OBSESSIVE-COMPULSIVE DISORDER

Course #487 V.2

4 Contact Hours

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About the Author

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 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. She attended the Obsessive-Compulsive Conference in San Jose in 1996 to make sure her information is up to date. Cherlene lives in North Las Vegas, Nevada, with her husband, Jim, her son, James, and two cats, Melodie and Spunkie.

About the Editor

Shelda L. Hudson, RN, BSN, PHN completed her Baccalaureate Degree in Nursing and public health certificate at Azusa Pacific University. She is a member of the International Association of Forensic Nurses (IAFN) and an academic member of the American Botanical Council. She is the Nurse Supervisor of the Instructional Systems Development section of the National Center of Continuing Education. In this capacity, she is responsible for directing the activities of this department, selecting qualified, credentialed authors for the courses offered by the National Center as well as advising staff of required course design and criteria. Ms. Hudson has over 18 years of extensive experience in publishing courses in continuing education for health care professionals with the National Center.

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Obsessive-Compulsive Disorder
Instructional Objectives

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

1. State the lifetime prevalence of Obsessive-Compulsive Disorder (OCD).
2. Name the essential features of OCD, and define obsessions and compulsions.
3. State the most recent theories about the cause of OCD.
4. List symptoms of OCD the nurse is likely to see in patients.
5. Identify the therapies most often used for treating OCD.
6. List the five medications most commonly used in treating OCD, the side effects of each, and contraindications.
7. Identify the side effects of monoamine oxidase inhibitors (MAOI’s), the food and medication precautions needed during treatment with MAOI’s, and the danger of combining them with serotonin reuptake inhibitors (SRI’s) and selective serotonin reuptake inhibitors (SSRI’s).
8. Summarize information about behavior and cognitive therapies in a way patients can understand.
9. Identify areas in which supportive psychotherapy may be helpful in treating patients with 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 breast feeding.
12. Identify comorbid diagnoses that can complicate OCD treatment.
13. Discuss 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 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. I didn’t realize that acting on an obsession only begins a cycle of obsessing and compulsive behavior.

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 four 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, repeating myself, and demanding perfection. It was much more difficult for both of us, but it was what I needed.

What is OCD?

OCD is the fourth most common psychiatric diagnosis with a lifetime prevalence rate of up to 2.0%. 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 DSM-IV-R (Diagnostic and Statistical Manual of Mental Disorders, Fourth 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 are 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

Within the last decade, both basic and clinical research into the causes of OCD has 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 b-hemolytic streptococci. These disorders, called PANDAS (pediatric autoimmune neuropsychiatric disorders associated with streptococcal infection) 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, 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 females are more likely to develop OCD, males 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 had symptoms beginning in puberty,
and they reported 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).

Symptoms of OCD

The most common symptoms 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 obsessionals” 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 obsessive 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, the patient is aware of his 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. Signs of possible OCD are presented in the box below. Recognizing these signs can help your patient come out of his self-imposed closet and seek treatment. (See Table 1)

Table 1

- Checking things over and over – light switches, faucets, appliances, locks, paperwork assignments
- Worrying about making even small mistakes
- Taking longer to perform even simple tasks; staying up late to finish projects
- Overly concerned about details
- Washing hands excessively; red or chapped hands
- Taking very long showers
- Being extra meticulous about cleaning things, places, rooms
- Being overly concerned about contamination and germs
- Arranging items in a certain order or with perfect symmetry
- Worrying excessively about harming others
- Fear of behaving improperly, such as making sexual advances, saying the wrong thing, swearing
- Counting objects over and over
- Having lucky and unlucky numbers
- Repeating an action, such as sitting down or walking through a door, over and over until “it feels right”
- Frequent questions, often the same question rephrased
- Constant need for reassurance
- Scrupulosity – excessive religious concerns/praying, not in keeping with the patient’s background
- Frequent need for confessing sins or wrong doings
- Filling the house with mail, trash, or other collected objects
- Late for work or school, frequent absences
- Avoiding certain items or situations
- Change in sleep pattern or appetite
- Getting upset over small problems
- Apparent daydreaming when fixated on an obsessional thought
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 impairment, 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 they 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 was 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 and 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 had 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 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

The medications most commonly used in treating OCD are antidepressants. The five drugs proven to be useful in OCD treatment are fluvoxamine (Luvox), fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), and clomipramine (Anafranil). Venlafaxine (Effexor) may be effective, but more study is needed.

Anafranil is an older medication, a tricyclic antidepressant. It is a serotonin reuptake inhibitor (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. The fact that Anafranil 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. Luvox, Prozac, Zoloft, and Paxil are selective serotonin reuptake inhibitors (SSRI’s). These medications are not chemically related, but they all work by inhibiting the reuptake of serotonin. 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. The SRI’s and SSRI’s slow the reuptake of serotonin, making it more available to the receiving cell and prolonging its effect on the brain.

Sometimes a patient will not respond to the first medication, and will have to try two or more of the SSRI’s before finding one that works for him. Side effects are common with all of these medications. Rarely, patients taking any antidepressant can become manic or psychotic, or have seizures. The SSRI’s seem to have less frequent side effects than Anafranil. The nurse should observe for signs of impaired clotting, such as bruising or nosebleeds, because serotonin is involved in platelet function.

Seizure rates are lower and the risk of overdose is lower with the SSRI’s than with Anafranil. They have few anticholinergic side effects and they do not appear to alter cardiac conduction. Side effects of SSRI’s include weight gain, restlessness, impulsiveness, sleepiness, insomnia, a heightened sense of energy, headaches, and impaired clotting.

Gastrointestinal side effects include nausea, abdominal pain, loss of appetite, heartburn, and diarrhea. Self-injurious behavior and suicidal thoughts have been reported with fluoxetine. The SSRI’s 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.

Anafranil 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. Encourage patients to tell their doctors about side effects: 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 Anafranil, when the target dose is reached, and periodically during treatment. Anafranil can affect electrical conduction through the heart. Yearly liver function tests may be done. Anafranil should be discontinued slowly; abrupt withdrawal can cause nausea, vomiting, hyperthermia, headache, sleep problems, and malaise. Combining alcohol with Anafranil may trigger aggressive behavior.

The SSRI’s and SRI’s 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. Notify your patient of these side effects, and encourage him to discuss them with his doctor if he experiences them. 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-obessional 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 very low (1-2 mg/day). A very 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-obessional medications during pregnancy and 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.

Anafranil should be avoided in elderly patients because it can interfere with thinking and cause or worsen confusion in the elderly. 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-obessional medications, elderly patients are more likely than others are 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-obessional medications 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 from 20 to 30% of cases may be refractory to treatment. Two or more SRI's may be combined to get the best results. If this is done, the Anafranil dose should be kept low because the blood level of Anafranil 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's disorder, body dysmorphic disorder, or trichotillomania (compulsive pulling out of one's own hair). The SRI's and the 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 SRI's 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 Anafranil.

Monoamine oxidase inhibitors (MAOI's), such as tranylcypromine (Parnate) and phenelzine (Nardil), are occasionally used to treat OCD. MAOI's 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 MAOI's. 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 the patient not to take any medications, including over the counter medicine, amino acids (such as tyrosine, tryptophan, D-L phenylalanine, and phenylalanine), or other supplements, without consulting the doctor.

Side effects of MAOI’s include dizziness, drowsiness, anorexia, orthostatic hypotension, hypertension, and dysrhythmia. Less common side effects include anemia, confusion, headache, anxiety, tremors, CNS 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, palpitation, dysrhythmia, or prodromal signs of hypertensive crisis.

MAOI’s are contraindicated in the elderly and in those with hypertension, CHF, 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 SSRI’s, SRI’s, or buspirone, MAOI’s are particularly dangerous, and can even be fatal. One must be stopped for at least two weeks before starting the other. Adverse reactions have been reported up to four weeks after discontinuing MAOI’s. Prozac is longer lasting, so the interval is five weeks. Hypertensive crisis or serotonergic syndrome can result from combining these medications with an MAOI, or from inadequate 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 he 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-obssessive medications are added to L-tryptophan, lithium, fenfluramine, or buspirone.

Alcohol can have a greater effect on individuals taking anti-obssessional medications. It is not known if alcohol can counteract some of the therapeutic effects of these medications.

Behavior 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 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 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 do find applied relaxation techniques to be helpful. I find practicing relaxation techniques to be helpful between behavior therapy exercises.

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 will depend 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. I observe my family and friends to help me determine “normal” behavior. When I am not sure if my behavior is appropriate, I ask one of my support people.

Family members should be asked to participate in the therapy. Role-playing under the supervision of the therapist can help them 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 disorder 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 postponed until 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 will help 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.

We 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.

We 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 the patient adapt a more realistic sense of his 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

The UCLA School of Medicine has been studying OCD for over 10 years. They have developed a self-directed cognitive-behavioral therapy to supplement exposure and response prevention.

Dr. Jeffrey Schwartz has written a book, Brain Lock, that details this therapy, which he calls the Four-Step Self-Treatment Method. See Table 2.

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. Evidence is growing 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. It also may be helpful in dealing with obsessive perfectionism, indecisiveness, doubting, and procrastination, although clinical data are not available to support these clinical impressions.

Support Groups

Support groups help OCD patients realize that their symptoms are not unique. The family 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 by Roy C., “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.

Quick Summary

Quick summary of the four steps of cognitive-biobehavioral self-treatment for OCD:

Step 1:
RELABEL — Recognize that the intrusive obsessive thoughts and urges are the result of OCD.

Step 2:
REATTRIBUTE — Realize that the intensity and intrusiveness of the thought or urge is caused by OCD; it is probably related to a biochemical imbalance in the brain.

Step 3:
REFOCUS — Work around the OCD thoughts by focusing your attention on something else, at least for a few minutes: do another behavior.

Step 4:
REVALUE — Do not take the OCD thought at face value. It is not significant in itself.
group in the country. Emphasis is on choosing behavioral goals to work on between meetings. Jonathan Grayson, Ph.D., one of GOAL’s founders, advises having a professional experienced with OCD 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,” by Jonathan Grayson, Ph.D. and Gayle Frankel. It is also available through the OCD Foundation.

Other Therapies

Severely treatment resistant patients 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. They 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. The booklet, “School Personnel: A Critical Link in the Identification, Treatment, and Management of OCD in Children and Adolescents,” (available from the Obsessive-Compulsive Foundation) addresses this subject very well.

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 two and seven, 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 development, 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 adult-like 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 and/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. Observe for 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. He or she 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 only an hour.

Obsession with numbers is especially common among young boys with OCD. He 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, reading sentences over and over, 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.

Children and Medications

Controlled studies have shown clomipramine (Anafranil) to be effective in the treatment of OCD in children and adolescents. The usual starting dose is 25 mg/day. It is increased by 25 mg every 5 days as tolerated to 75 to 100 mg/day. If needed and well tolerated, it may be increased over the next two weeks to a maximum daily dose of 3 mg/kg. The typical dose range is 100 to 150 mg/day with some children and adolescents requiring higher doses. It can be taken in a single dose, but may be better tolerated if given in two doses.

Blood levels of Anafranil and its active metabolite, desmethylclomipramine, may be drawn periodically. Blood levels are only weakly correlated with therapeutic effect, and there seems to be great variability in the metabolism of Anafranil in children and adolescents. Assessing blood levels can identify patients at the extremes of metabolic distribution, and can help detect noncompliance. Crude guidelines for the level of Anafranil and its metabolite fall in the range of 150-550.

Fluoxetine (Prozac) has been shown to be effective in treating children in several studies and through clinical experience. Prozac now comes in a 10 mg capsule and a liquid, which allows for lower doses. The usual starting dose is 5 mg or less for younger children and 10 mg for older children. Dose increases should be introduced slowly because of the long half-life of Prozac and the even longer half-life of its active metabolite. The dose range for children and adolescents is 5 to 60 mg/day, with an average dose of 10 to 40 mg/day.

There have been reports of suicidal ideation and self-injurious behavior with the use of Prozac. The nurse should be alert to the emergence of suicidal thoughts or self-injurious behavior. This is true with all antidepressant medications. There are fewer published studies of sertraline (Zoloft), fluvoxamine (Luvox), or Paroxetine (Paxil) in children and adolescents with OCD. As with Anafranil and Prozac, these medications are started at a low dose and gradually increased. Dose ranges are: Zoloft – 50-150 mg/day; Luvox – 100-200mg/day; Paxil – 10-40 mg./day.

Pregnancy and OCD

OCD may worsen during pregnancy, perhaps due to hormonal changes. 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 having difficulty eating or sleeping can adversely affect the fetus. In the booklet, “OCD and Parenting,” the following approaches are recommended, progressing from the most to least conservative:

- “If it is reasonable, discontinue medication prior to attempting to become pregnant and throughout the pregnancy”...
- “If medication discontinuation for the entire pregnancy is not possible, consider discontinuation for the first trimester”...
- “When it is necessary to take medication during a pregnancy, it is best to use the smallest dose that is reasonable and to avoid multiple medications”...
- “If you are taking clomipramine (Anafranil) or fluvoxamine (Luvox), consider switching to an alternative anti-OCD medication”...

Anti-obsessional medications
are all secreted in breast milk and there have been several reports of breast-fed babies becoming hyper-irritable when the mothers were taking these medications. These symptoms include excessive crying, irregular sleeping, and difficult feeding. They 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's 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. Obsessive-Compulsive Disorder 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 is found in less than 20% of OCD patients. Obsessive-Compulsive Personality Disorder is characterized by a pervasive pattern of preoccupation with perfectionism, orderliness, and control. Obsessions and compulsions are not symptoms of the disorder.

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, then bring educational materials into the home. Share the information in a gradual and non-threatening way.

Do not assist the person with their obsessive-compulsive behaviors. Tell him or her 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 the person, answering the same question repeatedly, and offering frequent reassurance. Offer to help the person find a psychiatrist that has experience treating OCD.

Once the person with OCD begins 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. See Table 3.

The Nurse's Role

Detection

The family doctor may be the first one to see signs of OCD in patients. Nurses play an important role in assessment. Familiarize yourself with the signs and symptoms of OCD and depression. Recognizing these signs can help your patient come out of his self-imposed closet and seek treatment. Parents and family members may mention their concern about the person washing frequently, counting, or checking. Excessive worry about having acquired immune deficiency syndrome (AIDS) and other illnesses should alert the physician.
Non-psychiatric clinical specialists likely to detect OCD include dermatologists, oncologists, infectious disease specialists, neurologists, neurosurgeons, obstetricians, pediatricians, pediatric cardiologists (Sydenham’s chorea), plastic surgeons, and dentists. Chapped hands and eczema-type conditions may be seen by dermatologists. Patients may present themselves to plastic surgeons for repeated consultations for “abnormal lesions.” Gum lesions from excessive teeth cleaning can alert the dentist. Signs of OCD may be seen postpartum and during pregnancy. Neurologists and neurosurgeons see signs of OCD associated with Tourette’s Disorder, head injury, epilepsy, chorea, and other basal ganglia lesions or disorders.

Referral

If OCD is suspected, the patient should be referred to a psychiatrist or therapist experienced in behavior therapy. The Obsessive-Compulsive Information Center maintains a referral list. The OC Foundation and the Anxiety Disorders Association of America have listings of therapists who have indicated special interest in treating Obsessive-Compulsive Disorder. The Association for Advancement of Behavior Therapy membership directory indicates therapists’ interest or specialty. Addresses 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 motel or with friends and attend

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Family Member Support

Steps the family can take to encourage recovery:

- Reduce stress, especially during early treatment. Keep the family routine as normal as possible.
- Communicate with the health care team and with each other. Keep communication simple and clear.
- Be supportive and encouraging.
- Recognize even small signs of success. Avoid comparisons with others who have OCD or with family members without the disorder. The patient may already have a low self-image.
- Don’t place blame for OCD on anyone. OCD is no one’s fault. Try not to react critically to OCD behaviors and thoughts.
- Set rules for behavior and be consistent with enforcement.
- Encourage compliance with medication and behavior therapies. Due to side effects, the patient may need reminders to take his medication. I put my medication in a weekly reminder box to avoid missed or extra doses.
- Help the patient set reasonable goals. Setting expectations too high sets the patient up for failure.
- Beware of reassurance seeking. Patients often try to avoid anxiety by seeking reassurance from others. This becomes an avoidance behavior in the same way that a ritual does. There are times when reassurance is allowed, such as reassuring the patient that behavior therapy is effective in treating OCD. My family offered reassurance once when I was obsessing about something. When I repeated a question or rephrased it, they tried not to answer it again. A good response would be, “The doctor has instructed us not to reassure you,” delivered in a monotone voice.
- With the patient, practice responses you will give to reassurance seeking.
- Be familiar with signs of relapse and encourage the patient to seek professional help when these signs are first noted.

Table 3

Steps the family can take to encourage recovery:

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<td>• Reduce stress, especially during early treatment. Keep the family routine as normal as possible.</td>
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<td>• Communicate with the health care team and with each other. Keep communication simple and clear.</td>
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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.

**Nursing Interventions**

The suggestions given for family and friends are also appropriate for the nurse. 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 in the side effects of all medications and encourage your patients 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.

Anafranil 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 SRI’s are processed in 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. Familiarize yourself with all the medications the patient is on and other incompatibilities.

The SRI’s 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 SRI’s and neuroleptics, so 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 Anafranil.

Serious side effects, and even fatal reactions, can occur if MAO’s are taken with certain foods and medications. Combined with SSRI’s, SRI’s, or buspirone, MAO’s are particularly dangerous, and can even be fatal. One must be stopped for at least two weeks before starting the other. Adverse reactions have been reported up to four weeks after discontinuing MAO’s. Prozac is longer lasting, so the interval is five 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 SSRI’s and SRI’s often produce sexual side effects in both men and women. Notify your patient of these side effects and encourage him to discuss them with his doctor if he experiences them.

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 psychiatrists may be tempted to give up on the medication too soon, since it usually takes only four to six 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 the doctor may stop the medication once a year to determine if medication is still needed. This is done by tapering the dose. If the OCD symptoms recur as the medication is tapered, the dosage can be increased again. 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 antiobsessional medications, so it is worth trying not to drink alcohol, especially during the first couple months of medication therapy. If patients do drink while on medication, they should not drive, operate heavy machinery, or perform other duties requiring concentration or coordination after drinking any alcohol, even one drink. Instruct patients to restrict driving and other activities requiring alertness when dizziness, drowsiness, or cognitive impairment is present.

Relaxation techniques may be helpful. Ask the patient’s therapist when they may be used. 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 the patient may need instruction on maintaining skin integrity or may even need wound care. Diet instruction may also be needed. Instruct the patient on dietary measures to relieve constipation or diarrhea that is often a side effect of medication.

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 for my therapist to communicate with my supervisor about my behavior therapy and the best way to offer support without encouraging dependency or allowing excessive reassurance.

With a combination of medication and behavior therapies, the majority of OCD patients will be able to function well at work. There are advantages and disadvantages to disclosing OCD to an employer. This is a decision the 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.

Sources of Additional Information

Association for Advancement of Behavior Therapy (AABT)
305 Seventh Ave.
New York, NY 10001
(212) 647-1890

OC Foundation, Inc.
PO Box 9573
New Haven, CT 06535
(203) 315-2190

Obsessive-Compulsive Information Center
7617 Mineral Point Rd, Ste. 300
Madison, WI 53717-1914
(608) 827-2470

Obsessive-Compulsive Foundation
www.ocfoundation.org

OCD Online
www.ocdonline.com

OCD Action
www.ocdaction.org

Obsessive-Compulsive Disorder
www.mentalhealth.com

Natural Supplements for OCD
www.amoryn.com

Stop OCD Naturally
www.help-for.com/stop-ocd

OCD Research at John Hopkins
www.hopkinsmedicine.org/ocd

Healthy Place
www.healthyplace.com
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