chemical messengers besides serotonin and has a wider variety of side effects. That clomipramine was effective in treating the symptoms of OCD while other tricyclic antidepressants were not was one of the first important clues to the role of serotonin in this disease.

SSRIs are usually preferred over clomipramine when treating OCD. Examples of SSRIs are fluoxetine (Prozac), paroxetine (Paxil), sertraline (Zoloft), fluvoxamine (Luvox), citalopram (Celexa), and escitalopram (Lexapro). Although these medications are not chemically related, they all work by inhibiting the reuptake of serotonin. Two other drugs in the class of antidepressants known as serotonin-norepinephrine reuptake inhibitors (SNRIs), venlafaxine (Effexor) and duloxetine (Cymbalta), may have good efficacy in the treatment of OCD, but they are not FDA-approved for OCD.

Sometimes a patient will not respond to the first medication used to treat OCD, and he or she will have to try two or more medications before finding one that works for him. Additionally, it may take 6-10 weeks for a clinical response to become evident. When deciding whether or not a medication has been ineffective, physicians consider the dose given, the duration of treatment, and the compliance of the patient before the decision to change medications is made.

Side effects are common with all of these medications; however, the SSRIs have less frequent side effects than clomipramine, including seizure rates and risk of overdose. SSRIs also have few anticholinergic side effects and do not have the risk for cardiac arrhythmia associated with the tricyclic antidepressants. Citalopram has been associated with prolonged QT intervals that are dose dependent.

In October 2004, following careful analysis of clinical trial data, the FDA issued a black box warning (the most serious warning for a prescription drug that indicates the potential for serious or life-threatening adverse effects) for antidepressants following thoughts and at-

tempts of suicide in children and adolescents being treated for depression with SSRIs. In 2007, the warning was extended to include young adults up to age 25. Although there were no actual suicides, the rate of suicidal thoughts or attempts was approximately 2% for those treated with a placebo compared to a rate of 4% for those treated with an SSRI. At present, there is no evidence for increased risk of suicide in patients being treated for OCD with SSRIs. All patients treated with SSRIs must be closely monitored for suicidal thoughts or actions, especially in the first 2 months of treatment.

General side effects of SSRIs include weight gain, restlessness, impulsiveness, sleepiness, insomnia, a heightened sense of energy, headaches, and impaired clotting. Healthcare workers should observe patients for signs of impaired clotting, such as bruising or nosebleeds, because serotonin is involved in platelet function.

Gastrointestinal side effects may include nausea, abdominal pain, loss of appetite, heartburn, and diarrhea. Self-injurious behavior and suicidal thoughts have been reported with fluoxetine. SSRIs are processed by the liver, and therefore can interact with other medications metabolized in the liver. This can cause an elevation of both drugs and increased side effects. This interaction seems to be more likely to occur with fluoxetine and least likely with sertraline.

Clomipramine may cause more pronounced side effects, including anticholinergic symptoms, such as dry mouth, constipation, excessive sweating, and urinary retention. Other side effects include fatigue, drowsiness, increased appetite, weight gain, tachycardia, dizziness, tremors, seizures, mania, agitation, memory problems, difficulty concentrating, sedation, and hypotension. Increased incidence of seizures at doses above 250 mg/day has been reported. Patients should be encouraged to tell their doctors about any side effects because simple actions such as adjusting the dosage or changing the time of day that the medication is taken may relieve many of them.

Although not required, electrocardiograms are often done before beginning treatment with clomipramine, when the target dose is reached, and periodically during treatment. Clomipramine can affect electrical conduction through the heart. Yearly liver function tests may be done. Clomipramine should be discontinued slowly; abrupt withdrawal can cause nausea, vomiting, hyperthermia, headache, sleep problems, and malaise. Combining alcohol with clomipramine may trigger aggressive behavior.

The SSRIs and SRIs often produce sexual side effects in both men and women. These include lowered sexual drive, delayed ability to have an orgasm, and complete inability to have an erection or orgasm. Some patients have increased interest in sexual activity. Spontaneous orgasms while yawning have been reported. Patients should be notified of these side effects and encouraged to discuss them with their doctor. Some patients have been able to reduce sexual side effects and enjoy sexual activity on the weekends by stopping the medication on Fridays and Saturdays. This is not as effective with Prozac because it is longer acting. Patients should not adjust their medications without their doctor's approval and supervision.

High dosages of medication are usually needed to obtain anti-obsessional effects. Recommended dosages are Luvox-up to 300 mg/day; Prozac-40-80 mg/day; Zoloft-up to 200 mg/day; Paxil-40-60 mg/day; and Anafranil-up to 250 mg/day. Some patients are very sensitive to even the lowest dosages.

Starting with the lowest dose possible, even breaking pills in half, and gradually increasing the dosage, may be effective. Prozac comes in a liquid form, which allows patients to start with a very low dose (1-2 mg/day). A small number of patients who have not had a reduction in OCD symptoms at large dosages, have had good results with extremely low doses.

It is best to avoid anti-obsessional medications during pregnancy and while breast-feeding. Long-term effects on the fetus or infant are not known at this time. Risk to the fetus would be highest during the first trimester, so medication should at least be avoided during this time.

Clomipramine should be avoided in elderly patients because it can interfere with thinking and cause or worsen confusion. Tachycardia, dry mouth, constipation, urinary retention, and memory problems are other side effects that can make it a poor choice for the elderly. Prozac, Zoloft, Luvox, and Paxil can be used at greatly reduced dosages. With all of the anti-obsessional medications, elderly patients are more likely than others to experience agitation, restlessness, nervousness, confusion, and changes in heart rhythm and rate. Special caution should be used when giving these medications to patients with heart disease. They may need close monitoring and frequent cardiograms. Patients with liver disease need closer monitoring of dosage. Some patients with liver disease will not be able to take these medications. Dosage adjustment may be needed if other medications metabolized in the liver are being taken.

Anti-obsessional medications can take up to 12 weeks to begin working. When these medications are stopped, they should be withdrawn gradually.

Improvement following adequate OCD drug treatment is frequently only partial, and 20% to 30% of cases may be refractory to treatment. Two or more SRIs may be combined to obtain the best results. If this is done, the clomipramine dose should be kept low because the blood level of clomipramine can be greatly increased by adding another medication. Studies have been conducted using neuroleptic medications (haloperidol and risperidone) in combination with an SRI. This may be particularly effective in patients with OCD accompanied by tics, Tourette syndrome, body dysmorphic disorder, or trichotillomania (compulsive pulling out of one's own hair). The SRIs and neuroleptics can compete for metabolism in specific hepatic pathways, so the rate of metabolism can be influenced. This can result in a net increase in the doses of both medications. Oculogyric crisis (eyes fixed upward and involuntary tonic movements) has been reported in two children treated with paroxetine and a neuroleptic. The addition of a neuroleptic may cause additional side effects, such as cognitive dulling, fatigue, weight gain, akathisia, and tardive dyskinesia. Quinidine-like cardiac effects can occur with the combination of SRIs and neuroleptics. An electrocardiogram should be performed, especially in patients over 40 years old, when a cardiac history is present, or when pimozide is combined with a tricyclic antidepressant, such as clomipramine.

Monoamine oxidase inhibitors (MAOIs), such as tranylcypromine (Parnate) and phenelzine (Nardil), are occasionally used to treat OCD. MAOIs may be effective in OCD patients with comorbid panic, anxiety, or depressive disorders.

Certain foods and medications can cause serious side effects, and even fatal reactions, if they are taken with MAOIs. Foods high in tyramine are to be avoided. These include wine, beer, alcohol, soda, orange juice, coffee, tea, aged cheese, sour cream, yogurt, pickled products, smoked herring, brains, liver, avocados, tomatoes, raisins, bananas, figs, broad beans, eggplant, peanut butter, meat tenderizers, vanilla, cocoa, chocolate, and caffeine. Instruct patients not to take any medications, including over-the-counter medicine, amino acids (e.g., tyrosine, tryptophan, D-L phenylalanine, and phenylalanine), or other supplements, without consulting the doctor.

Side effects of MAOIs include dizziness, drowsiness, anorexia, orthostatic hypotension, hypertension, and dysrhythmia. Less common side effects include anemia, confusion, headache, anxiety, tremors, central nervous system stimulation, weakness, hyperreflexia, mania, insomnia, fatigue, weight gain, constipation, dry mouth, nausea, vomiting, diarrhea, urinary frequency, change in libido, rash, flushing, increased perspiration, hypertensive crisis, and blurred vision. Instruct the patient to report immediately: headache, palpitations, dysrhythmia, or prodromal signs of hypertensive crisis.

MAOIs are contraindicated in the elderly and in those with hypertension, congestive heart failure, severe hepatic disease, pheochromocytoma, severe renal disease, and severe cardiac disease. They should not be given to patients who may not be compliant with food and medication restrictions. Hepatic studies and other lab work may be done on a routine basis.

Combined with SSRIs, SRIs, or buspirone, MAOIs are particularly dangerous, and can even be fatal. One must be stopped for at least 2 weeks before starting the other. Adverse reactions have been reported up to 4 weeks after discontinuing MAOIs. Fluoxetine (Prozac) is longer lasting, so the washout period is 5 weeks. Hypertensive crisis or serotonergic syndrome can result from combining these medications with an MAOI, or from an inadequate washout time between trials.

Serotonergic syndrome, or serotonin syndrome, is characterized by fever, muscular rigidity, vital sign fluctuations, agitation, delirium, or coma. All of these symptoms need not be present. If your patient is on a MAOI, make certain the patient understands the side effects, special diet restrictions, and the importance of not taking unprescribed medications. Serotonin syndrome can also occur, usually more mildly, when anti-obsessional medications are added to L-tryptophan, lithium, fenfluramine, or buspirone.

Alcohol can have an enhancing effect on anti-obsessional medications. It is not known if alcohol can counteract some of the therapeutic effects of these medications.

Behavioral Therapy

Completion of a course of behavior therapy appears to work as well as medication for the treatment of OCD. Research is finding that, over time, behavior therapy can change a person's brain chemistry. Patients who undergo behavioral therapy tend to stay in remission long term, requiring only occasional refresher sessions.

The complication is that behavior therapy requires great motivation and cooperation on

the patient's part. When used together, medication and behavior therapies complement each other. Medication alters the level of serotonin relatively quickly, while behavior therapy helps modify behavior by teaching the patient how to resist compulsions and obsessions. Exposure and response prevention are the principal behavioral techniques for treating OCD. Thought stopping, desensitization, flooding, implosion therapy, and aversive conditioning have also been used.

The purpose of exposure is to decrease the anxiety and discomfort associated with obsessions through habituation. This may be done by desensitization with brief imaginal exposure or prolonged exposure to the real-life ritual-evoking stimuli. For example, the person may be exposed to garbage or other contaminated objects without relieving the anxiety by washing his or her hands. As the person realizes that the feared consequences will not occur, the anxiety decreases. This is called habituation. The purpose of response prevention is to decrease the frequency of rituals. Patients are faced with feared stimuli without practicing rituals, such as hand washing or excessive checking. At first, the patient may be allowed to delay performing a ritual, working gradually towards resisting the compulsion.

Relaxation is usually not used during exposure and response prevention exercises because it interferes with progress. It is important not to let coping tactics lead to avoidance. However, some patients find applied relaxation techniques to be helpful. I find practicing relaxation techniques to be helpful between behavior therapy exercises.

In exposure and response prevention, a graded hierarchy of anxiety-producing activities and situations is constructed. The Yale-Brown Obsessive-Compulsive Scale can help with identification. Exposure usually begins with the least anxiety-provoking situation. Some therapists focus on the most anxiety-producing situations first to achieve more rapid progress. Which one is employed depends on the therapist's and the patient's ability or willingness to tolerate anxiety. One or two obsessions and rituals should be worked with at a time to avoid overwhelming the patient. The patient is assigned homework exercises. He or she may need assistance with these assignments from family members or therapist home visits. Participant modeling may be incorporated in exposure and response prevention. The patient is asked to copy the therapist. Patients observe their family and friends to help them determine "normal" behavior. When they are not sure if my behavior is appropriate, they ask one of their support people.

Family members should be asked to participate in the therapy. Role-playing under the supervision of the therapist can help patients understand homework assignments. Keeping a diary serves as a reminder of progress. It also helps the therapist identify areas of resistance.

In some cases, patients experience OCD symptoms only in particular situations. Exposure and response prevention may need to be carried out in special settings. Home visits or field trips may be required by the therapist. For best results, the therapist needs to be well trained in behavior therapy, the patient must be highly motivated and faithful in fulfilling homework assignments, and the patient's family needs to be cooperative.

Treatment for primary obsessional slowness may involve prompting, pacing, and reminders of the passage of time. Repeated exposure to can also be used. Patients with obsessions and few compulsions are more difficult to treat with behavior therapy. OCD patients whose obsessive thoughts focus on real-life problems may benefit from therapy used for chronic worriers. The patient is instructed to refocus on the present moment when worrying occurs. Worrying is limited to a prescribed 30-minute worry period each day. During this time the patient engages in formal problem solving. Exposure in the form of writing out or saying the obsession aloud may be helpful.

Behavior therapy for hoarding involves encouraging the patient to gradually discard items. The therapist helps the patient determine the order in which things can be thrown out. Hoarders need guidelines for what to save and discard. The therapist may need to visit the patient's home to get a clear picture of the problem.

Cognitive Therapy

Cognitive therapy involves attempts to change distorted thinking and beliefs. There is little controlled research evidence that cognitive therapy is effective in the absence of behavior therapy. Most OCD patients have already spent a large amount of time trying to correct their faulty thinking. They usually are aware that their thinking is obsessive and abnormal. With this disclaimer, it is my opinion that cognitive therapy is helpful, and it may be gaining more acceptance. It helped me with my recovery.

Cognitive therapy works best if the patient is intellectually able to understand abstract thinking. The therapist helps the patient identify inaccurate thoughts, and replace them with healthier ones. OCD patients tend to overestimate risks. Cognitive therapy can attempt to

challenge the patient's overestimation of the probability of the feared catastrophe.

People with OCD also tend to overestimate consequences. These false beliefs are also challenged. Even a low probability of catastrophe can cause great anxiety in the OCD patient, so the therapist may also concentrate on what makes the consequences of feared events so unacceptable to the patient.

Sufferers of OCD often have a poor tolerance of uncertainty. Knowing that a particular negative event might happen is enough to cause anxiety. The therapist may point out that routine behaviors that the patient regularly engages in are more dangerous than the risk associated with the obsessional fear. Many OCD patients participate in quite risky behavior unrelated to their obsessions.

OCD patients tend to have an inflated sense of responsibility. "If something bad happens, it will be my fault." The therapist can help patients adapt a more realistic sense of their own responsibility.

Anxiety and depression frequently interfere with the patient's ability to concentrate on the therapist's instruction. Many patients do not know what beliefs or appraisals are behind their obsessive thoughts and compulsive behaviors. Cognitive therapy can be used to assist in behavior therapy. If the person with OCD is reluctant to try behavior therapy, cognitive approaches can be used to explore and address fears about the therapy.

Cognitive-Behavioral Therapy

Researchers at the UCLA School of Medicine has been studying OCD for many years. They have developed a self-directed cognitive-behavioral therapy to supplement exposure and response prevention.

Brain Lock, by Dr. Jeffrey Schwartz, that details this therapy, which he calls the Four-Step Self-Treatment Method.

Psychotherapy

OCD appears to be resistant to treatment with psychotherapy. OCD was once thought to be the result of life experiences, such as attitudes about cleanliness learned in childhood. Growing evidence suggests that the disorder has a biological basis; however, supportive psychotherapy may be helpful in conjunction with behavior and medication therapies. The therapist empathizes with the anxiety the patient is feeling, reminds the patient that improvement is likely, and helps monitor changes. It is important that the therapist

not offer repeated reassurance, since this is a form of checking and is counterproductive to behavior therapy goals.

Psychotherapy may be beneficial in understanding what precipitates exacerbations and encouraging compliance with medication and behavior therapies. This type of therapy also may be helpful in dealing with obsessive perfectionism, indecisiveness, doubting, and procrastination, although clinical data are not available to support these clinical impressions.

Other Therapies

Patients who are severely resistant to treatment are sometimes treated with electroconvulsive therapy (ECT) and psychosurgery. Cingulotomy is the most common psychosurgical procedure for OCD. Other surgeries include anterior capsulotomy, subcaudate tractotomy, and limbic leukotomy. Seizure development is the most common complication of psychosurgery. Seizures are almost always controlled with anticonvulsants.

OCD in Children and Adolescents

OCD often develops in young adulthood, adolescence, or childhood. OCD begins in childhood in 30-40% of reported cases. Months or years may pass before parents become aware that their child has a problem, so it is important that school personnel and others involved in the lives of children learn to identify signs of OCD.

By definition, adults with the traditional form of OCD, at some point during the course of the disorder, recognize that the obsessions or compulsions are excessive or unreasonable. This requirement for diagnosis does not apply to children. They may lack adequate cognitive awareness to make this judgment. When they are anxious and obsessing, even adults may not realize they are being unreasonable. Most children go through developmental stages characterized by obsessive compulsive behaviors, which are quite normal. These behaviors are common between the ages of 2 and 7, and seem to be a response to a child's need to control his or her environment.

Compulsive behavior and rituals are more evident at bedtime. Children's words and actions become more repetitive. They may undress and dress several times, touch objects in a certain way, fix bed linens, or say good night repeatedly. And of course we have all played the "step on a crack and you'll break your mother's back" game. Normal childhood rituals enhance socialization, advance develop-

ment, and help children deal with separation anxiety. OCD, however, produces dysfunction, appears bizarre to adults and other children, and occurs later in childhood. Rituals normally disappear in time, but in children with OCD they remain the same or become worse. Children and teenagers with OCD often have a tendency towards perfectionism and rigidity or stubbornness. They are likely to have above normal intelligence, have a more adultlike moral code, have more anger and guilt, be disruptive, and have a more active fantasy life.

Obsessions with fear of contamination, with avoidance of suspected contaminants, or excessive washing is one of the most commonly reported obsessions in children. Eighty percent of children and adolescents with OCD participate in washing or cleaning rituals at some point during their illness. They may wash in a self-prescribed manner, more frequently, or for long periods of time. An obsession with contamination sometimes produces the opposite effect. In these cases, fear of contamination of body parts, personal objects, or both, leads to a refusal to touch them. Children with this obsession may have untied shoes, unbrushed teeth, sloppy clothing, and uncombed, dirty hair.

Checking compulsions are also common in children and adolescents with OCD. They are often precipitated by fear of harm to self or others, or the child may be troubled by extreme doubt. Checking of doors, light switches, windows, electrical outlets, and appliances may take much of the child's time. The child may feel compelled to check and recheck answers on assignments, to the point of interfering with the completion of homework or spending several hours on an assignment that should take much less time.

Obsession with numbers is especially common among young boys with OCD. Children with this obsession may have "safe" and "unsafe" numbers, repeat actions a certain number of times, or repeatedly count to a given number. Children may also repeat actions, such as walking through a doorway until it "feels right" or in a self-prescribed manner. Look for repetitious questioning, repeating of sentences, and numerous eraser marks on papers from erasing and rewriting words or numbers. Symmetry rituals may be manifested by tying and retying shoes, or constantly rearranging objects until they are even. Items must be arranged in such a way that they appear symmetrical to the child.

Treatment of Children

OCD that has an onset in childhood is the single strongest predictor of a poor prognosis. Children are treated with a combination of behavioral therapy and medication, with the ultimate goal being a reduction in the frequency and severity of their OCD symptoms. Treatment with SSRIs has been the most successful. It is important to be patient because treatment often occurs, slowly and different medications may need to be tried until the best one is found. It should also be noted that relapse rates may be high when medications are discontinued.

Pregnancy and OCD

OCD may worsen during pregnancy, perhaps due to hormonal changes. Caution must be taken with medications for pregnant women. Anafranil and Luvox have been shown to be toxic to the fetus in animal studies. There are several reports of symptoms of withdrawal, including tremors and seizures, in infants born to women taking Anafranil. Significant toxicity has not been demonstrated in Prozac, Paxil, and Zoloft in animal studies.

The effects of untreated OCD versus the effects of medications on the unborn child must be weighed when deciding to discontinue medication. Emotional stress and difficulty eating or sleeping can adversely affect the fetus. Experts agree that if it is possible, medication should be discontinued prior to becoming pregnant and throughout the pregnancy. If this length of time is not possible, consideration should be made to discontinue medication for at least the first trimester. If medication cannot be discontinued, only the smallest effective dose should be used, and the use of multiple medications should be discouraged. Alternatives to clomipramine or fluvoxamine should also be considered.

Anti-obsessional medications are all secreted in breast milk and there have been several reports of breast-fed babies becoming hyperirritable when their mothers were taking these medications. These symptoms include excessive crying, irregular sleeping, and difficult feeding. Symptoms will resolve when formula is substituted. Women with OCD are more likely to develop postpartum depression, and it tends to be more severe. Emotional and practical support is important to these new mothers. One of the anti-obsessional antidepressants may improve the depression.

Comorbidity

Patients with depression should be assessed for OCD because the patient with OCD is often very secretive about his or her obsessive thoughts and compulsions. OCD symptoms are frequently masked by depression and anxiety. Approximately one-third of OCD patients suffer from depression when they seek treatment. About two-thirds of OCD patients have had at least one major depressive episode in their lifetime.

Other comorbid diagnoses that can complicate the treatment of OCD are panic disorder, phobias, eating disorders, other anxiety disorders, affective disorders, organic mental disorders, substance abuse, personality disorders, and Tourette syndrome (TS).

There is evidence that some forms of OCD may be genetically related to TS and that both disorders may involve the basal ganglia. TS is characterized by frequent motor and vocal tics. Compulsive symptoms are seen in about 90% of TS patients. As many as two-thirds of TS patients meet the diagnostic criteria for OCD. OCD is also seen in other disorders involving the basal ganglia, such as Sydenham's chorea and Huntington's chorea.

Other disorders that may be related to OCD are compulsive gambling, body dysmorphic disorder, hypochondriasis, kleptomania, trichotillomania (compulsive pulling out of one's own hair), sexual behaviors, compulsive eating, nail biting, and compulsive spending. There is evidence that the same treatments will help some of these patients, but more research is needed in this area.

Obsessive compulsive personality disorder (OCPD) is found in less than 20% of OCD patients. OCPD is characterized by a pervasive pattern of preoccupation with perfectionism, orderliness, and control. Other characteristics include being inflexible, being extremely controlling, paying attention to minute details, making schedules, and following rules. Obsessions and compulsions are not symptoms of the disorder. Persons with OCD have unwanted thoughts, whereas persons with OCPD believe their thoughts are correct, and these thoughts are not linked to repulsive thoughts, urges, or images.

Family Support

Sometimes family members or friends recognize signs of OCD before the patient does, or the patient may refuse to seek help. If you know someone with symptoms of OCD, educate yourself about the disorder, and then bring educational materials into the home.

Share the information in a gradual and non-threatening way.

Do not assist people with OCD with their obsessive compulsive behaviors. Tell them that you will help them resist the compulsions, and you will help them obtain help, but you will no longer be a part of their compulsions. Examples would be participating in washing rituals, checking appliances for them answering the same question repeatedly, and offering frequent reassurance. Offer to help sufferers find a psychiatrist that has experience in treating OCD.

Once people with OCD begin treatment, family members play an important part in recovery. Patients often need a support person at home to assist them with the exposure tasks and homework assignments. Before taking on the role of support person, one should learn what will be expected. This will be a long-term project, often requiring regularly scheduled time to help with homework assignments. Family members and friends who are not taking on the role of support person can also help the OCD patient.

Nursing Interventions

Nurses play an important role in recovery for the patient with OCD, beginning with making referrals to proper resources. If OCD is suspected, the patient should be referred to a psychiatrist or therapist experienced in behavior therapy. The International Obsessive-Compulsive Disorder Foundation (IOCDF) and the Anxiety and Depression Association of America have listings of therapists who have indicated special interest in treating OCD. The membership directory at the Association for Behavioral and Cognitive Therapies (ABCT) indicates therapists' interest or specialty. Contact information for these groups are listed at the end of this course.

If an experienced therapist is not available locally, the patient may be able to travel to a center where behavior therapy is practiced. The patient can stay in a hotel or with friends and attend an outpatient clinic for evaluation and intensive therapy. Subsequent sessions may be possible by telephone. Inpatient treatment may be necessary if there is substantial risk of suicide, if intensive behavior therapy is available only on an inpatient basis, or if there are medical problems requiring treatment.

If behavior therapy is not available to the patient, self-help guides are available in some of the books about OCD. Several have been written for OCD patients and families. The suggestions given for family and friends are typically appropriate for nurses, as well.

Because medication therapy is an important part of treatment of OCD, nurses need to educate their patients on the purpose and side effects of anti-obsessional medications. Be aware of the actions and side effects of all of the patient's medications. Familiarize yourself with the type of behavior therapy your patient is receiving. Communicate with the psychiatrist or therapist about your role in behavior therapy. If your patient has the added stress of another illness, the therapist may want to put therapy on hold or adjust the therapy until the patient recovers.

General health should be monitored periodically, including vital signs, height, and weight. Electrocardiograms, liver and thyroid function tests, and complete blood counts may also be ordered. Instruct patients in the side effects of all medications and encourage them to tell their doctors about side effects. Tolerance to most side effects usually develops. Adjusting the dosage, dividing the dosage, or changing the time of day that the medication is taken may relieve the side effects. Starting doses of the anti-obsessional medications should be low to avoid side effects. The dosage should be increased gradually to avoid overshooting the effective dose.

Because clomipramine and other tricyclics can affect electrical conduction through the heart, electrocardiograms are often done as a baseline at the beginning of treatment, when the target dose is achieved, and periodically during treatment.

The nurse should observe for signs of impaired clotting, such as nosebleeds or bruising because serotonin is involved in platelet function. The SRIs are processed in the liver and therefore can interact with other medications metabolized in the liver. This can cause an increased effect of both drugs and increased side effects. This interaction seems to be more likely to occur with fluoxetine and least likely with sertraline. Familiarize yourself with all the medications the patient is taking, and be familiar with other incompatibilities.

The SRIs and the neuroleptics can compete for metabolism in specific hepatic pathways, so the rate of metabolism can be influenced. This interaction can result in a net increase in the dose of both drugs, which may increase the risk of adverse effects. The addition of a neuroleptic may cause additional side effects, such as cognitive dulling, fatigue, weight gain, akathisia, and tardive dyskinesia.

Quinidine-like cardiac effects can occur with the combination of SRIs and neuroleptics, so an electrocardiogram should be performed, especially in patients over 40 years old, when a

cardiac history is present, or when pimozone is combined with a tricyclic antidepressant such as clomipramine.

Serious side effects, and even fatal reactions, can occur if MAOIs are taken with certain foods and medications. Combined with SSRIs, SRIs, or buspirone, MAOIs are particularly dangerous, and can even be fatal. One must be stopped for at least 2 weeks before starting the other. Adverse reactions have been reported up to 4 weeks after discontinuing MAOIs. Prozac is longer lasting, so the interval is 5 weeks. Hypertensive crisis or serotonergic syndrome can result from combining these medications with an MAOI or from inadequate time between trials. If your patient is on a MAOI, make certain he understands the side effects, special diet restrictions, and the importance of not taking unprescribed medications. The SSRIs and SRIs often produce sexual side effects in both men and women. Notify your patient of these side effects and encourage the patient to discuss them with the doctor if they occur.

Anti-obsessional medications take up to 12 weeks to begin working. During the first few weeks patients may have many side effects, but no relief of OCD symptoms. Even clinicians may be tempted to give up on the medication too soon, since it usually takes only 4 to 6 weeks for depressed patients to improve. Knowing this will help the patient endure the side effects and the long wait for relief of OCD symptoms.

Your patient may ask how long he or she will need to be on medication. Studies suggest that OCD symptoms often return when medication is withdrawn after short-term treatment. Some patients may have a spontaneous remission, so clinicians may stop the medication once a year to determine if it is still needed. This is done by tapering the dose. If OCD symptoms recur as the medication is tapered, the dosage can be increased again and the medication will regain its effectiveness.

Advise the patient to talk to his or her doctor concerning alcohol use during treatment, especially with medication therapy. Alcohol can have a greater effect on individuals who are taking some medications. It is not known if alcohol can counteract some of the therapeutic effects of anti-obsessional medications, so alcohol avoidance is recommended, especially during the first couple months of medication therapy. If patients drink while on medication, they should not drive, operate heavy machinery, or perform other duties requiring concentration or coordination after drinking any amount of alcohol. Instruct patients to restrict driving and other activities requiring alertness if dizziness, drowsiness, or cognitive

impairment is present.

Relaxation techniques may be helpful. Ask the patient's therapist when they may be used since relaxation may interfere with exposure and response prevention.

Some OCD patients may have skin breakdown due to frequent hand washing or compulsive picking. During early therapy, patients may need instruction on maintaining skin integrity or may even need instruction on wound care.

Diet instruction may also be needed. Instruct patients on dietary measures to relieve constipation or diarrhea that can often be a side effect of medication.

Support groups help OCD patients realize that their symptoms are not unique. Family members should also be involved in a support group, if one is available. This is especially important for parents of children and adolescents. Support groups can also help with education about the disorder.

OCA (Obsessive-Compulsive Anonymous) was founded in 1988 by Roy C. OCA utilizes principles similar to other 12-step programs. The program is described in the book *Obsessive-Compulsive Anonymous – Recovering from Obsessive-Compulsive Disorder*. It is available through the OC Foundation.

GOAL (Giving Obsessive-Compulsives Another Lifestyle) is a support group in Philadelphia. Founded in 1981, it is probably the oldest OCD support group in the country. Emphasis is placed on choosing behavioral goals to work on between meetings. Jonathan Grayson, one of GOAL's founders, advises having a professional who is experienced with OCD to assist the group. This person would help keep the meeting on track, give individual assistance when needed, and answer questions.

GOAL meetings are divided into three parts: discussion of a particular topic chosen by the group leaders prior to the meeting; goal planning; and informal socializing. GOAL groups are discussed in the audio cassette, "Making and Maintaining Goals-G.O.A.L. Support Groups," which is by Jonathan Grayson, Ph.D. and Gayle Frankel. It is also available through the OC Foundation.

OCD on the Job

Ignoring OCD symptoms was not good for me or for my employer. This allowed my symptoms to become unmanageable. When I went back to work, I signed a consent form for my therapist to communicate with my supervisor about my behavior therapy and the best way to offer me support without encouraging

dependency or allowing excessive reassurance.

With a combination of medication and behavior therapies, the majority of OCD patients are able to function well at work. There are advantages and disadvantages to disclosing OCD to an employer. This is an individual decision that each patient must make. The Americans with Disabilities Act offers protection to employees with disabilities, including OCD. An attorney can advise the person with OCD of his or her rights.

Conclusions

OCD is most often a lifelong condition. Total elimination of symptoms is rare. Caregivers and family members must be patient in working with the person suffering from OCD. It is important to remember that there is help for those undergoing recovery. Nurses are an important component of that recovery process.

References and Suggested Readings

- Anxiety and Depression Association of America. Understanding the facts: Obsessive compulsive disorder. Avail at: <http://www.adaa.org/understanding-anxiety/obsessive-compulsive-disorder-ocd>; 2010–13.
- International OCD Foundation. About OCD. Avail at: <http://www.ocfoundation.org>.
- Jenike M, Dailey S. Sudden and severe onset OCD (PANS/PANDAS): Practical advice for practitioners and patients. Avail at: <http://www.ocfoundation.org/pandas/>; 2012.
- National Institute of Mental Health. Antidepressant medications for children and adolescents: Information for parents and caregivers. Avail at: <http://www.nimh.nih.gov/health/topics/child-and-adolescent-mental-health/antidepressant-medications-for-children-and-adolescents-information-for-parents-and-caregivers.shtml>; 2013.
- National Institute of Mental Health. PANDAS: Frequently asked questions about pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections. Avail at: <http://www.nimh.nih.gov/health/publications/pandas/pandas-frequently-asked-questions-about-pediatric-autoimmune-neuropsychiatric-disorders-associated-with-streptococcal-infections.shtml>

National Institute of Mental Health. Press release: Possible causes of sudden onset OCD in kids broadened. Avail at: <http://www.nimh.nih.gov/science-news/2012/possible-causes-of-sudden-onset-oed-in-kids-broadened.shtml>; 2012.

U.S. Food and Drug Administration. Celexa (citalopram hydrobromide): Drug safety communication: Abnormal heart rhythms associated with high doses. Avail at: <http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm269481.htm>; 2011.

Sources of Additional Information

There are numerous nonprofit organizations dedicated to disseminating information related to the understanding and treatment of OCD, OC spectrum disorders, and related anxiety disorders. Below are some of the best organizations in the United States, Canada, England, Europe, Australia, and New Zealand.

- International Obsessive-Compulsive Foundation (IOCDF)
- Obsessive-Compulsive Foundation of Greater Boston
- OCD Chicago
- Obsessive-Compulsive Foundation of Jacksonville, FL
- Obsessive-Compulsive Foundation of New Jersey
- Obsessive-Compulsive Foundation of Western Pennsylvania
- OCD Foundation of Michigan
- Anxiety Disorders Association of America (ADAA)
- Association For Behavioral and Cognitive Therapies (ABCT)
- Trichotillomania Learning Center (TLC)
- Social Phobia Association
- BDD Central
- Tourette's Syndrome Association (TSA)

Additional information and resources can be found online at the following Web sites:

Anxiety and Depression Association of America

<http://www.adaa.org>

Association for Behavioral and Cognitive Therapies (ABCT)

www.abct.org

International Obsessive-Compulsive Disorder Foundation

www.ocfoundation.org

Mental Health America

<http://www.mentalhealthamerica.net>

National Institute of Mental Health (NIMH)

<http://www.nimh.nih.gov/index.shtml>

OCD Online

www.ocdonline.com

OCD Action (United Kingdom)

www.ocdaction.org

Livestrong Foundation

<http://www.livestrong.com/article/379340-supplements-to-help-ocd/>

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