11-12-2015

Obsessive-Compulsive Disorder

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Vignette #1

- Jack, a middle-aged man, thought about pushing the lady next to him onto the subway tracks. He was afraid by the thought and the fear that he may act on it, so he immediately left the subway and decided to walk home. Jack remained worried and continued to visually replay the situation to ensure that he did not actually harm the lady. Jack frequently finds himself worrying that he may want to or will harm others and these thoughts greatly upset him. He knows that his thoughts come from within his own mind and are excessive in nature. However, even knowing this he remains upset by the thoughts and is not able to stop them.

eAppendix B. Vignette-based questions

1. Based on the vignette which option most likely applies?

___ Adjustment disorder
___ Agoraphobia with panic disorder
___ Agoraphobia without panic disorder
___ Alcohol abuse
___ Alcohol dependence
___ Anger management issues
___ Anorexia nervosa
___ Antisocial personality disorder
___ Asperger's disorder
___ Attention deficit hyperactivity disorder
___ Autism disorder
___ Avoidant personality disorder
___ Bipolar I disorder
___ Bipolar II disorder
___ Body dysmorphic disorder
___ Borderline personality disorder
___ Bulimia Nervosa
___ Delusional disorder
___ Due to a general medical condition
___ Generalized anxiety disorder
___ Histrionic personality disorder
___ Hypochondriasis
___ Impulse control disorder, NOS
___ Intermittent explosive disorder
___ Major depression disorder
___ Marital problems
___ Narcissistic personality disorder
___ No disorder/condition
___ Obsessive-compulsive disorder
___ Obsessive-compulsive personality disorder
___ Panic disorder
___ Paranoid personality disorder
___ Pedophilia
___ Posttraumatic stress disorder
___ Primary Insomnia
___ Psychosis
___ Sexual identity confusion
___ Schizophrenia
___ Schizoid personality disorder
___ Schizotypal personality disorder
___ Social phobia/social anxiety disorder
___ Somatization disorder
___ Specific phobia
___ Strong religious values
___ Tourette's
___ Trichotillomania
___ Other (please specify)_____

Vignette #2

- Jack, a middle-aged man, constantly worries about dirt and germs. He knows that his thoughts come from within his own mind and are excessive in nature. However, even knowing this he remains upset by the thoughts and is not able to stop them. He is unable to complete many of his daily activities because he tries at all costs to avoid touching things he thinks may be dirty. However, if he does touch a “dirty” object, Jack will immediately wash his hands so that he will not catch a disease.

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___ Social phobia/social anxiety disorder
___ Somatization disorder
___ Specific phobia
___ Strong religious values
___ Tourette's
___ Trichotillomania
___ Other (please specify)_____

Vignette #3

- Jack, a middle-aged man, loved spending time with his nieces and nephews and was considered their “favorite uncle.” However, he started having images of touching the children in a sexual manner. He had no desire to touch the children and did not experience any sexual arousal during the image, but the worry of “what if” remained. He knows that his thoughts come from within his own mind and are excessive in nature. However, even knowing this he remains upset by the thoughts and is not able to stop them. He now tries to avoid being with the children and refuses to spend time alone with them.

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___ Somatization disorder
___ Specific phobia
___ Strong religious values
___ Tourette's
___ Trichotillomania
___ Other (please specify)_____

Obsessive-Compulsive Disorder

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Relevance to Family Medicine

- PCP's:
  - Provide ~1/3 of all mental health care in the US
  - Prescribe 80% of all psychotropic drugs
- OCD particularly prone to misdiagnosis bc of heterogeneity
- 6/2015 study in Journal of Clinical Psychiatry:
  - 208 PCPs in NYC area
  - Misdiagnosed 50.5% of OCD vignettes
    - Most common correctly diagnosed OCD = symmetry obsessions, contamination obsessions
    - Least common correctly diagnosed OCD = aggression obsessions, sexual obsessions
  - (p.s. mental health providers don't do such a great job either)

Goals for the learner:

- Define OCD as a heterogeneous and disabling disorder with good but specific treatment options
- Appreciate the epidemiology of OCD across the lifespan
- Diagnose or suspect OCD in the primary care setting
- Manage OCD appropriately with SSRIs
- Refer patients to appropriate providers of exposure-response prevention based cognitive behavioral therapy.

NOT covered in this talk

- How to perform exposure-response prevention therapy
- Neurosurgical management of OCD
- Management of refractory disease
- Diagnosis and management of mimickers of OCD or associated diagnoses (e.g. Tourette's, trichotillomania, excoriation disorder, hoarding disorder, body dysmorphic disorder)

Definitions

DSM-5 Definition:

A. Presence of OBSESSIONS, COMPULSIONS, or BOTH
B. TIME-CONSUMING, causing IMPAIRMENT IN FUNCTIONING
C. Not 2/2 another medical condition or substance
D. Not better explained by another mental disorder

Definitions: OBSESSIONS

1. 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

2. Patient attempts to IGNORE or SUPPRESS such thoughts, urges, or images or to NEUTRALIZE them with some other thought or action

Definitions: COMPULSIONS

1. 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.

2. 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 either are NOT CONNECTED in a realistic way with what they are designed to neutralize or prevent or are clearly EXCESSIVE.

Defining Insight – new requirement of DSM-5
Is OCD always ego dystonic?

- With good/fair insight: beliefs are definitely or probably not true
- With poor insight: beliefs are probably true
- With absent insight or with delusions: completely convinced beliefs are true.

Common Obsessions

- Aggressive impulses – e.g. images of hurting a child, parent or other loved one
- Contamination – e.g. contracting hepatitis or HIV by touching a “dirty” object
- Need for order – e.g. intense distress when objects are disordered or asymmetric
- Religious – e.g. blasphemous thoughts or concerns about unintentionally sinning
- Repeated doubts – e.g. wondering if the stove was turned off
- Sexual imagery – e.g. recurrent pornographic images

Common Compulsions

- Checking – e.g. repeatedly checking locks, alarms, appliances
- Cleaning – e.g. handwashing
- Mental Acts – e.g. praying, counting, analyzing or figuring out
- Ordering – e.g. reordering objects to achieve symmetry
- Reassurance-seeking – e.g. asking others for reassurance ad nauseum
- Repetitive actions – e.g. walking in and out of a doorway multiple times

Definitions: Review

- OCD
  - Obsessions –
    - Recurrent, persistent thoughts, urges, images → distress/anxiety
    - Patient tries to SUPPRESS them
  - Compulsions –
    - behaviors or mental acts in response to obsessions or in accordance w/ strict rules
  - Functional Impairment
  - Not 2/2 other mental d/o or medical condition

Epidemiology and Pathogenesis

Epidemiology

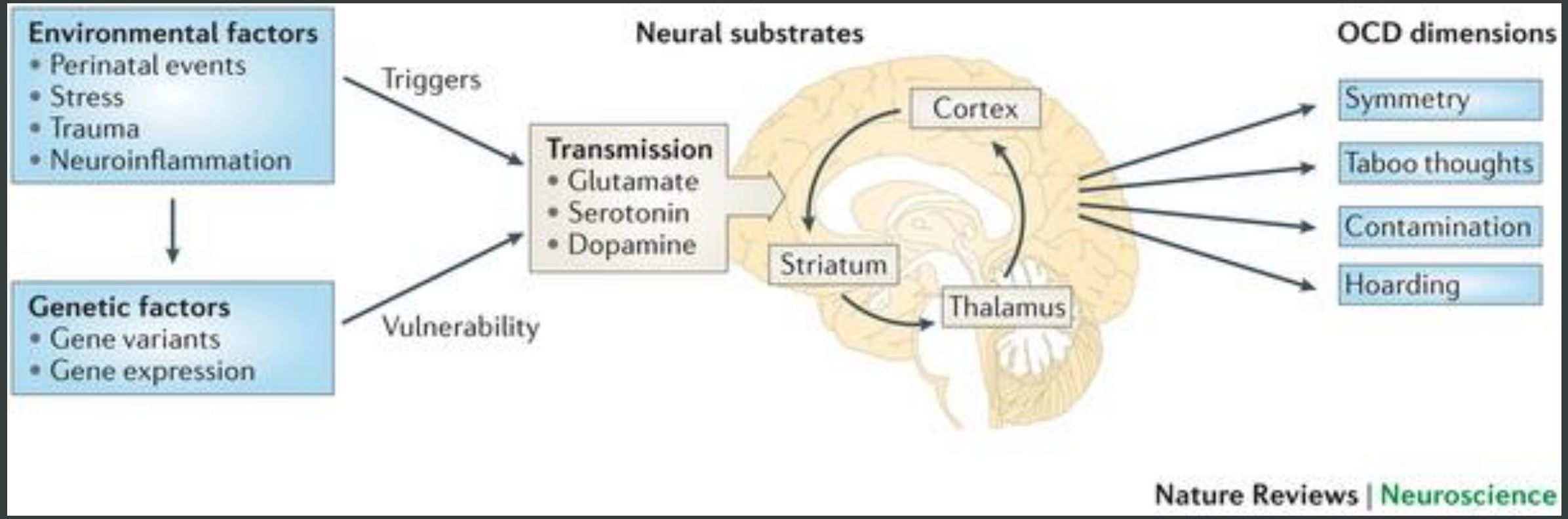
- Lifetime prevalence of 2.3%
- Incidence is higher in adult women than men.
- But incidence is higher in boys than girls.
- Mean age of onset: 19.5 years in US
- 25% by age 14. Males earlier than females (25% before age 10)
- 50% by mid-20s.

Comorbidities

- Other anxiety disorder: 76%
- Mood disorder: 63% (MDD = 41%)
- Suicidal ideation: 50%. Suicide attempts: 15%
- Obsessive-compulsive personality disorder: 23-32%
- Tic disorder: 29% (esp males w/ childhood onset)
- More common in patients with:
  - Bipolar disorder
  - Schizophrenia or schioaffective disorder
  - Tourette's disorder
  - Anorexia nervosa and bulimia nervosa
  - Body dismorphic disorder

Pathogenesis

- Largely unknown and complex
- Likely multifactorial combination of environmental and genetic factors
- Research implicates the Cortico-striato-thalamo-cortical (CSTC) circuits +/- others
  - orbitofrontal cortex
  - anterior cingulate cortex
  - striatum
- Likely involves serotonin, glutamate, possibly dopamine as important neurotransmitters


Environmental factors
• Perinatal events
• Stress
• Trauma
• Neuroinflammation
Genetic factors
• Gene variants
• Gene expression
Triggers
Vulnerability
Transmission
• Glutamate
• Serotonin
• Dopamine
Neural substrates
Cortex
Striatum
Thalamus
OCD dimensions
Symmetry
Taboo thoughts
Contamination
Hoarding
Nature Reviews | Neuroscience

Pathogenesis

- Genetic factors:
  - Twin studies show genetic component, probably greater in pediatric-onset disease
  - Precise genes are unknown
- Environmental factors:
  - ?PANDAS (Pediatric Autoimmune Neuropsychiatric Disorder Associated w/ Streptococcal Infection)
  - Onset or worsening associated with:
    - PMS, postpartum periods
    - Traumatic events and stress
    - Neurological lesions or pathology (e.g. stroke, TBI, brain tumor, encephalitis)

Epidemiology and Pathogenesis Review

- OCD is common
- Presents younger than other mental disorders with nearly equal M:F ratio
- Comorbities are the RULE not the exception
- Pathogenesis is unknown exactly but seems to do with genetic and environmental factors influencing the cortico-striato-thalamo-cortical (CSTC) circuit

Diagnosis

Tips for Diagnosis in PCP Office

- High degree of suspicion in patients with psych complaint
- Embarrassment and stigma play big role
- Average time from symptom onset to presentation to care is 11 YEARS!
- Still listed among anxiety disorders in ICD-10 as among "neurotic, stress-induced, somatoform disorders"
- Patients may allude to intrusive thoughts or repetitive behaviors
- May avoid particular locations or objects
- May have excessive concerns about a particular illness or injury
- May repeatedly ask for reassurance

Screening Questions

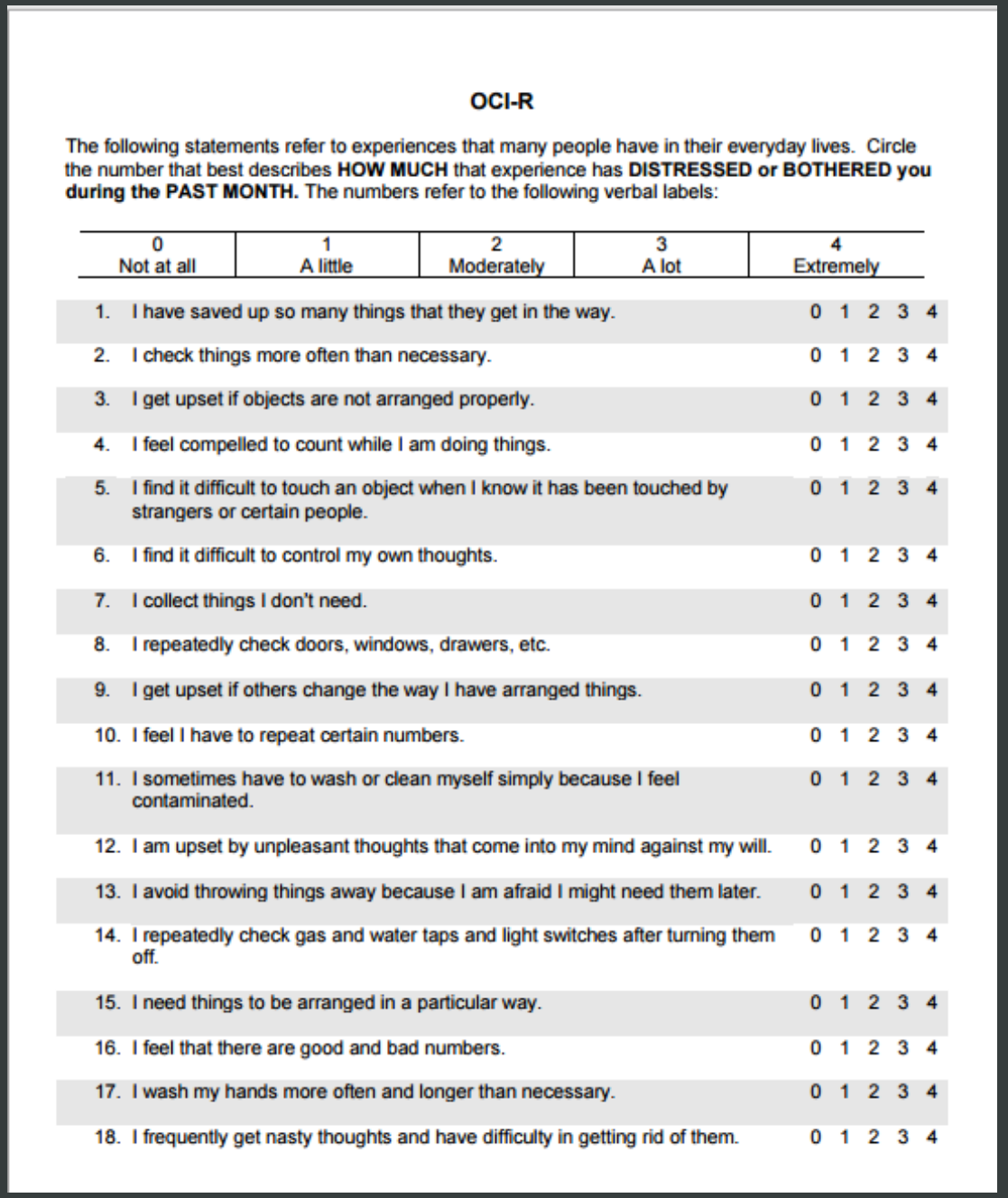
- “Do you have thoughts or images that keep coming back to you and are difficult to put out of your head? For example, being contaminated by something, having something terrible happen to you or someone you care about, or doing something terrible?”
- “Do you ever feel the need to perform certain actions that don’t make sense or that you don’t want to do, such as washing, cleaning, counting, or checking things over and over?”

Obsessive-Compulsive Inventory – Revised

Score 0-72

Mean OCD score is 28

Suggested cut off is 21



OCI-R

The following statements refer to experiences that many people have in their everyday lives. Circle the number that best describes **HOW MUCH** that experience has **DISTRESSED or BOTHERED you during the PAST MONTH.** The numbers refer to the following verbal labels:

0 Not at all	1 A little	2 Moderately	3 A lot	4 Extremely

1.	I have saved up so many things that they get in the way.	0 1 2 3 4
2.	I check things more often than necessary.	0 1 2 3 4
3.	I get upset if objects are not arranged properly.	0 1 2 3 4
4.	I feel compelled to count while I am doing things.	0 1 2 3 4
5.	I find it difficult to touch an object when I know it has been touched by strangers or certain people.	0 1 2 3 4
6.	I find it difficult to control my own thoughts.	0 1 2 3 4
7.	I collect things I don't need.	0 1 2 3 4
8.	I repeatedly check doors, windows, drawers, etc.	0 1 2 3 4
9.	I get upset if others change the way I have arranged things.	0 1 2 3 4
10.	I feel I have to repeat certain numbers.	0 1 2 3 4
11.	I sometimes have to wash or clean myself simply because I feel contaminated.	0 1 2 3 4
12.	I am upset by unpleasant thoughts that come into my mind against my will.	0 1 2 3 4
13.	I avoid throwing things away because I am afraid I might need them later.	0 1 2 3 4
14.	I repeatedly check gas and water taps and light switches after turning them off.	0 1 2 3 4
15.	I need things to be arranged in a particular way.	0 1 2 3 4
16.	I feel that there are good and bad numbers.	0 1 2 3 4
17.	I wash my hands more often and longer than necessary.	0 1 2 3 4
18.	I frequently get nasty thoughts and have difficulty in getting rid of them.	0 1 2 3 4

Florida Obsessive-Compulsive Inventory

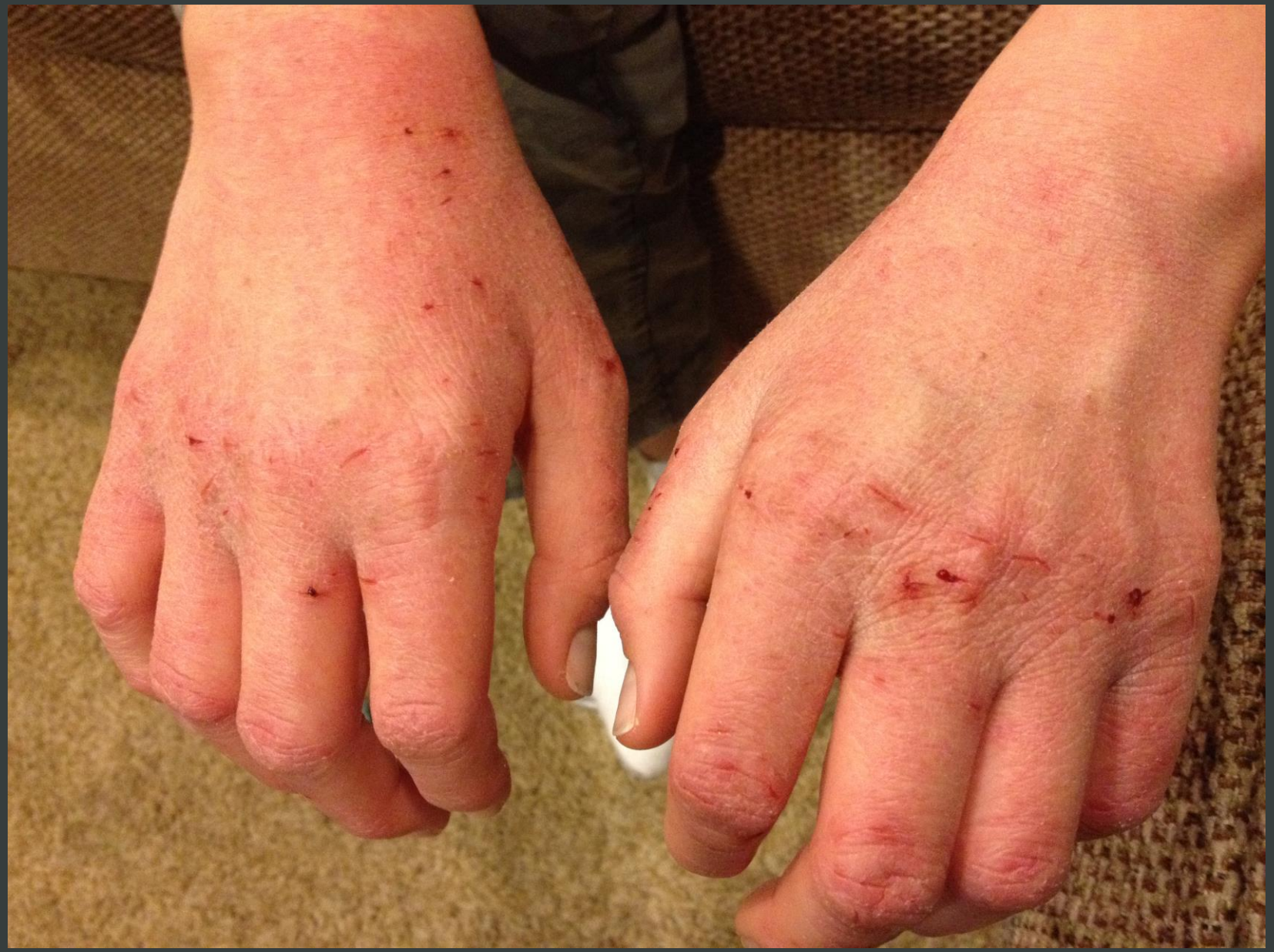
- http://www.ocdscales.org/index.php?page=scales

Case #1

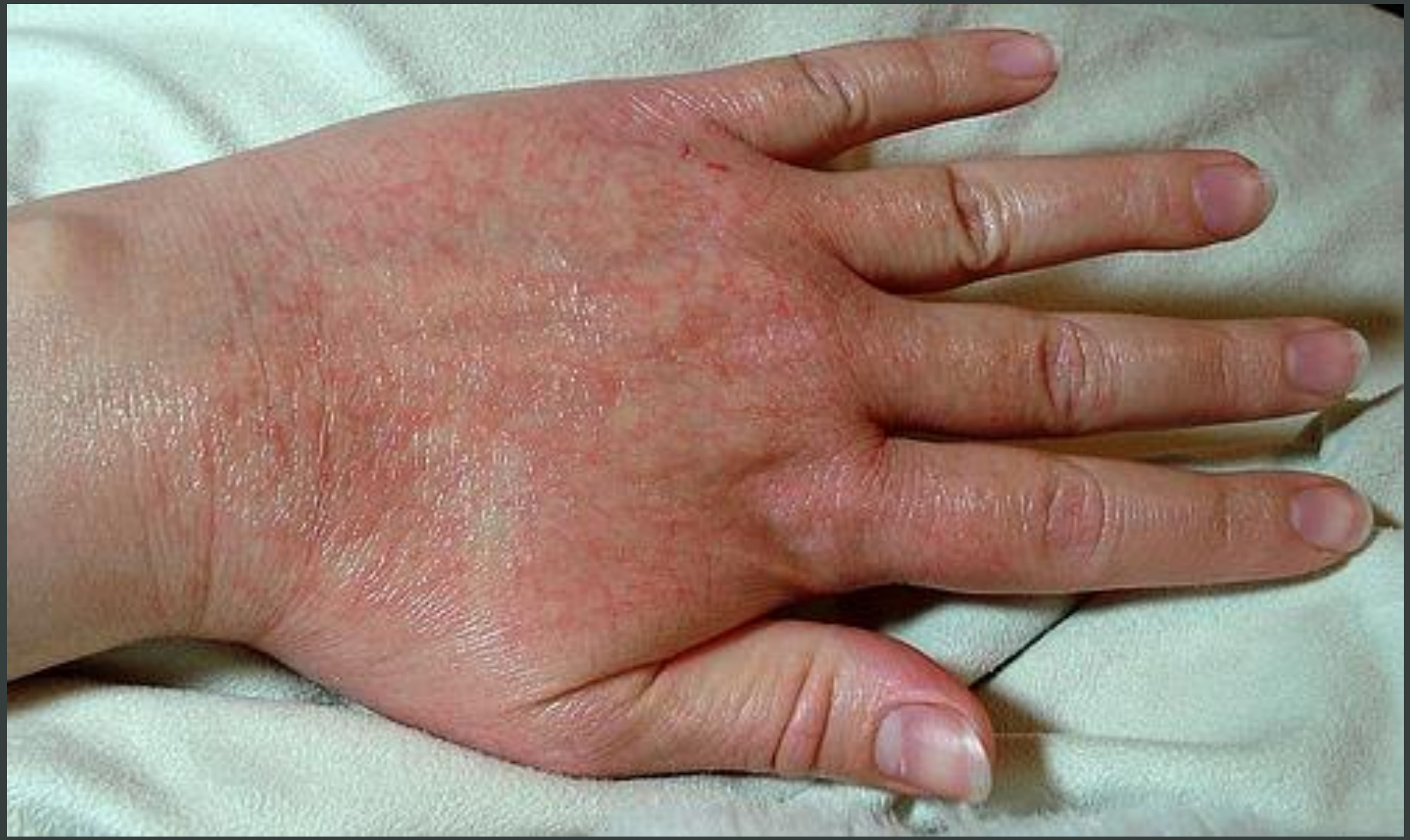
JH is a 12 year old girl who presents with her mom for a well child check. You ask her how she's doing, and she says "fine." You remember her being more interactive last year at her well child visit. Her mom said she's concerned because JH is acting more withdrawn lately. She also reports JH seems to disappear when she's at home and notes that it's been a real effort to get her out of the house lately because she takes so long to get ready.

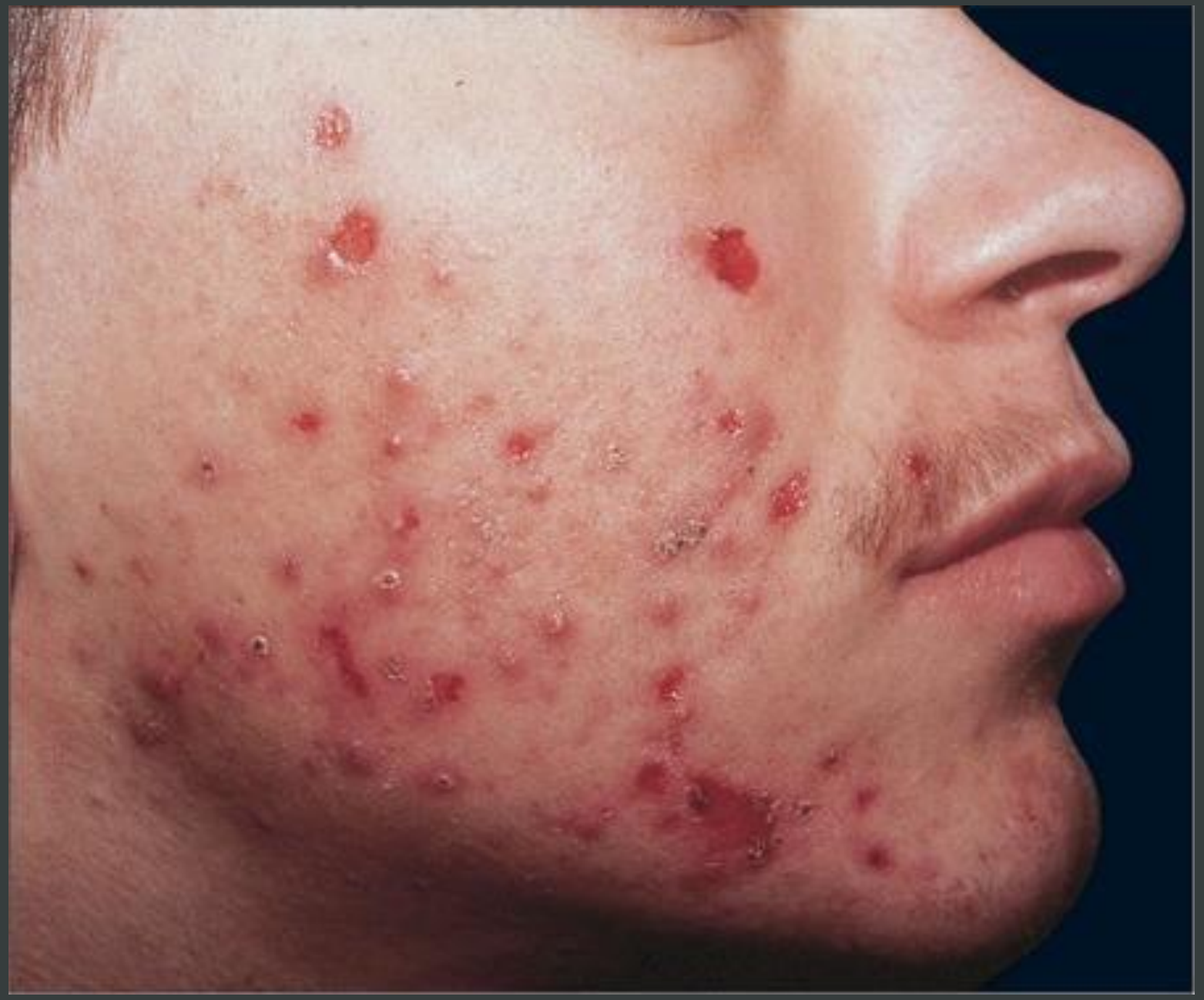
You notice that at the start of the visit, JH was sitting on her hands on the exam table. You ask her to give you her usual enthusiastic high five and you notice she covers her hand with her shirt sleeve first.

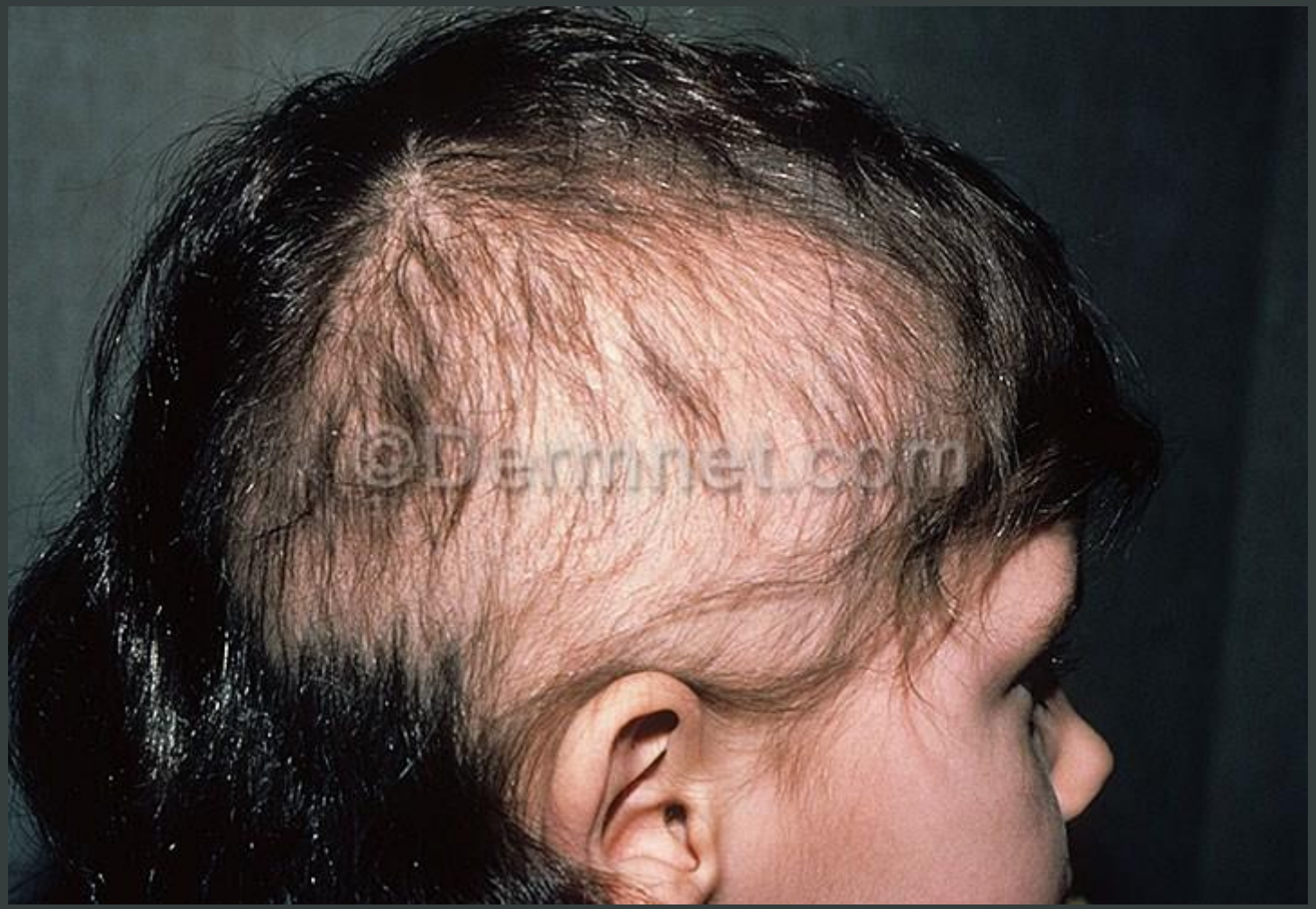
s/p high-five, she uncovers her hands and you see this…



Dermatologic Manifestations






@Dermnet.com

Diagnosis - Review

- Maintain high index of suspicion in patients with anxiety or depression complaints
- Patients unlikely to be forthcoming about embarrassing sx
- Be aware of dermatologic findings associated with OCD
- ASK about obsessions and compulsions
- Standardized tools are available
  - Obsessive-Compulsive Inventory-Revised
  - Florida Obsessive-Compulsive Inventory
- Refer if dx in doubt

Management

Course

- Typically gradual but sometimes acute onset
- Chronic (although ~40% pediatric cases resolve by adulthood)
- Waxing/waning, episodic or deteriorating course
- w/o tx: only 20% remission over 40 years
- w/ tx: 25-58% remission over 12wks (remission = no more than mild sx)
- Developmental/social problems are common

Treatment of Obsessive-Compulsive Disorder

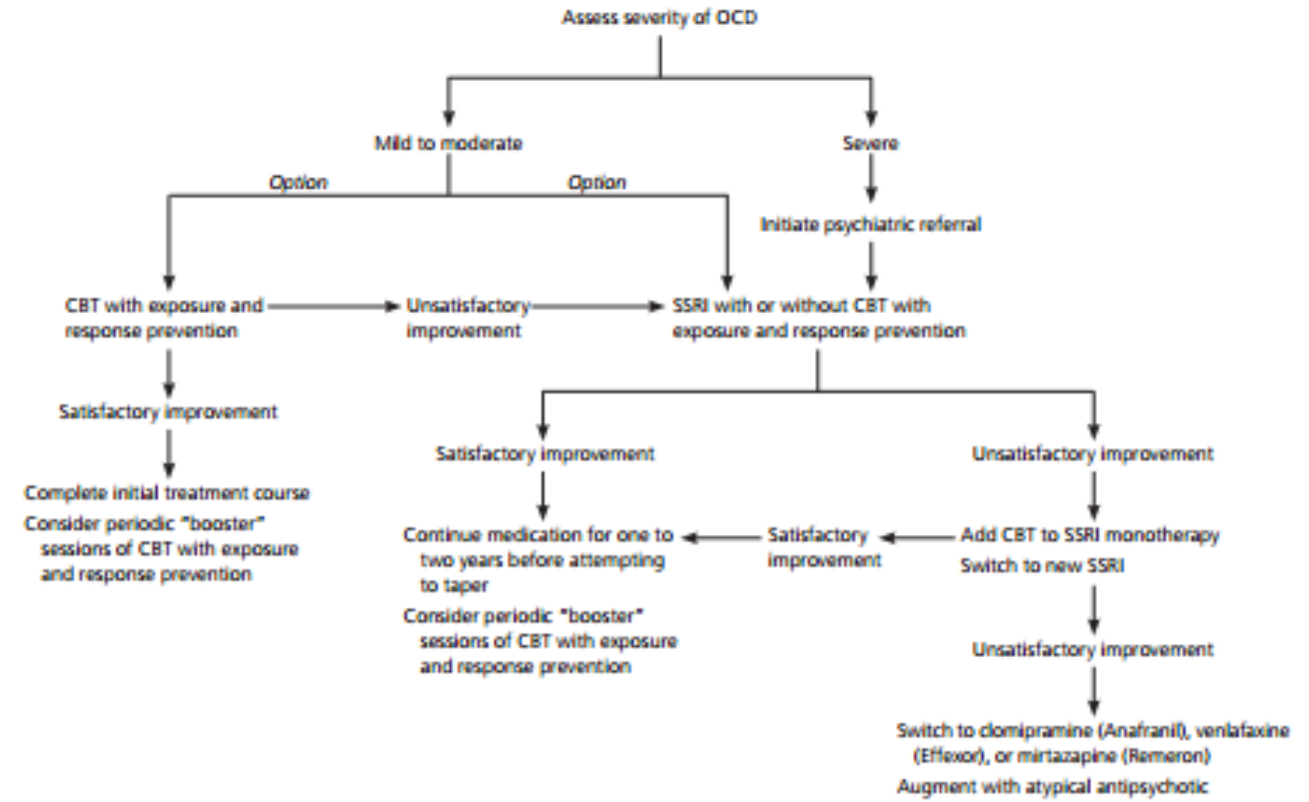


Figure 1. Treatment algorithm for patients with obsessive-compulsive disorder. (CBT = cognitive behavior therapy; OCD = obsessive-compulsive disorder; SSRI = selective serotonin reuptake inhibitor.)

Information from references 16 and 21.

Y-BOCS (Yale-Brown obsessive-compulsive scale)

Yale-Brown obsessive-compulsive scale

Obsession rating scale

Item	None (0 points)	Mild (1 point)	Moderate (2 points)	Severe (3 points)	Extreme (4 points)
Time spent on obsessions	0 hrs/day	0-1 hrs/day	1-3 hrs/day	3-8 hrs/day	>8 hrs/day
Interference from obsessions	None	Mild	Manageable	Severe	Incapacitating
Distress from obsessions	None	Mild	Moderate	Severe	Disabling
Resistance to obsessions	Always resists	Much resistance	Some resistance	Often yields	Completely yields
Control over obsessions	Complete control	Much control	Moderate control	Little control	No control
Obsession subtotal (add items 1-5)	_____	+ _____	+ _____	+ _____	+ _____ = _____

Compulsion rating scale

Item	None (0 points)	Mild (1 point)	Moderate (2 points)	Severe (3 points)	Extreme (4 points)
Time spent on compulsions	0 hrs/day	0-1 hrs/day	1-3 hrs/day	3-8 hrs/day	>8 hrs/day
Interference from compulsions	None	Mild	Manageable	Severe	Incapacitating
Distress from compulsions	None	Mild	Moderate	Severe	Disabling
Resistance to compulsions	Always resists	Much resistance	Some resistance	Often yields	Completely yields
Control over compulsions	Complete control	Much control	Moderate control	Little control	No control
Compulsion subtotal (add items 6-10)	_____	+ _____	+ _____	+ _____	+ _____ = _____

Total (add obsession and compulsion subtotals) _____

Range of OCD severity

0-7 points = Subclinical
8-15 points = Mild
16-23 points = Moderate
24-31 points = Severe
32-40 points = Extreme

Adapted with permission from Goodman, WK, Price, LH, Rasmussen, SA, et al, Arch Gen Psychiatry 1989; 46:106.

Graphic 80107 Version 3.0

Pharmacologic Mgmt

- SSRI's are mainstay of pharm tx (Evidence Rating: A)
  - 2008 Cochrane Review
    - 17 RCT's and 3097 patients
    - superior to placebo for OCD for reduction of sx according to Y-BOCS at 6-13 weeks
    - No significant difference between any of the SSRIs studied
  - FDA approved SSRIs for OCD: (all except citalopram and escitalopram)
    - fluoxetine
    - fluvoxemine
    - sertraline
    - paroxetine

Pharmacologic Mgmt (cont'd)

- Clomiprimene (TCA) also with good evidence
  - 2002 meta-analysis of 7 RCTs with 392 patients showed superiority over placebo
- head-to-head comparisons of clomprimene and SSRIs show neither is superior to other
- SSRIs typically better tolerated, lower side effect profile
- 40-60% of patients show improvement on either SSRIs or Clomiprimene
- Can expect 20-40% reduction in symptoms
- Very little evidence on improvement of sx w/ SNRIs
  - One small trial (n=30) showed no improvement w/ venlafaxine over placebo after 8 weeks
  - No other RCTs

Note on SSRI dosage

- Higher than typical dosage for depression to be effective
- Must use for longer periods of time before seeing improvement.

Drug	Effective Dosage in OCD
Fluoxetine	40-80mg/day
Fluvoxamine	200-300mg/day
Paroxetine	40-60mg/day
Sertraline	200mg/day
Citalopram*	20-40mg/day
Escitalopram*	20-40mg/day

*not studied in randomized control trials for OCD

Psychotherapy for OCD = CBT with ERP

- Evidence rating = A
- 2007 Cochrane Review of 7 studies showed significant improvement with CBT vs treatment as usual
- Exposure response prevention (ERP) – component of CBT for OCD and specific phobias
- Exposure to an obsession-causing stimulus with Abstinence from performing compulsion → gradual desensitization of stimulus
- Typically stepwise

- Psychodynamic and psychoanalytic (Freudian-based) therapies have no evidence base in OCD
  - Some evidence they make things worse
  - Even Freud said so (eventually…)

CBT and ERP

- ERP is HARD
- Requires significant buy-in by patient
- May be more difficult for developmentally delayed or cognitively impaired patients
- CBT for OCD comprised of 3 things:
  - Psychoeducation
  - Exposure and response prevention
  - Cognitive therapy

Case: “S” the surfer

- Young-ish newly married man who presents w/ violent, disturbing thoughts of harming his new wife over the last few months. The thoughts appeared paroxysmally after watching a violent movie. The thoughts initially involved slicing his wife’s torso in half with a knife and watching her die painfully with blood scattered about her. The thoughts eventually expand to encompass a profound fear that he might commit violent acts against anyone. These thoughts are extremely distressing, often causing him to lie in a fetal position in fear that he might act on them. His work is suffering as he often pictures himself violently killing his customers as he talks to them. He has never had homicidal thoughts about his wife and reports loving her very much. His wife describes him as “a gentle soul” who would never hurt an ant. He has begun avoiding all things that might be used as a weapon. He feels he is having a “psychological breakdown.” He is becoming increasingly afraid that instead of being mentally ill, he may actually be having real desires to be violent.

NPR Invisibilia Podcast “Dark Thoughts” Jan 8, 2015.

To find an ERP-trained mental health provider:

https://iocdf.org

Resources

General

- International Obsessive-Compulsive Disorder Foundation (ERP Therapist Finder): https://Iocdf.org
- Online Support Group: https://groups.yahoo.com/neo/groups/OCD-Support/info
- Freedom From Obsessive-Compulsive Disorder: A Personalized Recovery Program for Living with Uncertainty
  by Jonathan Grayson, PhD
- Getting Over OCD: A 10-Step Workbook for Taking Back Your Life
  by Jonathan S. Abramowitz, PhD

Philadelphia Region

- Anxiety and OCD Center of Philadelphia:
  - http://www.ocdphiladelphia.com
- Center for the Treatment and Study of Anxiety @ Penn:
  - http://www.med.upenn.edu/ctsa/ocd_treatment.html
- Free Support Group in Philadelphia "GOAL":
  - http://www.ocdphiladelphia.com/free-support-group

Management – Summary

- SSRIs are the mainstay of pharmacotherapy
- Start w/ SSRI and/or CBT in mild-mod
- Start w/ psych referral and both SSRI and CBT in severe
- Inpatient treatment, neurosurgical options available for refractory cases
- Avoid psychoanalytic or psychodynamic therapy
- ERP is difficult and patent buy-in is essential
- Goal is amelioration, not cure
- Workbooks or support groups may be good alternative to individual tx in patients w/o access to treatment

Books

- The Boy Who Couldn't Stop Washing: The Experience and Treatment of Obsessive-Compulsive Disorder
  by Judith L. Rapoport, MD
- The Boy Who Finally Stopped Washing: OCD From Both Sides of the Couch
  by John B.
- Check Mates: A Collection of Fiction Poetry and Artwork About Obsessive-Compulsive Disorder by People with OCD
  by E.I. Muse and Jennifer Abrams
- Triggered: A Memoir of Obsessive-Compulsive Disorder
  by Fletcher Wortmann

THANK YOU!

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