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

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

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

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

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

ASSESSING OCD, COMORBID CONDITIONS

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

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

An alternative may be the Mini International Neuropsychiatric Interview (MINI).16 The MINI is a short, structured, diagnostic interview for DSM-IV and ICD-10 that takes about 15 minutes and screens for most conditions commonly comorbid with OCD. The MINI provides less-detailed information than the SCID-IV or the ADIS-IV but allows for a quick, accurate diagnosis while using a structured format.

OCD severity. After you have diagnosed OCD and

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**Table 1**

Common psychiatric comorbidities with OCD

<table>
<thead>
<tr>
<th>Comorbidities</th>
<th>Estimated prevalence in OCD patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personality disorders</td>
<td>63%</td>
</tr>
<tr>
<td>Major depressive disorder</td>
<td>28 to 31%</td>
</tr>
<tr>
<td>Simple phobia</td>
<td>7 to 48%</td>
</tr>
<tr>
<td>Social phobia</td>
<td>11 to 16%</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>15%</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>8 to 13%</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>8%</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>6 to 12%</td>
</tr>
<tr>
<td>Tourette’s syndrome or tic disorders</td>
<td>6 to 7%</td>
</tr>
</tbody>
</table>

Source: Data from references 1-6

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

**IS OCD PRIMARY?**

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

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

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

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

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**OCD severity.** After you have diagnosed OCD and

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continued on page 61
Many studies supporting ERP’s efficacy in OCD have included relatively homogenous samples under well-controlled conditions. Some investigations have also found good effects for ERP when including patients with complex treatment histories, concomitant pharmacotherapy, and comorbid conditions. Medication. Functional imaging studies suggest that OCD results from dysregulation in the so-called “OCD circuit”—the orbitofrontal cortex, anterior cingulate, and caudate nucleus. In patients with OCD, metabolic activity in this region is increased at rest relative to controls, increases further with symptoms, and decreases after successful treatment. The serotonin hypothesis—which emerged from observation that OCD symptoms responded to serotonergic medications but not to noradrenergic ones—suggests serotonin system dysregulation in patients with OCD. High dosages of SRI’s—selective serotonin reuptake inhibitors or the tricyclic antidepressant clomipramine—are first-line OCD medications.

### TREATING UNCOMPLICATED OCD

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

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

### Common assessment tools for patients with suspected OCD

<table>
<thead>
<tr>
<th>Structured clinical interviews</th>
<th>Time to administer</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety Disorders Interview Schedule-IV (ADIS-IV)</td>
<td>2+ hrs</td>
<td>Detailed assessment of anxiety disorders</td>
</tr>
<tr>
<td>Mini-International Neuropsychiatric Interview (MINI)</td>
<td>15 to 30 min</td>
<td>Brief screen for diagnosis</td>
</tr>
</tbody>
</table>

#### OCD-specific measures

| Yale-Brown Obsessive Compulsive Scale (YBOCS) | 30 min | Severity and OCD symptom types |
| Obsessive Compulsive Inventory-Revised (OCI-R) | 5 to 10 min | Self-report severity of OCD symptoms |

Source: Data from references 10-14
(Table 3, page 66). Double-blind clinical trials have found clomipramine, fluoxetine, sertraline, paroxetine, fluvoxamine, and citalopram more effective than placebo, and the first five of these drugs are FDA-approved for treating adult OCD.

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

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

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

- Augmenting SRI therapy with a low-dose atypical antipsychotic such as risperidone, 1 to 2 mg bid, or olanzapine, 5 to 10 mg/d, may be effective, even in patients without a comorbid psychotic or tic disorder.23,24 It is worth noting that trials using atypicals as adjunctive therapy for OCD have been brief (12 weeks), and long-term use of these medications carries a risk of metabolic side effects such as weight gain, diabetes, and hyperlipidemia.

- The serotonin-norepinephrine reuptake inhibitor venlafaxine, $\geq 225$ mg/d, showed efficacy in a naturalistic study of patients who did not respond to SRIs.25

- Augmentation with pindolol, lithium, buspirone, trazodone, tryptophan, or thyroid hormone has shown mixed results.24

**FACTORING IN COMORBIDITIES**

**Acute risk?** Conditions that endanger the patient take precedence over OCD treatment. Suicidal risk and self-mutilating behaviors, for instance, must be addressed before a patient can engage in ERP therapy. Active psychosis also would exclude ERP and may be best handled by augmenting SRI therapy with an antipsychotic.17
Treating OCD successfully may depend on identifying comorbid psychiatric conditions. Address comorbidities that pose acute danger or may thwart psychotherapy before you try exposure and response prevention (ERP). Otherwise, ERP and SRIs are first-line treatments, requiring only slight modification with most comorbidities. from ERP without depression-specific interventions.

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

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

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

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

The same medications are appropriate for some overlapping conditions such as depression and anxiety disorders, which simplifies simultaneous drug therapy. Treatment is more complicated in OCD patients with bipolar disorder, however, as the antidepressants used to treat OCD can induce...
mania or hypomania and worsen the mood disorder.\(^\text{20}\) In these patients, stabilize mood before starting an antidepressant.

References


Related resources


