Obsessive–compulsive and related disorders in adults

A comprehensive clinical guide

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Introduction

The Physician that bringeth love and charity to the sick, if he be good and kind and learned and skillful, none can be better than he.

Savonarola

This book is written for clinicians. As a result, it omits a great deal of neuroanatomical, neurochemical and neuropsychological speculation and research regarding the disorders considered. While these hypotheses and investigations will ultimately improve our ability to help patients, the fruits of these labors lie in the future. This book seeks to provide clinicians with information they can use to help patients now.

The disorders considered here, that is, obsessive–compulsive disorder (OCD) and some of the disorders that hypothetically belong to an "obsessive–compulsive spectrum," reflect my experience and interests. Because I am a specialist in adult psychiatry, the perspective centers on adult patients. From among the disorders often considered part of the OCD spectrum (Hollander, 1993), I have selected those with which I have the most experience and for which treatment approaches are reasonably well supported by evidence. For many of these disorders, however, well-controlled treatment trials are scarce or unavailable. Consequently, I have included treatments supported by case reports and case series so that clinicians can explore their utility.

Which diagnoses belong under the umbrella concept of OCD spectrum disorders is a matter of debate. Early advocates of the spectrum concept suggested the following collection (Hollander and Wong, 1995):

(1) Somatoform disorders (body dysmorphic disorder and hypochondriasis).
(2) Dissociative disorders (depersonalization disorder).
(3) Eating disorders (anorexia nervosa and binge-eating disorder).
(4) Schizo-obsessive disorders (OCD with loss of insight, OCD in patients with schizotypal personality disorder, OC symptoms in patients with schizophrenia).
(5) Tic disorders (Tourette's syndrome).
(6) Neurological conditions (Tourette's syndrome, Huntington's disease, autism, epilepsy, Sydenham's chorea).
(7) Impulse control disorders (compulsive buying, kleptomania, self-injurious

behaviors, sexual compulsions [nonparaphilic sexual disorders], trichotillomania and pathological gambling).

(8) Impulsive personality disorders (borderline and antisocial).

Others have suggested including certain habit disorders (skin picking and nail biting), phobias, post-traumatic stress disorder, intermittent explosive disorder, obsessive–compulsive personality disorder and tic disorders other than Tourette's syndrome (McElroy, Phillips and Keck, 1994b).

The clearest case for a relationship among these disorders lies in their phenomenology – each disorder is characterized by "obsessional" thoughts (repetitive, often senseless, preoccupying, unwanted ideation) and "compulsive" behaviors (repetitive behaviors performed in response to a strong urge that is often felt to be "irresistible," followed by tension or anxiety relief). Shared phenomenology is, however, an untrustworthy guide to shared pathophysiology or etiology. The history of psychiatric diagnostic systems from the eighteenth century through the twentieth is littered with the discarded remains of classifications built on phenomenology alone. Phenomenological comparisons generate hypotheses about pathophysiology or etiology; the tests that weed out error take place in biological terrain, albeit taking cognizance of how psychosocial characteristics of the individual, the family and the community modify disease.

Even within the realm of phenomenology, OCD and the spectrum disorders have been noted to differ (McElroy et al., 1993, 1994b; Black et al., 1994). The signs and symptoms of OCD usually express harm avoidance, whereas those of many spectrum disorders more often express stimulation or pleasure seeking and have harmful consequences. OCD patients usually retain insight, resist their symptoms and experience only tension relief while performing or completing compulsions. Patients with impulse control disorders often lack insight into the irrationality of their behaviors, do not resist urges and experience pleasure or excitement while performing impulsive behaviors (despite later painful consequences, sadness and remorse). Whether arraying OCD and the OCD spectrum disorders along a continuum from compulsivity (risk or harm avoidance) to impulsivity (excitement or pleasure seeking) (Hollander and Wong, 1995) will help clinicians choose among pharmacotherapies and psychotherapeutic approaches remains to be seen.

Hollander and Wong (1995) believe that the spectrum disorders and OCD share many features other than phenomenology, i.e., symptom profile; patterns of demography, family history, comorbidity, and clinical course; neurobiology; and, response to behavioral and pharmacological therapies. Others caution that the spectrum concept may be overly inclusive (Rasmussen, 1994), a caution its proponents acknowledge. Skeptics note that the spectrum disorders vary widely in how closely they resemble OCD, that the data needed to judge the degrees of resemblance are mostly missing, and, that OCD and each spectrum disorder may all turn

out to be collections of diseases, so that a shared pathophysiology may not span all of the entities inhabiting each current diagnostic label. In addition, differences exist among the spectrum conditions with regard to gender distribution, neurobiology, patterns of comorbidity and treatment response (McElroy et al., 1994b).

In my view, the spectrum concept is valuable primarily as a stimulus to basic and clinical research. Investigators and funding sources may become more interested in disorders that have attracted less attention than the mood disorders and schizophrenia. In addition, since some treatments, such as serotonin reuptake inhibitors and behavioral therapies, have application to many spectrum disorders, clinicians who become skilled in treating one disorder may become more interested in treating others. A shared therapeutic response to serotonin reuptake inhibitors is not, however, a strong indicator of pathophysiological relationships. Aspirin, for example, is useful in rheumatoid arthritis, headache and the prevention of myocardial infarction, but no one would argue on this basis for a shared etiology.

Clinicians applying a diagnostic system to the human problems brought for their care can increase the clarity of analysis by keeping in mind the distinctions between a disease, a disorder, an illness and a diagnosis. A disease is a pathological anatomical or physiological condition of known cause or causes. A disorder is a collection of pathological signs and symptoms (mental or physical) believed by physicians to cohere fairly well in onset, course, prognosis and treatment response, but whose etiology is unknown. Disorders are carved from a body of repeated observations of patients whose conditions seem similar. An illness is a disease or disorder as experienced by the patient, physically, psychologically and socially. A diagnosis, Scadding reminds us, is simply a label applied by the clinician to a disease, disorder or illness in order to bring medical knowledge to bear on altering its course or consequences (Mindham, Scadding and Cawley, 1992). None of the pathological conditions discussed in this book have attained the conceptual level of disease; all are disorders whose biological causes remain unknown.

Each chapter presents for the disorder it discusses the diagnostic criteria given in the *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition (American Psychiatric Association, 1994) and notes any important differences between these criteria and the diagnostic guidelines set out in the *ICD-10 Classification of Mental and Behavioural Disorders* (World Health Organization, 1992). The comparisons remind us that these two diagnostic classification systems are simply tools, not truths. The chapters next describe the differential diagnosis for each disorder, summarize the available epidemiological data and describe the clinical picture, including common comorbid conditions. In discussing treatments, the results of controlled trials, case series and cases are presented. Pharmacological and psychotherapeutic approaches are described in sufficient detail that the clinician can apply these treatments with an informed expectation of the results. Some

treatment recommendations identified are derived from my clinical experience. At times, clinical research that may widen the range of effective treatments is suggested to encourage clinicians to publish novel observations. Physicians (and scientists) concerned about the care of individual patients have often made observations that ultimately have led to previously unimagined treatments.

Fortunately, medical science is continually progressing. As a consequence, however, some ideas and recommendations contained in this text will be outdated by the time they are read. For this I am both grateful and chagrined.

I could find no smooth phrasing to encompass both genders when writing of clinicians and patients. As a result, I have settled on the male gender in referring to clinicians and have utilized the male or female gender, as reflected in the studies cited, to refer to patients. I happily acknowledge that wisdom, caring and clinical skill are independent of the clinician's gender and hope that my phrasing engenders no offense.