Obsessive Compulsive Disorder

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What is a Psychiatrist?

Physician, from the Greek:
- physis: growth, nature, the natural world
- -ian: a person skilled in the art or science

Psychiatrist, from the Greek:
- psyche: breath, life; also soul or spirit
- -iatreia: healing, medical treatment
- -ist: a person devoted to an art or method, science, branch of knowledge
OCD Diagnostic Criteria (1)

- Either obsessions or compulsions
- The obsessions or compulsions:
  - Cause marked distress
  - Take > 1 hour/day
  - Greatly interfere with normal routine, functioning, or relationships

DSM-IV-TR = *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed, Revised. 2000
OCD Diagnostic Criteria (2)

- The person recognizes the obsessions or compulsions are excessive or unreasonable.

- Not due to physiologic effects of a substance (e.g., drug abuse) or a general medical condition.
Common OCD Obsessions

- Fear of contamination
- Fear of causing harm to someone else
- Fear of harm coming to self
- Need for symmetry or exactness
- Sexual and religious obsessions
- Fear of offending others
- Fear of making a mistake
- Pathologic doubt
Common OCD Compulsions

- Cleaning
- Hand washing
- Checking
- Ordering and arranging
- Hoarding
- Asking for reassurance
- Counting
- Repeating rituals
- Neutralizing thoughts
Epidemiology of OCD

- Affects ≈ 2.2 Million U.S. adults
- Lifetime prevalence: 1.6% to 2.5%
- 1-year prevalence: 0.5% to 2.1%
- Among OCD cases > 1-year duration:
  - 51% serious disease
  - 34% moderate disease
  - 15% mild disease
- Equally common in men and women in adults
  - In children, boys > girls
Epidemiology of OCD (Cont’d)

• Usual onset: adolescence or early adulthood
  – Boys (6–15 yrs) < Girls (20–29 yrs)
  – Usually gradual, but can be acute

• Typically chronic and debilitating, with an episodic course that may be triggered by stress
What Causes OCD?

• Genetics
  – Twin/Family studies; Tourette’s
• Neurochemistry
  – Serotonin, DA, Glutamate, GABA
• Neuroanatomy
  – ↑ activity in certain brain areas
• Neuroimmunology
  – PANDAS, Syndenham’s chorea
Commonly Associated Conditions (Lifetime Rates)

- Major Depression (67%)
- Social Anxiety Disorder (28%)
- Panic Disorder (18%)
- Substance Use Disorder (26%)
- Tourette Syndrome (5%)
Treatment of OCD (1)
American Psychiatric Association Guideline

First Line treatments

1. CBT (Exposure/Response Prevention)
   – time intensive, less accessible
2. Medication (an SSRI, e.g., Prozac)
   – side effects, drug interactions
   – higher doses produce better outcomes
3. Combination of CBT + SSRI
### TABLE 3. Dosing of Serotonin Reuptake Inhibitors (SRIs) in Obsessive-Compulsive Disorder (OCD)

<table>
<thead>
<tr>
<th>SRI</th>
<th>Starting Dose and Incremental Dose (mg/day)&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Usual Target Dose (mg/day)</th>
<th>Usual Maximum Dose (mg/day)</th>
<th>Occasionally Prescribed Maximum Dose (mg/day)&lt;sup&gt;b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citalopram</td>
<td>20</td>
<td>40–60</td>
<td>80</td>
<td>120</td>
</tr>
<tr>
<td>Clomipramine</td>
<td>25</td>
<td>100–250</td>
<td>250</td>
<td>___&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>10</td>
<td>20</td>
<td>40</td>
<td>60</td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>20</td>
<td>40–60</td>
<td>80</td>
<td>120</td>
</tr>
<tr>
<td>Fluvoxamine</td>
<td>50</td>
<td>200</td>
<td>300</td>
<td>450</td>
</tr>
<tr>
<td>Paroxetine</td>
<td>20</td>
<td>40–60</td>
<td>60</td>
<td>100</td>
</tr>
<tr>
<td>Sertraline&lt;sup&gt;d&lt;/sup&gt;</td>
<td>50</td>
<td>200</td>
<td>200</td>
<td>400</td>
</tr>
</tbody>
</table>

<sup>a</sup> Some patients may need to start at half this dose or less to minimize undesired side effects such as nausea or to accommodate anxiety about taking medications.

<sup>b</sup> These doses are sometimes used for rapid metabolizers or for patients with no or mild side effects and inadequate therapeutic response after 8 weeks or more at the usual maximum dose.

<sup>c</sup> Combined plasma levels of clomipramine plus desmethyliclomipramine 12 hours after the dose should be kept below 500 ng/mL to minimize risk of seizures and cardiac conduction delay.

<sup>d</sup> Sertraline, alone among the SSRIs, is better absorbed with food.
Combined Treatment

- More effective than monotherapy for some, but not necessary for all.

- Consider for inadequate response to monotherapy; co-occurring psychiatric conditions; and patients wishing to limit drug Rx duration.

- For patients with severe OCD.
Second Steps

1. Switch to a different SSRI
2. Switch to clomipramine (an SNRI)
3. Augment with dopamine-blocker
4. Switch to Effexor or Remeron
Treatment of OCD (3)
American Psychiatric Association Guideline

1. Augment with different dopamine blocker
2. Switch to 3rd SSRI, 4th, or 5th
3. Add clomipramine (an SNRI) to an SSRI
4. Add other meds, e.g., memantine
5. Switch to d-amphetamine, morphine, tramadol, or ondansetron
6. Transcranial Magnetic Stimulation
7. Deep brain stimulation or neurosurgery
Concerns in Treating OCD in Women

- Pre-menstrual worsening of symptoms
- Effects of meds on birth control
- Safety of meds during pregnancy
- Postpartum onset / worsening of OCD
- Safety of meds during nursing
- Sexual side effects of meds
Implementing Pharmacotherapy

- Start low, titrate to max tolerated dose.
- Continue for 8-12 weeks, including 4-6 weeks at max tolerated dose.
- Manage side effects, e.g., insomnia, fatigue, bruxism, sweating, sexual dysfunction.
CBT and Other Psychotherapies

- CBT (exposure & response prevention)
- Cognitive Therapy
- Psychodynamic psychotherapy
- Motivational Interviewing
- Family Therapy
Implementing CBT

• Adequate trial: 13-20 weekly sessions with daily homework (or, 3 weeks of daily Mon-Fri).
• Individual, group or family format, session from <1 hour to 2 hours.
• Booster sessions after response achieved.
• Self-help treatment guides are OK.
Reasons For Med Non-response In “OCD”

• Incorrect diagnosis
• Inadequate medication trial
• Coexisting condition limits efficacy
• Counter-therapeutic influences
• OCD’s biological heterogeneity
Changing Treatment

• 1\textsuperscript{st} Rx rarely abolishes all symptoms.
• Patients may accept residual symptoms. Is depressed mood \downarrow hopefulness, or is OCD associated with secondary gain?
• ? problems in therapeutic alliance, co-occurring conditions, poor adherence, psychosocial stressors, family accommodation.
Discontinuing Treatment

• Continue med for 1-2 years, then gradual taper (10%-25% q 1-2 months).
• Follow successful CBT with monthly booster sessions for ≥ 3-6 months.
• Relapse rates are high. Most require continued treatment of some form.
• “Relapse” 4-6 months after stop CBT may be less likely than after stop med.
Some Areas for Research

- Pathophysiology of OCD – nature of the genetic risk, and the biochemical lesion(s)?
- Predictors of response or side effects to a given drug (use gene chips, brain scans)
- Predictors of response to CBT, e.g., brain circuitry maps
- Best means of preventing relapses
- New treatments: meds, TMS, psychotherapies