SPEAKER NOTES

Variable Expression of the Obsessive-Compulsive Disorder Spectrum

Summarized by Thomas T. Thomas

Many people experiencing a mental illness also suffer from an underlying anxiety disorder which may be expressed in various ways. The speaker at our November 18 meeting was **Scott Granet, LCSW**. He has practiced adolescent and adult psychotherapy for nearly 30 years and taught continuing education classes at JFK University, the University of California at Berkeley Extension, the University of Arizona Extended University, the University of Chicago School of Social Service Administration, and elsewhere. He is a board member and past president of the Obsessive-Compulsive Foundation of the San Francisco Bay Area and is a clinical social worker at the Palo Alto Medical Foundation's Department of Psychiatry and Behavioral Health. In 2008, he founded the first OCD-BDD[1] clinic in Northern California, located in Redwood City.

SCOTT GRANET, LCSW

"Everyone has a little bit of obsessive-compulsiveness," he said, "but it only becomes a disorder when the behaviors are out of control and get in the way of day-to-day life." The obsessive-compulsive (OC) spectrum of disorders has been recognized since 1992, Granet said. The various disorders may be classified differently, but they are similar in that the patient is unable to control the symptoms, onset is usually in the late teens and early '20s, there are similar underlying brain chemistry and co-morbidity, and that, while there is no cure, the disorders wax and wane and respond similarly to treatment.

The OC spectrum of disorders includes:

- **Body dysmorphic disorder (BDD),** in which the obsessional content is the person's physical appearance. "He may believe his ears stick out," Granet said, "or his nose is too big, his skin is bad, or his hair is thinning—whether or not it is." The disorder derives from the amount of energy the patient puts into checking in the mirror and being concerned with appearance. Granet stressed that this is not an eating disorder such as anorexia, whose criteria include losing a certain percentage of body weight. But eating disorders have some similarities with BDD.
- **Hypochondriasis,** which is an anxiety about health, including imagining diseases, visiting doctors, and checking the internet for signs and symptoms.
- **Impulse control disorders** such as pathological gambling, kleptomania or uncontrolled theft, trichotillomani or hair pulling, and skin picking.

[1] Obsessive Compulsive Disorder-Body Dysmorphic Disorder.

- **Tourette's syndrome,** which has overlaps with OCD. "About 20 percent of people with Tourette's also have OCD," Granet said.

Obsessive-compulsive disorder is the fourth most common mental illness after phobias, substance abuse, and depression. It is estimated to affect two to three million Americans, occurring in men and women equally and in people of all ages, occupations, and cultural backgrounds. "In other cultures the manifestations may be different," he said, "but the underlying disease is the same all over the world."

The cause of OCD is unknown, although research suggests it may involve problems in communication between the front part of the brain and its deeper structures. It tends to run in families, and a parent with OCD has a 2% to 8% probability of passing it on to a child. Serotonin is suspected in the brain chemistry of OCD, and medications that work on serotonin seem to help in treatment. There is an illness, PANDAS,[2] that tends to trigger OCD; so if a child suddenly exhibits obsessive-compulsive symptoms, it's a good idea to check for a strep infection. Stress does not cause OCD, although it has a role in other anxiety disorders such as post-traumatic stress disorder and social anxiety disorder.

"On average," Granet said, "people with OCD go nine years before receiving an accurate diagnosis and 17 years before receiving appropriate treatment."

The *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (DSM-IV) defines OCD as the presence of both obsessions and compulsions. The DSM-IV diagnosis requires that the obsessions and compulsions be both time consuming and interfere with normal everyday life.

Obsessions are "recurrent and persistent thoughts, impulses, or images that are experienced, at some point during the disturbance, as intrusive and inappropriate, and that cause marked anxiety and distress." The important point, Granet said, is that the person knows the obsession is inappropriate and is bothered by it. "This is not the criminal mind. People with OCD have fairly good insight and recognize their thoughts are irrational. By definition, these people are not psychotic, not hallucinating, not seeing and hearing things."

Common obsessions include:

- **Contamination** with dirt, germs, disease, and bodily wastes.
- **Aggressiveness,** such as violent thoughts about hitting someone with a car, throwing objects, or cutting with sharp objects.
- **Need for exactness,** such as putting items in a certain place, order, or symmetry.
- **Religious or moral fears** about blaspheming or doing something believed to be wrong. This is also known as "scrupulosity."
- **Hoarding and saving** out of fear of losing something believed to be of value.

Compulsions may be physical acts such as checking doors or mental acts such as counting. "But people are very creative," Granet said, "and the behavior is different for everyone." The neutralizing acts are usually not realistically connected to the obsession or are generally excessive.

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[2] Pediatric autoimmune disorder associated with strep.

Common compulsions include:

- **Checking** stoves, ovens, doors, windows, and locks.
- **Cleaning** and washing oneself, clothes, shoes, the home, office, money, and papers.
- **Mental acts** like praying, singing, and silently saying words or phrases.
- **Repeating** thoughts, numbers, or behaviors.
- **Ordering and arranging** items in a certain way.
- **Hoarding and saving** shopping bags, newspapers, disposable dishware, or old clothes.
- **Obsessive slowness** in routine tasks such as eating, dressing, or bathing.

Comorbidity, or having a concomitant but unrelated disease or disorder, is common with OCD. Comorbid conditions include major depression, a simple phobia, social phobia, panic and agoraphobia, panic disorder, generalized anxiety disorder, post-traumatic stress disorder, Tourette's syndrome, substance abuse, and one of the eating disorders. "Comorbidity is important," Granet said, "because if you are treating a person and they're not getting better, you have to consider what else may be going on."

The best treatment for OCD is a combination of medication and cognitive-behavior therapy (CBT). However, research indicates that up to 80% of patients improve with behavior therapy alone, and 50% to 70% improve with medication alone.

"The first line of approach with medication is the serotonin drugs or SSRIs[3] like Prozac, Zoloft, or Paxil. An older, non-SSRI antidepressant, Anafranil, is also prescribed, although sometimes the newer antipsychotics like Abilify and Zyprexa are also used." he said. "Note that people with OCD need the medication at the higher end of the dosing range, and this makes them susceptible to any side effects." Granet said that the treatment trial is also longer for OCD—12 to 16 weeks—than for depression.

Cognitive therapy is "all about your thoughts," he said. He warned about using cognitive therapy alone with an irrational disorder—although it's sometimes useful to ask someone who is, say, continually checking a door lock, "If you had to bet, what would you decide about that lock?" Granet might also suggest the patient ask three people who don't have OCD about the state of the lock.

Behavior therapy is the most important part of treatment for most people because "the proof is in the doing." Behavior therapy uses exposure and response preventions (ERP), also known as ritual prevention. This treatment depends on the skill of the clinician familiar with OCD and the willingness of the patient to take risks. ERP involves, first, exposure to the triggering event, thought, image, or impulse. The patient experiences the resulting thought or anxiety, and the clinician coaches him or her in blocking the responsive behavior. This can sometimes be done in the office, Granet said, but since most compulsions occur at home, the patient must be willing to do "home work." The patient learns that, even without the compulsive behavior, the obsessive thought or anxiety eventually goes away and the ritual is not necessary to relief.

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[3] Selective serotonin reuptake inhibitor.

Group therapy is also useful, because people with OCD benefit from meeting people with similar conditions and can provide support for each other.

Granet said that treatment for hoarding is different, and that San Francisco has the Institute on Hoarding and Cluttering because of the condition's impact on renting. He noted that Marin and Sacramento also offer partial hospitalization programs for OCD that require four to five hours a day for six to eight weeks, and that Wisconsin and Massachusetts have residential treatment facilities.