

# Management of Obsessive- Compulsive Disorder

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Consultant Psychiatrist  
April 2011

# Epidemiology of OCD

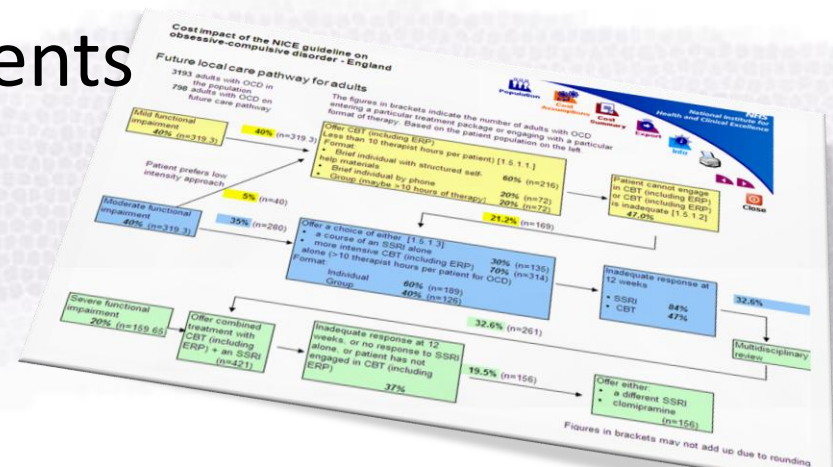
- Lifetime prevalence of 2.3%; 12-month prevalence of 1.2%
- M:F ratio approximately 1:1
- Age of onset tends to be earlier for males (6-15 years) than for females (20-29 years)
- Long delays between onset of symptoms and diagnosis
- Even longer delay between onset and treatment; 17 years in one study

RUSCIO, A. M., STEIN, D. J., CHIU, W. T. & KESSLER, R. C. (2010) The epidemiology of obsessive-compulsive disorder in the National Comorbidity Survey Replication. *Molecular Psychiatry*, 15, 53-63.

RASMUSSEN, S. A. & EISEN, J. L. (1990) Epidemiology of obsessive compulsive disorder. *Journal of Clinical Psychiatry*, 51 (Suppl 2), 10-13.

# OCD in Tayside

- Prevalence of OCD = 1.1%
- 20% of cases will have severe functional impairment
- In Tayside (pop = 404,424) there will be 889 patients with severe functional impairment
- 37% won't respond to NICE guideline treatments = 329 patients



# Why don't we see much OCD?

- People unwilling to divulge symptoms (esp. sexual, violent, religious)
- Not recognised – anxiety acknowledged but diagnosis missed
- Simply not asked about
- Misattribution of symptoms to other disorders; sometimes OCD can seem almost psychotic

# Alternative manifestations of OCD

**Table 1** Non-psychiatrists likely to see patients with obsessive-compulsive disorder (OCD)

<b>Professional</b>	<b>Reason for consultation</b>
General practitioner	Depression, anxiety
Dermatologist	Chapped hands, eczema, trichotillomania
Cosmetic surgeon	Concerns about appearance (body dysmorphic disorder)
Oncologist	Fear of cancer
Genitourinary specialist	Fear of HIV
Neurologist	OCD associated with Tourette's syndrome
Obstetrician	OCD during pregnancy or puerperium
Gynaecologist	Vaginal discomfort from douching

# Quality of Life in OCD

- OCD has significant impact on the domains of:
  - Family life
  - Instrumental performance
  - Activities of daily living
- QoL reductions generally comparable to that of major depression
- Impairment of social functioning is linearly related to severity of OCD
- As would be expected, comorbid depression lowers quality of life even further

LOCHNER, C., MOGOTSI, M., DU TOIT, P. L., KAMINER, D., NIEHAUS, D. J. & STEIN, D. J. (2003) Quality of life in anxiety disorders: a comparison of obsessive-compulsive disorder, social anxiety disorder, and panic disorder. *Psychopathology*, 36, 255-62.

KORAN, L., THIENEMANN, M. & DAVENPORT, R. (1996) Quality of life for patients with obsessive-compulsive disorder. *American Journal of Psychiatry*, 153, 783-788.

# Burden of OCD

**Table** The leading causes of disability worldwide, 1990

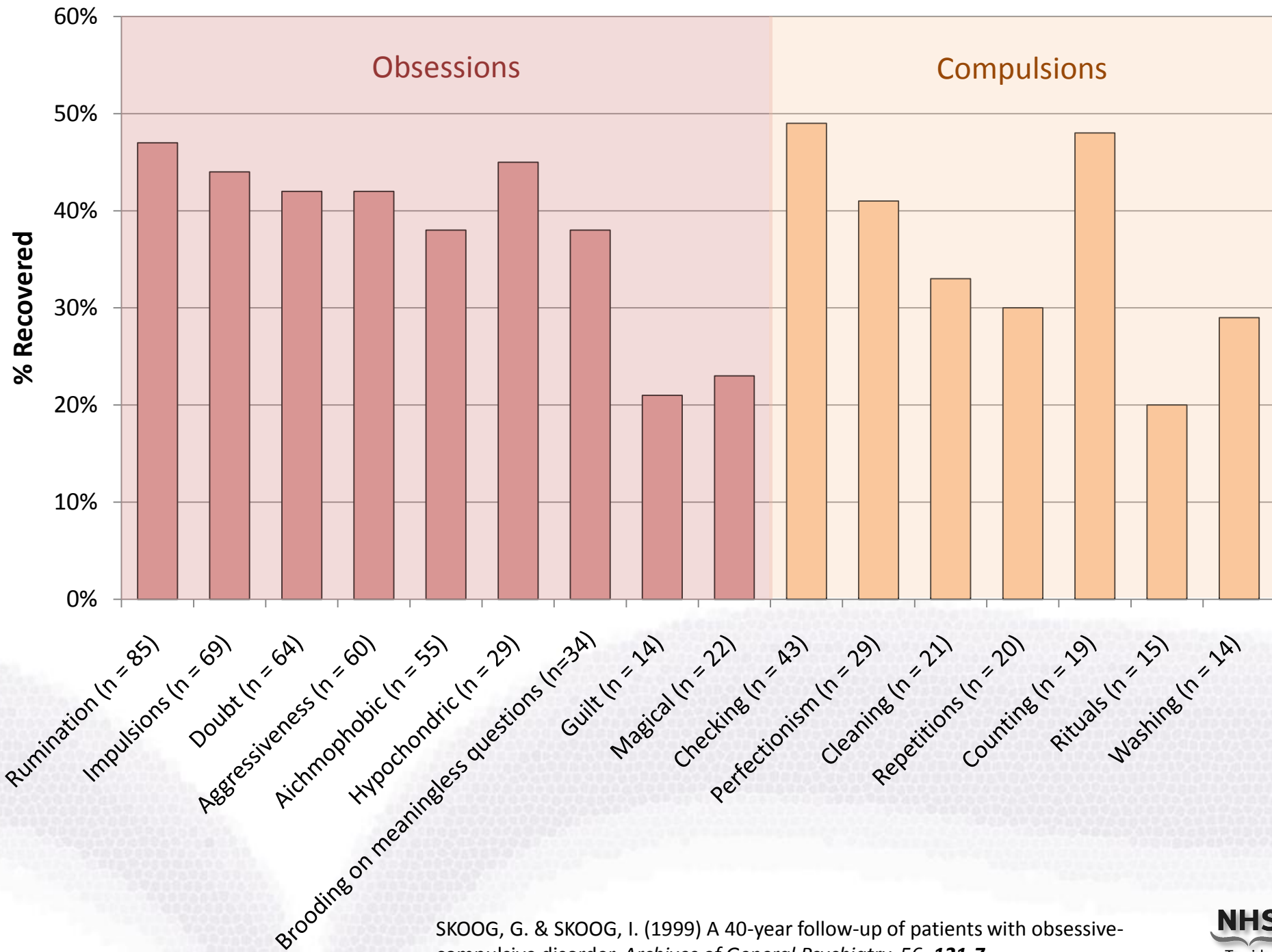
(As measured by years of life lived with a disability, YLD)	Total YLDs (millions)	Percent of total
All causes	472.7	
1. Unipolar major depression	50.8	10.7
2. Iron-deficiency anemia	22.0	4.7
3. Falls	22.0	4.6
4. Alcohol use	15.8	3.3
5. Chronic obstructive pulmonary disease	14.7	3.1
6. Bipolar disorder	14.1	3.0
7. Congenital anomalies	13.5	2.9
8. Osteoarthritis	13.3	2.8
9. Schizophrenia	12.1	2.6
10. Obsessive-compulsive disorders	10.2	2.2

# Course and outcome in OCD | 1

- In possibly one of the longest follow-up studies:
  - 251 patients were examined using semi-structured interview between 1954-1956
  - 122 of these were reviewed by same psychiatrist between 1989-1993
- Mean length of follow-up was 47 years
- Response rate in surviving patients was 82%

# Course and outcome in OCD | 2

- After almost 50 years:
  - Improvement seen in 83%
  - Recovery in 20%, recovery with subclinical symptoms in 28%
  - 38% of recoveries had done so in the 1950s
- 48% had had OCD for more than 30 years
- Qualitative symptom changes had occurred in 58% of patients



SKOOG, G. & SKOOG, I. (1999) A 40-year follow-up of patients with obsessive-compulsive disorder. *Archives of General Psychiatry*, 56, 121-7.

# Course and outcome in OCD | 3

- Other studies have found that 4-11 years later, over 2/3 of patients still had OCD
- Persistence rate of OCD (from adolescent to adulthood) of 41%
- 40% of childhood/ adolescent patients had a diagnosis other than OCD at follow-up

ROSS, S., FALLON, B. A., PETKOVA, E., FEINSTEIN, S. & LIEBOWITZ, M. R. (2008) Long-Term Follow-Up Study of Patients With Refractory Obsessive-Compulsive Disorder. *Journal of Neuropsychiatry and Clinical Neuroscience*, 20, **450-457**.

MICALI, N., HEYMAN, I., PEREZ, M., HILTON, K., NAKATANI, E., TURNER, C. & MATAIX-COLS, D. (2010) Long-term outcomes of obsessive-compulsive disorder: follow-up of 142 children and adolescents. *British Journal of Psychiatry*, 197, **128-134**.

# Predictors of outcome in OCD

- Worse outcome is associated with:
  - Early age of onset
  - Low social functioning at onset
  - Duration of illness at first assessment
- Higher baseline OCD symptoms predict the presence of other disorders at follow-up

SKOOG, G. & SKOOG, I. (1999) A 40-year follow-up of patients with obsessive-compulsive disorder. *Archives of General Psychiatry*, 56, 121-7.

MICALI, N., HEYMAN, I., PEREZ, M., HILTON, K., NAKATANI, E., TURNER, C. & MATAIX-COLS, D. (2010) Long-term outcomes of obsessive-compulsive disorder: follow-up of 142 children and adolescents. *British Journal of Psychiatry*, 197, 128-134.

# DIAGNOSIS

How to screen for it, diagnose it, and exclude other disorders

# Screening for OCD

- In the past **month** have you been bothered by recurrent thoughts, impulses, or images that were unwanted, distasteful, inappropriate, intrusive, or distressing? (e.g., the idea that you were dirty, contaminated **or** had germs, or fear of contaminating others, **or** fear of harming someone even though you didn't want to, **or** fearing you would act on some impulse, **or** fear or superstitions that you would be responsible for things going wrong, **or** obsessions with sexual thoughts, images or impulses, **or** hoarding, collecting, **or** religious obsessions.)
- In the past **month**, did you do something repeatedly without being able to resist doing it, like washing or cleaning excessively, counting or checking things over and over, or repeating, collecting, or arranging things, or other superstitious rituals?

# PHENOMENOLOGY

How to recognise OCD and differentiate it from other disorders

# Phenomenology | Obsessions

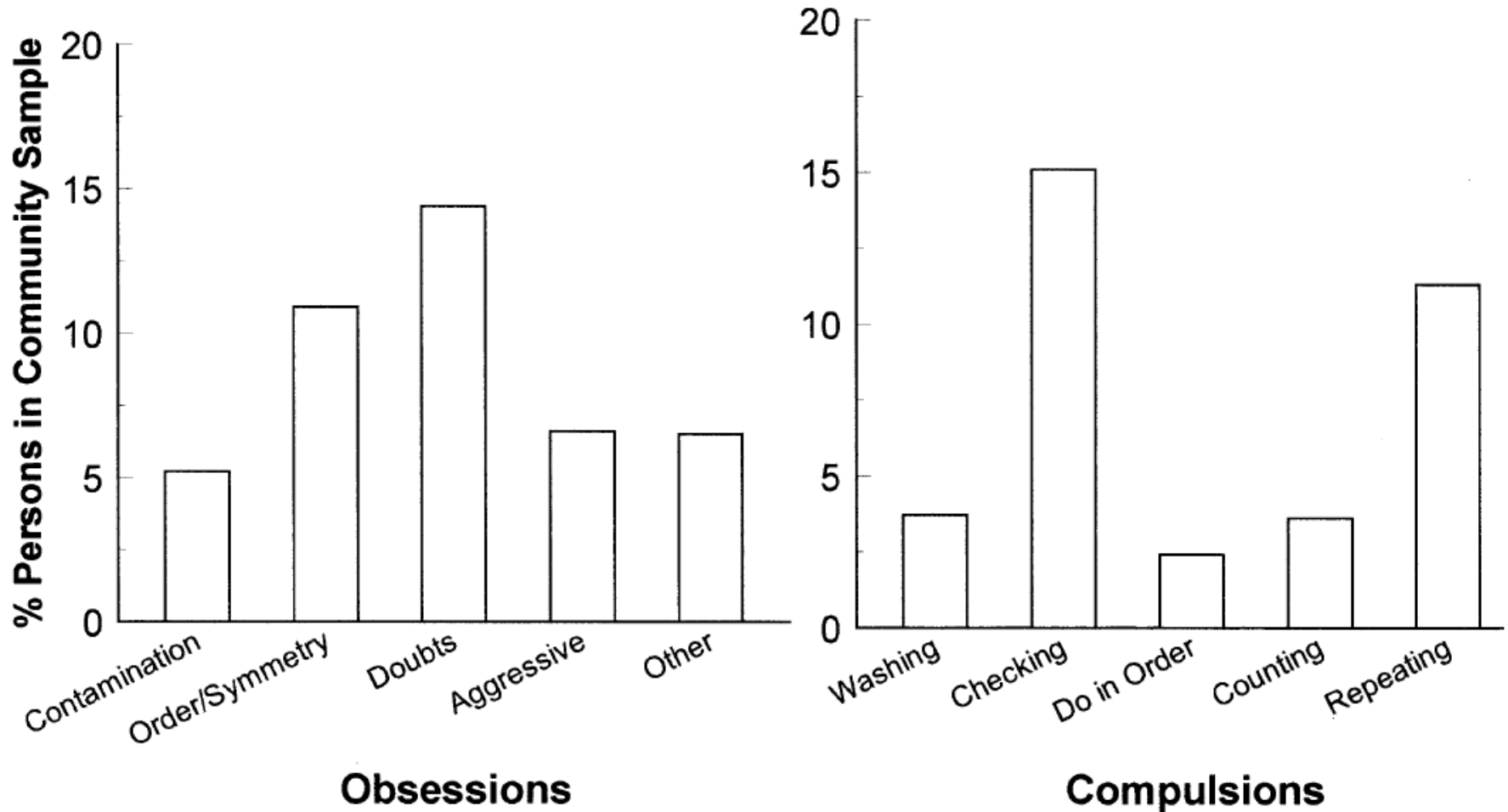
- Ideas, thoughts, impulses, images
- Intrusive and inappropriate
- Excessive and unreasonable (not in children)
- Cause marked anxiety or distress
- Ego-dystonic:
  - Product of own mind, but experienced as alien (“*not the thoughts I’d normally have*”)
  - Outwith own control
- Attempt to resist the intrusion or repetition
  - May be absent in very longstanding disorder

# Phenomenology | Compulsions

- Repetitive behaviours or mental acts
- Aim is to reduce anxiety
- Not pleasurable in themselves
- Have to be recognised as excessive and unreasonable
- Usually linked to obsession(s)

Obsession	Compulsion
Dirt, germs, contamination	Handwashing
Harm to others	Checking, phoning, seeking reassurance
Door left unlocked/ oven left on/ switch left on	Checking

# Pattern of symptoms (N=2,261)



STEIN, M. B., FORDE, D. R., ANDERSON, G. & WALKER, J. R. (1997) Obsessive-compulsive disorder in the community: an epidemiologic survey with clinical reappraisal. *American Journal of Psychiatry*, 154, 1120-6.

# Phenomenology | Magical thinking

- For example, the belief that if you step on a crack, something bad will happen
- An example of '*thought-action fusion*' – that the idea and the action/ consequence are the same
- '*Thought-object fusion*' – the merger of a 'bad' idea with an object. For example, if a bad idea occurs whilst driving over a bridge, the person will have to drive over the bridge whilst trying to dissociate the bad thought from the action
- In many cases, rituals will be used

# Phenomenology | Covert compulsions

- The patient may have compulsions which are not apparent
- For example, mental acts which have all the characteristics of compulsions but are not visible
- Typically, these might involve the repetition of words/ phrases, or other acts aimed at reducing anxiety
- Are often present in 'pure' obsessives (no compulsions)

# Phenomenology | Neutralising behaviours

- If the patient has to postpone a compulsion (e.g. Handwashing), this generates anxiety
- However, many patients can temporarily reduce the intensity of anxiety by reassuring themselves that they can wash when they leave the office
- So, an exposure session might seem successful but the patient has managed to 'neutralise' the anxiety until later

# Phenomenology | 'Just right'

- Patients on TV have to perform their rituals a certain number of times
- In reality, many patients have to do them until it feels 'just right'
- This might not be a consistent number

# ICD-10 versus DSM-IV

## ICD-10 (DCR-10)



- Obsessions or compulsions (or both) present on most days for a period of at least two weeks
- Cause distress or interfere with the subject's social or individual functioning, usually by wasting time

## DSM-IV



- No specifier for duration
- Cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational functioning, or usual social activities or relationships

# Comorbidity

Disorder	Prevalence
Depression	50-60%
Specific phobia	22%
Social phobia	18%
Eating disorder	17%
Alcohol dependence	14%
Panic disorder	12%
Tourette's syndrome	7%
Schizophrenia	14%

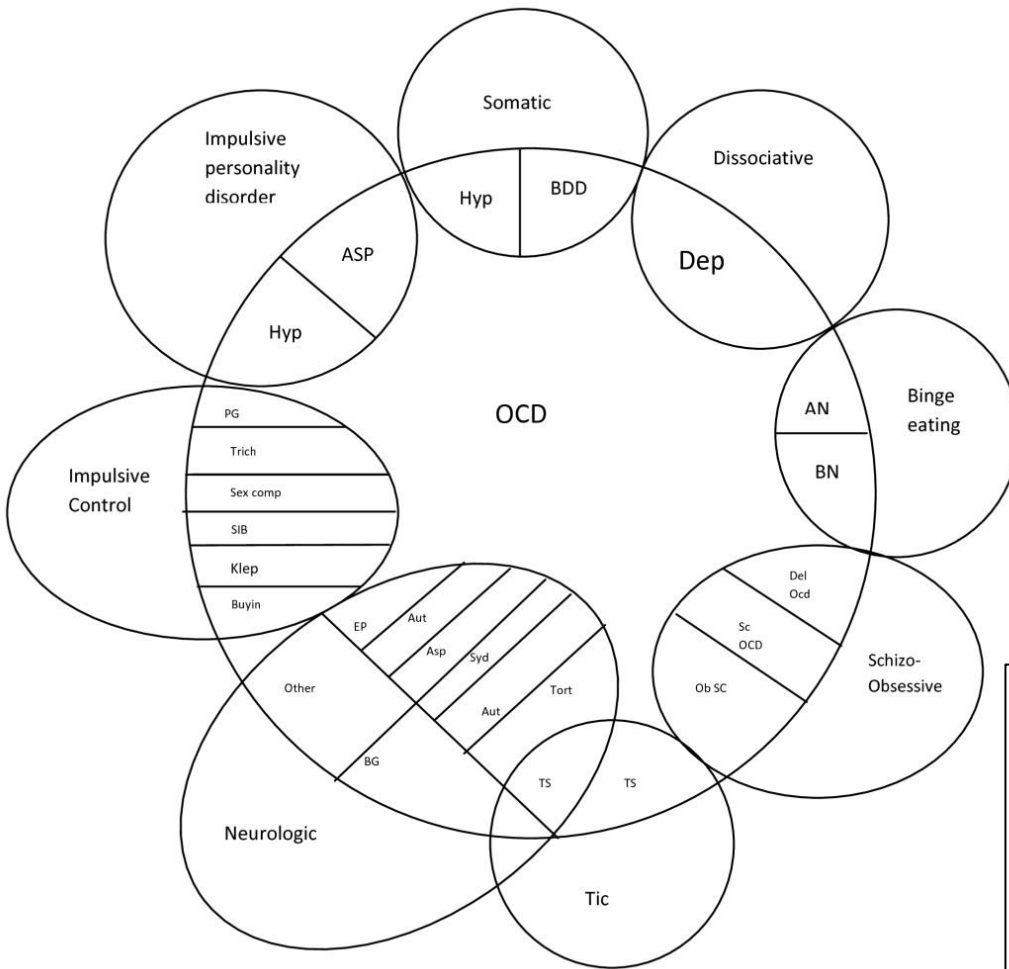
Anxiety Problem	<i>n</i>	%
Type I: Those who met criteria for OCD only		
OCD only	65	7.1
Type II: OCD and one additional anxiety problem		
OCD + GAD	163	17.9
OCD + PD	16	1.8
OCD + PTSD	5	0.5
OCD + SP	19	2.1
Type III: OCD and two additional anxiety problems		
OCD + SP + GAD	116	12.7
OCD + PD + GAD	145	15.9
OCD + GAD + PTSD	21	2.3
OCD + PD + SP	12	1.3
OCD + PD + PTSD	3	0.3
OCD + SP + PTSD	0	0.0
Type IV: OCD and three additional anxiety problems		
OCD + PD + GAD + SP	200	22.0
OCD + PD + GAD + PTSD	38	4.2
OCD + GAD + SP + PTSD	20	2.2
OCD + PD + SP + PTSD	5	0.5
Type V: OCD and four additional anxiety problems		
OCD + PD + GAD + SP + PTSD	82	9.0

*Note.* OCD = obsessive-compulsive disorder; GAD = generalized anxiety disorder; PD = panic disorder; SP = social phobia; PTSD = posttraumatic stress disorder.

## 910 patients who met full criteria for OCD

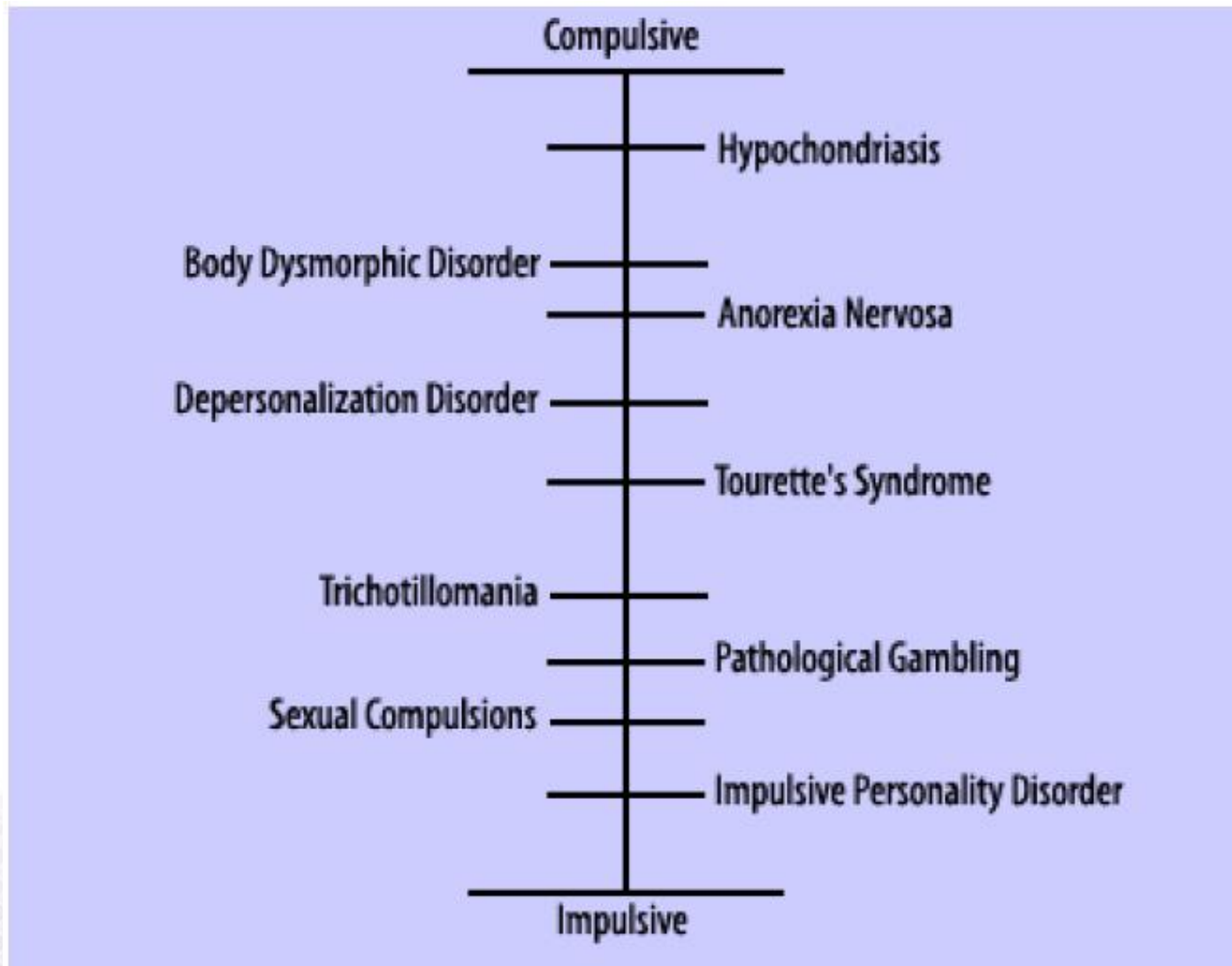
WELKOWITZ, L. A., STRUENING, E. L., PITTMAN, J., GUARDINO, M. & WELKOWITZ, J. (2000) Obsessive-compulsive disorder and comorbid anxiety problems in a national anxiety screening sample. *Journal of Anxiety Disorders*, 14, 471-82.

# OCD Spectrum Disorders | 1



AN: anorexia nervosa	Ep: epilepsy	Tort: torticollis
Asp: Asperger's syndrome	Hyp: hypochondriasis	Trich: trichotillomania
ASPD: antisocial personality disorder	Klept: kleptomania	TS: Tourette's syndrome
Aut: autism	Ob Sc: schizo-obsessive	
BN: bulimia	PG: pathological gambling	
BG: basal ganglia disorder	Sc OCD: schizotypal OCD	
BDD: body dysmorphic disorder	Sex Comp: sexual compulsions	
Del OCD: delusional OCD	SIB: self-injurious behaviour	
Dep: depersonalization Disorder	Syd: Sydenham's chorea	

# OCD Spectrum Disorders | 2



# Schizo-OCD

- OCD patients do not appear to be at higher risk of schizophrenia but schizophrenia patients are at higher risk of OCD (approx. 20-30%)
- Clozapine and Quetiapine can trigger O-C symptoms in schizophrenic patients
- Symptoms of OCD in schizophrenia very similar to 'pure' OCD
- Some studies have suggested use of anti-obsessionals and antipsychotics

POYUROVSKY, M. & KORAN, L. M. (2005) Obsessive-compulsive disorder (OCD) with schizotypy vs. schizophrenia with OCD: diagnostic dilemmas and therapeutic implications. *Journal of Psychiatric Research*, 39, **399-408**.

GANESAN, V., KUMAR, T. C. & KHANNA, S. (2001) Obsessive-compulsive disorder and psychosis. *Canadian Journal of Psychiatry*, 46, **750-4**.

# Differentiating OCD from other disorders | Axis I disorders

- Schizophrenia:
  - Delusional thoughts/ stereotyped behaviours are not ego-dystonic and are not subject to reality testing
  - *“of course I’m going to wash my hands because they’re trying to poison me...”*
- Anorexia nervosa:
  - Preoccupation with food not ego dystonic; avoidance of food due to perceived deleterious consequences (i.e. weight gain)

# Differentiating OCD from other disorders | Axis II disorders

- Anankastic/ Obsessive-Compulsive Personality Disorder:
  - Doesn't have clear obsessions and/ or compulsions; usually below threshold
  - Typically involves a pervasive pattern of preoccupation with orderliness, perfectionism, and control
  - Must begin by early adulthood
- OCPD behaviour is usually ego-syntonic and there is rarely any resistance
- Prevalence of OCPD in patients with OCD is not any higher than other psychiatric disorders

# OCD 'DIMENSIONS'

# The 4 domains of OCD: 'COSH'

Dimension	Factor (Y-BOCS)
<b>C</b> ontamination/ cleaning	<i>Cleaning</i> : cleaning and contamination
<b>O</b> bsessions/ checking	<i>Forbidden thoughts</i> : aggression, sexual, religious, and somatic obsessions and checking compulsions
<b>S</b> ymmetry/ ordering	<i>Symmetry</i> : symmetry obsessions and repeating, ordering, and counting compulsions
<b>H</b> oarding	<i>Hoarding</i> : hoarding obsessions and compulsions
<p>MATAIX-COLS, D., DO ROSARIO-CAMPOS, M. C. &amp; LECKMAN, J. F. (2005) A Multidimensional Model of Obsessive-Compulsive Disorder. <i>American Journal of Psychiatry</i>, 162, <b>228-238</b>   RUFER, M., FRICKE, S., MORITZ, S., KLOSS, M. &amp; HAND, I. (2006) Symptom dimensions in obsessive-compulsive disorder: prediction of cognitive-behavior therapy outcome. <i>Acta Psychiatrica Scandinavica</i>, 113, <b>440-6</b>.</p>	<p>BLOCH, M. H., LANDEROS-WEISENBERGER, A., ROSARIO, M. C., PITTENGER, C. &amp; LECKMAN, J. F. (2008) Meta-Analysis of the Symptom Structure of Obsessive-Compulsive Disorder. <i>American Journal of Psychiatry</i>, 165, <b>1532-1542</b>.</p>

# Other subtypes | Obsessional Slowness

- 9/10 are male, often with a history of prenatal problems
- Typically secondary to avoidance strategies and/or rituals
- Activity must be done 'just right' and without error
- May involve excessive repetition – appears 'frozen'
- Typically looks bizarre and possibly psychotic, but a good history will identify underlying obsessions and/or compulsions

RATNASURIYA, R. H., MARKS, I. M., FORSHAW, D. M. & HYMAS, N. F. (1991) Obsessive slowness revisited. *British Journal of Psychiatry*, 159, 273-274.

VEALE, D. (1993) Classification and treatment of obsessional slowness. *British Journal of Psychiatry*, 162, 198-203.

# Prader-Willi syndrome

- Genetic disorder (paternal deletion) affecting chromosome 15
- Psychiatric symptoms include:
  - Ritualistic behaviours
  - Routines, hoarding, and ordering
  - Repetitive actions and speech
- However, checking, cleaning, and obsessional thoughts are rare

CLARKE, D. J., BOER, H., WHITTINGTON, J., HOLLAND, A., BUTLER, J. & WEBB, T. (2002) Prader-Willi syndrome, compulsive and ritualistic behaviours: the first population-based survey. *British Journal of Psychiatry*, 180, 358-362.

DYKENS, E. M., LECKMAN, J. F. & CASSIDY, S. B. (1996) Obsessions and compulsions in Prader-Willi syndrome. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 37, 995-1002.

# PANDAS

- **P**ediatric **A**utoimmune **N**europsychiatric **D**isorders **A**ssociated with **S**treptococcal infections
- Associated with group A  $\beta$ -haemolytic streptococcal (GABHS) infections
- Criteria:
  - Presence of OCD and/or a tic disorder
  - Prepubertal symptom onset
  - Episodic course of symptom severity
  - Association with GABHS infections
  - Association with neurological abnormalities

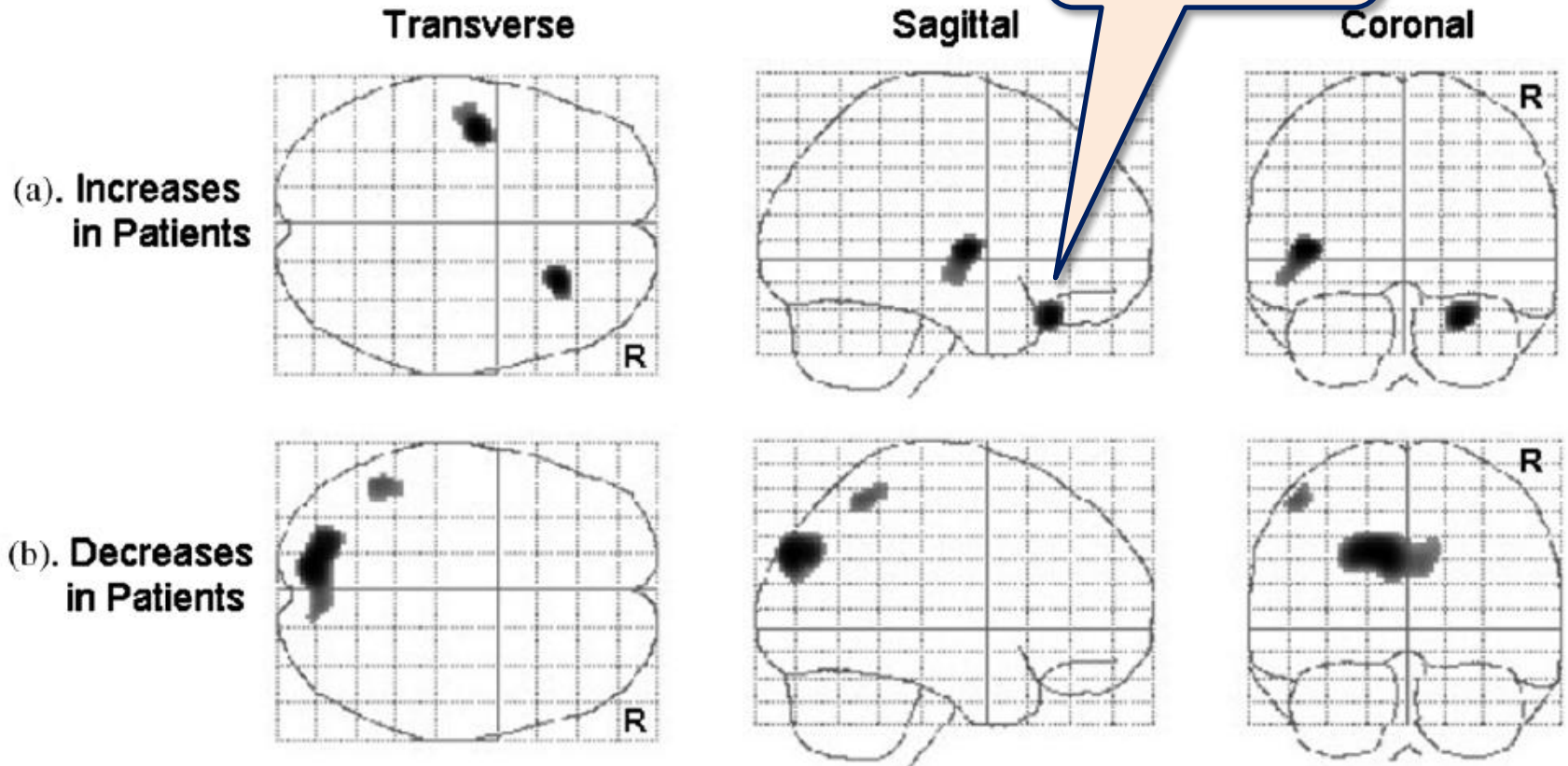
# NEUROBIOLOGY OF OCD

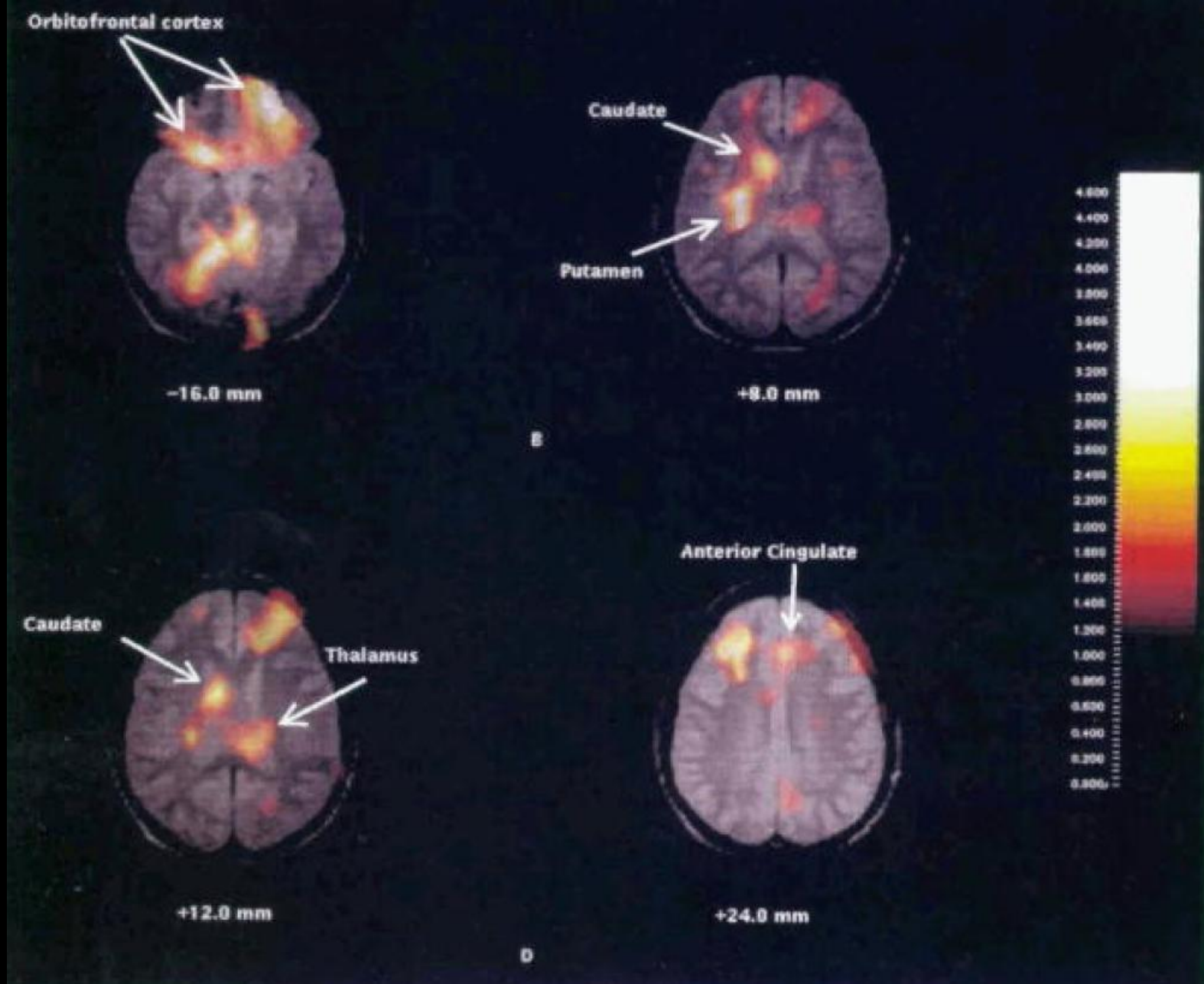
Evidence from imaging studies

# CSTC loops

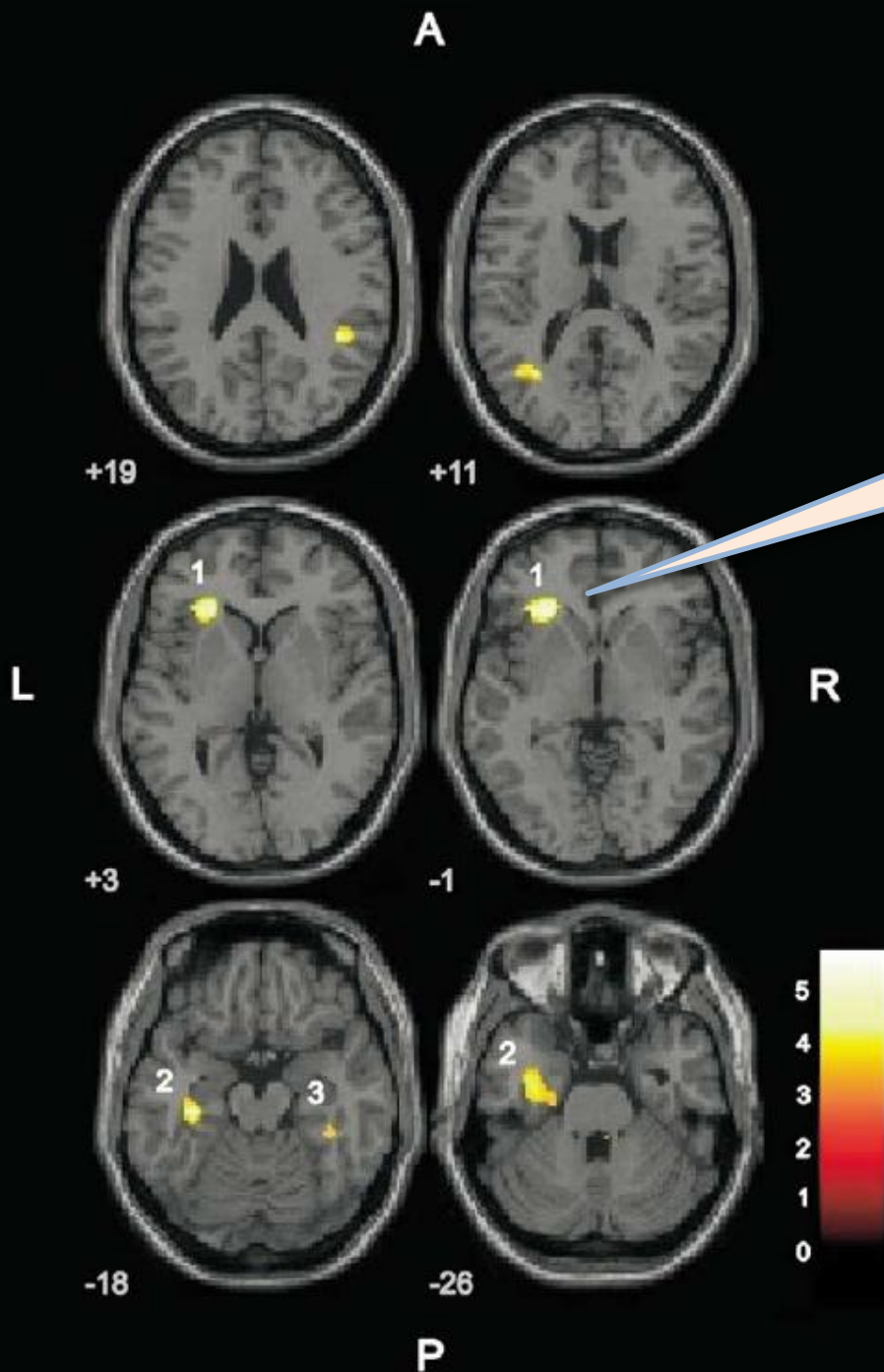
- Cortico-Striatal-Thalamic-Cortical (CSTC) Loops/circuits
- Structural and functional

Right OFC





RAUCH, S. L., JENIKE, M. A., ALPERT, N. M., BAER, L., BREITER, H. C., SAVAGE, C. R. & FISCHMAN, A. J. (1994) Regional cerebral blood flow measured during symptom provocation in obsessive-compulsive disorder using oxygen 15-labeled carbon dioxide and positron emission tomography. *Archives of General Psychiatry*, 51, 62-70.



Left post. OFC  
and insula

VALENTE JR, A. A., MIGUEL, E. C., CASTRO, C. C., AMARO, J. E., DURAN, F. L. S., BUCHPIGUEL, C. A., CHITNIS, X., MCGUIRE, P. K. & BUSATTO, G. F. (2005) Regional Gray Matter Abnormalities in Obsessive-Compulsive Disorder: A Voxel-Based Morphometry Study. *Biological Psychiatry*, 58, 479-487.

# Summary of changes in OCD

- Fairly consistent abnormalities found in:
  - Orbitofrontal cortex (OFC)
  - Anterior Cingulate Gyrus (ACC)
  - Caudate nucleus
- With treatment, OFC, ACC and caudate activity improve toward normal, with drug therapy or behaviour therapy

# ASSESSING OCD

Tools of the trade

# What tools do you need?

- A copy of the MINI (for diagnosis of OCD and confirming comorbid conditions)
- The Y-BOCS (for assessing severity)
- A treatment 'guideline'
  - NICE (2005)
  - Fineberg (2005)

NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE (2005) Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder. London, National Collaborating Centre for Mental Health.

FINEBERG, N. A. & GALE, T. M. (2005) Evidence-based pharmacotherapy of obsessive-compulsive disorder. *International Journal of Neuropsychopharmacology*, 8, 107-29.

# Guidelines for managing OCD

*International Journal of Neuropsychopharmacology* (2005), 8, 107–129. Copyright © 2004 CINP  
DOI: 10.1017/S1461145704004675

## Evidence-based pharmacotherapy of obsessive–compulsive disorder

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<sup>2</sup> *Department of Psychology, University of Hertfordshire, Hatfield, UK*

### Abstract

Obsessive–compulsive disorder is a prevalent and disabling lifespan disorder. Clomipramine and the SSRIs have been found to be effective across the range of symptoms, both in acute and longer-term studies. Meta-analyses have reported a larger treatment effect for clomipramine relative to the SSRIs, but this is not supported by evidence from head-to-head comparator studies and, based on their superior safety and tolerability, SSRIs are the preferred option for long-term treatment in most cases. The treatment-effect is usually gradual and partial, and many patients fail to respond adequately to first-line treatment. Pharmacological options for refractory cases include switching SRI, increasing the dose, or augmenting with an antipsychotic agent. Novel strategies are under investigation for this highly morbid group. This paper reviews the key questions related to OCD pharmacotherapy, synthesizing evidence derived from randomized controlled trials, meta-analyses and consensus guidelines.

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**Key words:** Obsessive–compulsive disorder, pharmacological treatment, review.

## Obsessive-compulsive disorder:

### Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder

**National Clinical Practice Guideline Number 31**  
*developed by*

**National Collaborating Centre for Mental Health**  
*commissioned by the*

**National Institute for Health and Clinical Excellence**

*published by*  
**The British Psychological Society and  
The Royal College of Psychiatrists**

# Yale-Brown O-C Scale | 1

- The 'gold-standard' scale for OCD research
- Comes in clinician-rated version (with semi-structured interview) and patient-rated version
- Clinician-rated version includes a symptom checklist (very useful to avoid missing symptoms)
- Reasonable correlation between the two, although patient-rated version usually rated higher

GOODMAN, W. K., PRICE, L. H., RASMUSSEN, S. A., MAZURE, C., FLEISCHMANN, R. L., HILL, C. L., HENINGER, G. R. & CHARNEY, D. S. (1989) The Yale-Brown Obsessive Compulsive Scale. I. Development, use, and reliability. *Archives of General Psychiatry*, 46, 1006-11.

GOODMAN, W. K., PRICE, L. H., RASMUSSEN, S. A., MAZURE, C., DELGADO, P., HENINGER, G. R. & CHARNEY, D. S. (1989) The Yale-Brown Obsessive Compulsive Scale. II. Validity. *Archives of General Psychiatry*, 46, 1012-6.

# Yale-Brown O-C Scale | 2

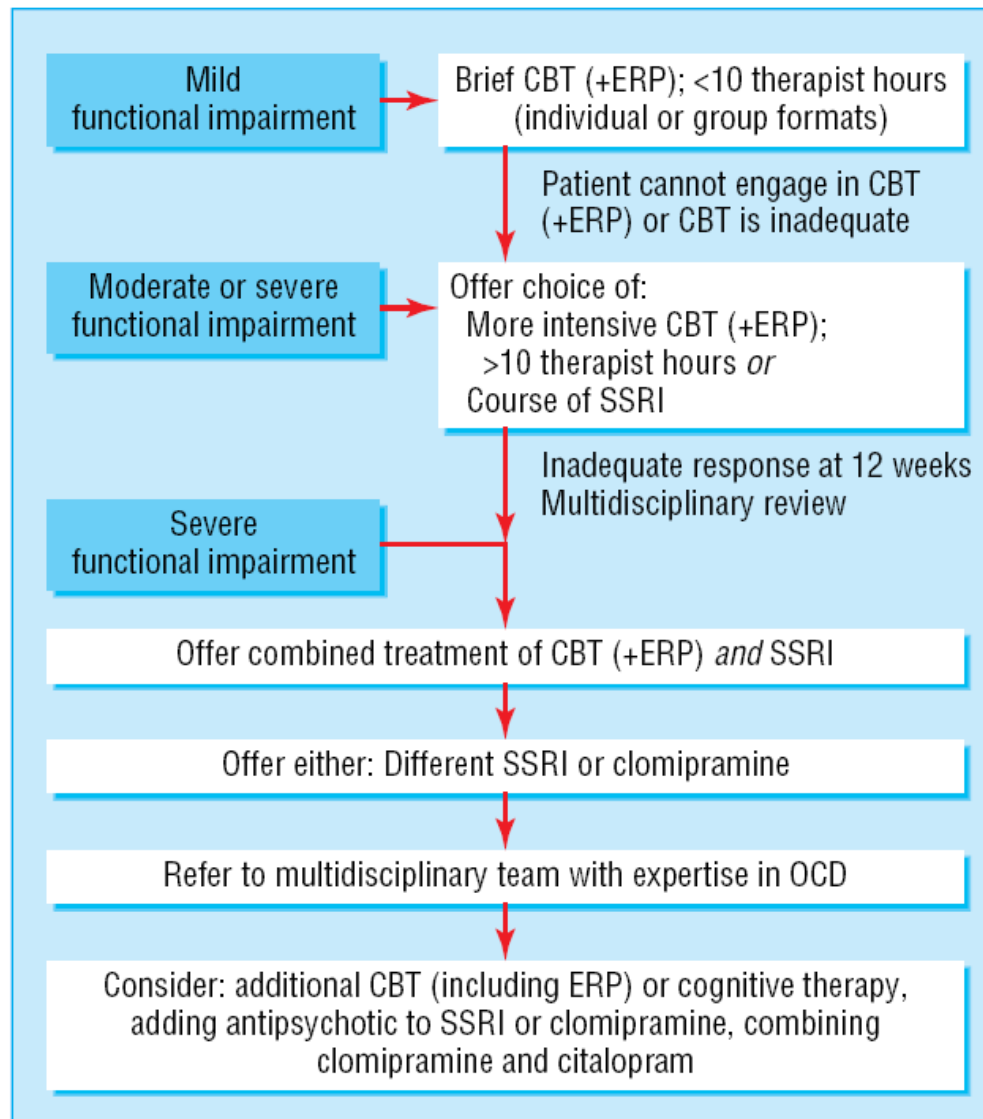
- Scored out of 40
- Obsession subscale (/20) and compulsion subscale (/20)
- Each subscale rates the same components of obsessions and compulsions

GOODMAN, W. K., PRICE, L. H., RASMUSSEN, S. A., MAZURE, C., FLEISCHMANN, R. L., HILL, C. L., HENINGER, G. R. & CHARNEY, D. S. (1989) The Yale-Brown Obsessive Compulsive Scale. I. Development, use, and reliability. *Archives of General Psychiatry*, 46, **1006-11**.  
GOODMAN, W. K., PRICE, L. H., RASMUSSEN, S. A., MAZURE, C., DELGADO, P., HENINGER, G. R. & CHARNEY, D. S. (1989) The Yale-Brown Obsessive Compulsive Scale. II. Validity. *Archives of General Psychiatry*, 46, **1012-6**.

# Yale-Brown O-C Scale | 3

Category	Y-BOCS Score
Extreme	32-40
Severe	24-31
Moderate	16-23
Mild	8-15
None	0-7

# Rational treatment of OCD



# SRIs in OCD

- Mainstay of drug treatment are Serotonin Reuptake Inhibitors
- Includes all the SSRIs
- Gold-standard is Clomipramine
- As high doses are required, and response is delayed, careful dose titration is paramount
- Too fast, too soon = failed drug trial
- Whilst dose-response relationships for SSRIs are not established in depression, they are in OCD

# SRI doses in OCD

Drug	Target daily dose in OCD
Clomipramine	≥ 250mg
Fluoxetine	60mg
Paroxetine	60mg
Citalopram	60mg
Sertraline	≥ 200mg
Fluvoxamine	300mg
Escitalopram	≥ 20mg

# Other antidepressants in OCD

- There is some evidentiary support for Venlafaxine in OCD
- Target dose  $\geq 225\text{mg/ day}$
- However, not all studies demonstrate benefit

# Combination treatments

- Not much evidence, but adding Citalopram (well-tolerated SSRI which doesn't inhibit CYP-450) to Clomipramine has been reported to be helpful
- May be a strategy worth considering if someone is experiencing prolonged QT<sub>c</sub> with Clomipramine

# Other treatments

Treatment	Comments
IV Clomipramine	Rarely used, but benefit consistently reported in studies
Ondansetron	Benefit reported, but in small trials in non-refractory patients
Memantine	Small, open-label studies of augmentation report benefit but no good controlled studies
D-Cycloserine	A number of studies report enhanced response to CBT/ ERP when DCS is used

# Ineffective treatments

Treatment	Comments
Buspirone	Not effective
Benzodiazepines	Effective anxiolytics but not demonstrated benefit for O-C symptoms. Probably reserved for when someone has to use them short-term for a family wedding, for example.

# Augmentation strategies

Drug	OCD symptom reduction	Anxiety/ Depressive Symptom reduction
Olanzapine	-	-
Risperidone	++	++
Quetiapine	+	+

- Risperidone is first-line SGA for OCD
- Quetiapine should be second-line
- Haloperidol also beneficial
- Patients with tics may have differential response to antipsychotics

KOMOSSA, K., DEPPING, A. M., MEYER, M., KISSLING, W. & LEUCHT, S. (2010) Second-generation antipsychotics for obsessive compulsive disorder. *Cochrane Database of Systematic Reviews 2010, Issue 12*. Art. No.: CD008141. DOI: 10.1002/14651858.CD008141.pub2. Chichester, UK, John Wiley & Sons, Ltd.

BLOCH, M. H., LANDEROS-WEISENBERGER, A., KELMENDI, B., CORIC, V., BRACKEN, M. B. & LECKMAN, J. F. (2006) A systematic review: antipsychotic augmentation with treatment refractory obsessive-compulsive disorder. *Molecular Psychiatry, 11*, 622-32.

# Monitor response

- Use rating scales
  - PADUA (revised)
  - Y-BOCS (self-report)
- *Response* is typically categorised as a  $\geq 25$ -35% reduction in Y-BOCS score **and** a CGI-I score of 1 or 2
- *Remission* is not universally agreed, but a Y-BOCS score  $<10$  discriminates between active and control treatments in recent studies

# Once response is established

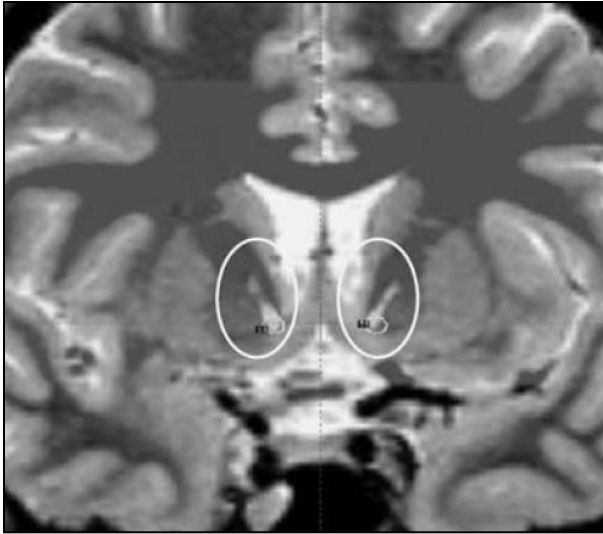
1. Don't reduce the dose
  2. Don't reduce the dose
  3. Don't reduce the dose
- There is no evidence to support dose reduction in long-term treatment

# NEUROMODULATION

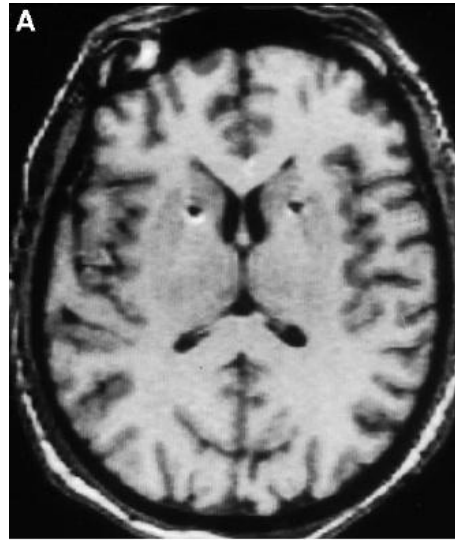
Deep Brain Stimulation (DBS) for OCD

A decorative background pattern consisting of a large, light-colored, semi-circular shape filled with a fine, repeating pattern of small, light-colored dots or hexagons, positioned at the bottom of the slide.

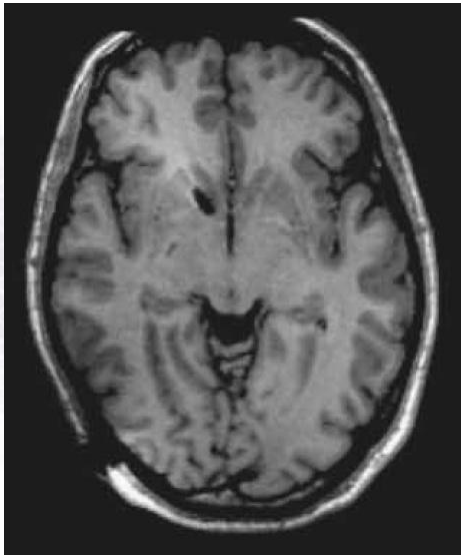
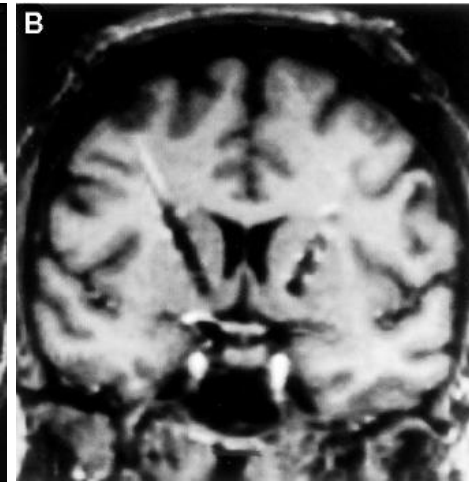
# Targets



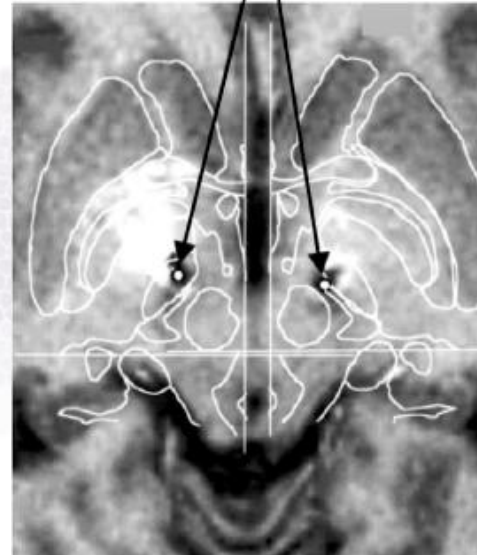
Int. Caps. (Greenberg, 2006)



Int. Caps. (Nuttin, 2003)

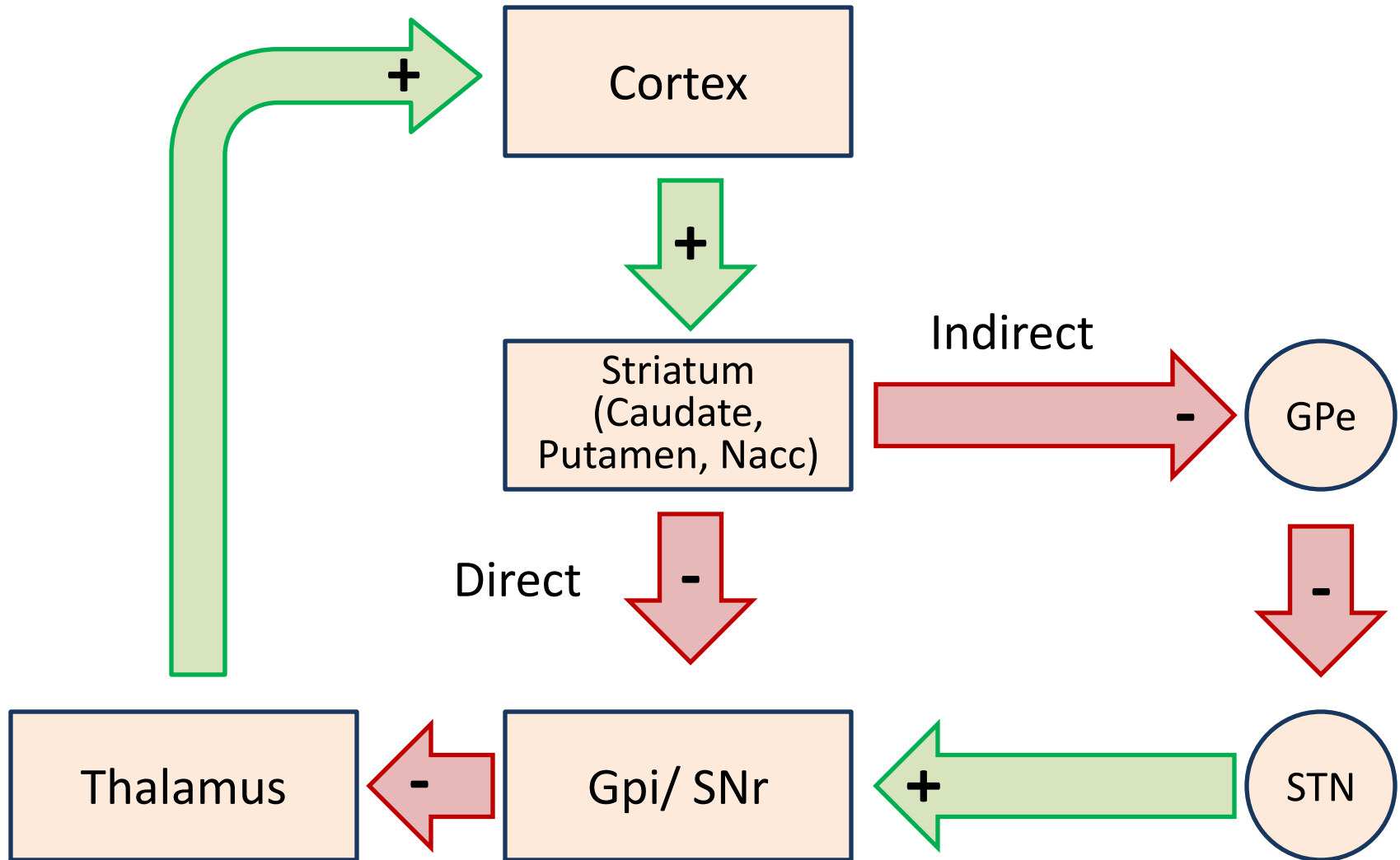


Nucleus  
Accumbens  
(Sturm, 2003)



Subthalamic  
nucleus (Mallet,  
2002).  
INCIDENTAL  
FINDING in PD  
(n=2)

# Putative neurocircuitry of OCD



# DBS for OCD: Outcomes

Study	N	Target	Duration	Response
Nuttin <i>et al</i> , 1999	4	Ant. Limb of IC	N/S	“beneficial” in 3/4 (75%)
Nuttin <i>et al</i> , 2003	4	Ant. Limb of IC	≥6 months	Response in 3/4 (75%)
Gabriëls <i>et al</i> , 2003	3	Ant. Limb of IC	≥33 months	Improvement in 2/3 (66%)
Abelson <i>et al</i> , 2003	4	Ant. Limb of IC	4-23 months	One responder (25%) during blind phase; two (50%) during open phase
Sturm <i>et al</i> , 2003	4	Shell of (R) N Acc	24-30	Response in 3/4 (75%)
Denys, 2010	16	Bilateral NA	8 mo (N=16) + 4 week blind cross- over (N=14)	9/16 (56%) after open phase; mean Y-BOCS difference was 8.8 between active and sham phases
<b>Total/ Average</b>	<b>35</b>			<b>Response in 50-75%</b>

Case reports and incidental findings not listed above.

# Conclusions

- OCD is at least as common as schizophrenia
- However, it is often missed
- Long delays occur between symptom onset and presentation/ treatment
- Treatment is usually insufficient and symptom burden is high and quality of life is low
- Rating scales exist and can be used to make better treatment decisions

# Conclusions

- Mainstay of treatment for mod-severe cases is SRIs
- Augmentation can be a helpful strategy, but follow the evidence
- Drugs need to be used at sufficient doses (max.) for sufficient lengths of time ( $\geq 12$  weeks)
- Drugs will often allow sufficient reduction in symptoms for the patient to benefit from ERP

# Further reading

Source	URL
FINEBERG, N. A. & GALE, T. M. (2005) Evidence-based pharmacotherapy of obsessive-compulsive disorder. <i>International Journal of Neuropsychopharmacology</i> , 8, 107-29.	<a href="http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&amp;db=PubMed&amp;dopt=Citation&amp;list_uids=15450126">http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&amp;db=PubMed&amp;dopt=Citation&amp;list_uids=15450126</a>
NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE (2005) Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder. London, National Collaborating Centre for Mental Health.	<a href="http://www.nice.org.uk/CG031">http://www.nice.org.uk/CG031</a>

# Further reading

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### The assessment and management of obsessive-compulsive disorder: Part 1

by [Dr Amit Nigam](#), [Dr Lynne Drummond](#), [Dr Joanne Farrow](#), [Dr Ali Al-Allaq](#), [Dr Sanjay Nelson](#) and [Professor Naomi A Fineberg](#)

Obsessive-compulsive disorder (OCD) is a prevalent, chronic and disabling disorder characterised by obsessional thoughts and compulsive behaviours ([American Psychiatric Association, 1994](#)). It is a condition shrouded with stigma and shame.



Although effective psychological and pharmacological treatments are available, delays in diagnosis and treatment of the disorder occur. Better recognition and improved access to evidence-based treatment is needed.

This module provides guidance on how common obsessive-compulsive disorder is, its aetiology and how best to recognise people with the disorder. Aimed at psychiatrists and mental health workers in general adult, forensic, old age and child and adolescent psychiatry, it will take the reader through the epidemiology, aetiology, co-morbid disorders, diagnostic issues and differential diagnoses of OCD.

By the end of this module the reader should be able to demonstrate an understanding of the complexities involved in the assessment and management of OCD.

**Start the module**

In the second module in this series, [The assessment and management of obsessive-compulsive disorder: Part 2](#), we look at the treatment options and recently published guidelines on treating OCD.

If you like this module, you may also be interested in:

- [The assessment and management of obsessive-compulsive disorder: Part 2](#) by Dr Amit Nigam, Dr Joanne Farrow, Dr Ali Al-Allaq, Dr Lynne M Drummond, Dr Sanjay Nelson and Professor Naomi A Fineberg
- [The diagnosis of personality disorder in clinical practice](#) by Professor Patricia Casey
- [The pharmacological management of anxiety disorders](#) by Dr Zia Nadeem and Dr Allan Scott

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### The assessment and management of obsessive-compulsive disorder: Part 2

by [Dr Amit Nigam](#), [Dr Joanne Farrow](#), [Dr Ali Al-Allaq](#), [Dr Sanjay Nelson](#) and [Professor Naomi A Fineberg](#)

In the first module of this series, [The assessment and management of obsessive-compulsive disorder: Part 1](#) we looked at the prevalence, various aetiological theories and the differing diagnostic and assessment tools of obsessive-compulsive disorder (OCD).



OCD is a prevalent, chronic and disabling disorder characterised by obsessional thoughts and compulsive behaviours ([American Psychiatric Association, 1994](#)).

Although effective psychological and pharmacological treatments are available, delays in diagnosis and treatment of the disorder occur. Better recognition and improved access to evidence-based treatment are needed.

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- [An introduction to CBT](#) by Dr Chris Williams and Dr Rebecca Martinez

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