OCD Treatment

Ratana Saipanish

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โรคย้ำคิดย้ำทำเป็นโรคหนึ่งที่รักษายาก

มีผู้ป่วยเพียงไม่กี่คนที่จะรักษาหายจากอาการทั้งหมด

OCD Treatment

- Pharmacotherapy
- Non-pharmacotherapy

Pharmacotherapy

Drugs	Starting dose	Target dose	Maximum Dose	Higher maximum dose
Clomipramine	25	100-250	250	-
Escitalopram	10	20	40	60
Fluoxetine	20	40-60	80	120
Fluvoxamine	50	200	300	450
Paroxetine	20	40-60	60	100
Sertraline	50	200	200	400

Non-pharmacotherapy

Psychotherapy

- Exposure and Response prevention
- Cognitive Therapy
- Group Therapy
- Other : Yoga, mindfulness

Non-pharmacotherapy

Other Somatic Therapy

- Transcranial Magnetic Stimulation **(TMS)**
- Electroconvulsive Therapy **(ECT)**
- Deep Brain Stimulation **(DBS)**
- Neurosurgical Stereotactic Lesion Procedures

First line treatment for OCD

Serotonin reuptake inhibitors (SRIs)

- Clomipramine
- SSRIs: fluoxetine, fluvoxamine, paroxetine, sertraline, escitalopram

Cognitive behavior therapy (CBT)

- Exposure and response / ritual prevention (EX/RP or ERP)

How to choose treatment modality

ERP alone

- Not too depressed, anxious, severely ill to cooperate
- Prefer not to take medication
- Willing to do the work in ERP

SRI alone

- Not able to cooperate with ERP
- Has previously responded to drugs
- Prefer SRIs alone

APA. Practice Guideline for the Treatment of patients with OCD, 2007

How to choose treatment modality

Combined treatment

- Unsatisfied response to monotherapy
- Severely ill
- Co-morbid conditions for which SRIs are effective
- Pts wish to limit the duration of SRIs

APA. Practice Guideline for the Treatment of patients with OCD, 2007

Response VS Remission

- **No standard criteria for response and remission**
- **No Recovery**
- **Typically chronic, waxing and waning course**

Simpson HB, et al. J Clin Psychiatry 2006;67:269-76

Pharmacotherapy

- Most patients will not experience substantial improvement until **4–6** weeks after starting medication
- Some who will ultimately respond

will experience little improvement for as many as **10–12** weeks.

Pharmacotherapy

- Some clinicians prefer to titrate doses more rapidly (in weekly increments to the maximum recommended dose -- if tolerated), rather than waiting for **1–2** months before each dose increment to evaluate results.

APA. Practice Guideline for the Treatment of patients with OCD, 2007

Pharmacotherapy

"Higher doses of SSRIs
- α improved treatment efficacy
- α significantly higher proportion of dropouts due to side-effects."

MH Bloch, et al. Mol Psychiatry. 2010 August ; 15(8): 850–855.

Outcome of SRIs

Response
- ~ 30% responded to first drug trial

- Minimal symptoms (Remission)
- ???

What to do next?

Response
- Continue
  for 1-2 yr, then consider gradual taper off

Partial response
- Augment with SGA
- Add ERP

Little or no response
- Switch to
  - different SSRI (may try more than one)
  - Clomipramine
  - Venlafaxine
  - Mirtazapine
- Augment with SGA

APA. Practice Guideline for the Treatment of patients with OCD, 2007

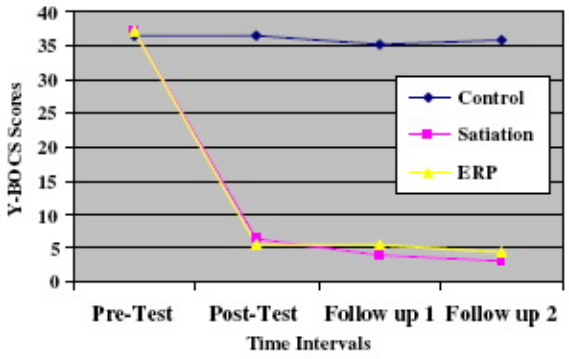
What to do next?

Consider
- Switch to different SRI, different augmenting with SGA
- Augment with Clomipramine, Buspirone, Pindolol, Morphine, Inositol, Glutamate antagonist, MAOI
- CBT (ERP) if not already provided.

- TMS, DBS, ablative neurosurgery

APA. Practice Guideline for the Treatment of patients with OCD, 2007

Outcome of ERP in OCD



Khodarahimi S. J Contemp Psychother 2009; 39: 203-7

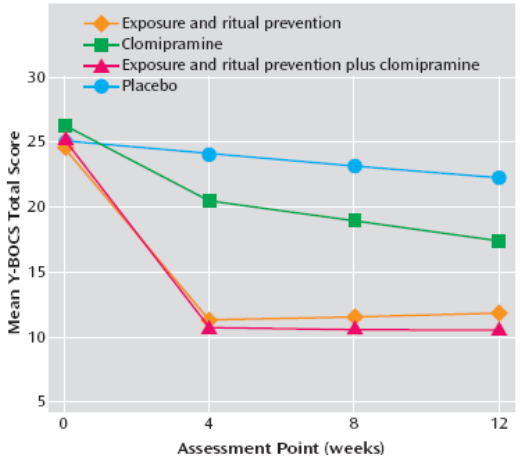
Outcome of ERP in OCD

- ERP > Waiting list
  - Fritzler, Hecker, & Losee, 1997
  - van Balkom et al, 1998
  - McLean et al, 2001
  - Vogel, Stiles, & Gotestam, 2004
  - Khodarahimi, 2009
- ERP > anxiety management Lindsay et al., 1997

  > Progressive Muscle Relaxation
  - Fals-Stewart et al., 1993
  - Marks et al., 2000
  - Greist et al., 2002

  > Stress Management Simpson et al., 2008b

Comparing SRI VS ERP

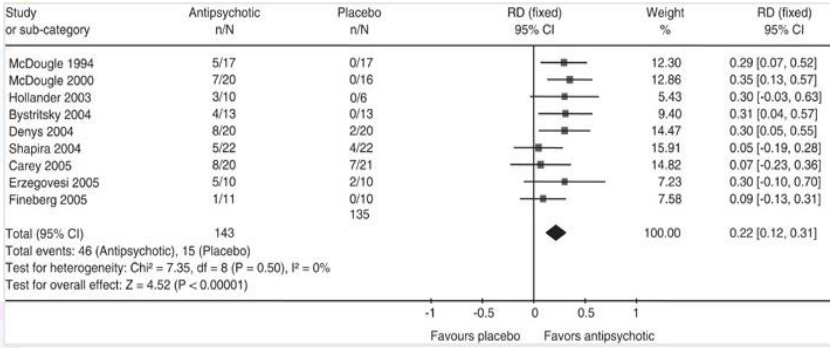


Foa, et al. Am J Psychiatry 2005;162:151-61

Augmentation

Augmentation: Antipsychotics

- Antipsychotics



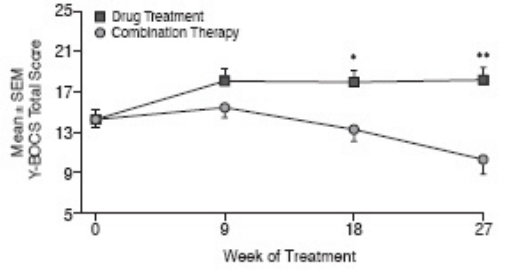
Augmentation: Antipsychotics

- Antipsychotics
  - Meta-analyses estimate that about one-third of patients with OCD receiving SRIs will respond.
  - Among SGA, risperidone appears to have the strongest effects. (3 small studies + 1 meta-analysis)

Int J Neuropsychopharmacol. 2013 Apr;16(3):557-74

Augmentation: ERP

Figure 1. Mean Y-BOCS Scores at Weeks 0, 9, 18, and 27 for Drug Treatment and Combination Therapy



*p < .01 for drug treatment vs. combination therapy.
**p < .001 for drug treatment vs. combination therapy.
Abbreviation: Y-BOCS = Yale-Brown Obsessive Compulsive Scale.

Tenneij et al. J Clin Psychiatry 2005; 66: 1169-75

Augmentation to SRIs

ERP VS antipsychotic

Augmenting SRIs:ERP vs Risperidone

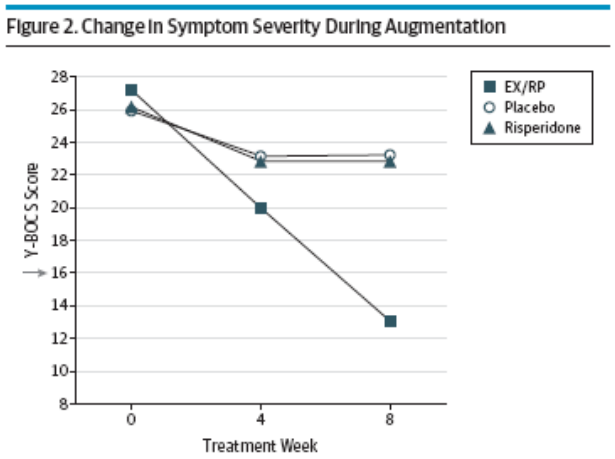
- 100 OCD patients on SRIs > 12 wks
- Moderate severity (YBOCS ≥ 16)

RCT

- ERP=40,Risperidone=40,placebo=40

Simpson, Foa et al. JAMA 2013;70(11):1190-8

Augmenting SRIs:ERP vs Risperidone



Simpson, Foa et al. JAMA 2013;70(11):1190-8

ERP has superior efficacy and less negative adverse effect profile than antipsychotics

Patients' views

- Overestimate the power of medication
- ERP is more difficult and challenging

How could we do ERP?

ERP

- Too aversive
- Pts need
  - Therapeutic relationship
  - sufficient support by therapist
  - Trust and safe environment

Basic principle of ERP

- Pt should fully confront the feared stimulus without engaging in safety behaviors (rituals)
- Pt should stay in the situation until the distress has been reduced by at least half

ERP

- Psycho-education is very important

ERP rationale

- The distress from exposure has a limited lifespan
- Ritual can reduce distress rapidly, but pts will rely on ritual

"The more you use it, the more you need it"

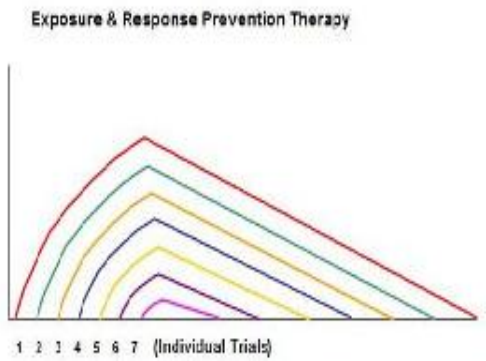
- This diminishes their sense of self-efficacy and self-control

ERP rationale

- Anxiety gradually diminishes
- Sitting with distress
  - may not be pleasant,
  - but can be tolerated,
  - and has many powerful positive outcome

"relaxation is not for OCD"

ERP



Setting up - Hierarchy

- Collaborative process
- Have client's snapshot of a typical day to assist with inventing the items
- This is a team effort

Setting up - Hierarchy

- Often pts will choose
  – most interfering area
- It is also possible to address: trigger

- Agree & start hierarchy construction
- Make sure – small increments on the distress scale

“เข้าใจแล้ว แต่ขอไปทำคราวหน้าได้ไหมหมอ”

SETTING UP - HIERARCHY

“Be Creative”

“Being warm and supportive
VS
Being challenging and directive”

“แล้วถ้ามันกลัวต่อไปเรื่อยๆ
ไม่หยุดซะทีทำอย่างไรล่ะ”

In-session ERP

- The 'discussion' usually acts as a distraction → ERP ineffective
- Pt might talk about their fear → escalate distress
- What should we do then?
  - Ensure pt to be 'present'
  - "How are you feeling right now?"
  - Recording pt's SUS rating - useful

ERP visits

CBT expert

- 13-20 sessions (weekly)
- 3 weeks (daily)

Treatment maintenance

For medication

- Continue for 1-2 yrs, then gradual taper over several months

For ERP

- Provide periodic booster sessions for 3-6 months

Typical error

- Poor hierarchy construction
- Ceasing exposure before habituation has occurred
- Poor explanation of the rationale for ERP
- Combining too many different target areas in one hierarchy

Group Therapy for OCD

Advantage

- Encourage participants to engage in ERP
- Save time & cost
- Reduce sense of being different, defective, and pathological

Thank You