Introduction

Beyond Refractory Obsessions and Anxiety States: Toward Remission

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At the Sixth International Obsessive-Compulsive Disorder Conference (IOCDC), held November 13–15, 2003, in Lanzarote, Spain, 2 issues were discussed that are of great importance to future research on obsessive-compulsive disorder (OCD). The first of these is the possible inclusion of obsessive-compulsive spectrum disorders (OCSD) in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders. OCSD resemble OCD in their clinical symptoms, associated features, comorbidity, family/genesetics, etiology, and neurocircuitry, as well as their selective response to treatment with serotonin reuptake inhibitors. The second issue is considering remission as the ultimate goal of treatment for OCD instead of just symptom reduction, as has been suggested in other disorders. These and other issues should be discussed at future meetings of the IOCDC and influence how we conceptualize the disorder and design future treatment trials.

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Introduction

Diseases, Tenth Revision (ICD-10), currently does not include OCD with the anxiety disorder category.

The authors of this article are currently chairing the research planning series of panels for the American Psychiatric Association and the National Institute of Mental Health regarding the creation of an Obsessive-Compulsive Behavior Spectrum. We are examining evidence of how OCD is very different from anxiety disorders and is more similar to OCSD.

OCSD are alike in several important ways, including clinical symptoms, associated features, etiology, and response to treatment. Clinical symptoms shared by OCSD include repetitive thoughts and behaviors. Common features associated with OCSD include age at onset, clinical course, family history, and comorbidity. There are high rates of certain disorders in patients with OCD, including somatoform disorders, such as body dysmorphic disorder, and impulse-control disorders, such as trichotillomania. Studies have found that these disorders may share an underlying neurocircuitry. These related disorders often run in first-degree family members, which seems to indicate that OCSD may share genetic transmission.4,6,7 Several other neurologically based disorders, such as Tourette’s syndrome and autism, have OCD-like and/or preservative behavior, and brain imaging suggests similar patterns in the frontal lobe and basal ganglia. The OCSD also seem to share treatment response; they selectively respond to SSRIs, especially those given for a long period of time at high doses, but not to norepinephrine reuptake inhibitors, in contrast to other mood and anxiety disorders. Other antidepressants, such as tricyclics and monoamine oxidase inhibitors, which are effective in the treatment of anxiety disorders, are often not effective in treating OCSD.

REMISSION IN OCD

The treatment goal for most anxiety disorders, of which OCD is currently classified, has moved from simply symptom reduction to full remission, and the goal of treatment for patients with OCD needs to move toward this as well. Hollander and colleagues8 performed a trial of fluvoxamine in the treatment of OCD in which 117 patients were started with a higher dose of medication than had been given to other patients in previous studies. Possibly due to this dosing difference, a more rapid response was found than in the earlier studies. A significant drug-versus-placebo separation was evident at week 2 and continued through all 12 weeks of the study. At the end of the study, remission rate was assessed using 2 different criteria: a score of 16 or lower on the Yale-Brown Obsessive-Compulsive Scale (YBOCS), which would generally be considered too low for the patient to be enrolled in a clinical trial, and a score of 8 or lower on the YBOCS, which is generally too low for the patient to be diagnosed with OCD. Fifty-one patients (44%) achieved remission de-