OCD Service: Back to Clinical Practice

August 7, 2015


FromResearch to
ClinicalPractice

Attitudes of Psychiatrists toward OCD patients

Pichaya Kusalaruk, Ratana Saipanish, Thanita Hiranyatheb

"You can live a perfectly normal life if you accept the fact that your life will never be perfectly normal."

First line treatment for OCD

Selective serotonin reuptake inhibitors (SSRIs)

Cognitive behavior therapy (CBT)

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

Cognitive Behavioral Therapy for OCD

Outline

- Concept of CBT
- Assessment for OCD
- Case conceptualization
- How does CBT tackle OCD?
- Let’s bring it to our practice!!

Concept of CBT

Assessment for OCD

Assessment for OCD

- Fear profiles
- Avoidance profiles
- Ritual profiles
- Reassurance seeking behaviors
- Involving others
- Stressors
- Past treatment

Measures

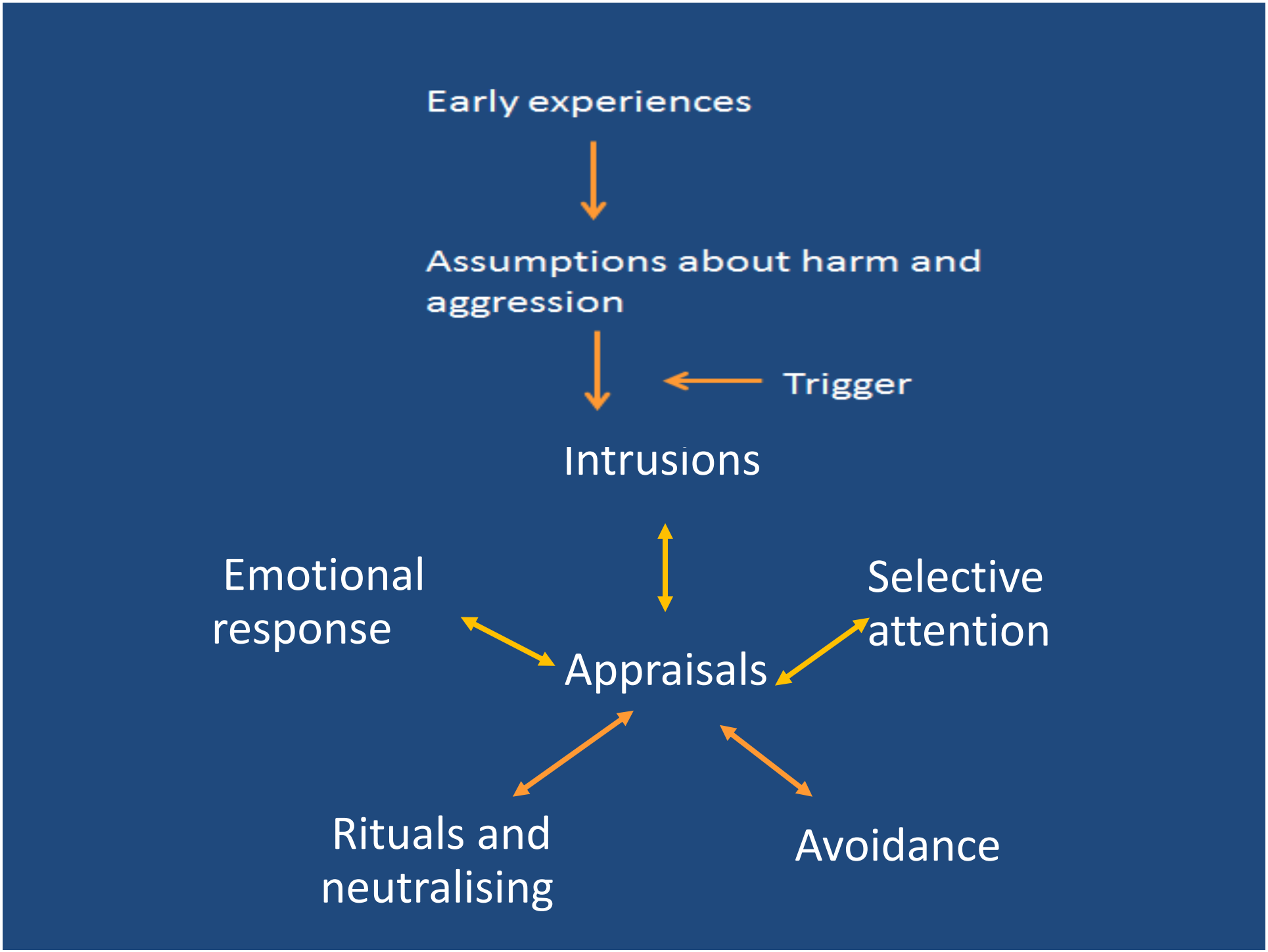
- Yale–Brown Obsessive Compulsive Scale (Y-BOCS)

- Yale–Brown Obsessive Compulsive Scale – Second Edition (Y-BOCS-II)

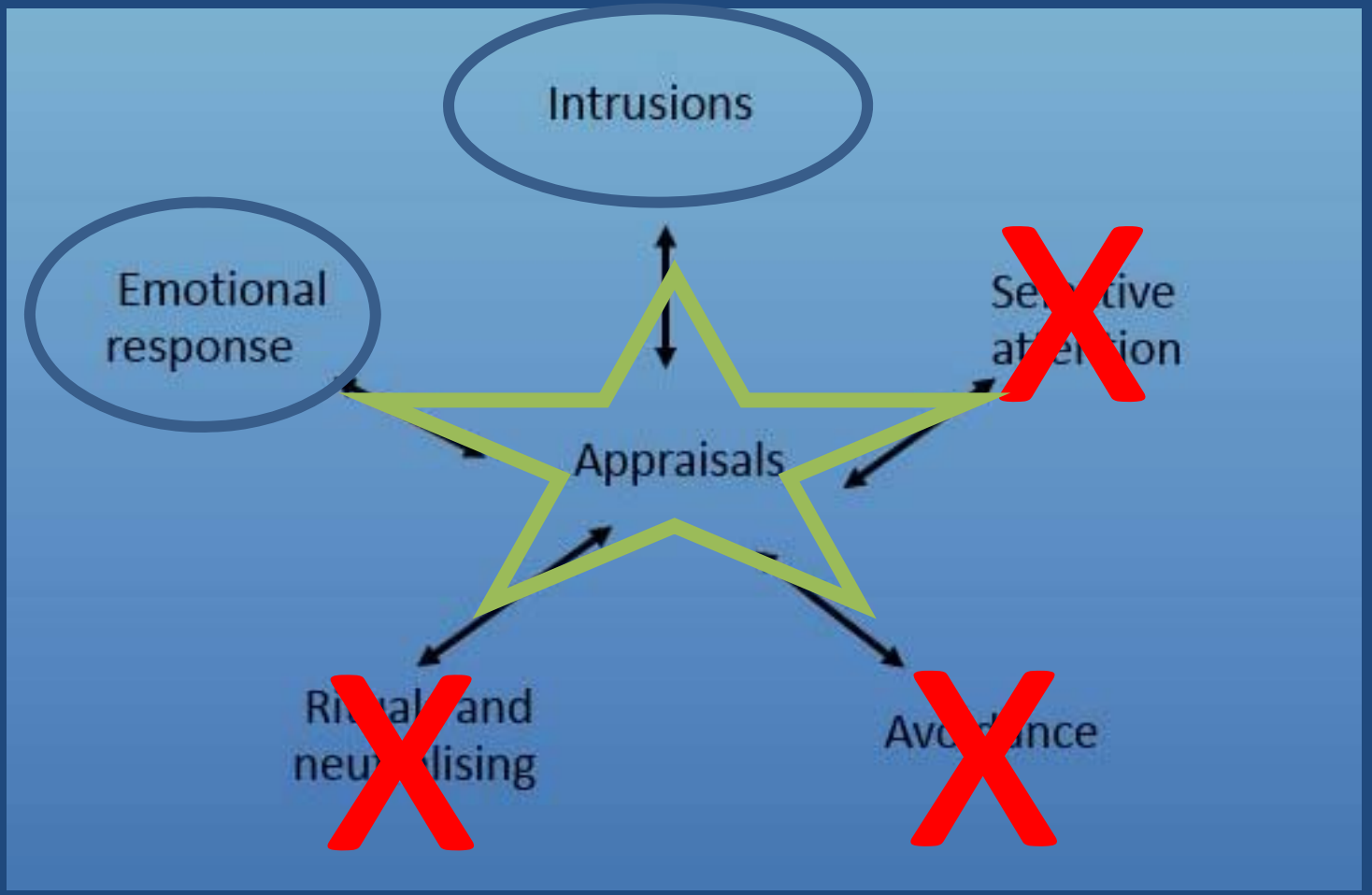
Florida Obsessive-Compulsive Inventory (FOCI)

	severity scale	symptom checklist
Thai version of the Yale–Brown Obsessive Compulsive Scale – Second Edition (Y-BOCS-II-T)	10	67
Thai self-report version of the Yale–Brown Obsessive-Compulsive Scale-Second Edition (Y-BOCS-II-SR-T)	10	67
Thai version of the Florida Obsessive-Compulsive Inventory (FOCI-T)	5	20

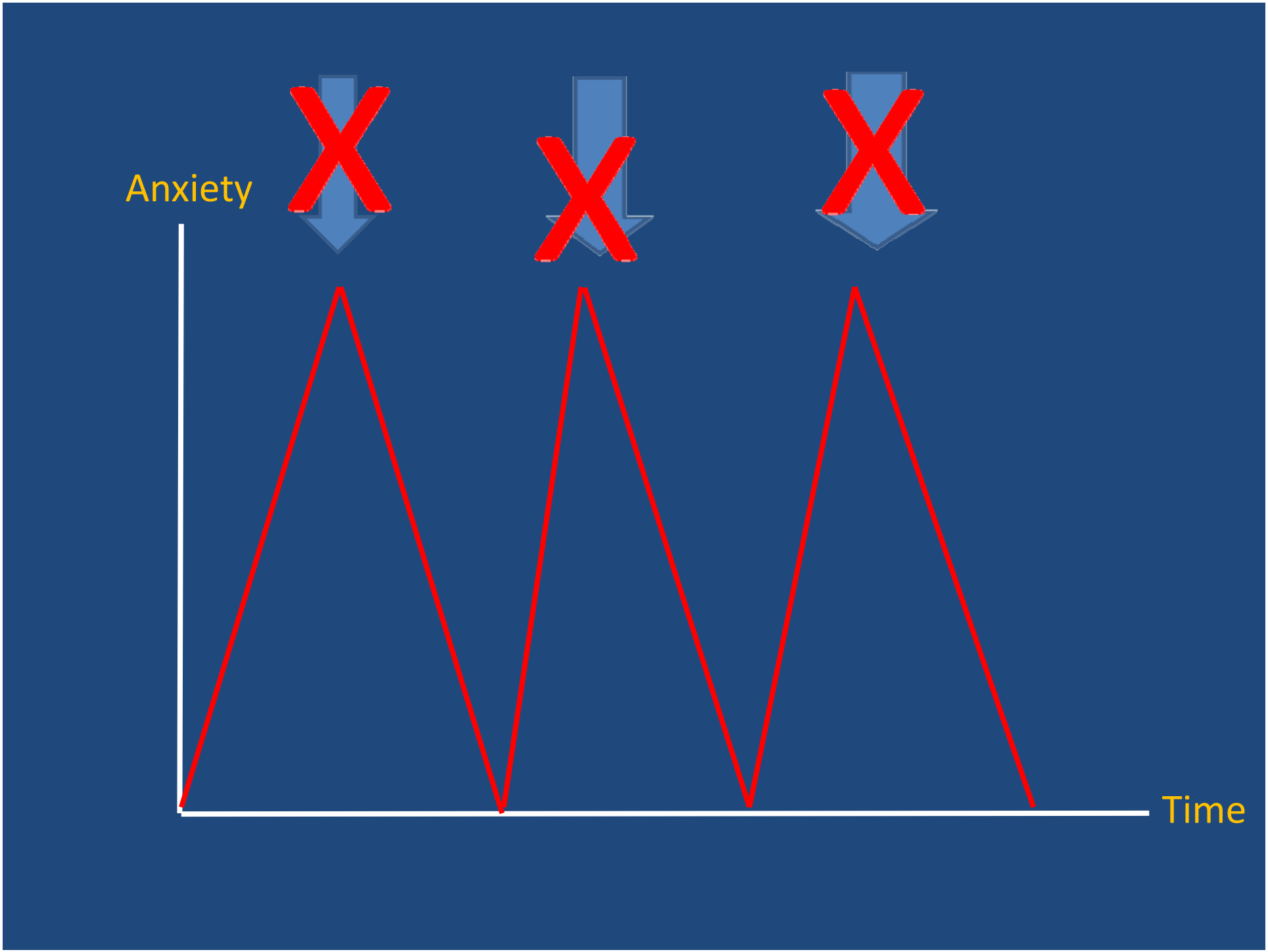
Case conceptualization

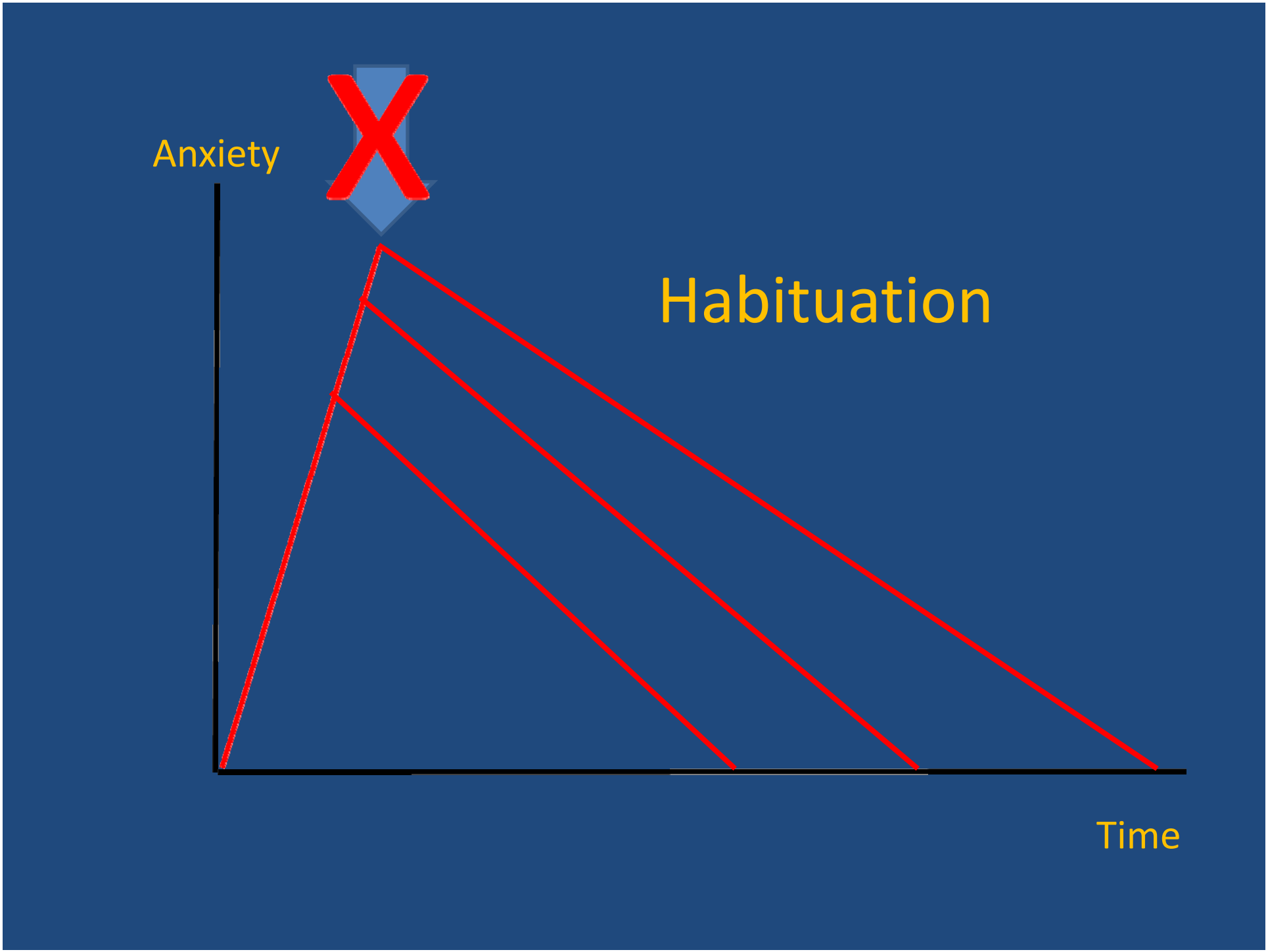

Early experiences
Assumptions about harm and aggression
Trigger
Intrusions
Emotional response
Selective attention
Appraisals
Rituals and neutralising
Avoidance

How does CBT tackle OCD?


Intrusions
Emotional response
Appraisals

Exposure and response prevention (ERP)


Anxiety
Time


Anxiety
X
Habituation
Time

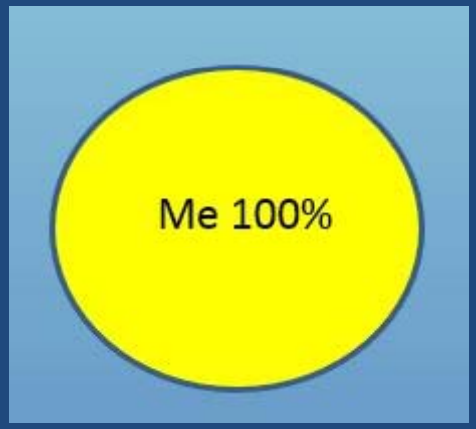
Let try some experiments!!

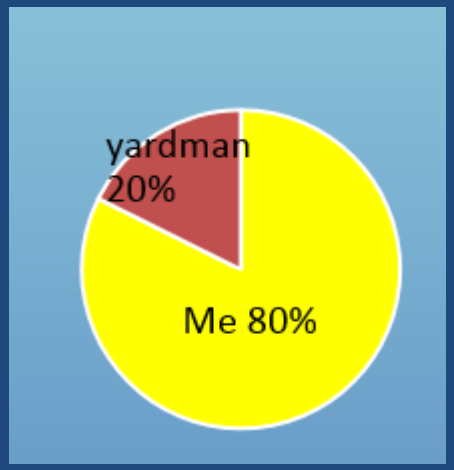
Cognitive restructuring

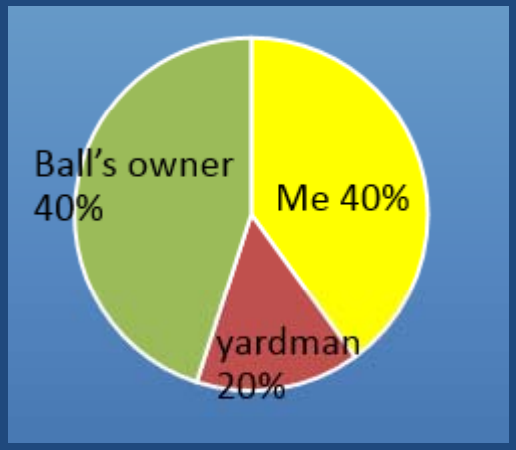
"Dysfunctional beliefs promote problematic behaviors"

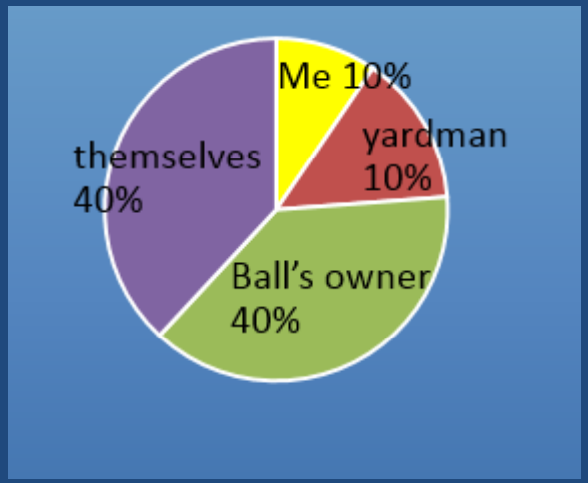
- Inflated responsibility
- Thought-action fusion
- Overestimate of threat
- Intolerance of uncertainty

Responsibility Pie chart









Socratic questioning

- Evidences support/against your beliefs?
- Another explanations of the situation?
- Effect of thinking or believing this?
- Effect of thinking differently?
- Third-person perspective?

Metaphor


PROTECT YOUR MOST
VALUABLE ASSET

Let’s bring it to our practice!!

1. Finding information & Get in Rx

- Assessment
- Case conceptualization
- Empathy, validation
- Psychoeducation & Socializing CBT

2.Exposure/Behavioral experiment

“Tackle OCD behaviors”

In-session exposure

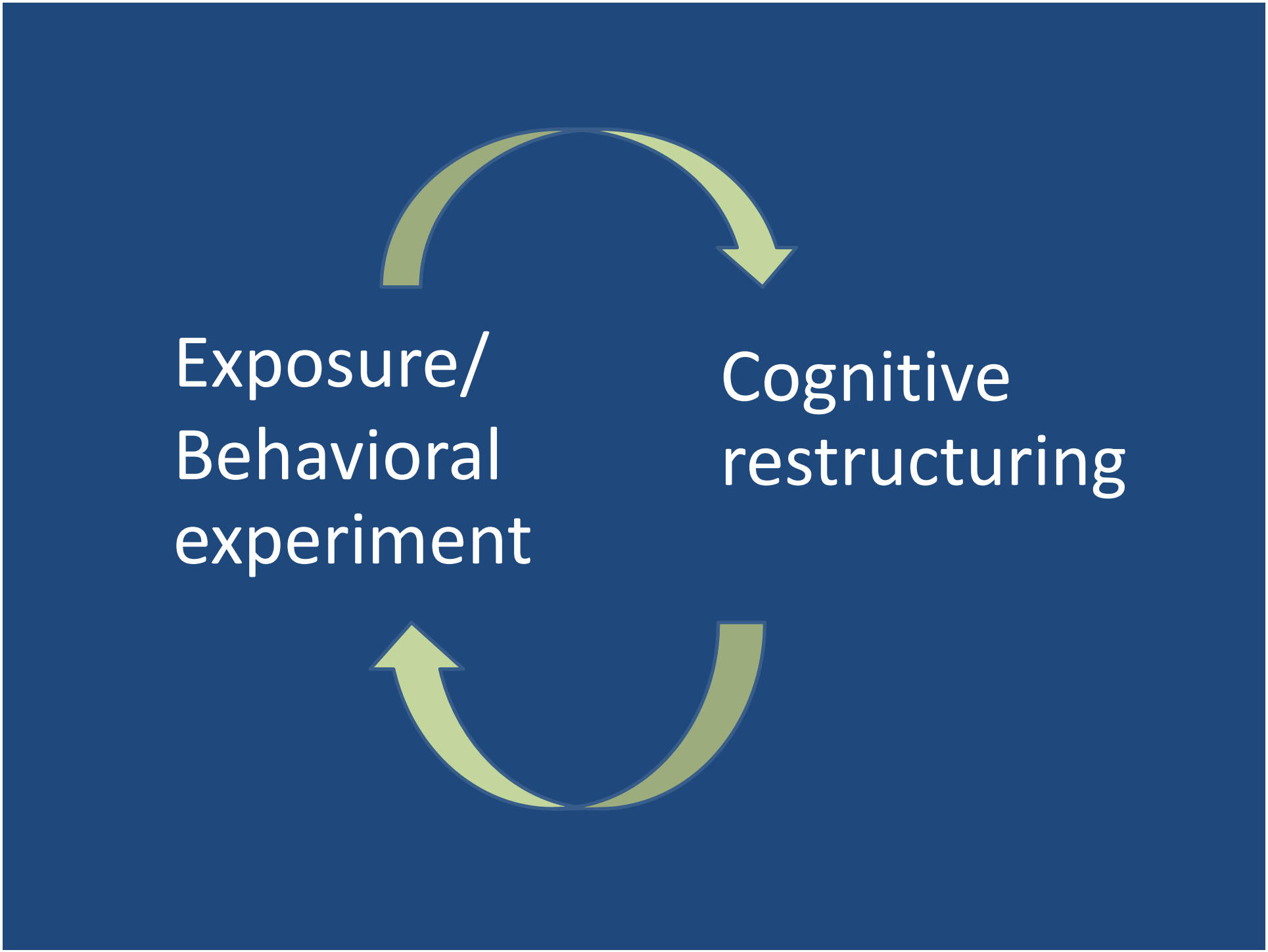
Events	Subjective unit of distress (SUDs)
Touching public bin	100
Using public toilet	80
Touching car	60
Cleaning table	40

- Rating scale of anxiety (0-10)
- Listing “avoidance situation”
- Stop avoidance
- Rate your anxiety level again!!
- Reflection

3. Cognitive restructuring

“Tackle OCD thoughts”

- Externalizing OCD : Naming OCD
- Pie chart, socratic questions, metaphor


Exposure/
Behavioral
experiment
Cognitive
restructuring

4. Feedback and Homework

- What you have learnt?
- What are useful/useless things?
- Homework

Conclusion


Assessment
ERP
Cognitive
restructuring
Feedback&
homework


ANY
QUESTIONS
?

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

Which SSRI do you usually prescribe for your OCD patients?

- Fluoxetine
- Fluvoxamine
- Paroxetine
- Sertraline
- Escitalopram

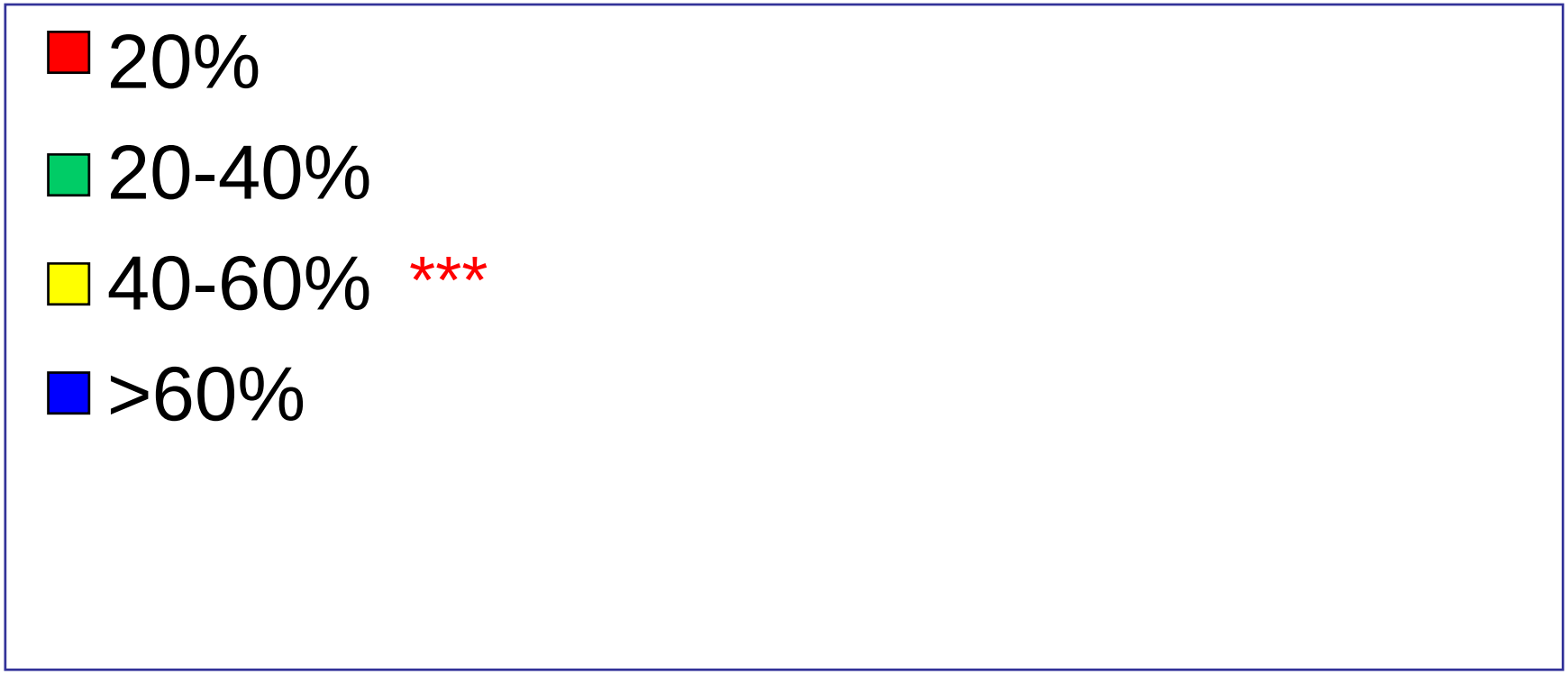
Pharmacotherapy

Drugs	Starting dose	Usual target dose	Usual maximum Dose	Occasionally 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

After starting medication, most OCD patients will experience improvement around….

- 4-6 weeks
- 6-10 weeks
- 10-12 weeks
- >12 weeks

How many of OCD patients do not response satisfactorily to SRIs monotherapy?



*** Pallanti and Qurecioli Prog Neuropsychopharmacol Bio Psychiatry 2006: 30; 400-12

Which drug do you use for augmentaion?

- Haloperidol
- Risperidone
- Olanzapine
- Quetiapine
- Aripipazole

Augmentation: Antipsychotics

- Antipsychotics
  - Risperidone appears to have the strongest effects.

    Dold M et al. Int J Neuropsychopharmacol. 2013; 16(3): 557-74

  - Aripiprazole, haloperidol, risperidone significantly outperformed placebo.

    Dold M et al. Int J Neuropsychopharmacol. 2015; 18(9): 1-11

Successful medication should be continue for….. ?

- 6 months
- 1 year
- 2 years
- 5 years

Successful medication treatment should be continued for 1–2 years before considering a gradual taper by decrements of 10%–25% every 1–2 months while observing for symptom return or exacerbation

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

Outcome of SRIs

	Number of favorable studies	Number of unfavorable studies	Comments
SSRIs			
Fluvoxamine	11 RCTs [30-33,124-130]	–	First-line treatment
Fluoxetine	4 RCTs [34,35,119,131]	–	First-line treatment
Sertraline	4 RCTs [36,37,132,133]	1 RCT [38]	First-line treatment
Paroxetine	4 RCTs [39-41,134]	–	First-line treatment
Citalopram	1 RCT [42]	–	First-line treatment
Escitalopram	1 RCT [43]	–	First-line treatment
Zimelidine	1 RCT [135]	–	Not recommended
SNRIs			
Venlafaxine	2 RCTs [134,136,137]	1 RCT [37]	Potential first-line treatment
PO clomipramine	21 RCTs [39,119,126-129,131,133, 136,138-148]	–	Second-line treatment due to side effects
IV clomipramine	1 RCT [55]	–	Third-line treatment, not recommended for drug-free patients

Fontenelle et al. Expert Opin. Pharmacother. 2007;8 (5):563-83.

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?

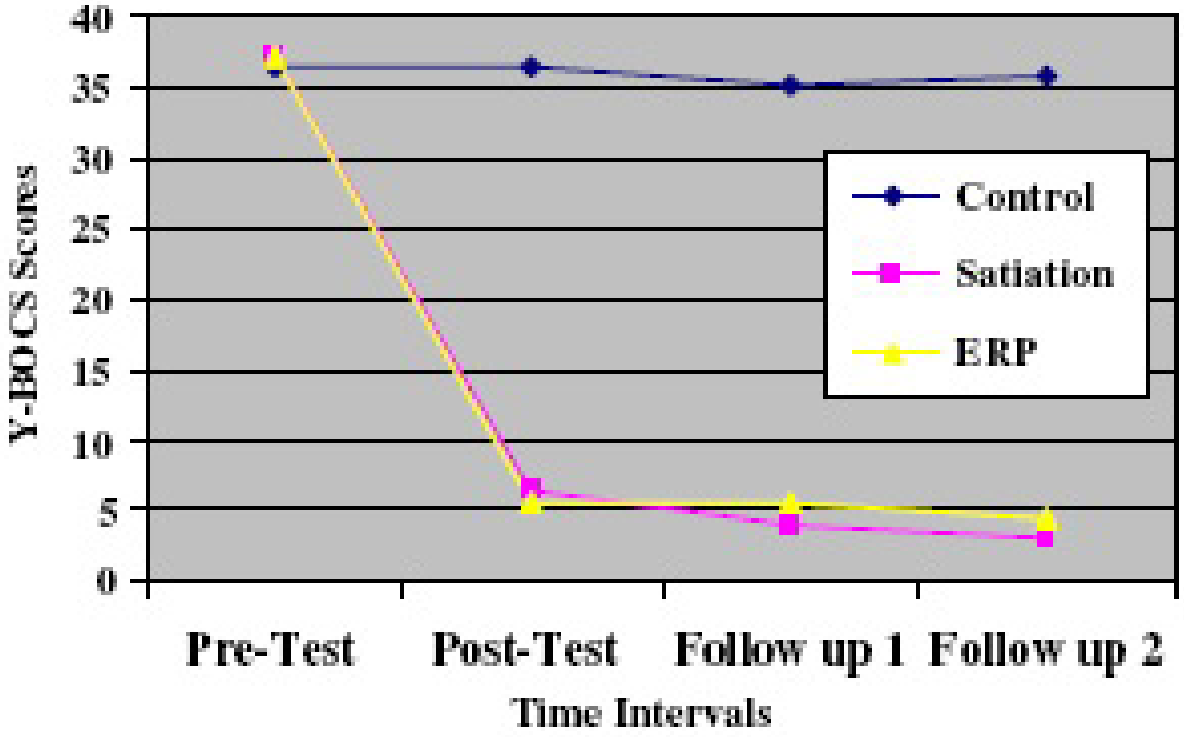
Consider

- 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

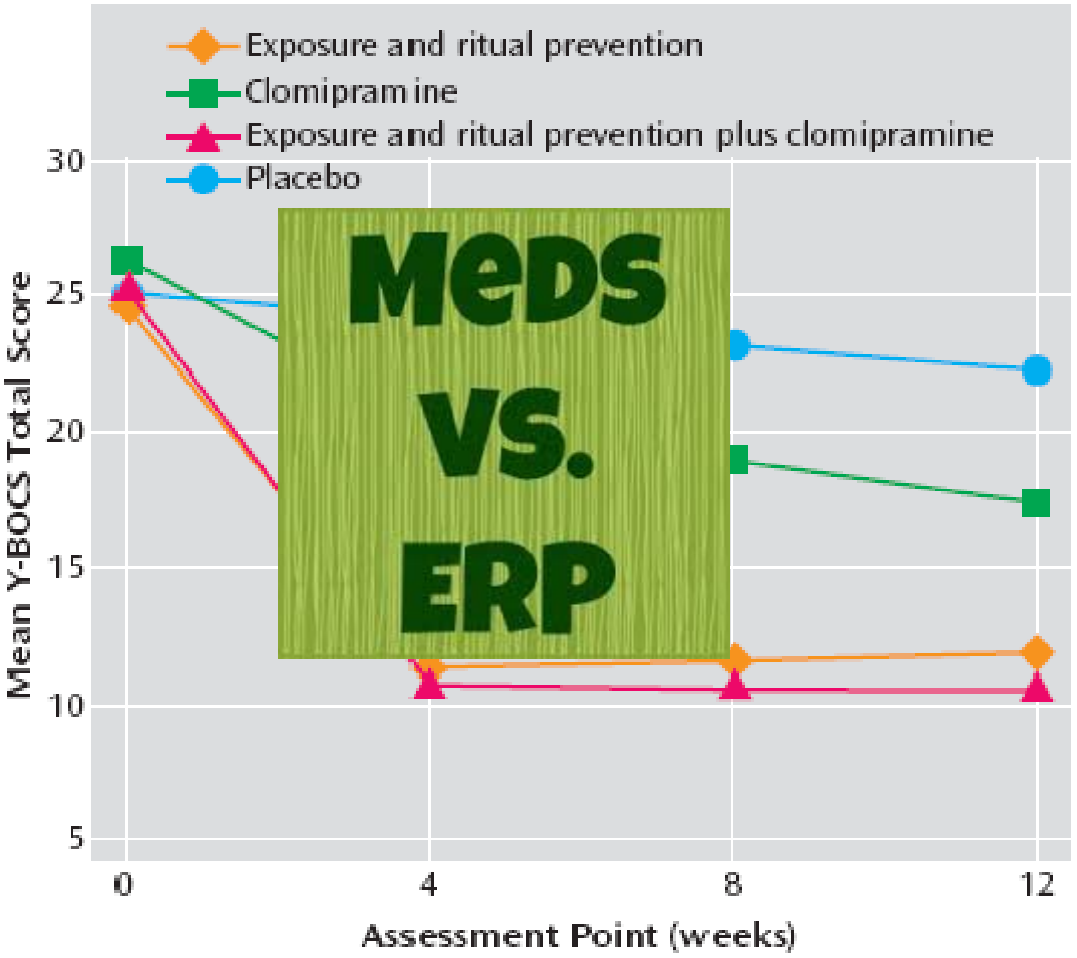
Outcome of ERP in OCD

- Half of all treated patients show clinically significant change with ERP

- Fewer still show full remission

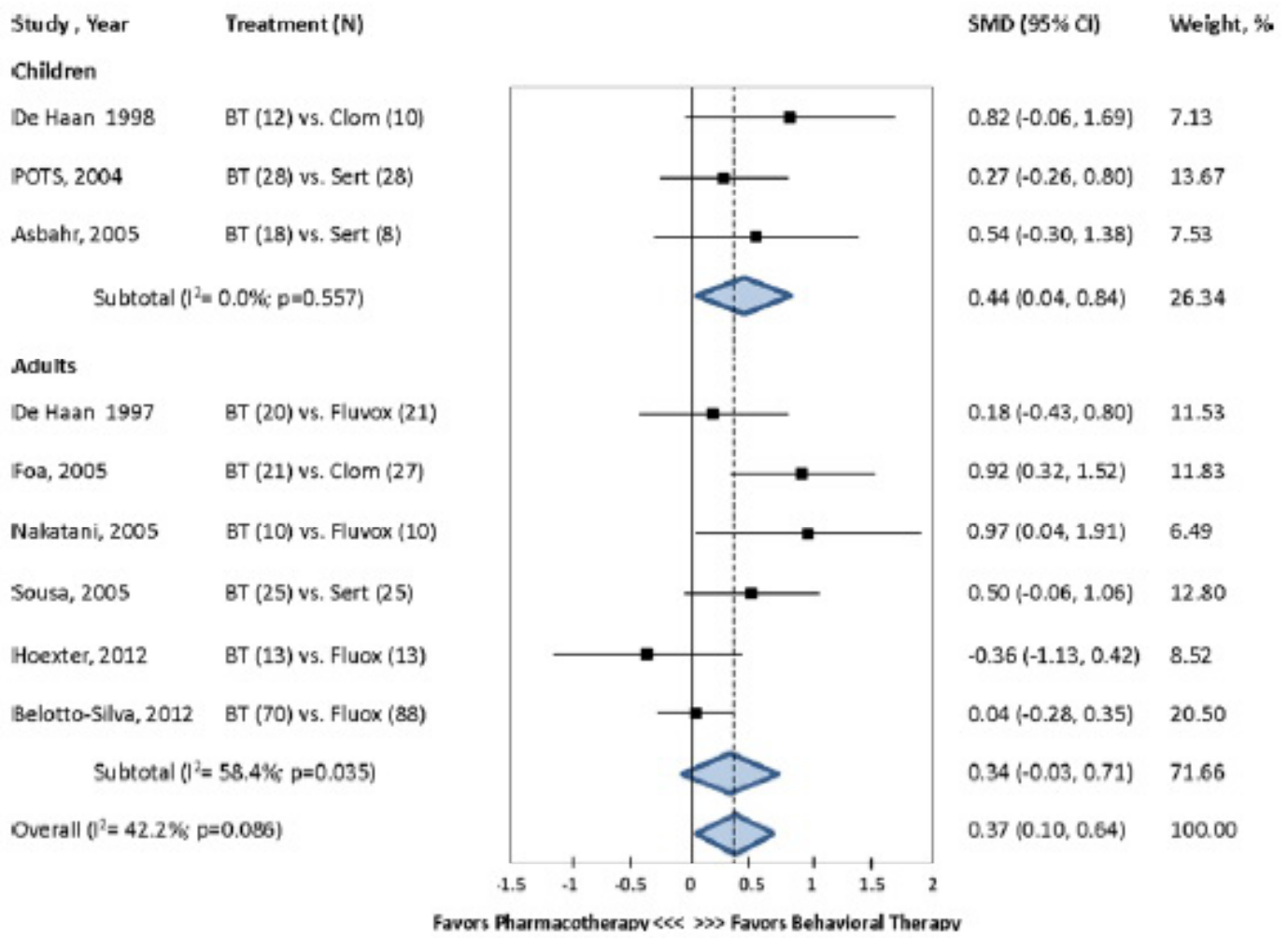
Ponniah et al. JOCRD (2013) 207–218

Comparing SRI VS ERP



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

Comparing SRI VS ERP

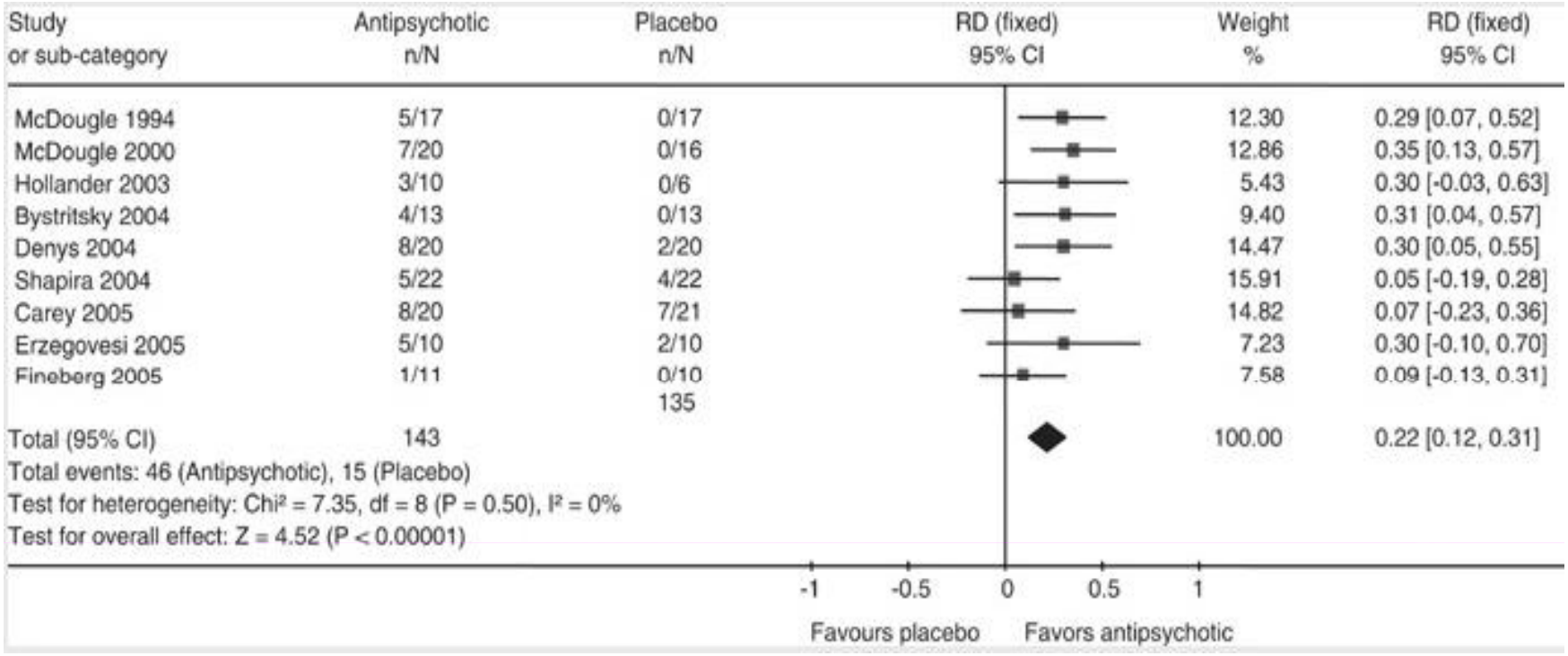


Romanelli et al. Depression & Anxiety 2014;1-12

Augmentation

Augmentation: Antipsychotics

- Antipsychotics

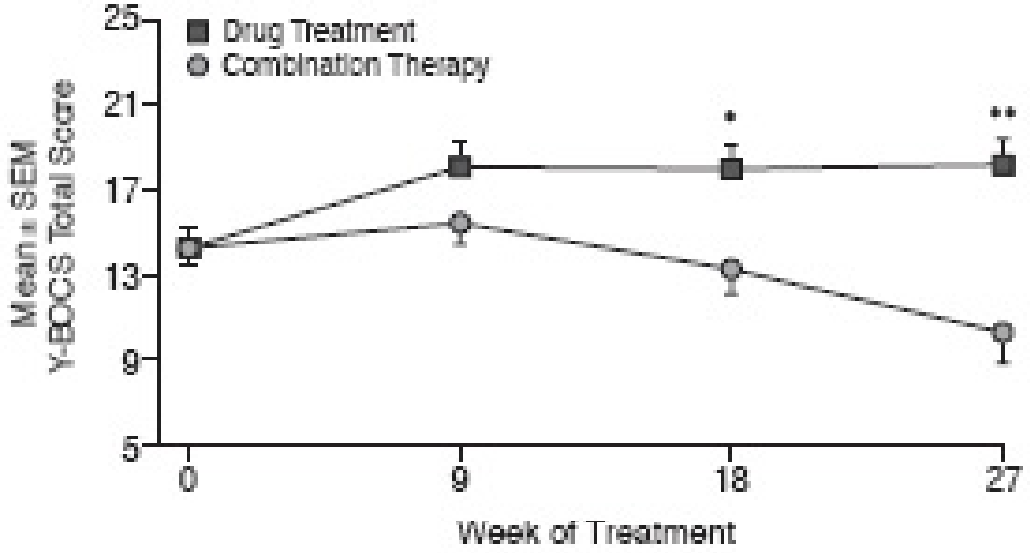


Study or sub-category	Antipsychotic n/N	Placebo n/N	RD (fixed) 95% CI	Weight %	RD (fixed) 95% CI
McDougle 1994	5/17	0/17		12.30	0.29 [0.07, 0.52]
McDougle 2000	7/20	0/16		12.86	0.35 [0.13, 0.57]
Hollander 2003	3/10	0/6		5.43	0.30 [-0.03, 0.63]
Bystritsky 2004	4/13	0/13		9.40	0.31 [0.04, 0.57]
Denys 2004	8/20	2/20		14.47	0.30 [0.05, 0.55]
Shapira 2004	5/22	4/22		15.91	0.05 [-0.19, 0.28]
Carey 2005	8/20	7/21		14.82	0.07 [-0.23, 0.36]
Erzegovesi 2005	5/10	2/10		7.23	0.30 [-0.10, 0.70]
Fineberg 2005	1/11	0/10		7.58	0.09 [-0.13, 0.31]
		135			
Total (95% CI)	143			100.00	0.22 [0.12, 0.31]
Total events: 46 (Antipsychotic), 15 (Placebo)					
Test for heterogeneity: $Chi^2 = 7.35$, df = 8 (P = 0.50), $I^2 = 0\%$					
Test for overall effect: Z = 4.52 (P < 0.00001)					

Bloch et al. *Mol Psychiatry*. 2006;11(7):622-632.

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 $\geq$ 16)

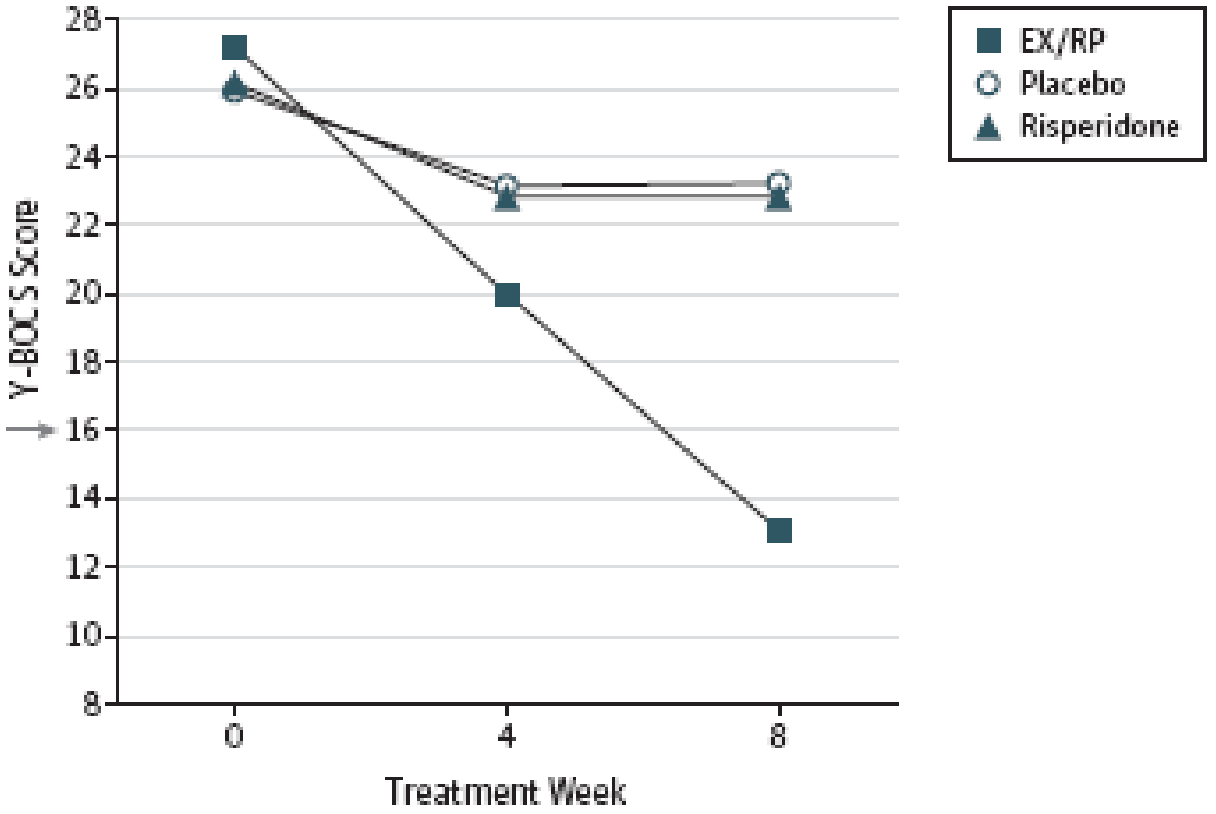
RCT

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

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

Augmenting SRIs:ERP vs Risperidone

Figure 2. Change in Symptom Severity During Augmentation



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

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