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/genetics, 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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The Sixth International Obsessive-Compulsive Disorder Conference (6th IOCDC), held November 13–15, 2003, in Lanzarote, Spain, brought together experts on obsessive-compulsive disorder (OCD) and related disorders. This biannual gathering always produces a lively and instructive discourse on topics related to OCD, including the state of the art in treatment for OCD, gaps in current knowledge about OCD, and methodological issues in OCD research. The articles in this supplement elaborate on some of the topics that were discussed in Lanzarote.

Two issues stand out in the authors' minds as being of particular importance to the future of OCD discourse, research, and treatment. The first of these issues is the proposed inclusion of obsessive-compulsive spectrum disorders (OCSD) in the upcoming fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V). Research tends to indicate that OCD should not be conceptualized as just another anxiety disorder; instead, for reasons related to its clinical course, phenomenology of symptoms, common comorbidities, family history data, functional neurocircuitry, and selectivity of response to serotonin reuptake inhibitors (SRIs), it may be better classified within a new category of OCSD (Figure 1).[1]

The second issue of special importance is a suggested move toward remission rather than simple symptom reduction as the goal of OCD treatment. Those who work with other anxiety disorders such as generalized anxiety disorder, social phobia, and panic disorder have begun to consider remission to be the goal of treatment, but OCD trials for the most part have not used remission as an outcome.

IS OCD AN ANXIETY DISORDER?

The classification of OCD as an anxiety disorder is currently under debate. In 1993, Stein and Hollander[2] argued that the classification of OCD as an anxiety disorder discounted its relationship to OCSD such as body dysmorphic disorder, trichotillomania, Tourette's syndrome, and pathological gambling. In the 10 years that have passed, research has been conducted and many articles have been published on the topic of OCD and OCSD that seem to support this claim.[1,3–5]

At the end of the 6th IOCDC, a vote was taken about the appropriate DSM-V category for OCD. The results came out overwhelmingly in favor of removing OCD from the anxiety disorders category and creating a new category of OCSD. Of note, the *International Classification of*

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

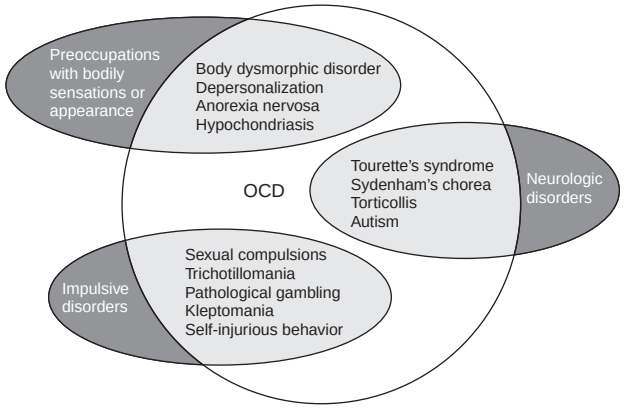
The authors of this article are currently chairing the research planning series of panels for the American Psychiatric Association and the National Institute of Mental Health regarding the creation of an Obsessive-Compulsive Behavior Spectrum. We are examining evidence of how OCD is very different from 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 SRIs, 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 colleagues[8] 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 defined as a score of 16 or lower on the YBOCS, and 21 patients (18%) achieved remission defined as a score of 8 or lower on the YBOCS, and this significantly separated from placebo on these remission measures.

Figure 1. Obsessive-Compulsive Spectrum Disorders[a]



[a]Reprinted with permission from Hollander et al.[1]

Many studies of medication treatment for OCD have not attempted to assess remission, only response; the few that did[9,10] defined remission in different ways. The definition of remission is an important issue that should be discussed at future IOCDCs and other gatherings of those who study OCD. There needs to be a consensus among researchers as to whether a standard definition of remission is needed, and if so, what it should be. Once an agreement has been reached, research on OCD and OCSD can gain momentum and knowledge can progress toward a virtual elimination of OCD symptoms.

Herein, Pallanti and colleagues discuss research into the standard of full remission in OCD and treatment developments for treatment-resistant OCD. Denys and colleagues analyze evidence on the role of dopamine in OCD, while Zohar and colleagues review the theories supporting the 5-HT_{1D} hypothesis of OCD. Also in this supplement, Westenberg and Liebowitz give an overview of panic and social anxiety disorders, and Stein and colleagues present research into the social anxiety disorder spectrum.

Disclosure of off-label usage: The authors have determined that, to the best of their knowledge, no investigational information about pharmaceutical agents has been presented in this article that is outside U.S. Food and Drug Administration–approved labeling.

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