Treating OCD: Recent empirical findings and clinical applications

Martin E. Franklin, PhD, and Sanjaya Saxena, MD

Monday, October 26, 2020

ROGERS Behavioral Health

1

Disclosures

Martin E. Franklin, PhD, has disclosed the following financial relationship(s) occurring in the last 12 months with a commercial interest whose products or services may be relevant to the educational content of this CE program presentation:

Commercial Interest Entity Name	Type of Relationship(s) with Entity	Related Product/Service
The Guilford Press	Book royalties	Publisher

Sanjaya Saxena, MD, has declared that he does not, nor does his family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation.

Drs. Franklin and Saxena have each declared that he does not have any relevant non-financial relationships. Additionally, all planners involved do not have any financial relationships.

2

Learning objectives

Upon completion of the instructional program, participants should be able to:

1. Explain four empirically supported interventions for OCD, including recent findings about pharmacotherapy and CBT augmentation strategies
2. Apply at least two evidence-based interventions for OCD patients, including CBT, pharmacotherapy, and combined treatment approaches, for those patients who have not responded completely to prior treatment

3

What we'll cover in this webinar

CBT and combined treatment for OCD
- Brief summary of current literature
- Highlights of recent findings

Pharmacotherapy for OCD
- Brief summary of practice guidelines
- Psychopharmacological and neuromodulatory treatment approaches for treatment-refractory OCD

Clinical applications
- Empirically supported interventions
- Approaches specific to partial and non-responders to prior treatment

4

CBT and combined treatment for OCD

- Brief summary of current literature
- Highlights of recent findings

Q&A

Please use the Q&A feature to send your questions to the moderator.

5

Yale-Brown Obsessive Compulsive Scale (Y-BOCS)

- Primary measure of OCD symptom severity (Goodman et al., 1989; Scahill et al., 1997)
- Y-BOCS severity scores range from 0 (no symptoms) to 40 (very severe)
- Mean pre-treatment Y-BOCS scores in the low to mid 20s for most published OCD studies
- Entry criteria typically Y-BOCS > 16

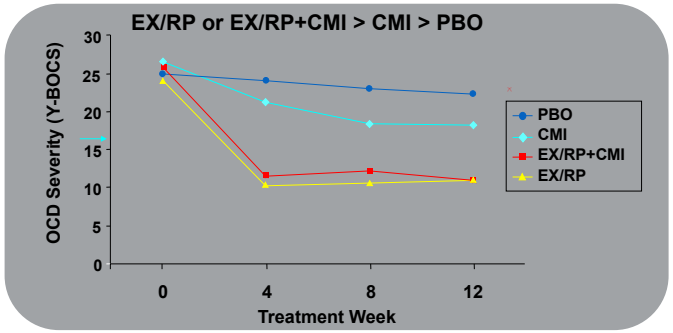
6

CBT for OCD: Summary

+ Typical reduction of 10-15 points on Y-BOCS
+ Maintenance of gains following discontinuation
- **Causes initial distress**
- **Not readily available**

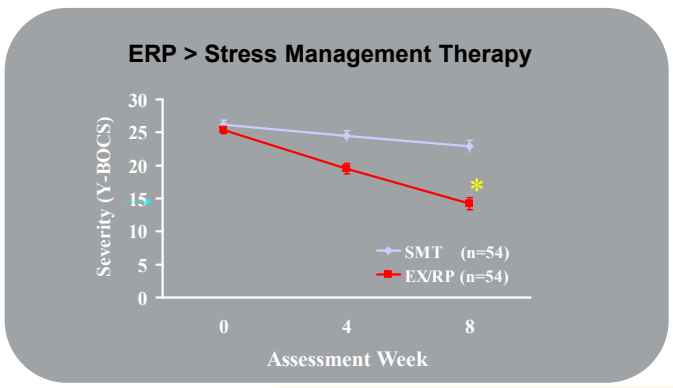
7

Monotherapies vs. combined treatment



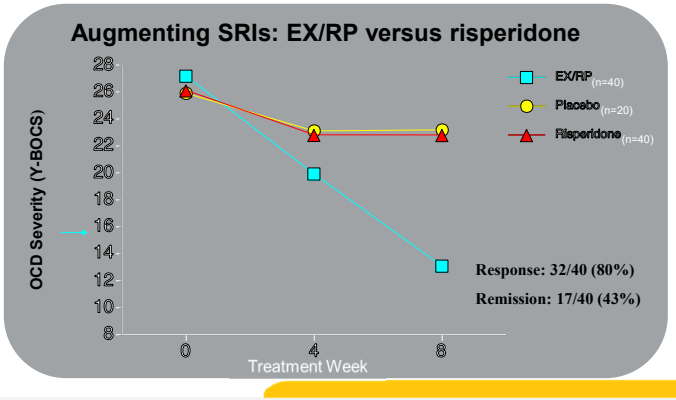
Foa et al. 2005 *Am J Psychiatry*

8



Simpson et al. (2008) *Am J Psychiatry*

9



Simpson, Foa et al. (2013) *JAMA-Psychiatry*

10

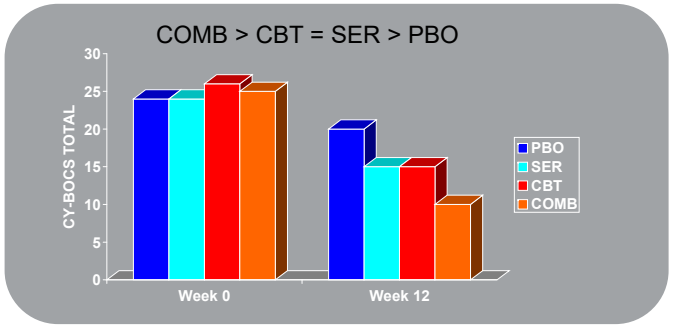
Combined treatments for adult OCD

Conclusions from outcome literature:

- Combined treatment <u>does not</u> impede monotherapies
- Combined treatment generally <u>not</u> superior to CBT, although some trends evident
- Studies have used simultaneous rather than sequential designs and thus may underestimate benefit of combined treatments

11

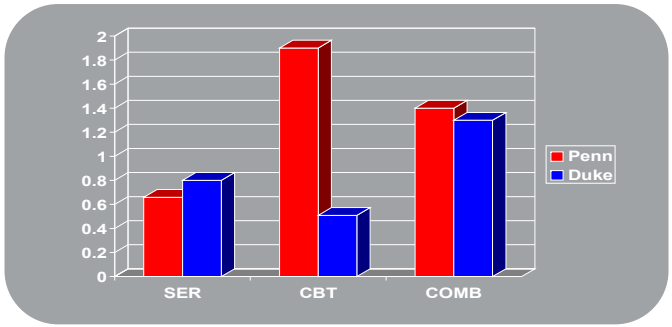
Kids: POTS I outcomes



Pediatric OCD Study Team (2004) *JAMA*.

12

Site x treatment interaction



Pediatric OCD Study Team (2004) *JAMA*.

13

Site and therapist effects: What can they actually teach us?

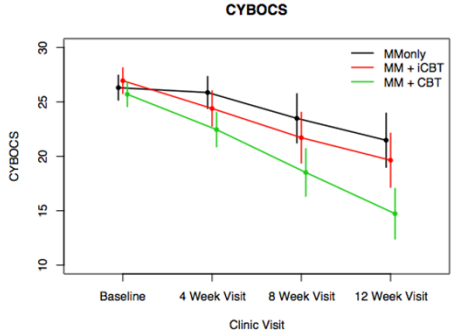
- Adherence and competence (e.g., what were Therapist 1 & 6 doing and/or not doing?)
- Can less tangible behaviors be manualized?
- These findings are produced with close supervision: What about without?
- Benito et al (in press): The Tom Petty Effect…

14

The Tom Petty effect???

15

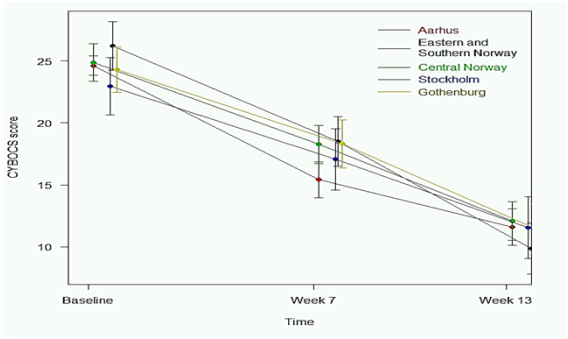
Kids: POTS II outcomes



Franklin et al. (2011) *JAMA*.

16

NORDLOTS outcomes



Torp et al. (2015). *Behaviour Research & Therapy.*

17

Pharmacotherapy for OCD

- Brief summary of practice guidelines
- Psychopharmacological and neuromodulatory treatment approaches for treatment-refractory OCD

Please use the Q&A feature to send your questions to the moderator.

18

Treatment of OCD

- **Pharmacotherapy**
- **Cognitive behavioral therapy (CBT) *using Exposure and Response Prevention***
- Psychotherapy: ineffective for OCD but may help patients cope
- Electro-convulsive therapy: ineffective
- Psychosurgery: "last resort"

- **Combination of CBT and medication is best**

19

Psychopharmacology

If you prescribe medication, you must:

1. ***Know what you're treating:*** target symptoms, fundamental processes of the patient's disorder(s), comorbid conditions
2. ***Know what works and what doesn't:*** effective vs. ineffective medications for each syndrome
3. ***Know how your medications work:*** mechanisms and loci of actions - relevant brain systems, neurochemical systems, downstream effects, etc.

20

OCD treatment planning

A. Assessment:

1. OCD Symptoms & Severity:
   OCI-R, Y-BOCS
   Y-BOCS Symptom Checklist
2. Comorbid Disorders: MINI, HAM-D, HAM-A, etc.

B. Treatment Planning:

1. Effective vs. Ineffective Treatments
2. Must Assess Insight and Motivation
3. Determine Most Appropriate Treatment Setting
4. Combine Medication and CBT if possible
5. Treat Comorbid Disorders
6. Address Family and Environmental Factors

C. Education:

Patient, family, etc.

21

Pharmacotherapy of OCD

Factors to consider before starting a medication:

1. Diagnosis, symptom pattern, severity
2. Comorbidity: psychiatric, other medical
3. Patient's Beliefs and Expectations
4. Demographic Factors
5. Drug Interactions
6. Predictors of Poor Response to Specific Medications
7. Individual and Family History of Treatment Response
8. Side Effect Profile and History

22

OCD comorbidity

A. Mood Disorders

1. Major Depression: 60%
2. Bipolar Disorder: 10-23%
3. Dysthymia: 13-20%

B. Anxiety Disorders

1. Social Anxiety Disorder: 35-45%
2. GAD: 8-20%
3. Panic Disorder: 15-20%
4. PTSD: 15-25%
5. Specific Phobia: 35-45%

23

OCD comorbidity

C. OCD Spectrum Disorders

1. Tic Disorders / Tourette's Syndrome
2. BDD, Somatoform Disorders
3. Habit Disorders
4. Eating Disorders

D. Schizophrenia / Schizoaffective Disorder: 12-15%

E. ADHD: 15-20%

F. Substance Use Disorders

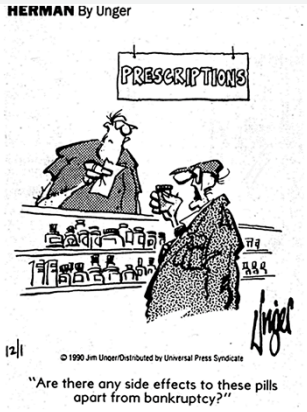
1. Alcohol Abuse/Dependence: 25-35%
2. Drug Abuse/Dependence: 15-25%

24

Pharmacotherapy for OCD: First-line agents

Drug	Usual Daily Dose (mg/day)	Maximum Dose
Citalopram	40-80	120
Escitalopram	20-40	60
Fluoxetine	40-80	120
Fluvoxamine	200-300	400
Paroxetine	40-80	100
Sertraline	150-300	400
Clomipramine	150-250	300

25



"Are there any side effects to these pills apart from bankruptcy?"

26

Pharmacotherapy for OCD: Duration

- SRI response builds over 12 weeks, so 10- to 12-week trial is required for any anti-OCD agent, before changing treatment. Early improvement within first 4 weeks predicts response at 12 weeks.
- Depressive symptoms often abate first in OCD patients with comorbid mood disorders.
- Continue maintenance treatment for at least 12 months in patients who respond.

27

Pharmacotherapy for OCD: Outcomes

- 40-60% of patients respond to a given trial of SRI medication
- Responders show a mean 40-50% reduction in symptom severity
- Very high relapse rate if medication is discontinued without behavioral therapy

28

Predictors of poor response to SRIs

- Greater symptom severity
- Early onset of OCD, longer duration
- Higher frequency and number of compulsions
- Sexual/religious obsessions
- Washing/cleaning rituals
- Poor insight
- Sensory phenomena leading to compulsions
- +/- Hoarding/saving symptoms
  (inconsistent, only in about half of studies)

29

Predictors of poor response to SRIs

- Comorbid tics or history of Tic Disorder (+/-)
- "Schizo-Obsessive":
  - Comorbid Schizotypal
  - Personality Disorder
  - Psychotic Disorder
- Other Personality Disorders (Avoidant, Borderline)
- Family history of other psychiatric illness

30

Pharmacotherapy for OCD: Other monotherapies

- **Venlafaxine** – probably effective, mixed results
- **Mirtazapine** – one placebo-controlled trial positive
- **Sarcosine** – (GlyT-1 inhibitor) may be effective, but effect is mild
- **IV Ketamine** – one placebo-controlled trial positive
- **Duloxetine** – good in one open trial and one small controlled augmentation trial
- **Vortioxetine, Vilazodone, Desvenlafaxine** – ??

31

Pharmacotherapy for refractory OCD

Augmentation strategies

- Atypical Antipsychotics –
  - 30-50% of patients respond
  - Mean 28-40% reduction on Y-BOCS
  - All appear effective, but Aripiprazole and Risperidone have the highest effect sizes
- Neuroleptics – for Tic-related or "Schizo-Obsessive"
- Clomipramine
- Glutamate Antagonists –

  Memantine > placebo in 3 controlled trials.

  Riluzole, NAC – mixed results in controlled trials

  Ketamine Augmentation – no better than placebo

32

Pharmacotherapy for refractory OCD

Augmentation strategies

- 5HT-3 antagonists:
  Ondansetron, Granisetron > placebo
- Anticonvulsants:
  Lamotrigine, Topiramate, Pregabalin: mixed results
  Gabapentin, and CBZ failed controlled trials
- Pindolol – mixed results in controlled trials
- Opioid agonists – *Morphine, Tramadol*
- Stimulants – *Dextroamphetamine, Caffeine*
- Mirtazapine – accelerated but did not improve response to SRIs.
- Benzodiazepines – for marked residual anxiety, panic, insomnia

33

Pharmacotherapy for refractory OCD

Novel and theoretical approaches

- IV SRIs: *Clomipramine, Citalopram, etc.*
- Celecoxib – 1 positive placebo-controlled augmentation trial
- Donepezil (adjunctive) – 1 positive case series
- Agomelatine – case reports look good.
- Nicotine
- Antiandrogens - *Ketoconazole, Glucophage, Cyproterone, etc.*
- 5-HT 1d Antagonists - *Sumatriptan, etc.*
- 5-HT 2a/2c Agonists - *LSD, Psilocybin, etc.*
- SAMe
- Zinc = placebo in controlled trial, but some patients improved.
- Cannabinoids - *Dronabinol, THC, CBD*
- D1 Antagonists, Substance P Antagonists, Enkephalin Agonists, Dynorphin Antagonists

34

Practice guidelines for treatment of OCD

- **CBT alone:** For children/adolescents, adults with mild or moderate OCD without significant comorbid depression, substance abuse, or other comorbid psychiatric disorders. Also for medication refusers/avoiders, pregnant or breast-feeding women.
- **SRI alone:** For patients with poor insight, low motivation, cognitive impairment, inability to follow instructions or comply with CBT, or those who refuse/avoid CBT.
- **SRI + CBT**: Everyone else.

35

Multimodal treatment: Simultaneous CBT + SRI

Efficacy:

- Better than SRI alone *(Marks et al, 1988; Foa et al, 2005)*
- May be better than CBT alone for adults *(Hohagen et al, 1998)*
- Better than CBT alone for children and adolescents, obsessions, depressive symptoms, and for the first 2 months of treatment in adults.
  (Marks et al, 1988; Cottraux et al, 1990; Hohagen et al, 1998; POTS Team, 2004)

36

Multimodal treatment: Simultaneous CBT + SRI

Relapse Prevention:

Combined CBT + SRI treatment yields lower relapse rates after treatment discontinuation than treatment with SRI alone.

(Simpson et al, 2004; Biondi & Picardi, 2005)

37

Multimodal treatment: Adding CBT to ongoing SRI treatment

- Produces an additional 25-45% reduction in YBOCS scores.
- Converts 40-74% of SRI non-responders to responders.
- Superior to adding Risperidone to SRI treatment.

(Simpson et al, 1999; Kampman et al, 2002; Tolin et al, 2004; Tenneij et al, 2005; Tundo et al, 2007; Simpson et al, 2008 & 2013)

38

Treatment-refractory OCD: Definitions

- ***Response:***
  > 35% Decrease in Y-BOCS score and a clinical global impression rating of "much" or "very much improved".
- ***Partial Response:***
  25-35% Decrease in Y-BOCS
- ***Non-Response:***
  < 25% Decrease in Y-BOCS score

- ***Levels of Non-Response:***
  to one SRI;
  to CBT;
  to SRI + CBT;
  to multiple SRIs;
  to SRIs + Intensive CBT;
  to SRIs + Augmentation medications;
  to other classes of medications; etc.

(Pallanti et al, 2002)

39

Treatment-refractory OCD: Common reasons

- Inadequate dose or duration of treatment (either drug or CBT)
- Wrong type of treatment (ineffective type of drug or psychotherapy)
- Non-compliance with treatment, poor insight or motivation
- Family accommodation
- Substance abuse
- Wrong diagnosis
- Severe chronic stressors
- "True" non-response

40

Intensive multi-modal treatment for refractory OCD

Partial Hospitalization or Intensive Outpatient Programs:

- 70-80% response rate, 40-50% decrease in OCD severity scores
- Significant improvement in depression, anxiety, and global functioning
- Also effective for BDD and Compulsive Hoarding

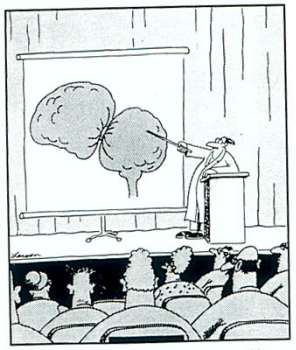
(Bystritsky et al, 1996; Saxena et al, 2001 and 2002)

Inpatient or Residential Programs:

- Inpatient, mean 102 days, 34% decrease in OCD severity
- Residential, mean 66 days, 30% decrease in OCD severity

(Calvocoressi et al, 1996; Stewart et al, 2005)

41



Professor Lundquist, in a seminar on compulsive thinkers, illustrates his brain-stapling technique.

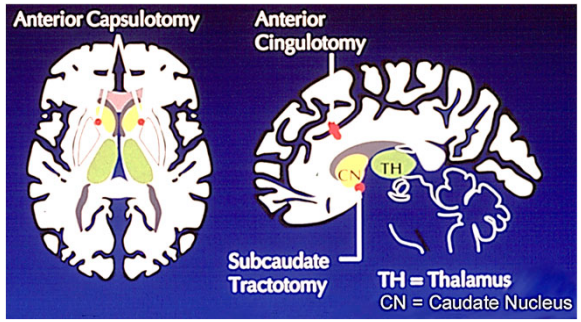
42

Treatment-refractory OCD: Neuroanatomical approaches

- **Neurosurgery**
  - Capsulotomy
  - Cingulotomy, etc.
- **Gamma Knife Capsulotomy**
- **Focused Ultrasound Capsulotomy**
- **Deep Brain Stimulation**
- **rTMS – to various cortical sites**
- **Transcranial Direct Current Stimulation**

43

Neurosurgery for refractory OCD



44

Clinical applications

- Empirically supported interventions
- Approaches specific to partial and non-responders to prior treatment

Q&A

Please use the Q&A feature to send your questions to the moderator.

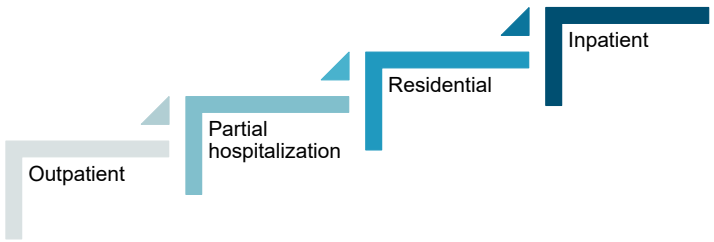
45

Clinical strategies for partial and non-response

- Higher levels of care
- Motivational Interviewing
- Pharmacotherapy strategies

46

Levels of care



47

Clinical factors that influence levels of care

These include:

- Severity
- Comorbidity
- Family factors
- Readiness for behavior change
- Willingness/capacity to tolerate emotion

48

Dissemination & Implementation:

Rogers Behavioral Health:
Multi-site, multimodal programming

20 years of treatment outcomes data from ***30,000*** patients

1 million patient self-assessments are completed a year

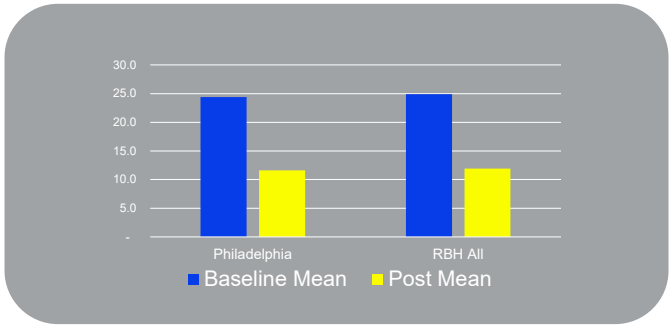
49

CBT at Rogers: A foundation

- Underpinning of Rogers' treatment is commitment to providing empirically supported interventions.
- Emphasis is on disorder-specific cognitive behavioral therapy (CBT)-based treatments.
- Specially trained psychologists work with staff using an established training and ongoing supervision model.
- Early adopter of measurement-based care to monitor treatment progress on a weekly basis.

50

Pediatric OCD: CY-BOCS outcomes



Franklin, Kay, Cook, Riemann, Eken et al. (2020). *In Prep.*

51

Motivational interviewing

- Initially used in substance abuse treatment, now extended to other mental health issues
- Involves meeting patients where they are: Readiness for change needs to be taken into account when using action-oriented treatments such as CBT and psychopharmacology
- Elicit change language from the patient:
  - Don't preach
  - Don't oversell
  - Try to be agnostic to the patient's decisions
- Allan Zuckoff and the sale of used cars…

52

Time for questions and answers...

53

Where to get additional information...

International OCD Foundation

https://iocdf.org

ADAA ANXIETY AND DEPRESSION ASSOCIATION OF AMERICA

https://adaa.org/

54

About the presenters...

Martin E. Franklin, PhD

Clinical Director, Philadelphia

Dr. Franklin is an internationally renowned expert on OCD, OC-spectrum disorders, and body-focused repetitive behaviors, as well as the study and treatment of anxiety and related conditions. In addition to serving as the clinical director of Rogers' Philadelphia location, Dr. Franklin is an associate professor emeritus of clinical psychology in psychiatry at the University of Pennsylvania Perelman School of Medicine.

Sanjaya Saxena, MD

Adult Psychiatrist, San Diego

Dr. Saxena, is a board-certified adult psychiatrist at Rogers San Diego clinic. In addition to his role caring for patients with Rogers, Dr. Saxena is a clinical professor in the University of California, San Diego Department of Psychiatry. He served as director of the UCSD Obsessive-Compulsive Disorders Program (2006-2020) and was director of the UCLA OCD Research Program and was Associate Director of the UCLA Anxiety Disorders Program (1996-2005).

Call or visit:

800-767-4411

rogersbh.org

ROGERS Behavioral Health

55