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Monnica T. Williams, PhD; Darlene M. Davis, MA; Mark Powers, PhD; and Laura O. Weissflog, MSN, PMHCNS-BC, CRNP

None of these medications, with the exception of anafranil, fluoxetine, fluvoxamine, paroxetine, and sertraline, is approved by the FDA for the treatment of OCD.

No commercial support was used in the development of this CME lesson.

KEY WORDS: Obsessive-compulsive Disorder • Selective Serotonin Reuptake Inhibitors • Treatment • Augmentation • Exposure and Ritual Prevention • Cognitive Enhancers

LEARNING OBJECTIVES: Upon completion of this lesson, practitioners and clinicians will have (1) learned the prominent features of obsessive-compulsive disorder (OCD) as outlined in the new Diagnostic and Statistical Manual of Mental Disorders (DSM-5), (2) reviewed the pharmacological approaches to treating OCD, and (3) reviewed current pharmacological and psychotherapeutic augmenting agents useful in treating OCD.

LESSON ABSTRACT: Obsessive-compulsive disorder (OCD), a leading cause of disability, is gaining increased recognition as evidenced by the disorder’s own category of related disorders in the DSM-5. Nonetheless, OCD remains undertreated despite the availability of well-researched and effective treatment options. Selective serotonin reuptake inhibitors (SSRIs) are a typical first-line approach, but these require 4-8 weeks to become fully effective and often result in only a partial response. Underdosing is a common problem, since higher doses are usually required for OCD than for antidepressant effects. Sexual side effects are a common problem and may result in discontinuation. For partial responders, serotonin reuptake inhibitors (SRIs; including SSRIs and the tricyclic clomipramine) are often augmented with neuroleptics, but new research calls into question the benefits of this approach. Exposure and response/ritual prevention (Ex/RP) is a more effective method for augmenting antidepressant medications. New research indicates that Ex/RP can be made more effective by augmentation with the cognitive enhancer D-cycloserine.

COMPETENCY AREAS: Practitioners prescribing medication to treat OCD may not be aware of the latest research on various augmenting agents. By reviewing this information, practitioners will learn how to get the best treatment results for their patients with OCD. Clinicians treating OCD will become familiar with pharmacological approaches in order to discuss with their patients the potential benefits of augmenting psychotherapeutic techniques.
Introduction

Impact of Obsessive-Compulsive Disorder:

Obsessive-compulsive disorder (OCD), a severe illness, is considered one of the leading causes of disability worldwide, with a global burden comparable to that of schizophrenia. OCD is highly disabling, with nearly two-thirds of those afflicted reporting severe role impairment, including much higher rates of unemployment compared to the general population (22% vs 6%). The majority of those with OCD have comorbid mental disorders (90.0%), with 40.7% suffering from major depressive disorder, 75.8% suffering from an anxiety disorder or posttraumatic stress disorder (PTSD), 55.9% suffering from an impulse control disorder, and 38.6% suffering from a substance use disorder. The average age of onset is 19.5 years, and childhood onset is common, particularly in males.

Diagnostic Criteria:

Obsessive-compulsive disorder is characterized by the presence of obsessions and compulsions. Obsessions are defined as “recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress; the individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action.” Compulsions are defined as “repetitive behaviors or mental acts that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly; the behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.” In addition, OCD symptoms “are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment” in an important area of functioning.

For a diagnosis of OCD, symptoms must not be “attributable to the physiological effects of a substance or another medical condition” and are “not better explained by the symptoms of another mental disorder.” However, some cases of OCD, particularly in children, can be attributed to an autoimmune response (Pediatric Acute-onset Neuropsychiatric Syndrome, a.k.a. PANS; or Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections, a.k.a. PANDAS. The specific diagnostic criteria for OCD changed in minor ways from the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) to the DSM-5. The word “impulse,” which was previously used in the description of obsessions, has been replaced with “urge.” The word “inappropriate,” used to describe obsessional thoughts, has been replaced with the word “unwanted.” The DSM-IV requirement that patients recognize their obsessions and compulsions as senseless and excessive has been removed. The insight specifier in DSM-5 now includes three options, which are “good or fair insight,” “poor insight,” and “absent insight/delusional beliefs.” This option was added to improve differential diagnosis, since people with OCD have a range of insight into the senselessness of their symptoms. Thus, people with OCD may completely lack insight without a diagnosis of a psychotic disorder.

The most notable change in the DSM-5 is that OCD is no longer classified as an anxiety disorder. The disorder is now included in a new category called Obsessive-Compulsive and Related Disorders. This change was made primarily to group together disorders characterized by obsessive thoughts and/or repetitive behaviors, since the evidence is increasing that these disorders are related. However, this regrouping is not without its detractors, since several OC-related disorders may more appropriately fit in other categories (such as impulse control disorders), and some disorders most similar to OCD were left out of this new section entirely (i.e., illness anxiety).

Although people with and without OCD experience unwanted thoughts, people with OCD are believed to perseverate on a subset of these unwanted thoughts and ascribe too much importance to them. These unwanted thoughts become obsessions, which then demand an action to produce relief. Any actions performed to alleviate an obsession are considered rituals or compulsions, although avoidance is also a common response. Within
the context of OCD, compulsions provide negative reinforcement by affording temporary relief. Although compulsions may initially relieve anxiety associated with obsessions, the compulsions actually reinforce the behavior, such that the likelihood of future compulsive behavior in response to obsessions increases. Continued use of compulsions to reduce associated anxiety creates a reinforced behavioral response that becomes increasingly more entrenched and difficult to resist, leading to increased impairment. Thus, obsessions and compulsions are functionally related. Similar to the DSM-IV, the DSM-5 permits a diagnosis if either obsessions or compulsions are present, but there is some scientific disagreement whether it is possible to have obsessions without compulsions (sometimes termed “pure obsessional” or “pure-o.”

Research and clinical observations indicate that virtually all patients with OCD report obsessions and compulsions. Since obsessions and compulsions come in many different forms, each patient’s symptom presentation may differ. Nonetheless, four specific symptom dimensions have emerged that appear to describe the majority of OCD sufferers: (1) contamination obsessions with washing/cleaning compulsions, (2) symmetry obsessions with ordering/arranging compulsions, (3) doubting obsessions with repeated checking compulsions, and (4) unacceptable/taboo thoughts with mental/covert compulsions and reassurance-seeking.

People with OCD may have worries in one or all of these areas. Because of the wide range of symptom presentation, OCD is frequently misdiagnosed in primary care settings and among mental health professionals, thus, understanding of the phenomenology of OCD is vitally important for all health professionals.

Common Treatment Approaches

There are several effective treatments for OCD, including behavioral options, pharmacological options, and a combination. Only cognitive-behavioral therapies (CBT)—most notably exposure and response/ritual prevention (Ex/RP) and cognitive therapy—have been consistently demonstrated to be effective. Nonetheless, use of “insight-oriented” or “talk therapy” approaches for the disorder are widespread, despite their lack of efficacy. Of the CBT approaches, Ex/RP has most empirical support, although clinicians may use Ex/RP in combination with cognitive therapy, acceptance and commitment therapy (ACT), and mindfulness approaches. These forms of CBT have shown some utility, particularly among those with unacceptable or taboo thoughts.

Although Ex/RP is the most effective approach, it is rarely the first treatment tried by those with the disorder. Many individuals do not have access to CBT for OCD because of a lack of therapists who use empirically supported treatments, particularly in rural areas. Most clinicians do not receive training in Ex/RP or empirically supported treatments in general, resulting in a lack of therapists who can effectively treat OCD. As a result, patients may have difficulty locating qualified providers in their communities; in fact, more than half of those with OCD state they are uncertain about where to go for help or who to see for their condition. Less than a third with OCD obtain OCD-specific treatment (32.6%), but more than half (53.6%) are seen by a general medical clinician, such as a primary care physician or nurse. Thus, the first-line treatment for OCD is typically a pharmacological option, specifically selective serotonin reuptake inhibitors (SSRIs), due to their wide availability and tolerability.

Pharmacologic Approaches:

First-line Treatment: Serotonin Reuptake Inhibitors

First-line psychopharmacologic treatment for OCD includes four selective SSRIs and the serotonin reuptake inhibitor (SRI) clomipramine (Anafranil). Blanco et al. noted that despite the availability of pharmacotherapy, many patients do not receive evidence-based treatments. In a review of physician-reported data from 1997 to 1999, it appeared there were departures from empirically based practice parameters, with evidence of underdosing and lack of adequate dose titration as well as management of side effects by no means other than discontinuation of treatment. SSRI s, usually indicated in depression, are considered the first line in treating anxiety-related disorders due to their efficacy, tolerability, and safety profile. In a Cochrane Review, SSRIs were more effective than...
placebo.34 The SSRIs approved by the U.S. Food and Drug Administration (FDA) for OCD are fluvoxamine (Luvox), fluoxetine (Prozac), sertraline (Zoloft), and paroxetine (Paxil). SSRI choice may be guided by patient or provider preference, since, although not all SSRIs have been approved by the FDA, they all appear to be equally effective in treating OCD.3 Dosing guidelines for medications that are approved by the FDA to treat OCD are included in Table 1, with the rate of titration determined by patient response and tolerance. Table 2 includes dosing guidelines for the remaining SSRIs that are not necessarily approved by the FDA for OCD treatment, but may be used off-label by clinicians due to the evidence in the literature of their efficacy and tolerability. Better tolerability and acceptability for SSRIs over clomipramine make SSRIs the treatment of choice for OCD, with clomipramine reserved as a second-line treatment for those who cannot tolerate SSRIs or do not respond to them.35,36 OCD is characteristically resistant to first-line SSRI interventions, with estimates of approximately 25%-60% who were initially treated with an SSRI demonstrating inadequate response.37 Relapse is likely within the first 24-52 weeks of treatment; therefore, patients are encouraged to continue for a minimum of 12 months.38 A trial of at least 2, or occasionally 3, SSRIs should be considered before changing to a different class of medication. Treatment is usually recommended indefinitely, since relapse occurs in 80%-90% of patients upon full discontinuation.31

Clomipramine was the first medication approved by the FDA to treat OCD.35 However, there is evidence in randomized controlled trials that SSRIs are superior in terms of tolerability.40 Although clomipramine is a tricyclic antidepressant (TCA), it is the only TCA that potently inhibits presynaptic reuptake of serotonin.41 Clomipramine should be considered in the course of treatment of OCD after adequate SSRI trials with sufficient treatment duration, dosing to efficacy, and management of side effects have been completed. Research indicates that clomipramine and SSRIs are equally effective for decreasing OCD symptoms.42 Clomipramine can be administered parenterally as a valid

### Table 1:
FDA-Approved Drugs for the Treatment of OCD

<table>
<thead>
<tr>
<th>Generic Name (Brand Name)</th>
<th>Starting Dose</th>
<th>Average Dose mg/day</th>
<th>Max Dose mg/day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clomipramine (Anafranil)</td>
<td>25 mg</td>
<td>150 mg</td>
<td>250 mg</td>
</tr>
<tr>
<td>Fluoxetine (Prozac)</td>
<td>20 mg</td>
<td>40 mg</td>
<td>80 mg</td>
</tr>
<tr>
<td>Fluvoxamine (Luvox)</td>
<td>50 mg</td>
<td>150 mg</td>
<td>300 mg</td>
</tr>
<tr>
<td>Paroxetine (Paxil)</td>
<td>20 mg</td>
<td>40 mg</td>
<td>60 mg</td>
</tr>
<tr>
<td>Sertraline (Zoloft)</td>
<td>50 mg</td>
<td>50 mg</td>
<td>200 mg</td>
</tr>
</tbody>
</table>

### Table 2:
Other Drugs Used for the Treatment of OCD42

<table>
<thead>
<tr>
<th>Generic Name (Brand Name)</th>
<th>Starting Dose</th>
<th>Average Dose mg/day</th>
<th>Max Dose mg/day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citalopram (Celexa)</td>
<td>20 mg</td>
<td>40 mg</td>
<td>40 mg*</td>
</tr>
<tr>
<td>Escitalopram (Lexapro)</td>
<td>10 mg</td>
<td>20 mg</td>
<td>40 mg</td>
</tr>
<tr>
<td>Vilazodone (Viibryd)</td>
<td>10 mg</td>
<td>20 mg</td>
<td>40 mg</td>
</tr>
</tbody>
</table>

* dose lowered from 60 mg due to potential for arrhythmia (FDA, 2011)39
treatment alternative but is toxic in overdose and potentially fatal with death resulting from cardiac arrhythmia, hypotension, or intractable seizures. Clomipramine should be avoided in patients with cardiac instability, and used with caution in patients with narrow-angle glaucoma or significant hepatic or renal impairment. Blood level and electrocardiogram (ECG) monitoring are recommended with baseline assessment and initially monthly blood levels and bimonthly ECG with repeated monitoring every 6-8 months.

Although these medications are generally considered safe, concerns have been raised about increased incidence of suicidal thoughts among depressed youths. Additionally, hypomania or mania can be a side effect, and this may be particularly important to be aware of in OCD since this effect can be dose dependent. Clinicians are advised to be aware of the risk and vigilant in monitoring manic and hypomaniac behaviors when using SRIs to treat OCD in youth, even with low doses and gradual dose increase. Although there is no evidence in the literature to associate increased risk of suicide in adult patients with OCD being treated with SSRIs, clinicians should monitor closely patients, in particular if a comorbid bipolar disorder is present, since SSRIs may result in activation of manic symptoms in some individuals.

Other problems include sexual side effects, which are a common reason for early discontinuation. SSRIs prevent or delay orgasm in 35% of patients, decrease libido in 20%, and cause problems with erectile function in 10% of men; the SRI clomipramine causes anorgas mia in 90% of patients. These difficulties may be more common in patients with OCD since they require larger doses of SSRIs compared to patients with depression in whom these problems have been studied. Sometimes sexual dysfunction diminishes on its own, but other direct means of addressing these side effects are often necessary. Adding a drug that specifically targets sexual dysfunction, such as sildenafil (Revatio, Viagra) vardena fil, and tadalafil, is generally considered a safe first-line agent, and can counter some of the sexual side effects of antidepressants in men. To facilitate compliance with treatment, clinicians should discuss the possibility of sexual dysfunction with patients in advance.

Though most people who try SRIs for OCD are “treatment responders,” research has shown that actual symptom decrease tends to be modest at best. Having a response to medication is not a complete cure, merely an indication that the treatment has reduced OCD symptoms by some measurable degree. Although dramatic improvements from SRIs alone have been reported, on average, people with OCD experience only about a 30% decrease in symptoms. Thus, many patients are unsatisfied with the result. Considering the long period SRIs may require to be effective, often 4-8 weeks, the waiting and switching process can be frustrating for patients, and partial responders to 1 SRI are vulnerable to similar problems with other SRIs. Thus, it is increasingly common to augment SRI medication with either a type of psychotherapy specifically for OCD or another type of medication.

Augmenting SRIs with Other Medications: When SRI monotherapy produces inadequate symptom reduction, prescribers often augment using other medications. Commonly prescribed medications include benzodiazepines (e.g., muscle relaxants such as clonazepam), mood stabilizers (e.g., lithium), and neuroleptics (e.g., risperidone [Risperdal]; olanzapine [Zyprexa]; quetiapine [Seroquel]).

Benzodiazepines
Benzodiazepines are effective in treating anxiety disorders, but have significant adverse side effects and a high potential for abuse. Limited research on benzodiazepines suggests that clonazepam (Klonopin) can be used as a monotherapy to reduce OCD symptoms, but is more useful as an augmenting agent. Patients with comorbid panic disorder and high levels of agitation and anxiety may be better candidates for alprazolam augmentation. Other benzodiazepine medications have been examined, but there is limited evidence to support a recommendation for regular use of any benzodiazepine for OCD.

Mood Stabilizers
Augmentation of fluoxetine with lithium proved effective in reducing OCD symptoms in an open-label trial among partial responders. However, augmentation with lithium showed little clinical benefit in
a double-blind study among partial responders who received clomipramine (and a double-blind placebo controlled trial among nonresponders who took fluvoxamine).56,57 More research is needed, given the number of possible augmenting combinations and the potential side effects of lithium.

**Atypical Neuroleptics**

Augmentation with atypical neuroleptics, or antipsychotics, was once considered a better method for approaching poor response to SRI treatment.31 One of the first neuroleptics studied as an augmenter was haloperidol, but it was effective only for people with OCD and comorbid tics.58 Small doses of newer, safer medications have since been added, namely, second-generation “atypical” neuroleptics. They include risperidone (Risperdal), olanzapine (Zyprexa), and quetiapine (Seroquel). These medications are approved by the FDA for use in treating other disorders, but are currently used off-label for treating OCD. Research on olanzapine and quetiapine showed positive results when compared to placebo, but risperidone demonstrated the most consistent performance based on three studies.59 Despite initial enthusiasm, recent studies suggest poorer treatment response than previously reported when compared to therapeutic augmenting agents. A randomized placebo-controlled trial found risperidone was no better than placebo as an augmentation strategy.60 Future research is needed to justify the benefits of neuroleptics versus side effects and risks.

Practice guidelines emphasize the importance of managing the adverse effects of augmenting medications.3 When prescribed neuroleptics, patients with OCD are at higher risk for cardiovascular issues.61,62 In addition, patients with a primary diagnosis of a psychotic disorder experienced worsening of OCD symptoms when prescribed atypical neuroleptics.63 The older generation of neuroleptic medications, administered in higher doses, has been connected to many serious side effects. Consideration of long-term effects is important since short-term effects may result in problems such as movement disorders, excessive sedation, increases in body mass index and fasting blood glucose, and increased cholesterol and triglycerides.64

### Augmenting SRIs with Exposure and Response/Ritual Prevention

**Cognitive behavioral therapy** (CBT), specifically **exposure and response/ritual prevention** (Ex/RP), is the most supported technique with the strongest evidence for treating OCD.25,25 Ex/RP involves direct confrontation (exposure) to anxiety-provoking material while intentionally refraining from compulsions and is extremely effective. In one study, Ex/RP was tested against stress management training (SMT); all patients remained on their SRI medicine and were randomly assigned to receive one of the add-on therapies. Over three-quarters of the patients treated with Ex/RP responded to treatment by the end of the 8-week treatment period, while the SMT group did not improve significantly (77% vs 22%, respectively). Thus, Ex/RP appears to be an effective augmentation strategy for those with SRI-resistant OCD.65 In a similar study, Ex/RP was tested against augmenting with risperidone. Augmenting SRIs with Ex/RP produced superior results when compared to risperidone and placebo, resulting in improved functioning with fewer negative adverse effects.65 These findings emphasize the benefits of augmenting SRIs with Ex/RP to improve the effects of the medication.

### Enhancing Exposure with Medications:

The hope is that combining medication and CBT will result in an additive or synergistic effect. However, the reality is that adding medications that reduce anxiety (e.g., benzodiazepines, SSRIs) to exposure-based treatment for anxiety disorders does not improve outcomes or it may actually detract from monotherapy.66-68 These medications may interfere directly with extinction learning,69 or patients may attribute success to the medication (rather than the therapy or their own efforts) and then resort to avoidance patterns again while discontinuing medication.70 However, adding medications that improve memory (at least for extinction learning) may augment exposure-based treatment efficacy. This growing class of drugs is referred to as “cognitive enhancers.” Examples of cognitive enhancers include D-cycloserine (DCS),71 yohimbine hydrochloride,72,73 and methylene blue.74 The most researched compound in this class, to date, is DCS.
DCS is an antibiotic originally used to treat tuberculosis. The high doses used to treat tuberculosis (500-1000 mg/day) came with a negative side effect profile. However, one side effect noted was improved memory. It is thought that memory improves because DCS also functions as a partial agonist at the glycine site of the N-methyl-D-aspartate (NMDA) receptor. NMDA receptors have been implicated in learning and memory.75 Due to its memory-enhancing effects, DCS was investigated as a treatment for Alzheimer’s disease and the negative symptoms of schizophrenia.76,77 Unfortunately, people develop rapid tolerance to the positive memory effects of DCS.78,79 Thus, DCS is not indicated for long-term administration to improve memory. Instead, DCS can be used for discrete learning episodes for material that is important to remember. In this way, DCS is used to enhance extinction learning that occurs with exposure-based treatment of OCD. In addition, unlike the high doses needed to treat infection, much lower doses appear effective for enhancing extinction memory (as little as 50 mg).80 At this dose, significant side effects are not reported.

A combination of DCS and exposure-based treatment for acrophobia was first investigated by Ressler et al.80 Participants received 50 mg DCS, 500 mg DCS, or placebo 2-4 hours before each of 2 sessions of exposure therapy (virtual reality therapy). Both drug groups outperformed placebo at post-treatment and 3-month follow-up on acrophobia indices. There was no difference between the 50 and 500 mg groups. DCS-augmented exposure therapy has now been investigated across many anxiety disorders (including OCD) and has shown a small to large effect size advantage over placebo-augmented exposure therapy.71,81 Several studies investigating the use of D-cycloserine to augment exposure-based OCD treatment yielded inconsistent results. Although Storch et al.82 found no significant benefit for augmentation, Kushner, Wilhelm, and Storch found potential benefits for the use of D-cycloserine during Ex/RP.83,84,85

Upon closer examination, it appears that DCS is most effective at increasing the speed and efficiency of Ex/RP when administered very close to the time of the exposure sessions (1 hour before or after) and that the benefit seems to decrease over repeated sessions.71,81,86 This is consistent with the finding that people quickly develop a tolerance to DCS and there is potential for floor effects given the already potent efficacy of Ex/RP over the usual 17 sessions. Although promising, DCS is still not in widespread use in clinical practice. If further studies replicate and extend this early research, DCS may be help reduce costs and drop-out rates and speed up therapeutic progress in Ex/RP.

In summary, medications that reduce anxiety do not appear to augment Ex/RP for OCD. However, medications that improve memory (cognitive enhancers) administered immediately before or after initial exposure sessions in Ex/RP may speed response. The most researched and safest cognitive enhancer to date is DCS. However, before DCS is used widely, more studies are needed. The search is currently under way to identify additional targets for pharmacological augmentation. For example, brain-derived neurotrophic factor (BDNF) appears important for brain plasticity, is associated with hippocampus volume, is compromised in those with anxiety disorders, and can be augmented with bouts of exercise.87 Future studies will help determine the full potential of BDNF manipulation for exposure therapy outcomes and whether other compounds can augment BDNF.

Conclusion

At one time, OCD was regarded as an intractable disorder, and no effective treatments existed. Current treatments represent considerable advances beyond those dark times. SRIs bring some measure of relief to most people with OCD. Augmentation with Ex/RP is a good option for those who still have significant symptoms, and DCS is a promising method for helping people progress through the Ex/RP process. Much research remains to be done, since it is now unclear whether augmenting SRIs with other medications is an effective strategy. Furthermore, despite the use of effective treatments, many patients continue to have only a partial response and poor quality of life. Nevertheless, every person suffering with OCD is encouraged to persist with the existing validated strategies until he or she has achieved the best quality of life possible. There is no cure for the disorder, but with appropriate treatment and persistence, many patients can and will overcome OCD.
About the Faculty

**Monnica T. Williams, PhD:** Dr. Williams is the Director of the Center for Mental Health Disparities and Assistant Professor of Psychological and Brain Sciences at the University of Louisville in Kentucky. She is also the Clinical Director of the Louisville OCD Clinic, Louisville, KY.

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References


Multiple-Choice Questions

65. Which of the following is not a prominent feature in most cases of obsessive-compulsive disorder?
   A. Unwanted, intrusive thoughts
   B. Rituals
   C. Delusional beliefs
   D. Avoidance

66. A patient comes into the office for an initial evaluation with complaints and symptoms consistent with a diagnosis of OCD. The clinician recommends psychopharmacologic management as part of her treatment regimen. All of the following medications would be an appropriate first-line choice, except:
   A. Fluoxetine
   B. Duloxetine
   C. Fluvoxamine
   D. Sertraline

67. A patient presents for follow-up medication management after being treated for 6 months with paroxetine. He was treatment naïve to SSRIs, and initially started on 20 mg and gradually titrated him up in increments of 10 mg to his present dose of 50 mg. Most of his side effects have diminished or disappeared completely, but he is still experiencing urges to complete compulsions, although the urges are not as strong. What is the best choice for next steps?
   A. Augment paroxetine with an atypical neuroleptic such as risperidone
   B. Discontinue paroxetine in favor of another SSRI via cross-taper
   C. Continue the titration of paroxetine dosing to side effects while maximizing the current regimen
   D. Add clomipramine to the current regime as an augmenting agent

68. According to the research, the most supported psychotherapeutic treatment approach with the strongest evidence for treating OCD is the following:
   A. Insight-oriented therapy
   B. Eye Movement Desensitization Reprocessing (EMDR)
   C. Family-systems therapy
   D. Exposure and response/ritual prevention therapy

By Monnica T. Williams, PhD; Darlene M. Davis, MA; Mark Powers, PhD; and Laura O. Weissflog, MSN, PMHCNS-BC, CRNP

ID#: L003339

This valuable take-home reference translates evidence-based, continuing medical education research and theory, acquired from reading the associated CME lesson, into a stepwise approach that reviews key learning points for easy assimilation into your knowledge base and daily practice.

CME Lesson Overview

This lesson will be helpful to prescribing general practitioners, psychiatrists, psychologists, and other mental health clinicians treating patients with OCD. Practice guidelines for prescribing medication for OCD recommends pharmacological and/or psychotherapeutic techniques to improve patient responses during treatment.

Key Point 1: Impact of OCD

OCD is a severe disease, considered one of the leading causes of disability worldwide.

Key Point 2: Diagnostic Criteria

The most significant change between the DSM-IV and the DSM-5 is that OCD is now included in a new category called Obsessive-Compulsive and Related Disorders and no longer classified as an anxiety disorder.

Key Point 3: Common Treatment Options

Although there are several effective treatment options for OCD, exposure and response/ritual prevention (Ex/RP) has been demonstrated to be the most effective in treating OCD.

Key Point 4: First-Line Pharmacologic Approach

SSRIs are the psychopharmacologic treatment of choice for OCD, and provide most patients some measure of relief. Clomipramine may be reserved as a second-line treatment for those who cannot tolerate SSRIs or do not respond to them.

Key Point 5: Augmenting SSRIs and Future Considerations

Research is needed for further investigation of the benefit of augmenting SSRIs in the treatment of OCD. Ongoing studies are needed to find higher response rates to behavioral and pharmacologic interventions.