Clinical Features & Management of Obsessive Compulsive Disorder

Outline

- Introduction
- History
- Epidemiology
- Comparative nosology
- Clinical features
- Management
- Summary

Introduction

- Diverse group of symptoms: intrusive thoughts, rituals, preoccupations, and compulsions
- Causes severe distress to the person
- Time-consuming, interfere significantly with normal routine, occupational functioning, usual social activities, or relationships
- Pt. may have an obsession, a compulsion, or both

Introduction

- Obsessions:
  - repetitive, unwanted intrusive thoughts, images or urges; mostly ego-dystonic; cause severe distress/anxiety.
- Compulsions:
  - repetitive behaviours/mental acts performed in response to an obsession to reduce anxiety/distress or prevent a dreaded consequence.

Introduction

- OCD pt. realizes irrationality of obsession and experiences both obsession and compulsion as ego-dystonic
- Completion of compulsive act may not affect anxiety, may even increase it
- Resistance to carry out compulsion – increases anxiety

History

- Late 19th century – Westphal described "*zwangsvorstellung*" – translated into English as obsessions and compulsions
- Viewed as a form of "depressive state."
- Janet – "incompleteness" in OCD pts. and other symptoms like tics
- Freud – earliest descriptions of OCD – Rat Man

History

- Early 1980s – ECA study – prevalence >1% , a/w marked impairment
- Middle 20th century – clomipramine useful in OCD - serotonin hypothesis
- Brain imaging – unique patterns of activation – interventions normalize functional neuroanatomy

Epidemiology

- Lifetime prevalence: 1-3%
- Psy. OPD – 10% outpatients (4th most common psychiatric illness)
- Adults: M=F (female preponderance)
- Adolescents: M>F
- Mean age of onset: 20 yrs (M=19, F=22) (2/3rd have onset before 25, 15% after 35)
- Single > Married; Blacks > Whites

Comparative Nosology

- DSM-III-R: compulsions exclusively as behaviors
- DSM-IV-TR: compulsions as behaviors/mental acts designed to reduce anxiety associated with an obsession
- DSM-5:
  - subtle changes to clarify symptoms; obsessions cause anxiety
  - OCD shifted into a new chapter on OCRDs
  - Insight specifier

DSM-5

A. Presence of obsessions, compulsions, or both

Obsessions:

1. Recurrent, persistent thoughts, urges, or images – intrusive and unwanted, causing anxiety/distress
2. Attempts to ignore/suppress such thoughts, urges, or images, or to neutralize them with thought/action

Compulsions:

1. Repetitive behaviors/mental acts which individual feels driven to perform in response to an obsession/rules
2. Behaviors/mental acts aimed at preventing/reducing anxiety/distress, or preventing some dreaded event or situation

DSM-5

B. Obsessions/compulsions - time-consuming/causing clinically significant distress/impairment in social, occupational or other areas of functioning
C. Symptoms not attributable to any substance/medical condition
D. Not better explained by symptoms of another mental disorder

Specifiers:

- Insight: Good/fair, poor, absent/delusional beliefs
- Tic-related

ICD-10

- Obsessional symptoms or compulsive acts, or both, must be present on most days for at least 2 successive weeks and be a source of distress or interference with activities.
- The obsessional symptoms should have the following characteristics:
  - Own thoughts/impulses
  - At least one thought/act still resisted unsuccessfully, others may be present which the sufferer no longer resists;
  - Thought of carrying out act must not in itself be pleasurable
  - Thoughts, images, or impulses must be unpleasantly repetitive.

ICD-10

- F42.0 Predominantly obsessional thoughts or ruminations
- F42.1 Predominantly compulsive acts [obsessional rituals]
- F42.2 Mixed obsessional thoughts and acts
- F42.8 Other obsessive-compulsive disorders
- F42.9 Obsessive-compulsive disorder, unspecified

ICD-11 - Proposals

- Separated from anxiety disorders
- Duration criteria and subtyping of OCD removed
- Diagnosis of OCD even in presence of comorbid disorders (SCZ)
- Includes: body dysmorphic disorder, hypochondriasis, olfactory reference disorder, hoarding disorder, trichotillomania, skin picking disorder
- Excludes: Substance-induced OC or related disorder, secondary OC or related syndrome, Tourette syndrome

Presentation

Specialist	Presenting problem
Dermatologist	Chapped hands, eczematoid appearance
Family practitioner	Family member washing excessively, counting or checking compulsions
Infc. disease internist	Insistent belief that person has AIDS
Neurologist	OCD a/w Tourette's disorder, head injury, epilepsy, choreas, other basal ganglia lesions or disorders
Neurosurgeon	Severe, intractable OCD

Presentation

Specialist	Presenting problem
Obstetrician	Postpartum OCD
Pediatrician	Parent's concern about child's behavior, usually excessive washing
Pediatric cardiologist	OCD secondary to Sydenham's chorea
Plastic surgeon	Repeated consultations for abnormal features
Dentist	Gum lesions from excessive teeth cleaning

Common Symptoms - Obsessions

- Contamination related obsessions
  - Concern/disgust with bodily secretions and waste (stools/urine)
  - Fear of dirt or germs/infections, concern with sticky substances
  - Fear of getting ill due to contaminants
- Sexual obsessions
  - Unwanted, forbidden sexual thoughts, images or urges about strangers, family friends, etc
  - Sexual thoughts of molesting children, thoughts of sexual identity

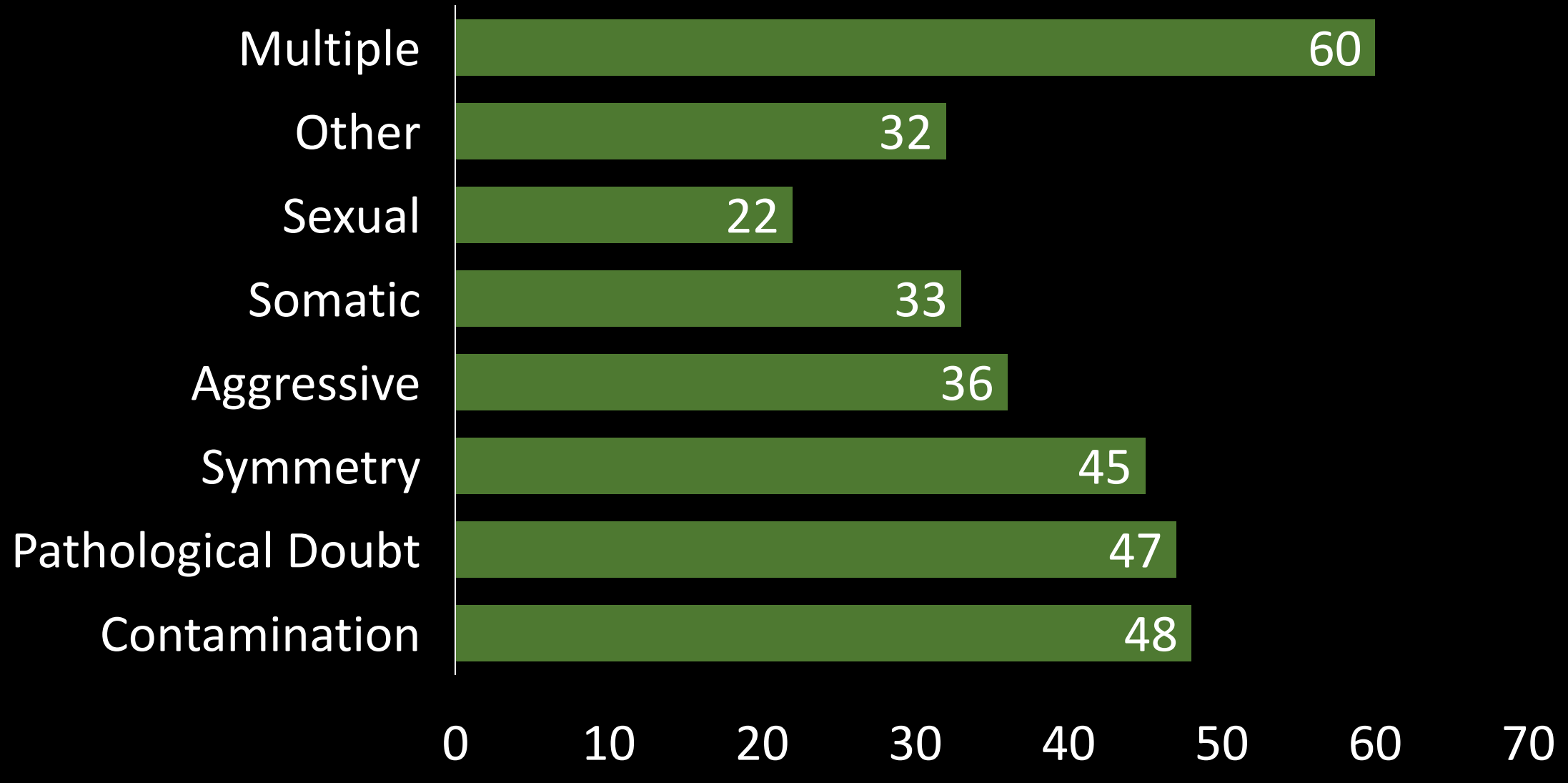
Common Symptoms - Obsessions

- Harm/aggression related obsessions
  - Fear might harm self or others
  - Violent/horrific images
  - Fear of uttering obscenities
- Religious/blasphemy
  - Sacrilege and blasphemy
  - Excessive concern about right/wrong, morality
- Pathological doubts about daily activities

Common Symptoms - Obsessions

- Need for symmetry and exactness
  - Concern about things being not properly aligned, symmetrical, perfect or exact
  - With magical thinking
- Miscellaneous
  - Need to know/remember
  - Intrusive non- violent images, thoughts
  - Superstitious fears
  - Lucky/unlucky numbers, colors

Presentation - Obsession



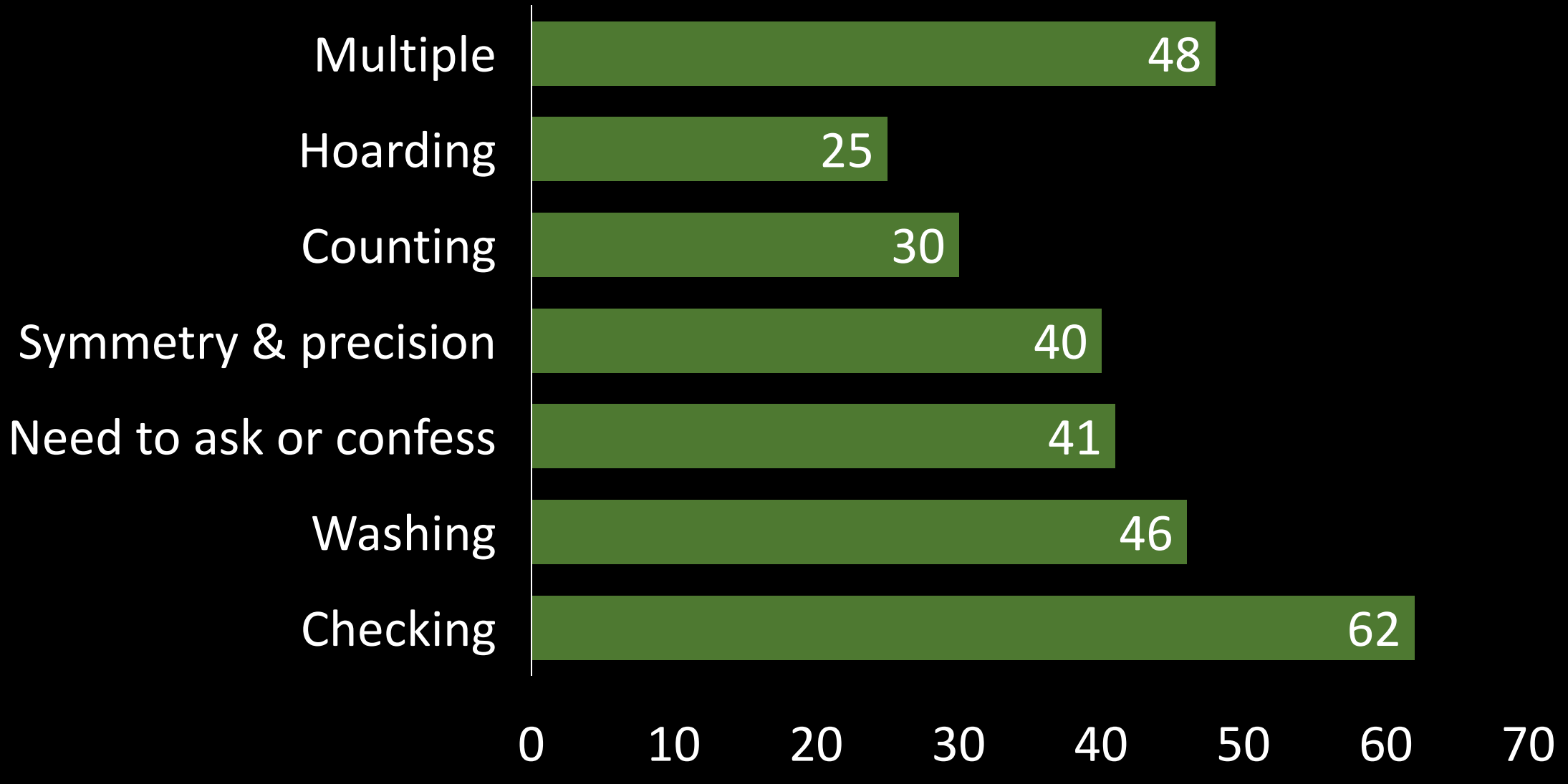
Common Symptoms - Compulsions

- Washing/Cleaning in response to contamination obsessions
- Checking
  - In response to pathological doubts
  - To prevent harm to self or others
- Repeating
  - Re- reading or rewriting because you didn't understand or write properly
  - Repeating routine activities

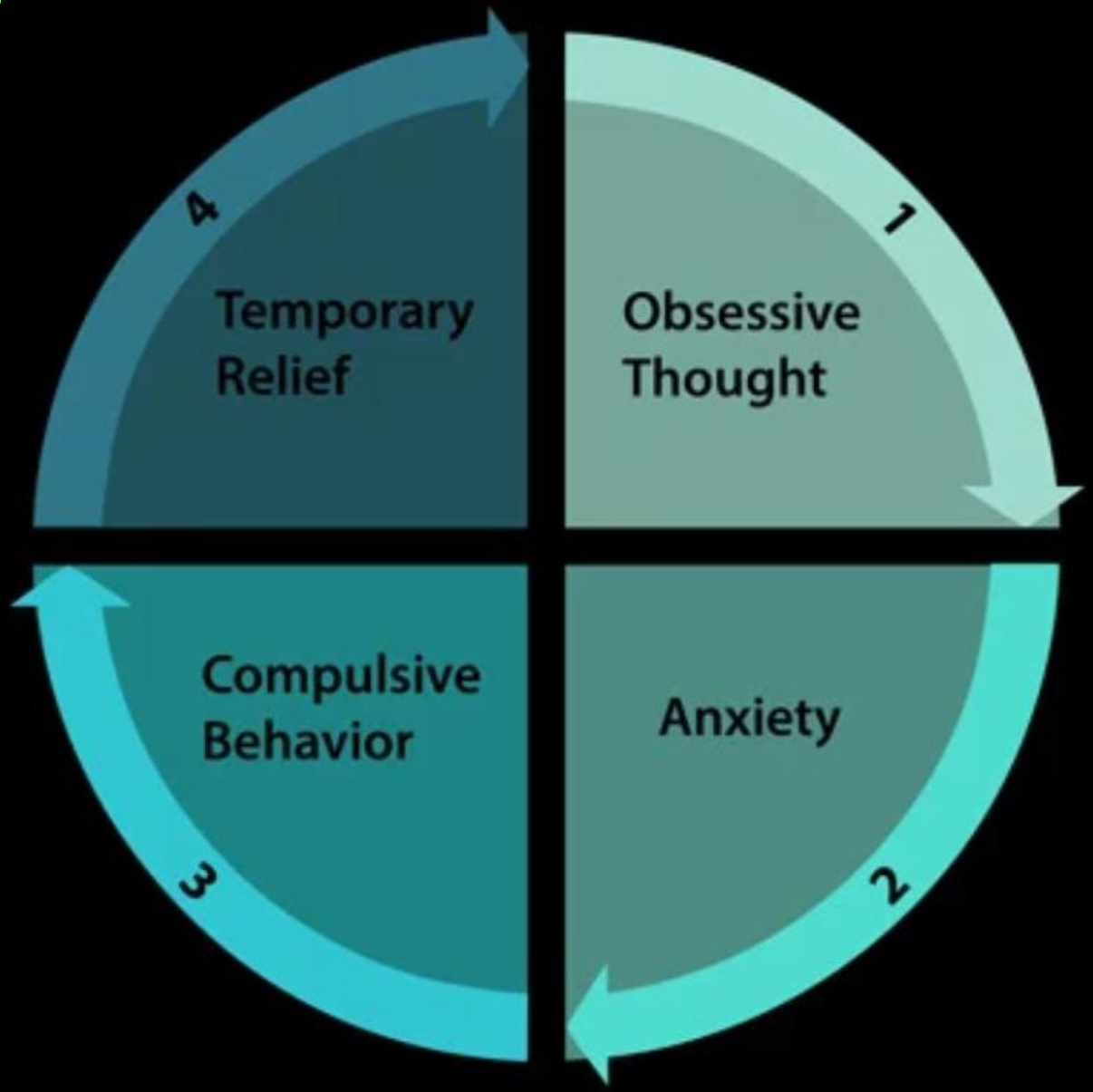
Common Symptoms - Compulsions

- Counting
- Ordering and arranging
- Miscellaneous
  - Mental rituals
  - Superstitious behaviours
  - Need to tell/ask/confess

Presentation - Compulsion



OCD Cycle


1
Obsessive Thought
2
Anxiety
3
Compulsive Behavior
4
Temporary Relief

Clinical features: Contamination

- Contamination obsessions are the most frequently encountered obsessions in OCD
- Such obsessions are usually characterized by a fear of dirt or germs
- Contamination fears may also involve toxins or environmental hazards (e.g., asbestos or lead) or bodily waste or secretions
- Patients usually describe a feared consequence of contacting a contaminated object, such as spreading a disease or contracting an illness themselves

Clinical features: Contamination

- Occasionally, however, the fear is based not on a fear of disease but on a fear of the sensory experience of not being clean
- The content of the contamination obsession and the feared consequence commonly changes over time
- Many patients with contamination fears use avoidance to prevent contact with contaminants
- In some cases, a specific feared object and associated avoidance become more generalized

Clinical features: Contamination

- Excessive washing is the compulsion most commonly associated with contamination obsessions
- This behavior usually occurs after contact with the feared object; however, proximity to the feared stimulus is often sufficient to engender severe anxiety and washing compulsions, even though the contaminated object has not been touched
- Most patients with washing compulsions perform these rituals in response to a fear of contamination, but these behaviors occasionally occur in response to a drive for perfection or a need for symmetry
- Some patients, for example, repeatedly wash themselves in the shower until they feel “right” or must wash their right arm and then their left arm the same number of times.

Clinical features: Need For Symmetry

- Need for symmetry is a term that describes a drive to order or arrange things perfectly or to perform certain behaviors symmetrically or in a balanced way
- Patients describe an urge to repeat motor acts until they achieve a “just right” feeling that the act has been completed perfectly
- Patients with a prominent need for symmetry may have little anxiety but rather describe feeling unsettled or uneasy if they cannot repeat actions or order things to their satisfaction

Clinical features: Need For Symmetry

- In addition to a need for perfection, the drive to achieve balance or symmetry may be connected with magical thinking
- Patients with a need for symmetry frequently present with obsessional slowness, taking hours to perform acts such as grooming or brushing their teeth

Clinical features: Somatic Obsessions

- Patients with somatic obsessions are worried about the possibility that they have or will contract an illness or disease
- In the past, the most common somatic obsessions consisted of fears of cancer or venereal diseases. However, a fear of developing AIDS has become increasingly common.
- Checking compulsions consisting of checking and rechecking the body part of concern, as well as reassurance seeking, are commonly associated with this fear

Clinical features: Sexual and Aggressive Obsessions

- People with sexual or aggressive obsessions are plagued by fears that they might harm others or commit a sexually unacceptable act such as molestation
- Often, they are fearful not only that they will commit a dreadful act in the future but also that they have already committed the act
- Patients are usually horrified by the content of their obsessions and are reluctant to divulge them

Clinical features: Sexual and Aggressive Obsessions

- It is striking that the content of these obsessions tends to consist of ideas that patients find particularly abhorrent
- Patients with these highly distressing obsessions frequently have checking and confession or reassurance rituals.
- They may report themselves to the police or repeatedly seek out priests to confess their imagined crimes

Clinical features: Pathological Doubt

- Pathological doubt is a common feature of patients with OCD who have a variety of different obsessions and compulsions
- Individuals with pathological doubt are plagued by the concern that, as a result of their carelessness, they will be responsible for a dire event
- Although many patients report being fairly certain that they performed the act in question, they cannot dismiss the nagging doubt “What if ?”
- Such patients often describe doubting their own perceptions

Clinical features: Pathological Doubt

- Excessive doubt and associated feelings of excessive responsibility frequently lead to checking rituals
- As with contamination obsessions, pathological doubt can lead to marked avoidance behaviour
- Some patients become housebound to avoid the responsibility of potentially leaving the house unlocked

Clinical features: Pathological Doubt

- Pathological doubt is also embedded in the cognitive framework of a number of other obsessions
- Patients with aggressive obsessions may be plagued by the doubt that they inadvertently harmed someone without knowing that they did so

Comorbidities

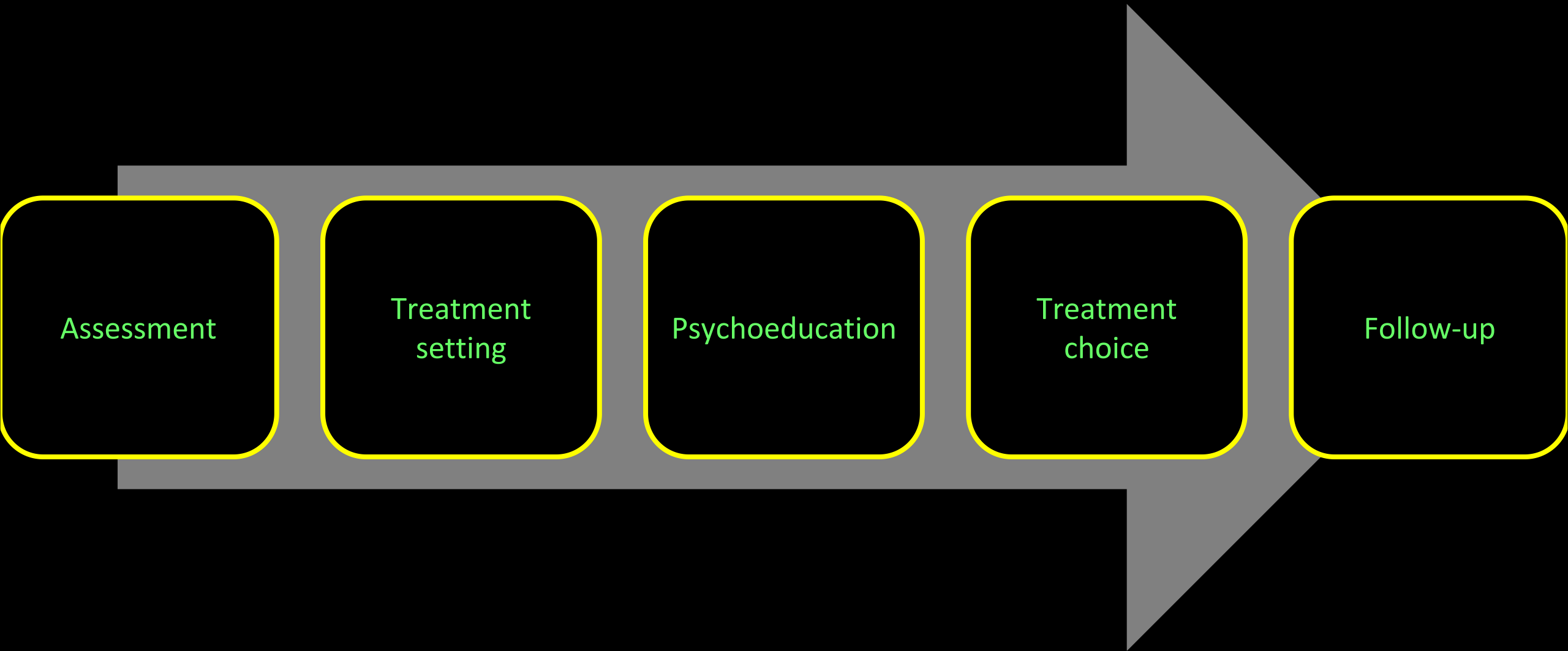
- Mood disorders
  - Major depression
  - Dysthymia
  - Bipolar disorder
- Anxiety disorders
  - Panic disorder
  - Generalized anxiety disorder
  - Social Phobia

- OCD related disorders

Comorbidities

- ADHD
- Oppositional defiant disorder
- Personality disorders
  - Obsessive- compulsive
  - Anxious- avoidant
  - Borderline
  - Schizotypal
- Schizophrenia

Management


Assessment
Treatment setting
Psychoeducation
Treatment choice
Follow-up

Assessment

- Detailed history: onset, duration, progression
- Effects of symptoms on well-being, functioning, and quality of life
- Risk assessment for suicide & self-injurious behavior
- Assess comorbidities
- Past history: course, treatment history, other co-occurring disorders
- Medical history: head trauma, LOC, seizures, recent β-hemolytic streptococci infections
- Others: Developmental, Educational, Occupational, Sexual, Family history

PANDAS

- Swedo and colleagues have described a subtype of OCD that begins before puberty and is characterized by an episodic course with intense exacerbations.
- Exacerbations of OCD symptoms in this subtype have been linked with group A beta-hemolytic streptococcal infections, which has led to the subtype designation of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS).

PANDAS

- PANDAS is believed to result from inflammatory effects on the basal ganglia following infection.
- This subgroup of patients may have specific neurobiological characteristics (eg, increased striatal volume) and may respond to immunological therapies

Assessment

- Mental status examination
- Physical examination
- Routine investigations
- Neuroimaging and EEG
- Structured/semi-structured interviews & rating scales

Assessment

- Diagnostics interview schedules:
  - The Mini International Neuropsychiatric Interview (MINI)
  - Structured Clinical Interview for DSM‐ 5 (SCID‐ 5)
- Severity rating scales:
  - Yale‐ Brown Obsessive‐ Compulsive Scale (YBOCS): symptom checklist and severity rating scale (adult and child versions)
  - Dimensional YBOCS (DYBOCS)

Assessment

- Assess insight:
  - Yale- Brown Obsessive- Compulsive Scale (YBOCS)
  - Brown- Assessment of Beliefs Scale (BABS)
  - Overvalued Ideas scale (OVIS)
- Obsessive-beliefs questionnaire (OBQ): measure beliefs underlying obsessions
- Family Accommodation Scale (FAS): assesses the degree to which family members of OCD pts. Accommodate his/her compulsions/ rituals

Differential Diagnosis

- Depression (ruminations usu. ego- syntonic)
- Generalized anxiety disorder (anxious ruminations about real- life concerns; not a/w compulsions)
- Body dysmorphic disorder (concerns about physical appearance)
- Trichotillomania (hair pulling)
- Skin picking disorder (excessive skin picking)

Differential Diagnosis

- Hoarding disorder (not secondary to obsessions)
- Eating disorders (weight & food)
- Tics (premonitory sensations; not aimed at neutralizing obsessions)
- Psychotic disorders
- Obsessive- compulsive personality disorder (ego-syntonic)

Treatment Setting

- OPD vs IPD
- OPD: mild-moderately ill; +ve drug compliance; periodic follow-ups
- IPD:
  - high suicide risk, dangerous to self/others, intolerant to side effects
  - CBT/pharmacotherapy
  - Comorbidities (severe depression, mania, psychosis)
- Rehabilitation services, if all else fails

Psychoeducation

- OCD – brain disorder
- Explain link b/w obsessions, compulsions and distress
- Clarify myths and misconceptions
- Explain biological & psychological basis of OCD
- Discuss course & outcome of OCD - waxing and waning course
- Discuss treatment strategies (Drugs/CBT)
- Regular long-term medication; medication takes time
- Prevent relapse by ensuring compliance
- Psychoeducate family members – reduce criticism, being supportive

Treatment

Overview:

- SSRI/intensive CBT
- SSRI + intensive CBT
- SSRI fails – clomipramine
- Suboptimal response – Clomipramine + Antipsychotic OR Clomipramine + Citalopram
- Other strategies

Psychotherapy

- Cognitive behaviour therapy (exposure & response prevention)
- Behaviour therapy (exposure & response prevention)
- Mindfulness based cognitive behaviour therapy
- Acceptance and commitment therapy
- Stress management and relaxation training
- Thought stopping
- Dynamic psychotherapy

Cognitive Behaviour Therapy

- Exposure & Response Prevention (ERP) – exposure to anxiety provoking situations in a graded manner with negotiations and contracts at every step
- List of anxiety provoking situations/triggers in a hierarchical manner using subjective units of distress (0 – 10)
- Expose patient starting from lowest anxiety provoking situation - gradually escalate the level
- Duration: 1- 1 ½ hours/session, till pt. reports reduction in distress/anxiety
- Homework assignments, consistent performance of ERP tasks

Cognitive Behaviour Therapy

- CBT/ERP – 1st line treatment option (if facilities available)
- CBT/ERP monotherapy – mild-moderately ill
- CBT + SSRI - severely ill (CBT > Risperidone/Placebo)
- Augmentation

Pharmacotherapy

- SSRIs – 1st line treatment
- TCA (Serotoninergic) - Clomipramine
- Network meta-analysis/comparison trials:
  - No efficacy advantage of clomipramine
  - SSRIs better tolerated
- All SSRIs equally efficacious; decision based on previous response, comorbidity, tolerability, acceptability, A/E, cost, drug interactions
- SSRI + Clomipramine: (fluoxetine, fluvoxamine): May increase clomipramine related A/E (seizures, cardiac effects, serotonin syndrome)

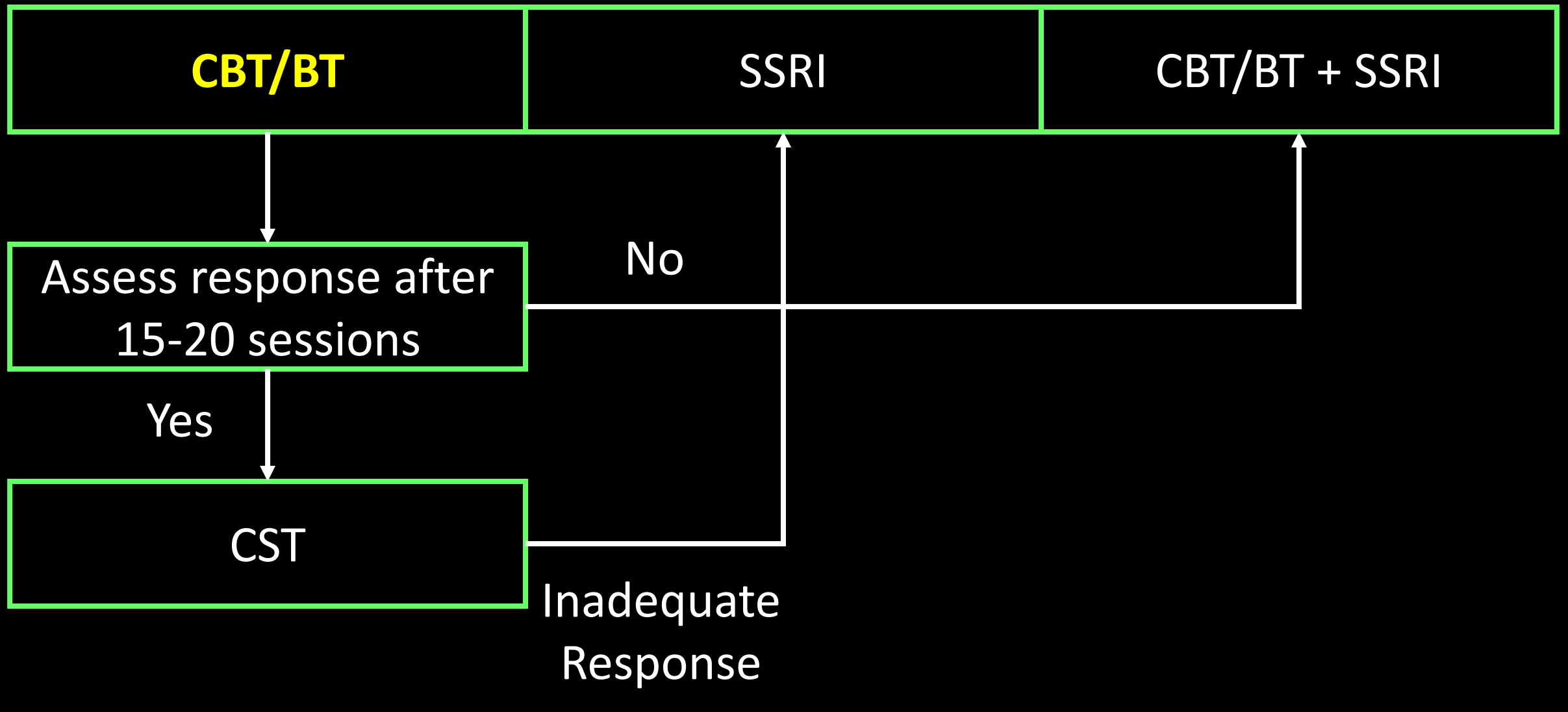
Pharmacotherapy

- Higher doses of SSRIs in OCD than in depression; consider low to medium doses if higher doses not tolerated
- Continue maximally tolerated effective dose for at least 12 weeks to check efficacy
  - Dose escalation to effective dose: within 4-6 weeks
  - Continue for 6-8 weeks
- Low dose antipsychotic augmentation: 1/3rd pts. responded; aripiprazole & risperidone better; continue for at least 8 weeks
- Glutamatergic drugs: memantine > lamotrigine, topiramate, riluzole, n-acetylcysteine

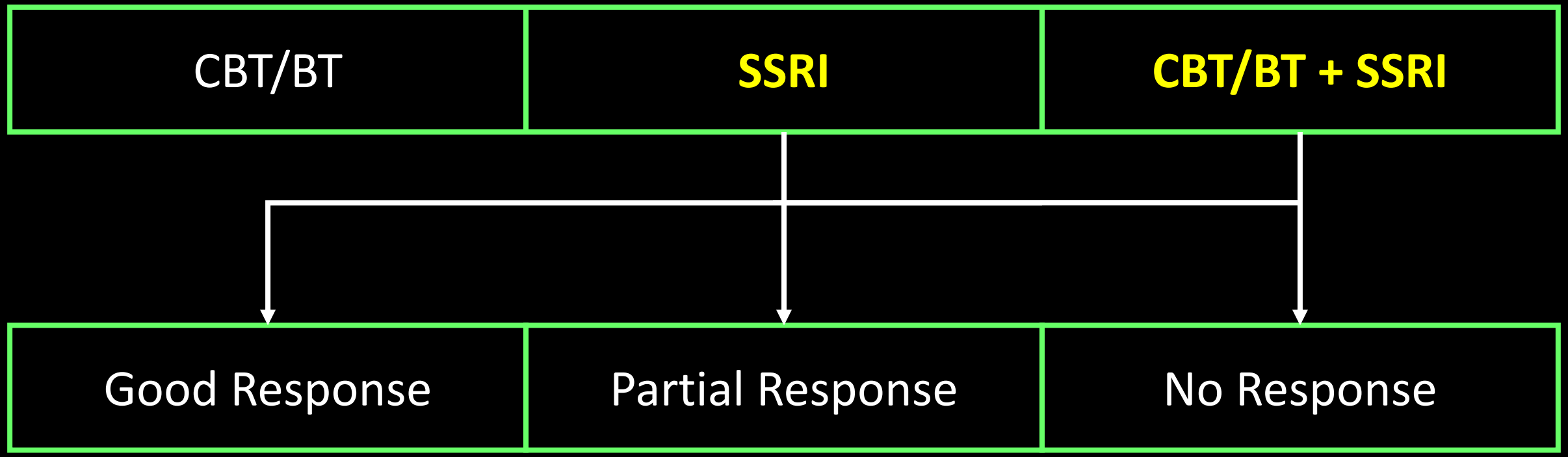
Drugs

Drug	Dosage
Escitalopram	20-30 mg
Fluoxetine	60-80 mg
Fluvoxamine	200-300 mg
Paroxetine	40-60 mg
Sertraline	150-200 mg
Citalopram	40-60 mg
Clomipramine	150-225 mg
Risperidone	1-3 mg
Aripiprazole	5-10 mg

Treatment


CBT/BT
SSRI
CBT/BT + SSRI
Assess response after 15-20 sessions
No
Yes
CST
Inadequate Response

Treatment

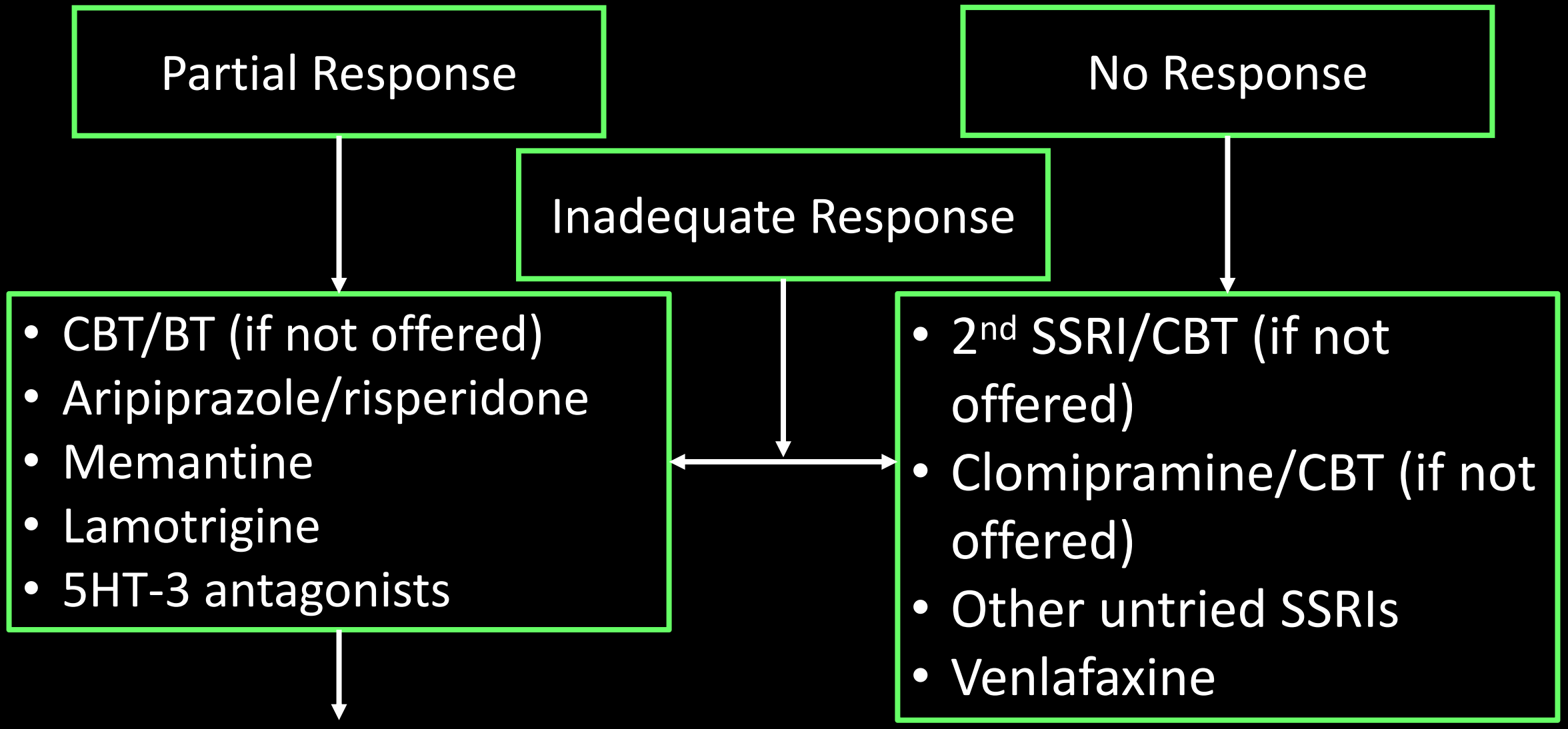

CBT/BT
SSRI
CBT/BT + SSRI
Good Response
Partial Response
No Response

Treatment

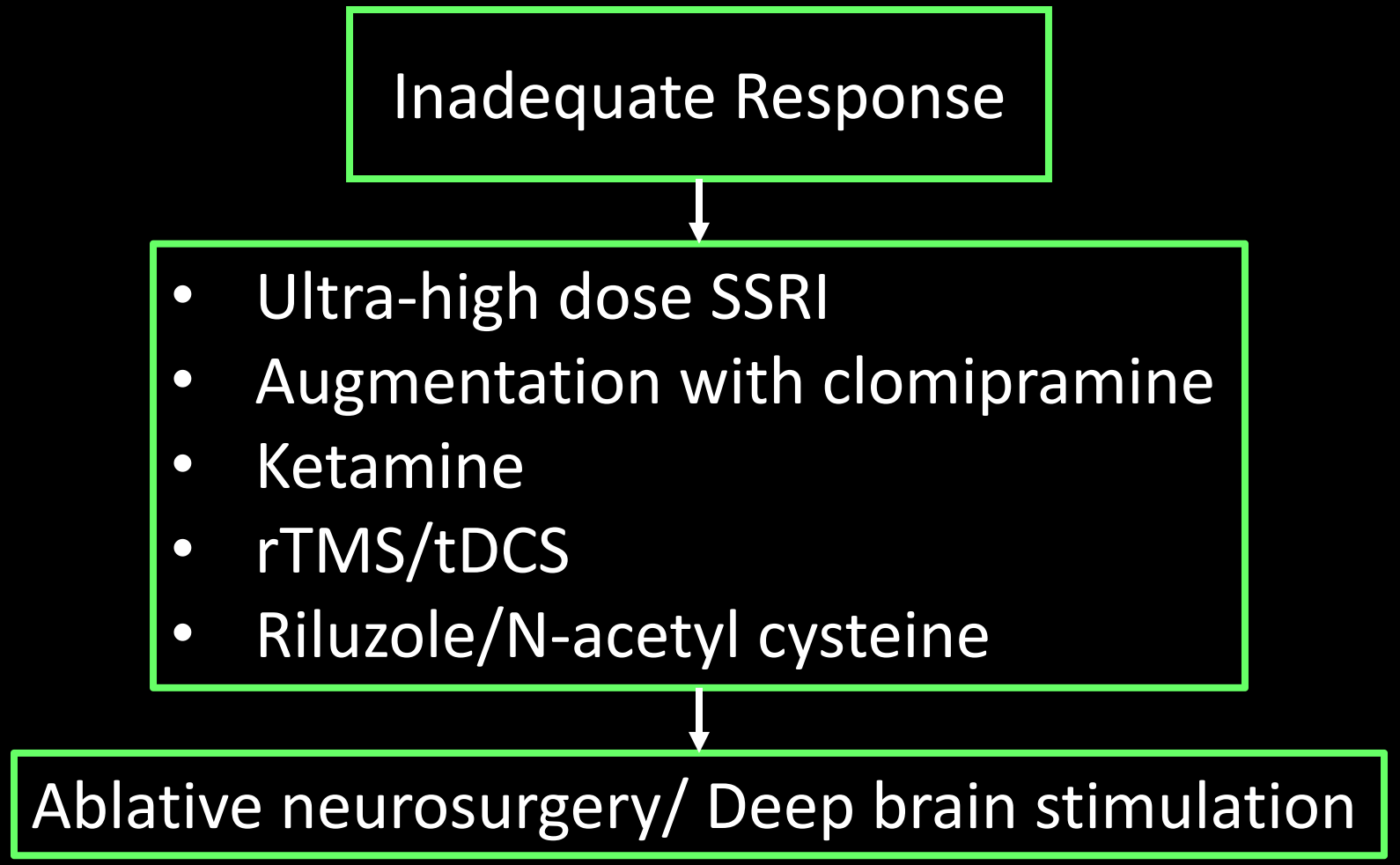
Good Response

- SSRI: If recovered or minimal symptoms continue for 1-2 years & then gradual taper over several months. Indefinite treatment: Persistent symptoms, previous history of relapses, severe illness
- CBT: booster sessions for 4-6 months

Treatment


Partial Response
No Response
Inadequate Response
• CBT/BT (if not offered)
• Aripiprazole/risperidone
• Memantine
• Lamotrigine
• 5HT-3 antagonists
• 2nd SSRI/CBT (if not offered)
• Clomipramine/CBT (if not offered)
• Other untried SSRIs
• Venlafaxine

Treatment


Inadequate Response
• Ultra-high dose SSRI
• Augmentation with clomipramine
• Ketamine
• rTMS/tDCS
• Riluzole/N-acetyl cysteine
Ablative neurosurgery/ Deep brain stimulation

Management of Comorbidities

- Depression & Anxiety disorders:
  - Severe depression: CBT/ERP on hold; suicidal ideas – ECT
  - Anxiety: SSRI + CBT
- Tic Disorders: SSRI + APs (Haloperidol, Pimozide, Risperidone, Aripiprazole)
- BPAD:
  - SSRIs: cause/exacerbate (hypo)mania; stabilize mood
  - OCD occurs/increases in depressive episodes, improves in (hypo)mania – only mood stabilizer
  - OCD outside mood episode: CBT > SSRI (SSRI + mood stabilizer/SGA)

Management of Comorbidities

- Psychosis:
  - SSRI may be used
  - SGAs (clozapine, olanzapine) – may induce/worsen OCD
  - Drug induced OCD – decrease dose/change Aps
- Personality disorders: Medication, CBT-ERP, Individual therapy

Follow-up

- Ongoing improvement with continued use of SSRIs and clomipramine for a period of up to 1 yr.
- Discontinuation often a/w relapse; based on individual pt. factors (severity, duration, past relapse history, residual symptoms, comorbities)
- Continue same dose at which improvement noted, unless dosage is not tolerated

Summary

- OCD prevalence: 1-3%, many pts. don’t seek treatment – 10 yr. lag b/w symptom onset and t/t
- OCD treatment characterized by pessimism until recently when CBT & SSRI were introduced
- Previously thought to be rare and untreatable, now recognized as common
- Screen for OCD in every MSE – early diagnosis – appropriate treatment results in improved quality of life and reduces chronicity

Summary

- 1st line treatment: SSRIs (Indian context) & CBT (mild-moderately ill)
- Combination for severely ill
- Partial responders & non-responders: CBT > SGAs
- Taper and stop SSRI after 1-2 yrs of sustained remission, most require indefinite treatment
- Other options: DBS and ablative surgery (chronic, severe OCD)

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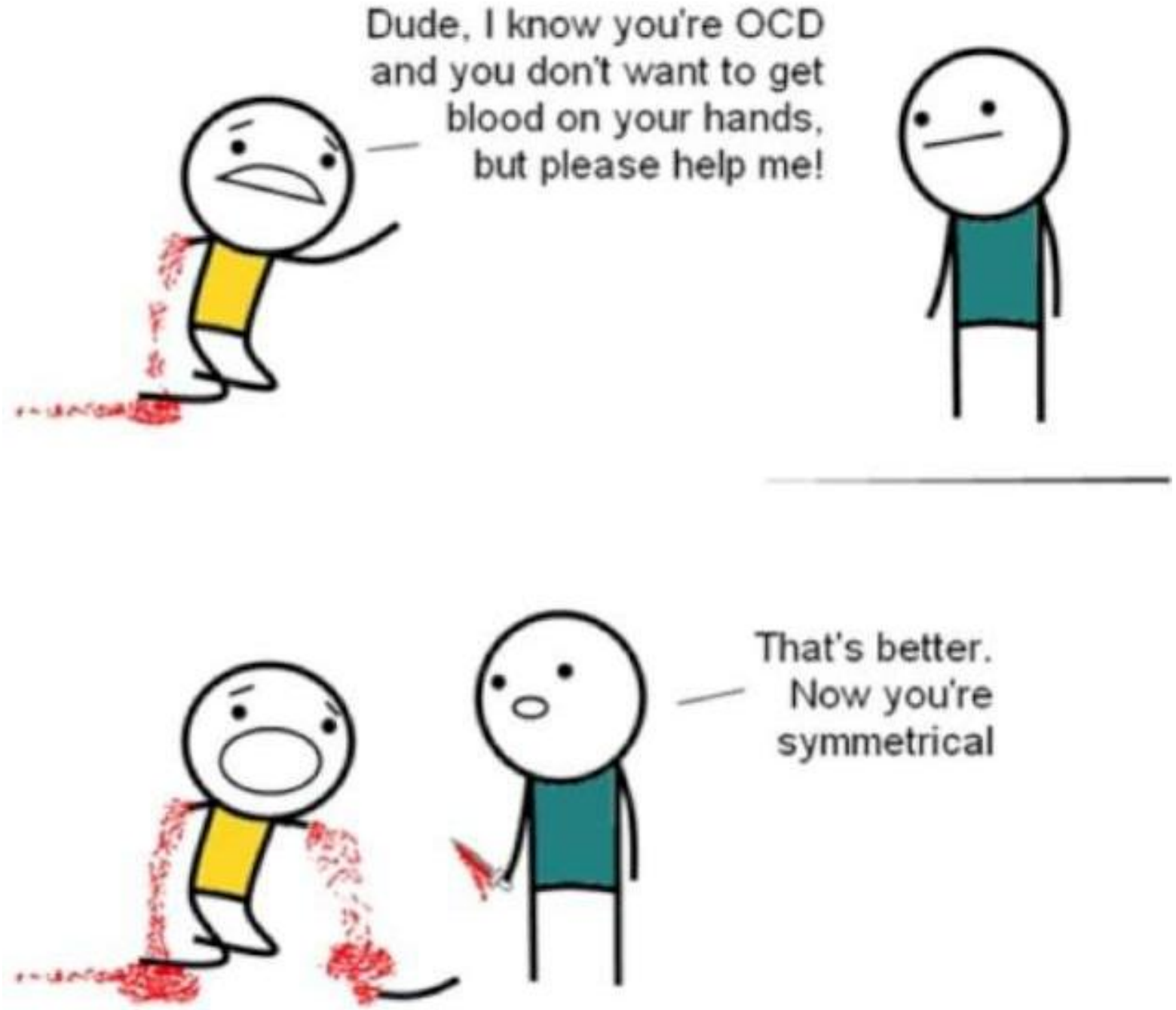
Dude, I know you're OCD and you don't want to get blood on your hands, but please help me!
That's better. Now you're symmetrical

Thank You