OCD

Obsessive Compulsive Disorder (OCD)

Clinical Overview: Obsessive Compulsive Disorder (OCD)

- Obsessions are intrusive repeated thoughts that cause anxiety.
- Compulsions are actions and/or rituals performed by the patient in the hope of preventing or neutralizing obsessions.
- Education is a critical component to obsessive compulsive disorder treatment.
- Medication, psychotherapy or a combination of both have been shown effective in treating OCD.
- If you have a patient who you feel may have an OCD, please refer him/her to HIP Behavioral Health Services (**1-888-447-2526**).

Clinical Snapshot: Obsessive Compulsive Disorder

- Brief "snapshot" of obsessive compulsive patient's presentation:
  - May avoid touching things in the office (e.g., door, chair, etc.).
  - May spend a great amount of time:
    - Washing (e.g., hands).
    - Checking (e.g., locks, gas, etc.).
    - Counting (may include repeating behaviors).
    - Cleaning (or organizing).
  - May seem rigid.
  - May have fear of germs or disease.
  - Skin may be dry from washing.

Facts about OCD

- Approximately three million Americans have OCD.
- OCD affects men and women equally.
- Signs of OCD typically begin in adolescence or childhood but OCD can also emerge in adulthood.
- Compulsions are behaviors often performed with the hope of preventing obsessive thoughts or in an attempt to make them go away. Performing them, however, provides only temporary relief, and not performing them markedly increases anxiety. Over time, compulsions are engaged in more and more.

How to Identify and Diagnose OCD

- ***Screening: DSM-IV Criteria for OCD***
  - OCD involves obsessions and/or compulsions. Obsessions are behavior defined as the presence of the following four symptoms:
    1. Recurrent and persistent thoughts, impulses or images that are experienced at some time during the disturbance as intrusive and inappropriate and that cause marked anxiety or distress.
    2. The thoughts, impulses or images are not simply excessive worries about real life problems.
    3. The person attempts to ignore or suppress such thoughts, impulses or images, or to neutralize them with some other thought or action.
    4. The person recognizes the obsessional thoughts, impulses or images are a product of his or her own mind.

  - Common obsessions include:
    - Fear of contamination by germs.
    - Fear of disease.
    - Fear that something “bad” will happen.
    - Concern that something has not been done correctly.
    - Forbidden thoughts.
    - Belief that one has hurt self or another person.
    - Imagining aggressive behaviors.
    - Excessive religious or moral doubt.
    - A need to have things a certain way (extreme order).

- Compulsive behavior is defined as the presence of the following two symptoms:
  1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., repeating words silently, counting) that the person feels driven to perform in response to an obsession or in response to rules that must be applied rigidly.
  2. The behaviors or mental acts are aimed at preventing or reducing 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.

- The most common types of compulsions include:
  - Washing (hands, showering, brushing teeth, etc.).
  - Counting (may include ordering, arranging, touching, praying, etc.).
  - Checking (may include locks, lights, gas, etc.).
  - Cleaning (tidying, organizing, etc.).

- In addition, for a diagnosis of OCD:
  1. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. Note: This does not apply to children.
  2. The obsessions or compulsions cause marked distress, are time-consuming (take more than one hour per day) or significantly interfere with a person's normal routine, occupational or academic functioning or usual social activities or relationships.
  3. The disturbance is not due to the effects of a substance or general medical condition.
  4. The behavior is not restricted to the presence of another mental health diagnosis (e.g., guilty obsessions in presence of depressive disorder).

Medical Rule-Outs

- OCD symptoms may result from the following conditions:
  - Carbon monoxide poisoning.
  - Post-viral encephalitis.
  - Sydenham's chorea.
  - Acute group A streptococcal infections.
  - Tumor invasion.
  - Traumatic brain injury.
  - Basal ganglia pathologies.
  - Dopamine agonist medications can induce repetitive behaviors.

- Common Comorbid Psychiatric Diagnoses:
  - Major depressive disorder.
  - Tourette's syndrome.
  - Body dysmorphic disorder.
  - Social phobia and simple phobia.
  - Trichotillomania.
  - Eating disorders.
  - Panic disorder.
  - Other tic disorders.
  - Generalized anxiety disorder.
  - ADHD.
  - Substance abuse.

Treatment of OCD

Education

- Regardless of the mode of treatment, education is a critical component of OCD treatment.

  It is helpful to provide the following educational information to patients:

  1. You are not alone, OCD affects millions of people.
  2. OCD does not mean that you are "going crazy." Studies suggest a strong biological component, probably involving a part of the brain called the striatum.
  3. There are highly effective medications and psychotherapy available to treat OCD.

- Discuss treatment options including patients' questions, preferences and concerns.

- Effective treatment modalities for OCD include medications, psychotherapy or both.

Medication

- Certain SSRIs and TCAs are commonly prescribed for OCD.

- When SSRIs or TCAs are prescribed, the following information can also be presented:

  1. Take your medication as prescribed.
  2. It may take up to four weeks of continuous medication use before experiencing symptom relief.
  3. Make a follow-up appointment to review medication within two to four weeks.
  4. Do not stop taking the medication without discussing this with you doctor.
  5. The medication is not generally "life long" but in most cases it should be taken for at least six months.

- If patient does not respond to an approximate SSRI dose within four to eight weeks, increasing the dose toward maximum is appropriate. If the response is inadequate after another four to six weeks, another SSRI should be tried before other classes of medications are considered.

- Patients should be made aware of possible side effects and the possibility that it may take up to four weeks to experience benefits from the medication.

- A discussion with patients pertaining to expected treatment length (at least six to eight months) and side effects of medication should be routinely conducted. Patients are often better able to adhere to treatment protocols when they are provided with detailed information.

- A follow-up appointment to discuss side effects and review the treatment gains made on the medication should occur typically within two weeks, as this represents a time when side effects may occur before symptom relief, which may, in turn, decrease adherence to the medication.

- ***Psychotherapy***
  - If psychotherapy is desired, patients should be referred for behavioral health services. Services are available at the HIP mental health centers, or by calling the Behavioral Health Service Line for a referral to a network provider **(1-888-447-2526)**.
  - Psychotherapy for OCD typically involves "exposure and response prevention." In this approach, the patient is deliberately and voluntarily "exposed" to triggers of obsessional thoughts (e.g., a patient who obsesses about germs would touch something "dirty") and is taught techniques to manage anxiety while avoiding engaging in compulsions.
- ***Deciding Whether to Treat with Medication, Psychotherapy, or Both***
  - Medication, psychotherapy and combination treatment have all been shown effective. The choice of which treatment to initiate should be based on clinical judgment, patient history and patient/physician preference.
  - It is recommended that medication be a part of the treatment plan in severe cases.
  - If medication alone is the selected mode of treatment and little or no response to the medication is noticed in four to eight weeks, it is recommended that psychotherapy be added to the treatment regimen.

Special Populations

- ***OCD in Children and Adolescents***
  - Physicians are likely to be contacted first when parents notice signs of OCD in their children.
  - In the initial stage of OCD, children/adolescents may try to hide symptoms from their parents.
  - In the next stage, the family usually tries to accommodate or limit the symptoms. When this becomes unbearable, medical help may be sought.
  - A greater likelihood of tic disorders and ADHD appears to be associated with an earlier age of OCD onset.
  - Among those with Tourette's syndrome (TS), at least 50 percent will experience OCD or related symptoms by adulthood.
  - Nearly 60 percent of children and adolescents evaluated for primary OCD were found to have a lifetime history of tics.

- When obtaining a clinical history, be sure to inquire about the following:
  - Personal and family history of OCD, Tourette's syndrome, tics and ADHD.

- It is a good idea to examine the child/adolescent for any skin damage or hair loss from excessive washing, skin picking or hair pulling.

- Acute group A streptococcal infections have been associated with an onset of OCD symptoms in some children/adolescents.

- When interviewing the child, the PCP should avoid the terms "obsessions" and "compulsions" and instead ask the child to describe the "worries" and "urges" in his or her own words.

- Symptoms reported by children are similar to those reported by adults. The most common compulsions are washing, checking, counting, repeating and touching.

- Preschool children insist on sameness, order and symmetry and may be frustrated if things are out of place. Routines, such as those at bedtime, may serve to alleviate anxiety in times of separation, uncertainty or transition. School-age children are fascinated with collections, rules and rituals. They may become enthralled with athletic team statistics or stamp collections. Such fascinations that do not cause distress and can be suppressed do not indicate OCD.

- Children and adolescents with OCD may exhibit tantrums when their routines or compulsions are disrupted.

- The general approach is to maintain drug treatment for children and adolescents for nine to 12 months after symptom resolution before considering discontinuation.

- Medication withdrawal should be gradual – not only to facilitate timely identification of symptomatic relapse, but also for amelioration of withdrawal symptoms.

OCD in the Elderly

- OCD in the elderly often occurs with comorbid conditions such as:
  - Depression.
  - Psychosis.
  - Bipolar disorder.
  - Phobia.

- OCD, like other anxiety disorders, is typically underrecognized and undertreated in the geriatric population.