Collaborative Care: Obsessive Compulsive Disorder Treatment

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International OCD Foundation
<table>
<thead>
<tr>
<th>Understand</th>
<th>Learn about clinical features of OCD</th>
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<tbody>
<tr>
<td>Describe</td>
<td>Describe treatments for OCD</td>
</tr>
<tr>
<td>How primary care clinicians can play a role in helping individuals with OCD</td>
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</table>
Collaborative care: OCD in primary care
OCD in primary care

- Primary care is the gateway for help seeking for mental health conditions
- OCD is underdiagnosed or misdiagnosed

Glazier et al., 2015
Collaborative Care

- Evidence Based
  - Patient outcomes are guided by evidence-based treatments and adjusted as needed

- Team-Driven, Patient-Centered
  - Team can include client, PCP, nurses, care managers, psychiatric consultant, support staff - all ideally located under one roof
  - Allows for better communication between providers, and shared care plans

- Population Based
  - Patients are tracked in a shared registry
  - Care management

- Measurement Guided
  - Patient outcomes are monitored via shared care plans
  - Improves clinical decision-making

Nguyen, A. 2017
Patient-Centered Integrated Behavioral Health Care Principles & Tasks Checklist. 2014
Sanchez, K. 2017
Collaborative Care Team

- Primary Care Provider
- Behavioral Health Specialist
- Client
- Psychiatric Consultant
Clinical features of OCD
OCD

- Lifetime prevalence ~2%
- Twice as common as schizophrenia

Ruscio et al. 2010; DSM-5
Onset and Course

• Median age of onset = 19
  • In 25%, age of onset is <=14 years old.
  • Typically chronic, with waxing and waning symptoms.

Ruscio et al. 2010
Hallmarks of OCD

- Obsessions
- Compulsions
Intrusive thought (e.g. "What if I get sick?")

Increase in Anxiety/Distress

Temporary Relief of Anxiety (Reinforcement)

Compulsion/Ritual (e.g. excessively wash hands)

O-C Cycle
DSM-5 criteria for OCD

A. Presence of obsessions, compulsions, or both

B. Symptoms are time-consuming (e.g., 1 hour per day) or cause clinically significant distress or impairment in functioning.

C. Symptoms are not attributable to the physiological effects of a substance or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder

APA, 2013
With good or fair insight

With poor insight
<table>
<thead>
<tr>
<th>Obsessions</th>
<th>Examples of Compulsions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contamination</td>
<td>Washing/cleaning</td>
</tr>
<tr>
<td>Aggressive theme (fear of harm to self/others)</td>
<td>Checking, Repeating</td>
</tr>
<tr>
<td>Symmetry/Exactness</td>
<td>Arranging, Ordering</td>
</tr>
<tr>
<td>Taboo thoughts (sexuality/religion)</td>
<td>Mental compulsions, reassurance-seeking</td>
</tr>
<tr>
<td>Collecting</td>
<td>Inability to discard</td>
</tr>
<tr>
<td>Common</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Reviewing thoughts, feelings, conversations, or actions</td>
<td></td>
</tr>
<tr>
<td>Self-reassurance (e.g., “everything is OK“)</td>
<td></td>
</tr>
<tr>
<td>Repeating special words, images or numbers</td>
<td></td>
</tr>
<tr>
<td>Counting and re-counting</td>
<td></td>
</tr>
<tr>
<td>Making mental lists</td>
<td></td>
</tr>
<tr>
<td>Replacing an unpleasant image with a pleasant image</td>
<td></td>
</tr>
</tbody>
</table>
### Comorbidity

Up to 25% of those with psychotic disorders will have OC symptoms or meet full OCD criteria.

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Lifetime prevalence (%)</th>
</tr>
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<tbody>
<tr>
<td>Anxiety (most common)</td>
<td>76</td>
</tr>
<tr>
<td>Affective disorder (Major depressive disorder)</td>
<td>41</td>
</tr>
<tr>
<td>Obsessive-compulsive personality disorder</td>
<td>23-32</td>
</tr>
<tr>
<td>Substance use disorders</td>
<td>39</td>
</tr>
</tbody>
</table>
Conditions misdiagnosed as OCD

Other disorders with:
- Unwanted thoughts “rumination”: Anxiety disorder, Depression
- Repetitive behaviors: Autism spectrum disorder, Trichotillomania, Excoriation Disorder
- Intrusive/unusual thoughts: Psychotic disorder

Maladaptive perfectionism/habits:
Obsessive Compulsive Personality Disorder
Suicidality

Suicidal thoughts occur at some point in as many as about half of individuals

Suicide attempts are reported in up to one-quarter of individuals

Torres 2011; Blom et al., 2011; Angelakis et al., 2015
Causes of OCD

Biological factors
- Genes (based on both family and twin studies)
- Abnormal brain development
- Infectious agents and autoimmune mechanisms
- Neurological insults

Environmental factors
(e.g., trauma) also implicated

Collaborative Care Team

Primary Care Provider

Client

Behavioral Health Specialist

Assess for OCD
<table>
<thead>
<tr>
<th>Purpose</th>
<th>Recommended Instruments</th>
<th>Time to administer/self-report</th>
<th>Interpretation of scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening</td>
<td>Obsessive-Compulsive Inventory-Revised</td>
<td>15 minutes</td>
<td>Possible score range from 0-72. 0-20: Below clinical threshold 21-71: Above clinical threshold</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Diagnostic and Statistical Manual of Mental Disorders -5</td>
<td>10-15 minutes</td>
<td></td>
</tr>
<tr>
<td>Initial assessment</td>
<td>Yale Brown Obsessive Compulsive Scale</td>
<td>30-45 minutes</td>
<td>Possible score range from 0-40. 8-15: Mild OCD 16-23: Moderate OCD 24-31: Severe OCD 32-40: Extreme OCD</td>
</tr>
<tr>
<td>Treatment monitoring</td>
<td>Yale Brown Obsessive Compulsive Scale</td>
<td>30-45 minutes</td>
<td></td>
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To learn more...

What you will find:
- Accessible, in-depth information about OCD and related disorders.
- Content for providers, individuals living with the disorder(s), and families/supporters.
- Connection to local resources in your area.

If you work primarily with adults or the lifespan:
www.iocdf.org

If you work primarily with youth:
www.OCDinKids.org
Treatments for OCD
First-line Treatments

Medications
- Serotonin reuptake inhibitors (SRIs) First line
  - clomipramine
  - selective serotonin reuptake inhibitors (SSRIs)
- Other medications e.g. antipsychotics, glutamate modulators

Psychotherapy
- Cognitive-Behavioral Therapy (CBT) with Exposure and Response/Ritual Prevention (EX/RP)
What to Try First?

When to start with SRIs:
- When EX/RP is not available
- When patient prefers medications
- When patient has comorbid disorder that may interfere with EX/RP and that disorder responds to medications

When to start with EX/RP:
- When available and patient prefers
<table>
<thead>
<tr>
<th>Serotonin Reuptake Inhibitor</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>fluoxetine (*FDA approved for adults and children)</td>
<td>60 mg/day</td>
</tr>
<tr>
<td>fluvoxamine*</td>
<td>250 mg/day</td>
</tr>
<tr>
<td>sertraline*</td>
<td>200 mg/day</td>
</tr>
<tr>
<td>paroxetine (FDA approved for adults only)</td>
<td>60 mg/day</td>
</tr>
<tr>
<td>clomipramine* - consider if SSRIs ineffective</td>
<td>250 mg/day</td>
</tr>
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</table>

Titrate to max FDA approved dose over 4-6 weeks, then wait an additional 6 weeks for response (APA Practice Guidelines).

APA guidelines recommend 1-2 years treatment at outset.

Relapse can occur if SRI is discontinued.
Serotonin Reuptake Inhibitors

Response vs Remission

• Response
  • Up to 65% achieve a 20-40% reduction in OCD symptoms

• Remission
  • \leq 25\% of OCD patients achieve remission (i.e., minimal symptoms)

• In sum: Some (not all) will respond to an SRI. Most responders will have clinically significant residual symptoms.
If SRIs don’t work:

• Consider EX/RP
What does EX/RP consist of?

- Exposures (in-vivo and imaginal)
- Response prevention

**Goals:**
- To break associations between stimuli and increased anxiety; and rituals reducing distress/anxiety
- To challenge distorted beliefs
- To promote more flexible behavior

Foa Yadin, Lichner, 2012
Treatment Rationale for Exposure

Doing exposures is similar to watching a scary movie. When watching a scary movie at first, it is very scary. The more times you watch it, the less scary and even boring it becomes.
Overview of treatment

- Session 1: Psychoeducation, Rationale for treatment
- Session 2: Develop Exposure Hierarchy and Ritual Prevention Plan
- Session 3: Conduct 1st exposure
- Session 4-17+: Exposures, Exposures, Exposures
- Last sessions: Maintenance and relapse prevention
Optimizing response to EX/RP

- Need an expert therapist
- Refer to an expert, if not trained
- Adherence – key for good outcome
What is the best treatment for OCD: an SRI, EX/RP, or their combination?

- CBT (with and without SRI) > SRI
- SRIs commonly lead to partial response
What to tell your patients about OCD treatment

Evidence-based treatments for OCD are CBT (EX/RP) and/or psychiatric medication (SRIs).

- EX/RP is a structured form of therapy that will have them face their obsessions without performing their compulsions.
- SRIs help to control and decrease symptoms, but they do not “cure” OCD.
Collaborative Care Team

- Primary Care Provider
- Behavioral Health Specialist
- Client
- Psychiatric consultant

Medication management
CBT EX/RP (if trained)
Treatment recommendations
<table>
<thead>
<tr>
<th>Primary Care Physicians</th>
<th>Behavioral Health Specialists</th>
<th>RNs, Care Managers, Specialists, Support Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><a href="#">To learn more about OCD/treatment in general - IOCDF’s Training Institute</a></td>
</tr>
<tr>
<td><strong>Webinar on medication treatment for OCD, coming soon!</strong></td>
<td>To learn about EX/RP treatment - the Behavior Therapy Training Institute (BTTI)</td>
<td>IOCDF’s Resource Directory to make local referrals in your community</td>
</tr>
</tbody>
</table>

[www.iocdf.org/training](http://www.iocdf.org/training) and [www.iocdf.org/find-help](http://www.iocdf.org/find-help)
Meet Jimmy
As a child

• Worried about bad things happening to his family

• Spent a lot of time on his homework

• Led to social avoidance, late assignments and difficulty finishing exams in high school
In the last year

• Father hospitalized with pneumonia

• Jimmy starts to obsess that he will contaminate his father and cause his death
Take home points

• Onset common in childhood and adolescence, but diagnosis often missed.
• Look for obsessions and compulsions (content can vary over time)
• OCD can disrupt functioning in many ways.
• Two proven first-line treatments: SRIs and EX/RP.
The International OCD Foundation is here to help!

• Visit our websites:
  • www.iocdf.org (main site)
  • www.OCDinKids.org (if you work with youth)
  • www.AnxietyInTheClassroom.org (for school-related issues)

• Use our Resource Directory to find specialists, support groups, clinics, and organizations in your community – www.iocdf.org/find-help

• Get trained to work with OCD – www.iocdf.org/training

• Give us a call if you have questions or get stuck – (617) 973-5801
Center for OCD Treatment and Related Disorders

Research clinic

• Expert evaluation
• Treatment at no cost

To learn more:

www.columbia-ocd.org

Contact Us

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Poll Question #1

What screening and assessment tools would you like to learn more about? (please check all that apply)

- DSM 5 diagnostic criteria for OCD
- Simple screening questions for OCD
- Validated self-reports that you can give patients to track their symptoms
- Validated structured interviews that you can use to assess OCD symptoms and their severity over time
Poll Question #2

Which topics/treatment options would you like to learn more about? (Check all that apply)

• Medication options
• Exposure and Ritual Prevention (EX/RP)
• EX/RP with families and children with OCD
• Special topic: Treating Postpartum OCD
• Special topic: Treating OCD when comorbid with psychotic disorders
Poll Question #3

What resources do you think would be most helpful to provide to individuals with OCD and their families? (Check all that apply)

- Educational Pamphlets about OCD
- Videos about OCD
- Infographics
- Community resources for treatment
- Podcasts
- Support groups
Thank you!

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International OCD Foundation