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INSIDE

Clinical features

Diagnosis

Assessment

Management

Other
management
considerations

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Obsessive-compulsive disorder in adults

Introduction

OBSESSIVE-compulsive disorder (OCD) is a chronic psychiatric disorder associated with significant morbidity and functional impairment.

With over half of all OCD patients developing the disorder in their teenage years, OCD may present a significant burden on those with the disorder, their families and partners. As the treatment of OCD

differs significantly from other anxiety-related disorders, and as many individuals with the condition are either unable or unwilling to access specialist treatment services, patients with OCD are often managed in the community, which can pose some challenges.

According to the 2007 Australian National Survey of Mental Health and Wellbeing, the median age of

onset of OCD was 19 years, with 25% of cases having started before the age of 13.¹ The 12-month prevalence rate of OCD was 2.7%. There is a small female preponderance, although it should be noted that this is less marked than for all other anxiety disorders.

Individuals with OCD are less likely to have ever been married compared with the general population, which

may reflect the early onset of symptoms as well as the associated morbidity of the condition.¹

This article reviews the approach to diagnosis and management of OCD in adults. OCD in children, while similar to OCD in adults, has significant differences in both clinical features and management, and is therefore outside the scope of this article.

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How To Treat – Obsessive–compulsive disorder in adults

Clinical features

THE key clinical features of OCD are obsessions and compulsions, and their presentation is very heterogeneous. That is, two patients with OCD may have completely different sets of symptoms. The overwhelming majority of patients with OCD have both obsessions and compulsions.²

Obsessions

Obsessions are defined as recurrent and persistent thoughts, urges or images, generally perceived by individuals as ‘ego-dystonic’, that is, intrusive and unwanted.² Obsessions cause marked anxiety or other distressing emotional states, such as disgust. Individuals try to neutralise obsessions in some way, such as performing either a physical or mental action. For example, an individual may worry about inadvertently leaving an electrical appliance on when they leave the house, resulting in a fire, and as a result may either repeatedly check electrical appliances before leaving, or check them in a detailed and stereotypic way.

Themes of obsession

Common themes of obsessions include obsessional doubt, such as doubting whether one has locked the door, turned off the stove, left the windows unlocked, left the handbrake on the car, or turned off heaters or gas appliances. Another common theme of obsessions is that of contamination by germs or chemicals.

Other themes of obsessions may focus on the potential to act in



an inappropriate and aggressive manner, such as harming oneself or others, blaspheming or swearing, or acting impulsively. Other individuals have obsessions about orderliness and symmetry, usually applied to their personal and other belongings. Individuals who have obsessions about health or illness may frequently present to general practice, seeking reassurance, examinations or investigations following apparently minor triggers. For example, a patient may request an HIV test after a physi-

cal encounter not associated with a risk of HIV transmission, such as hugging or shaking hands. Other themes of obsessions may be sexual or religious.

Compulsions

Compulsions are defined as repetitive behaviours that individuals feel driven to perform in response to having obsessions. The intention of compulsions is to reduce the emotional state caused by obsessions. For example, individuals who have a marked concern about biological

contamination after touching door handles or hand rails may wash their hands excessively and repeatedly throughout the day.

Common types of compulsions

There are several commonly occurring groups of compulsions, including decontamination compulsions (with repetitive or excessive cleaning or washing), checking compulsions, organising or aligning compulsions, compulsions to count or group objects, or compulsive repetition of certain acts, such as rereading certain

sentences. Individuals may spend hours ordering objects, or adjusting the position of their belongings, and often report a need for the item to be “just right” in position.

Stable symptom dimensions

Factor-analytic studies on symptoms of OCD have identified some stable symptom dimensions (which can be thought of as ‘symptom clusters’), including contamination obsessions and decontamination rituals, symmetry and ordering. There is some conflict in data across studies as to whether aggression, checking, sexual and religious symptoms are separate dimensions.³

Insight

The degree of insight individuals have may vary considerably in patients with OCD. Some may have very good insight into the nature of their obsessions, and acknowledge that what they fear might happen is very unlikely to occur.

For example, a patient may express frustration about their compulsions to check the stove, stating, “I know deep down that I have not left it on; I just feel compelled to check it”.

In others, the strength of their beliefs may be delusional — for example, a patient who literally believes that he had contracted HIV from hugging another person. Poorer levels of insight have been associated with poorer outcomes of OCD.

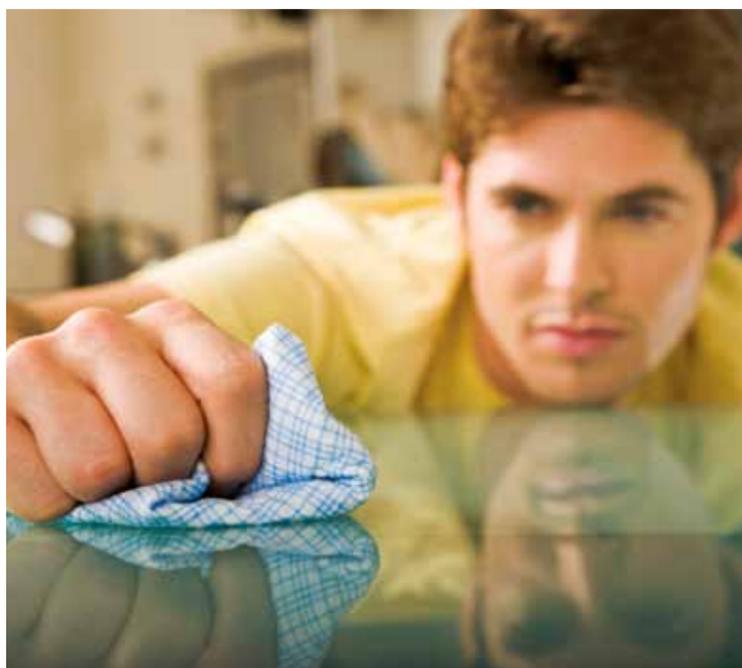
Diagnosis

THE diagnosis of OCD may be made by referring to the DSM-5 diagnostic criteria (see box). While diagnosed OCD is not very common (comparable in prevalence with psychiatric disorders such as bipolar disorder), obsessions themselves are thought to be common in the general population. An early survey of a non-clinical student population found that 88.2% reported experiencing some obsessions, the findings of which have been replicated on multiple occasions.⁴

In a survey of parents of newborn infants, 68.8% of mothers and 57.7% of fathers reported experiencing obsession-like intrusive thoughts.⁵ In both surveys, the content of the reported thoughts was described as distressing and had similar content to obsessions reported in samples of OCD patients. Thus the presence of intrusive, unwanted and distressing thoughts alone is not sufficient to make a diagnosis, and clinicians should obtain further information before reaching a diagnosis of OCD.

Comorbidities

According to data from the first National Survey of Mental Health and Wellbeing, major depressive disorder was the most common comorbid psychiatric condition in individuals with OCD, being identified in 54% of cases.⁶ Other anxiety disorders were also common, with OCD showing a specific relationship with panic disorder.



Interestingly, individuals with OCD were not at higher risk of having a comorbid substance-use disorder. There is no specific association between OCD and any specific personality disorder, including obsessive–compulsive personality disorder, despite the similar names. A current or past history of a tic disorder is present in up to 30% of individuals with OCD.²

Differential diagnoses

The differential diagnosis of OCD includes non-pathological obsessions, other anxiety-related disorders, and major depressive

DSM-5 Diagnostic criteria for obsessive–compulsive disorder²

A. Presence of obsessions, compulsions, or both:

Obsessions are defined by:

- Recurrent and persistent thoughts, urges, or images that are experienced ... as intrusive and unwanted, and that in most individuals cause marked anxiety or distress; and
- The individual attempts to ignore or suppress these, or to neutralise them with some other thought or action, such as performing a compulsion.

Compulsions are defined by:

- Repetitive behaviours or mental acts that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly; and
- These behaviours are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviours or mental acts are not connected in a realistic way with what they are designed to neutralise or prevent, or are clearly excessive.

B. The obsessions or compulsions are time-consuming (eg, over an hour a day) or cause clinically significant distress or impairment in functioning.

C. The obsessive–compulsive symptoms are not attributable to the physiological effects of a substance or another medical condition.

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

Specify if the patient has good or fair insight; poor insight; or absent insight/delusional beliefs. Also specify if the individual has a present or past history of a tic disorder. There is a subtype of OCD in which individuals also have motor tics, and risk factors for this subtype include male gender and childhood onset of OCD. The pharmacological management of these patients varies from non-tic-related OCD.

disorder. Individuals with eating disorders may have obsessions and compulsions about food, but in OCD the symptoms are not limited to food.

Some individuals with OCD may have symptoms that are as intensely held as delusions and thus be confused for schizophre-

nia and other psychotic disorders. The presence of thought disorder and hallucinations should suggest a psychotic disorder, rather than OCD. Individuals with obsessive–compulsive personality disorder may have very rigid rules and routines, but they do not see these as intrusive or unwanted.

Assessment

Structured assessment tools

THE gold standard for evaluation of severity of symptoms of OCD is the 14-item clinician-rated Yale-Brown Obsessive Compulsive Scale (Y-BOCS) and almost all clinical trials use this as a primary outcome measure.⁷ It may be used in clinical practice to measure treatment outcomes.

Probably more useful in clinical practice, including general practice, is the associated Yale-Brown Obsessive Compulsive Scale Symptom Checklist (see Online resources), which is a patient-completed checklist of symptoms. Patients are asked to identify current and past symptoms from a wide variety of clusters, such as aggressive obsessions, contamination obsessions, cleaning and washing compulsions, and checking compulsions. Clinicians should note this checklist is very comprehensive, and it is more time-effective for patients to complete this after the initial consultation.

Classification of OCD

OCD has been described in the scientific literature for a very long time, however, it was not until



the publication of the third edition of the *Diagnostic and Statistical Manual for Mental Disorders* (DSM-III) in 1980 that specific operationalised diagnostic criteria were widely disseminated.

Obsessive-compulsive and related disorders

Obsessive-compulsive disorder
Body dysmorphic disorder
Hoarding disorder
Trichotillomania
Excoriation (skin-picking) disorder
Substance/medication induced obsessive-compulsive and related disorders
Obsessive-compulsive and related disorders due to another medical condition

In DSM-III, OCD was classified as one of the anxiety disorders, a situation that remained, at least with respect to the American Psychiatric Association's nosological system, until the publication of the fifth edition of the *Diagnostic and Statistical Manual for Mental Disorders* (DSM-5) earlier this year.

Despite being classified as an anxiety disorder, OCD was long recognised to differ from other conditions within this diagnostic group.

It responded to a very narrow range of antidepressants, has a very low placebo response rate compared with other anxiety disorders, does not respond to standard cognitive behavioural interventions such as graded expo-

sure and cognitive restructuring, and in some individuals, the predominant emotion may not be anxiety, but rather, other distressing emotional states.

In DSM-5, OCD is now classified in its own diagnostic grouping, 'Obsessive-Compulsive and Related Disorders' (see box), which includes body dysmorphic disorder and other conditions that have clinical features in common.

For example, repeated checking of physical appearance is common in body dysmorphic disorder.

It is hoped that this reorganisation of the classification of anxiety-related disorders will result in more research into these conditions, including treatment-focused research.

Management

OCD in adults is generally a chronic disorder associated with ongoing functional impairment. It is also one of the anxiety-related disorders that is usually less responsive to either psychological or pharmacological treatments than other anxiety-related disorders, such as social phobia or agoraphobia.

Psychoeducation

All patients and their significant others should be provided with information about OCD, its symptoms, course and treatment. Where possible, this information should be reinforced by use of either printed or online resources. Several Australian organisations have information sheets on OCD, including Sane Australia and beyondblue, however, the most comprehensive English-language online resource is run by the British charity, OCD-UK (see Online resources for all of these resources).

Psychological treatment

Psychological treatment for OCD differs from that of other anxiety-related disorders. The most validated treatment is a specific cognitive behavioural therapy technique, exposure-response prevention (ERP), which is sometimes referred to as exposure-ritual prevention.^{8,9} In ERP, individuals systematically and repeatedly expose themselves to something that triggers an obsession, and then are advised to prevent themselves from performing their usual neutralising ritual. While the individual will initially experience an increase in their distress or anxiety, this will eventually fall, and with repeated attempts, the overall level of anxiety or distress evoked on exposure to the trigger gradu-



ally falls. For example, an individual with obsessional doubt about leaving their front door unlocked is advised to leave the house, closing the door without engaging in ritualised or repetitive checking, and then leave the environs. Even though they will initially become more distressed than usual when

Table 1: First-line pharmacological treatment for OCD (in alphabetical order)

SSRI	Minimum effective daily dose	Maximum recommended daily dose
Citalopram	20mg	40mg
Escitalopram	10mg	20mg
Fluoxetine	20mg	80mg
Fluvoxamine	50mg	300mg
Paroxetine	20mg	60mg
Sertraline	50mg	200mg

not allowed to check, over successive repetitions of this exercise, their distress will gradually fall. This may sometimes occur within two weeks, if individuals are able to practise this on a daily basis.

Individuals are instructed to focus on one or two specific symptoms at a time, mastering these, before moving on to other symptoms. ERP has been consistently demonstrated to be an effective treatment for OCD in clinical trials.⁹ In addition to ERP, some individuals with OCD benefit from CBT. British guidelines recommend at least 10 hours of individual therapy per patient, and patients need to implement the techniques on a regular basis between sessions.¹⁰ Where patients are agreeable and there is a willing participant, family members or partners may be taught how to assist with ERP exercises.

Accessing appropriate treatment

One of the major issues regarding psychological treatments in an Australian healthcare setting is the availability of suitably qualified and experienced mental health specialists to provide evidence-based psychological interventions. GPs in rural and regional settings may have very limited access to psychological treatments for their patients with OCD, and may have

to upskill or rely primarily on pharmacological treatments.

Supportive psychotherapy, non-specific counselling and psychodynamic psychotherapy lack an evidence base in the treatment of OCD.¹⁰

Pharmacological treatment

OCD has long been noted to respond specifically to serotonergic antidepressants, namely, the selective serotonin reuptake inhibitors (SSRIs) (table 1) and the serotonergic tricyclic antidepressant clomipramine. For reasons of tolerability and ease of dosing, as well as safety in overdose, the SSRIs are considered first-line treatment for the treatment of OCD.^{10,11}

The following antidepressants have a PBS indication for the treatment of OCD: fluoxetine, fluvoxamine, paroxetine, sertraline and clomipramine.

All standard clinical precautions should be undertaken before prescribing antidepressants and in ongoing clinical monitoring thereof. In the absence of specific recommendations for use of antidepressants in OCD and other anxiety-related disorders, safety guidelines developed for antidepressants in depression are recommended.¹²

cont'd page 22

How To Treat – Obsessive–compulsive disorder in adults

from page 19

SSRIs

There are multiple randomised controlled trials demonstrating that the SSRIs are effective for OCD.^{10,11,13}

A systematic review of 17 trials including 3097 patients showed that the SSRIs as a group were more effective than placebo, with little to differentiate individual SSRIs from one another in terms of efficacy.¹³

It is generally thought that individuals with OCD require longer periods of time to respond to antidepressant treatment, with an adequate trial considered to be between 10 and 12 weeks in duration.

Additionally, individuals with OCD may require SSRI doses towards the higher end of the typical ranges. Patients should be advised that clinical responses may not be seen until after two months of treatment.¹¹

If there has been no response to an initial 10-12-week trial of an SSRI at a high dose, it is recommended that after weaning the SSRI, a second 10-12-week trial of a different SSRI be conducted, again at a high dose.

Clomipramine

Clomipramine was the first antidepressant demonstrated to be effective in the treatment of OCD.^{10,11} Other tricyclic antidepressants are not considered effective in the treatment of OCD.¹⁰

Clomipramine should be started

at a dose of 25mg nightly, and titrated up by 25mg increments, until the dose range of 75-150mg a day is reached.

The product information for the Anafranil brand of clomipramine states that it may be increased every few days until a dose of 100mg is reached.

In my own clinical practice, I increase the dose from 25mg to 50mg if it is tolerated after three days, and then increase it again every 3-7 days, depending on tolerability.

It is important to note that clomipramine may be fatal in overdose, as is the case with other tricyclic antidepressant medications, whereas SSRIs may be safer in an isolated overdose.

While most tricyclic antidepressants are somewhat sedating, a small proportion of individuals treated with clomipramine may experience insomnia; these patients should take the medication in the morning.

All patients prescribed clomipramine should have a baseline ECG, and be advised about anticholinergic side effects.

An ECG should be conducted after initiation of clomipramine and after dose changes, looking for QT prolongation.^{10,13}

Other antidepressant medications

Other antidepressants with some serotonergic activity, such as venlafaxine or desvenlafaxine and duloxetine and mirtazapine, have been evaluated in the treatment



It is important to note that clomipramine may be fatal in overdose, whereas SSRIs may be safer in an isolated overdose.

of OCD, but there is insufficient evidence to support their use in uncomplicated OCD.^{10,11}

Similarly, tricyclic antidepressants other than clomipramine, and monoamine oxidase inhibitors have not been demonstrated to be effective in OCD.¹⁰

Augmentation strategies

Some OCD patients may still have clinically significant symptoms despite high-end doses of serotonergic antidepressants over an adequate trial period.

If switching antidepressants does not provide symptom relief, consideration can be given to augmenting an SSRI with another medication, such as a second-generation antipsychotic.

It is perhaps indicative of the poorer response that OCD has to antidepressants compared with other anxiety-related disorders that a Cochrane review of pharmacological augmentation strategies in treatment-resistant anxiety disorders identified 28 randomised controlled trials — 20 of which investigated treatment-resistant OCD.¹⁴

A recent review of clinical trials of second-generation antipsychotic medications used to augment antidepressants found some evidence to support the addition of risperidone or quetiapine, but insufficient data to support the use of olanzapine.¹⁵

Use of antipsychotic medications as augmenting agents is not recommended until at least two adequate antidepressant trials have been conducted.

I would recommend that this should not be undertaken in a primary care setting unless the patient is under the care of a psychiatrist, or the GP has access to psychiatrist advice.¹⁰

Even though the addition of an antipsychotic medication to an antidepressant may provide some clinical benefit, antipsychotic medications should not be used alone for the treatment of OCD.

Other management considerations

Social interventions

OCD may have a huge impact not only on those with the disorder, but others who live with the affected person. It is common for partners and family members to report that the OCD rituals affect others, such as families having to adhere to rituals around eating or orderliness, or partners having to allow considerable time to leave the home due to obsessional slowness. Repeated reassurance-seeking may be very common in patients with OCD, and this may be directed towards those living with them.

GPs are ideally placed to understand the impact OCD may have on a family unit, and in a good position to provide psychoeducation for family members and partners.

Assessing quality and integrity of treatment

The medical professional that is charged with managing the patient with OCD may have multiple roles to play depending on the patient and locally available resources. These include playing diagnostician, educator, prescriber, monitor, therapist, referrer and advocate. Some GPs are set up to provide their own psychological interventions and in the case of ERP, sessions of 30 minutes may be effectively used.

Not all psychologists or psychiatrists have a lot of experience in the delivery of cognitive and behavioural interventions for OCD. The



quality of psychological treatment to be provided should be assessed. This may be done by clarifying whether the psychologist or psychiatrist to whom the patient is referred has experience in providing psychological treatment for OCD.

It is reasonable and acceptable to ask a psychologist or psychiatrist what type of psychological intervention is going to be pro-

vided, and to enquire specifically whether ERP will be part of the treatment package. Confirmation should also be sought from the patients what techniques are being undertaken in psychological intervention, to ensure they are receiving evidence-based treatments.

The quality of the prescribed pharmacological treatments should also be assessed, first by checking that patients are pre-

scribed first-line antidepressants (SSRIs) and at adequate doses. If a patient has been on the minimum effective dose for more than 10-12 weeks with limited effect, a recommendation should be made to increase the dose. In clinical practice, psychiatrists may advise patients to increase the dose of their antidepressants well before the 10-12-week trial period.

When to refer

Referral to a psychiatrist is indicated if there is uncertainty about the diagnosis, if the patient has delusional intensity of OCD symptoms, if there is significant comorbidity, or if there is limited response to initial management interventions.

When writing the referral, a detailed medication history including doses used and durations of trials, as well as the GP's observations about the degree to which they were beneficial, will allow more comprehensive management advice to be provided to both the patient and doctor. Telepsychiatry services may be used if local psychiatric resources are limited, especially in rural and regional areas.

Referral for hospitalisation is rarely needed in most cases of OCD, and the main indication for admission would be where an individual has significant psychiatric comorbidity, such as a comorbid severe depressive disorder, or where an individual has suicidal ideation or behaviour.

In cases where patients are

reluctant to consider referral to a psychiatrist, or in regions where there are limited psychiatrists available, contacting the local mental health service and asking to speak to one of the psychiatrists for advice may be the only option available to GPs.

Prognosis

OCD has generally been considered to be a chronic psychiatric condition with longitudinal fluctuation in symptoms. Follow-up studies conducted since the 1930s have been consistent with this assessment.

A 1995 naturalistic two-year cohort study of 66 subjects who met diagnostic criteria for OCD demonstrated that 57% still met criteria for this disorder at the end of the two-year period. However, there were varying degrees of symptomatic improvement over this time.¹⁶

A follow-up study of 85 patients treated for OCD demonstrated that 87% of their sample demonstrated some clinical response to treatment.¹⁷ It is notable that 99% of this sample had received at least one 10-week trial of an SSRI, and 36% of the sample had also received at least two weeks of an augmentation strategy.



Case study

JAMES is a 27-year-old single man who works as a lawyer in an inner metropolitan area. He is referred by his GP for assessment of anxiety. He described a history of obsessions and compulsions from the age of 17. He reported marked fear that his house or workplace would burn down as a result of electrical appliances being left on.

James would repeatedly check appliances such as the stovetop, toaster, iron and electric kettle when at home, and when leaving the home, would have to ensure that all appliances were unplugged and placed at least 10cm from any power point. The stovetop would have to be checked at least three times before leaving the house. He would consistently check these, even if he knew they had not been used that day.

After leaving the house, James would have a strong urge to return to check these appliances, although he noted that if his flat-mates were still in the house, this urge was much weaker.

The same urge to check would occur at his place of employment, where he would repeatedly check emails and other communications that he had sent to his managers and coworkers.

James explained that he was afraid that he may have either made a mistake in communication or inadvertently included some inappropriate material.

James was provided with information about OCD, as well as treatment options, including medication and CBT. He had recently started a new job and was not certain of being able to attend regular consultations, so



opted for pharmacological treatment initially, with a view to undertaking psychological treatment at a later stage.

He was started on citalopram 20mg daily, which was increased to 40mg daily after four weeks with some improvement of his symptoms in the ensuing two months. He experienced mild

sexual dysfunction and some trismus, but these were not of significant concern to him.

James decided he wanted to address his ongoing symptoms using CBT.

He also planned to continue citalopram.

A hierarchy of symptoms was generated during his psychiatric consultation, ranging from the compulsions that generated the least distress, to the symptoms that generated the most distress. James stated that compulsions surrounding the electric kettle and the toaster were the least distressing, followed by the stovetop, and finally the iron.

James was instructed to plug in the electric kettle with the switch on at the power point, and then move to another part of his house for at least 30 minutes, and not check on the kettle. He was allowed to check the kettle after half an hour if he was still concerned.

Initially James' anxiety remained high for about 25 minutes, then gradually resolved over the hour. Daily application of this treatment resulted in a decline in his symptoms to a peak anxiety at 15 minutes by the end of the first week and minimal anxiety by day 10.

The same principles were applied to the ERP treatment for James' compulsions surrounding the stovetop and then the iron. At follow-up consultations, James was able to collaborate in developing further exercises that address his persistent and residual compulsions. He improved dramatically over the following 7-8 weeks.

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Conclusion

ADULT obsessive–compulsive disorder commonly develops in the teenage years and often persists throughout adult life, causing marked distress to both the patient and their family.

It is important to recognise that the treatment of OCD differs significantly from other anxiety-related disorders and appropriate exposure–response prevention treatments should be provided by suitably qualified health practitioners.

SSRIs and citalopram are useful pharmacotherapeutic options that should be given along with a holistic strategy providing education and psychosocial support to the patient and their family.



Online resources

OCD-UK

www.ocduk.org
Comprehensive information about clinical features and treatment of OCD, as well as information about disorders related to OCD, such as body dysmorphic disorder and trichotillomania.

Sane Australia

www.sane.org

Beyondblue

www.beyondblue.org.au

American Psychiatric Association – Practice Guideline for the Treatment of Patients with Obsessive-Compulsive Disorder

bit.ly/1cQ5S3m

The most current practice guideline on OCD.

Clinical Research Unit for Anxiety and Depression – online patient treatment manual for OCD

www.crufad.org/index.php/treatment-support/treatment-manuals
GPs should note that this manual is not a self-help manual, and is meant to provide the basis for psychological treatment delivered by a suitably qualified and experienced practitioner.

Y-BOCS Symptom Checklist

healthnet.umassmed.edu/mhealth/YBOCSymptomChecklist.pdf



How to Treat Quiz

Obsessive–compulsive disorder in adults — 17 January 2014

INSTRUCTIONS

Complete this quiz online and fill in the GP evaluation form to earn 2 CPD or PDP points. We no longer accept quizzes by post or fax.

The mark required to obtain points is 80%. Please note that some questions have more than one correct answer.

GO ONLINE TO COMPLETE THE QUIZ

www.australiandoctor.com.au/education/how-to-treat

1. Which TWO statements are correct regarding the epidemiology of adult obsessive–compulsive disorder (OCD)?

- a) The median age of onset of OCD is 19 years
- b) The 12-month prevalence rate of OCD was recently less than 1%
- c) The majority of OCD patients in the community are male and married
- d) 25% of OCD cases develop before the age of 13

2. Which TWO statements are correct regarding obsessions and compulsions in OCD?

- a) Obsessions are recurrent and persistent, intrusive and unwanted
- b) Compulsions are defined as being compelled by an external force to perform acts that are unintended or unwelcome
- c) Common stable symptom dimensions in OCD include contamination–decontamination, and symmetry and ordering
- d) Obsessions are usually associated with commanding auditory hallucinations

3. Which TWO statements are correct regarding the diagnosis and differential diagnoses of OCD?

- a) Eating disorders may be distinguished from OCD by being limited to a focus on food alone
- b) Schizophrenia may be distinguished from OCD by the presence of thought disorder and hallucinations

c) Obsessive–compulsive personality disorder may be distinguished from OCD by the presence of narcissistic traits

d) The presence of intrusive, unwanted and distressing thoughts alone is sufficient to make a diagnosis of OCD

4. Which TWO statements are correct regarding the assessment and classification of OCD?

- a) The gold standard for evaluation of severity of symptoms of OCD is the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS)
- b) The Y-BOCS Checklist is a simplified 14-item assessment of the severity of OCD symptoms
- c) OCD is classified in DSM-5 as an anxiety disorder
- d) Other conditions classified in the same group as OCD in DSM-5 include body dysmorphic disorder and hoarding disorder

5. Which TWO statements are correct regarding the non-pharmacological management of adult OCD?

- a) Exposure–response prevention (ERP) is a technique aimed at preventing exposure of the patient to the triggers for OCD
- b) ERP may show efficacy as early as two weeks if individuals are able to practise it on a daily basis
- c) Supportive psychotherapy, non-specific counselling and psychodynamic psychotherapy have all been shown to be effective in the treatment of adult OCD

d) The quality and type of psychological treatment provided to a patient should be assessed by seeking clarification with the therapist

6. Which TWO statements are correct regarding the pharmacological management of adult OCD?

- a) Anxiolytics such as diazepam are the first-line treatment for adult OCD
- b) An adequate pharmacological trial should be between 10 and 12 weeks in duration
- c) Fluoxetine has been shown to be much more effective in OCD than other SSRIs and clomipramine
- d) There is insufficient data to support the use of olanzapine as an augmenting agent

7. Which THREE conditions are comorbidities known to be associated with OCD?

- a) Major depressive disorder
- b) Motor tic disorder
- c) Substance use disorder
- d) Panic disorder

8. Sarah is a 21-year-old university student who reports a paralysing fear of contamination by germs since the age of 10. This has recently started to impact on her academic career because she cannot bear to attend university, which she perceives as being contaminated. Which THREE statements correctly identify the DSM-5 criteria for OCD that apply to her?

- a) Sarah has a recurrent, intrusive, unwanted fear of contamination by germs causing marked anxiety
- b) Her complaint cannot be better explained by another mental disorder
- c) Her fear causes significant impairment in her functioning
- d) The age of symptom onset was before 13

9. Sarah was diagnosed with OCD. Which TWO statements are correct regarding the clinical features associated with her diagnosis?

- a) The overwhelming majority of patients with OCD have both obsessions and compulsions
- b) Patients with OCD have poor insight into their symptoms
- c) Family members are often just as affected by the diagnosis as the patient
- d) The diagnosis of OCD greatly increases the risk of Sarah having an associated obsessive–compulsive personality disorder

10. Which TWO statements are correct regarding the management of Sarah's condition?

- a) Patients with OCD are highly sensitive to even low doses of SSRI
- b) OCD has a very low placebo response rate compared with other anxiety disorders
- c) Quetiapine may be given as a monotherapy for treating OCD
- d) OCD does not respond to standard cognitive behavioural interventions such as graded exposure and cognitive restructuring

CPD QUIZ UPDATE

The RACGP requires that a brief GP evaluation form be completed with every quiz to obtain category 2 CPD or PDP points for the 2014-16 triennium. You can complete this online along with the quiz at www.australiandoctor.com.au. Because this is a requirement, we are no longer able to accept the quiz by post or fax. However, we have included the quiz questions here for those who like to prepare the answers before completing the quiz online.

Australian Doctor Education

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NEXT WEEK People with cancer are living longer than ever before. Patients who have received surgery, radiotherapy or chemotherapy often present to their GP with symptoms stemming from these, but they do not always make the connection. The next How to Treat looks at the common problems cancer survivors may experience, and how GPs can best manage these. The author is Dr Robert Hitchins, medical oncologist, Bond University, Robina, Queensland.