MASSACHUSETTS GENERAL HOSPITAL
PSYCHIATRY ACADEMY

Obsessive-Compulsive Disorder

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Disclosures

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Wellcome Library (1950) Watts-Freeman lobotomy instruments. [Photo] from https://commons.wikimedia.org/wiki/File:Watts-Freeman_lobotomy_instruments._Wellcome_L0026980.jpg

Treatment of OCD

Cognitive behavioral therapy (CBT)

+

Selective serotonin reuptake inhibitors (SSRIs)

Diagnosis

- >2% prevalence, 10th leading cause of disability by WHO
- Takes ~14-17 years to get appropriate treatment because of misdiagnosis
- Early/accurate diagnosis critical:
  - Presence of **obsessions, compulsions, or both**
  - Obsessions: repetitive unwanted intrusive thoughts which cause anxiety or distress
  - Compulsions: repetitive behaviors or mental acts performed to neutralize obsessions or reduce anxiety
  - Obsessions/compulsions **>1h/day or cause distress or impairment**

"Just checking that I've turned off the lights, dear!"

Ruscio. *Molecular Psychiatry* 2010; Murray. *The Global Burden of Disease* 1996; Copyright 2017 by Graham Waters via CartoonStock - www.cartoonstock.com/cartoonview.asp?catref=gwan71

Obsessions

- Contamination
- Symmetry/exactness
- Losing control
  - By acting on unwanted (egodystonic) impulses to harm oneself or others
  - Blurting out insults
- Harm by carelessness (fire, driving)
- Egodystonic sexual thoughts
  - Perverse
  - Orientation
- Religious (scrupulosity)
- Superstitious (color, numbers)
- Fear of losing things
- Many more

Compulsions

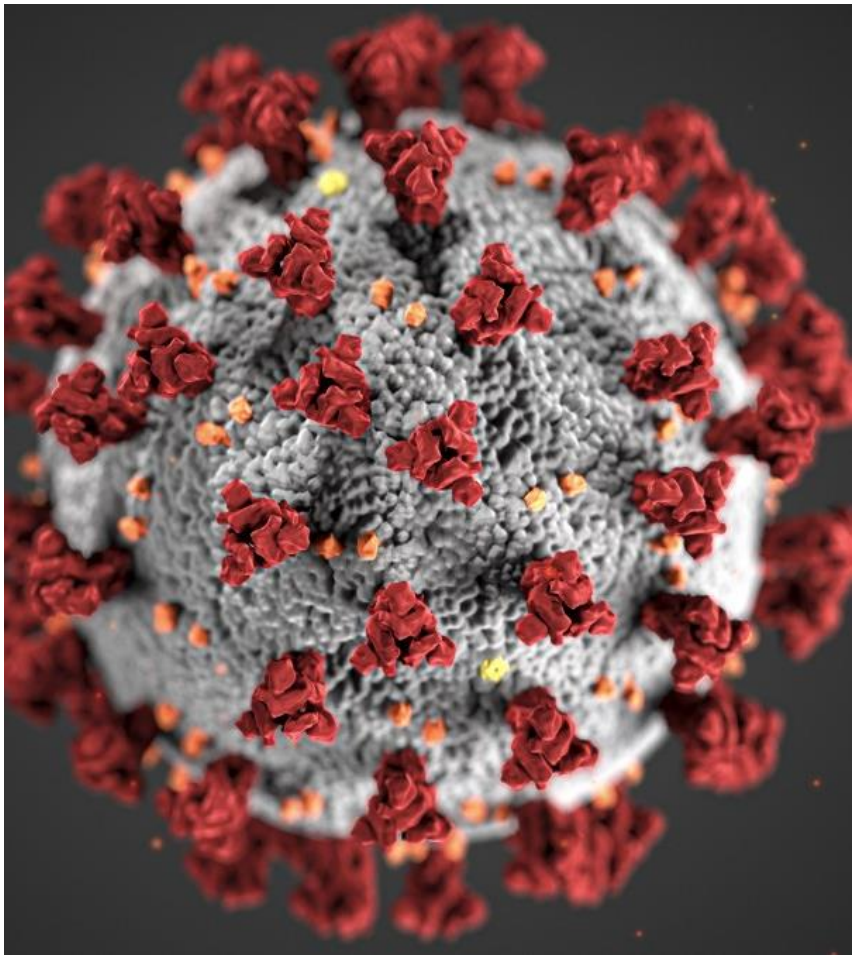
- Cleaning/washing
- Ordering/arranging
- Checking (including seeking reassurance)
- Repeating
  - Rereading, rewriting
  - Activities (going through door)
  - Body movements (touch, tap, rub)
  - Done in multiples or until it “feels right”
- Mental
  - Reviewing, praying, counting, undoing
- Others
  - Urge to confess
  - Excessive list-making
  - Eating rituals
  - Superstitious rituals

Adapted from https://iocdf.org/about-ocd/

Lesser known OCD

- **Suicidal OCD**
  - e.g., egodystonic (unwanted distressing) intrusive thoughts about driving into oncoming traffic
- **Violent OCD**
  - e.g., egodystonic intrusive thoughts about stabbing partner
- **Relationship OCD**
  - e.g., are we compatible, does he love me?
- **Sexual OCD**
  - e.g., egodystonic intrusive thoughts about sexual orientation or perverse content (pedophilia, incest)
- **Postpartum OCD**
  - e.g., fear of harming one's infant by accidentally dropping them or throwing them out a window
- **OCD eating disorders**
  - e.g., restricted eating due to fears of food being contaminated

OCD during the COVID-19 pandemic



- Contamination obsessions, cleaning rituals
- Superstitious obsessions (action will lead to loved one getting COVID-19), neutralizing rituals
- Compulsive checking on friends/family to verify good health
- Excessive researching of COVID-19

Therapy or meds?

Cognitive behavioral therapy (CBT) should be a top priority for OCD

- CBT alone has a very **large effect size** (1.39)
- CBT **improves long-term outcomes when added to SSRIs**, may reduce SSRI dosing needs, and can prevent future OCD relapses

CBT alone

- Mild impairment
- Pt refuses meds

CBT + SSRI

- Moderate/severe impairment
- When pt is too distressed to engage in CBT
- Pt has other major psychiatric comorbidities such as MDD/GAD

SSRI alone

- No access to CBT
- History of failed CBT
- Pt declines CBT

Olatunji. *Psychiatr Res.* 2013

SSRI trial in OCD- many differences

- **High doses** (max or >max) often required
- **Response delayed** (4-6 wks for initial effect, 10-12 wks for full effect)
- **Trial length: 12 wks** (4-6 wks at the maximum tolerable dose)
- **Rapid titration** recommended
- Duration of treatment
  - **1-2 years** recommended
  - Consider dose reduction after 1-2 years if mostly asymptomatic
  - When ready to taper, **taper no more than 10%–25% q1–2mo** to prevent relapse
  - Relapse risk lessened with CBT

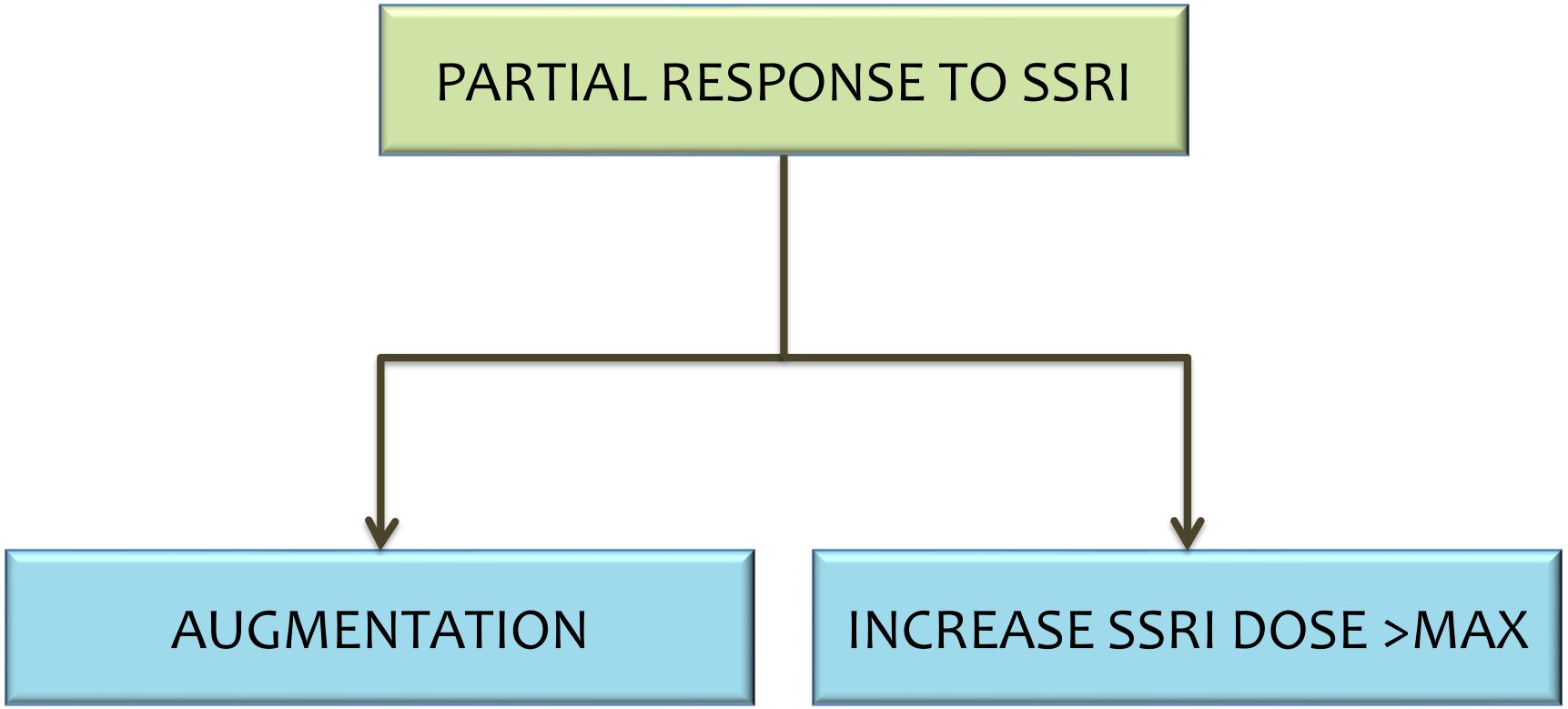
Reviewed in Koran. *Am J Psychiatry.* 2007

Which SSRI for OCD?

Drug Name	Target Dose	Advantages	Disadvantages
Escitalopram	20 mg/d	**well-tolerated**	
Sertraline	200 mg/d	**well-tolerated**	
Fluoxetine	80 mg/d	**well-tolerated, long half-life, activating**	drug interactions
Citalopram	40 mg/d	well-tolerated	potential ⇧QTc, reduced **max dose may not be sufficient in OCD**
Paroxetine	60 mg/d		**sedation, weight gain, short half-life**
Fluvoxamine	300 mg/d		**sedation, weight gain**

SSRIs thought to be equally effective but due to **high dose** requirements, SSRIs with **lower side effect profiles typically trialed first**

Improving a partial SSRI response



SSRI augmenting agents in OCD

- **Risperidone (~1-2 mg/d)**
  - 3 positive RCTs and meta-analyses, **most often used augmenting agent**
  - Start 0.5-1 mg PO QHS
  - Other antipsychotics like aripiprazole and haloperidone used but less well-studied
    - **Aripiprazole,** 2 positive RCTs, least risk of metabolic syndrome, ~10-15 mg/d
    - Haloperidone, 2 positive RCTs, useful in pts with tics, ~2-6 mg/d (beware of tardive dyskinesia)
  - Quetiapine and olanzapine ineffective in multiple studies so not routinely used

- **Memantine (10mg PO BID)**
  - 2 positive RCTs; Start **5 mg PO QHS x7d, then 5 mg PO BID x7d, then 10 mg PO BID,** >6wk trial

- **Clomipramine**
  - Several positive open-label studies and 1 positive RCT, ~55-150 mg/d (typically 50-75 mg)
  - SSRIs can unpredictably increase clomipramine levels, start low dose (25 mg PO QHS) and monitor QTc before and QTc/clomipramine level while titrating

- Additional agents: N-acetylcysteine, lamotrigine, topiramate

Reviewed in Arumugham. *Expert Rev Neurother.* 2013; Veale. *BMC Psychiatry.* 2014; Bloch. *Mol Psychiatry.* 2006; Dold. *Int J Neuropsychopharmacol.* 2013; Stewart. *J Clin Psychopharmacol. 2010*; Ghaleiha. *J Psychiatr Res.* 2013; Haghighi. *Psychopharmacology* 2013, Pallanti. *Eur Psychiatry* 1999; Ravizza. *Psychopharmacol Bull.* 1996; Diniz. *J Clin Psychopharmacol* 2011; Bruno. *J Psychopharmacol. 2012;* Mowla. *CNS Spectr.* 2012; Afshar. *J Clin Psychopharmacol.* 2012; Paydary. *J Clin Pharm Ther.* 2016

Benzodiazepines in OCD

- **Benzodiazepines not proven** to be helpful for OCD
  - Clonazepam ineffective in 2 RCTs
  - Blunt gains from CBT
  - Sometimes used when comorbid GAD or panic disorder present

- **Gabapentin**, 900 mg TDD, **accelerates response to SSRI** in open-label study

Onder. *Eur Arch Psychiatry Clin Neurosci.* 2008; Hollander. *World J Biol Psychiatry.* 2003; Crockett. *Ann Clin Psychiatry*. 2004

Above max SSRI dosing in OCD

SSRI

Drug	FDA Max Dose	Published OCD >max dosing	My >max dosing	Notes
Escitalopram	20 mg/d	Up to 60 mg/d	30 mg/d	check EKG
Sertraline	200 mg/d	Up to 400 mg/d	300mg/d	
Fluoxetine	80 mg/d	Up to 120 mg/d	120 mg/d	
Paroxetine	60 mg/d	Up to 100 mg/d	80 mg/d	
Fluvoxamine	300 mg/d	Up to 400 mg/d		
Citalopram	40 mg/d	Up to 120 mg/d	60 mg/d	**high dosing controversial** given QTc prolongation risk, I consider only with EKG monitoring, pt consent, and h/o failed medication trials
Clomipramine	250 mg/d			Above max dosing not recommended due to seizure risk

No guidelines on above maximum dosing in OCD exist – doses circled are generally well-tolerated in my practice

Koran. *Am J Psychiatry*. 2007; Ninan. *J Clin Psychiatry*. 2006; Dougherty. *Int Clin Psychopharmacol*. 2009

Limited alternative to SSRIs in OCD

- **Clomipramine,** 4 beneficial RCTs, very effective but second-line due to AEs

- SNRIs
  - **Venlafaxine**
    - Limited RCTs but appears to effectively treat OCD, larger placebo-controlled RCTs needed
    - Beneficial in 3 open-label studies
    - Venlafaxine ~265mg/d as effective as clomipramine in comparator RCT, no placebo
    - Venlafaxine ~300mg/d as effective as paxil in comparator RCT, no placebo
    - No sig effect in 1 small placebo-controlled RCT but trial too short (8 wks)

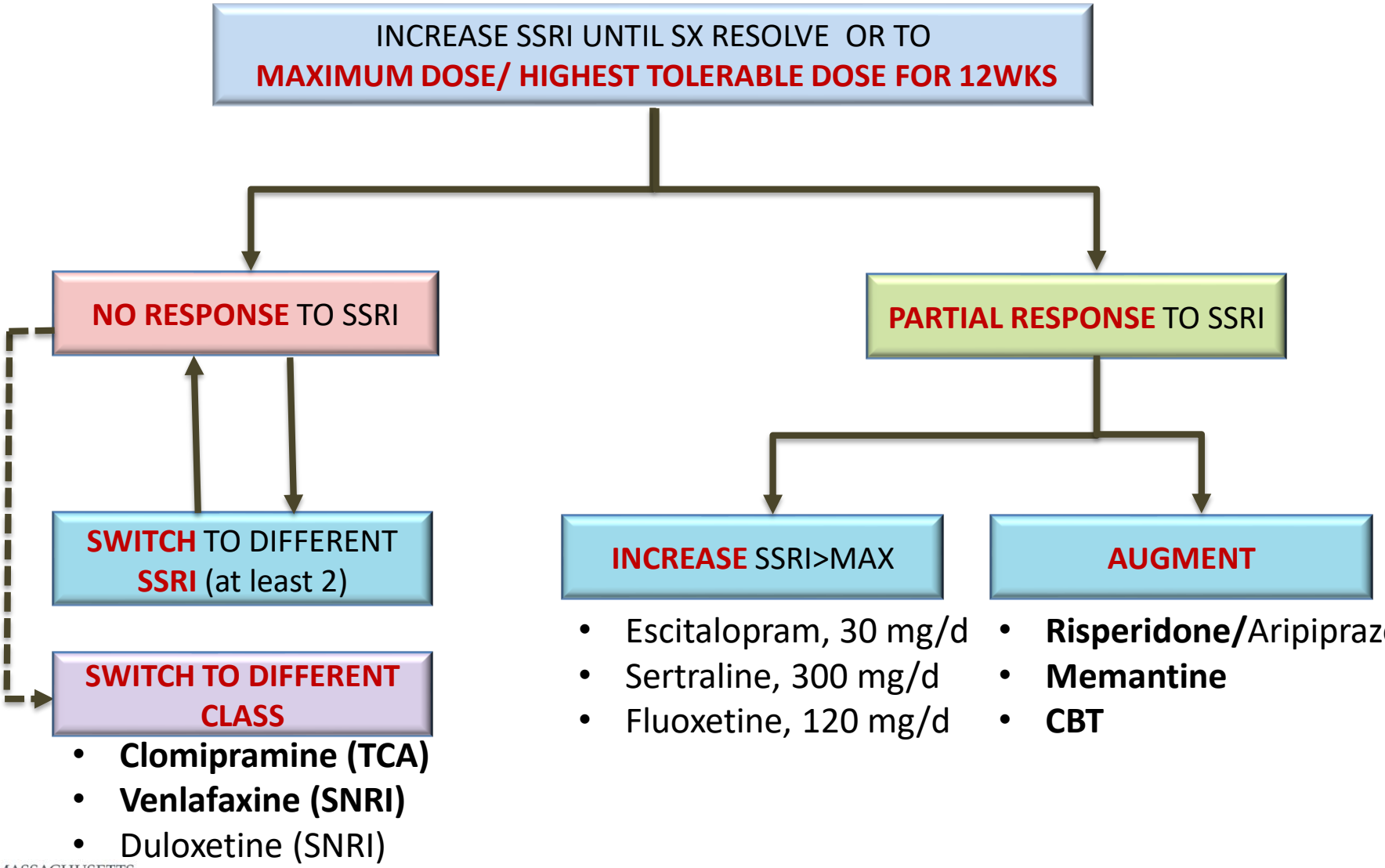
  - **Duloxetine**
    - Limited studies (no RCTs), but mostly positive, RCTs needed
    - Beneficial in case series in 3/4 patients, ~120mg/d
    - Beneficial in single open-label study ~120mg/day
    - Option for pts with pain

- **Buspirone**, 60 mg TDD, 1/3 positive RCTs

- **Mirtazapine,** 30-60 mg PO QHS, positive open-label study

Rauch. *J Clin Psychopharmacol.* 1996; Sevincok. *Aust N Z J Psychiatry.* 2002; Hollander. *J Clin Psychiatry.* 2003; Albert. *J Clin Psychiatry.* 2002; Denys. *J Clin Psychopharmacol.* 2003; Yaryura-Tobias. *Arch Gen Psychiatry.* 1996; Dell'osso. *J Psychopharmacol.* 2008; Dougherty. *Int J Neuropsychopharmacol.* 2015; Koran. *J Clin Psychiatry.* 2005; Grady. *Am J Psychiatry. 1993*

Suggested medication approach to OCD



For the reluctant patient…

- Patience (may take years)
- Propose **microdoses**
- Address w/ therapy
- **Pharmacogenomic testing** (e.g., Genesight)

Managing severe OCD

- Triple threat: **SSRI** + **memantine** + **antipsychotic** (e.g., risperidone)
- **CBT** (again but different)
- **Residential treatment**
  - **McLean OCDI Institute,** www.mcleanhospital.org/programs/ocd-institute-ocdi
  - **Rogers OCD Center,** rogersbh.org/what-we-treat/ocd-anxiety/ocd-and-anxiety-residential-services
  - **Houston OCD Program**, houstonocdprogram.org/residential-support-program/
  - Many others…
- **Transcranial magnetic stimulation (TMS)**
- **Psychosurgery** (cingulotomy, capsulotomy, DBS)

Resources for OCD

- ***Imp of the Mind*** *by Lee Baer* (comprehensive overview for pts, families, and clinicians)

- ***APA Practice Guideline for the Treatment Of Patients With Obsessive-compulsive Disorder*** by Lorrin Koran et al.

- **Finding specialists: International OCD Foundation**, www.iocdf.org

- **NOCD** mobile app (phone-based CBT with live coaching, cost covered by some insurances)