OCD, Psychosis or both?

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Agenda

- Differential diagnosis of OCD vs. Psychosis vs. both
- How OCD presents in adolescence
- Evidence based treatment of OCD
- Case presentations
- Take home points
- Q&A

Diagnosing OCD

- Obsessions, compulsions, or both
- Obsessions are intrusive/unwanted thoughts, urges, or impulses that cause marked anxiety or distress and that the individual tries to resist
- Compulsions are behaviors or mental rituals that an individual feels compelled to perform in response to obsessions that are excessive or unreasonable
- Take up at least 1 hour per day or significantly distressing or impairing
- Not better explained by substance use or another mental or physical disorder
- Specifiers: no insight (delusional), poor insight, good/fair insight
- Lifetime prevalence 2.3%

OCD/S is a Risk Factor for Schizophrenia…

- Individuals with OCD are more likely to later receive a diagnosis of schizophrenia/schizoaffective disorder

And….

- Schizophrenia is a risk factor for OCD
- Individuals with schizophrenia/schizoaffective disorder are more likely to receive a later diagnosis of OCD

Prevalence of Comorbid OCD/S and Schizophrenia

- Among people with schizophrenia, **~30-45%** have OC symptoms (OCS)
- Co-occurring OCD and schizophrenia = **12-14%**
- Some OCD onset/OCS exacerbation related to second generation antipsychotic (SGA) treatment (mostly clozapine)

Cederlof et al. 2015; Cunill et al. 2009; Pallanti et al. 2011

Differences between individuals with schizophrenia with vs. without OCD/S

- Poor prognostic indicator
- Earlier onset of psychosis
- More severe global, positive, and negative symptoms
- Greater impairments in social functioning
- More neurological abnormalities and more cognitive impairment
- More depressive symptoms and suicide attempts
- Worse quality of life

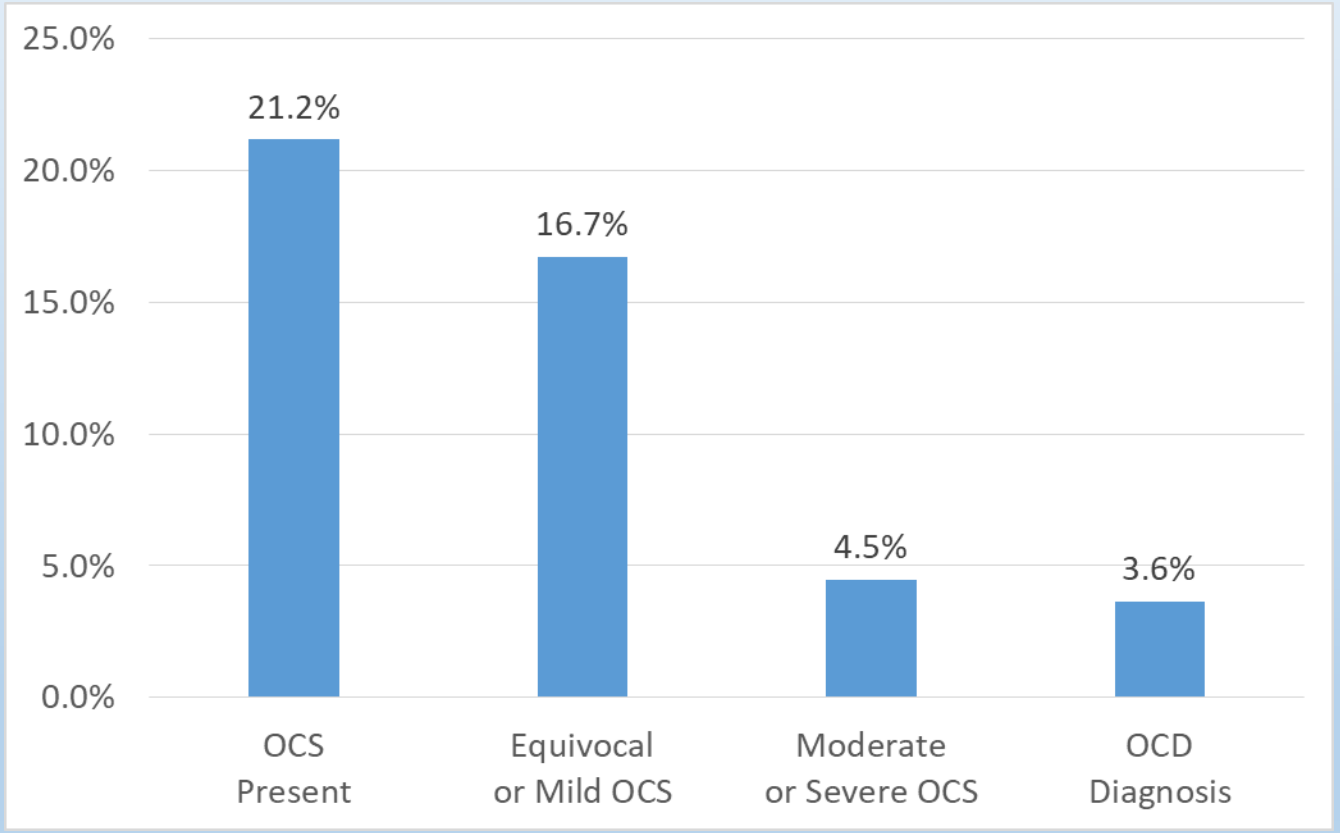
What about in First Episode Psychosis (FEP)?

- Norwegian study found comorbid OCD in 10.6% of a FEP sample

- Those with OCD:
  - Younger
  - More likely to have affective psychosis and psychosis-NOS
  - More depressive symptoms
  - More suicidal plans and attempts in the month prior to hospitalization

Hagen et al, *BMC Psychiatry*, 2013

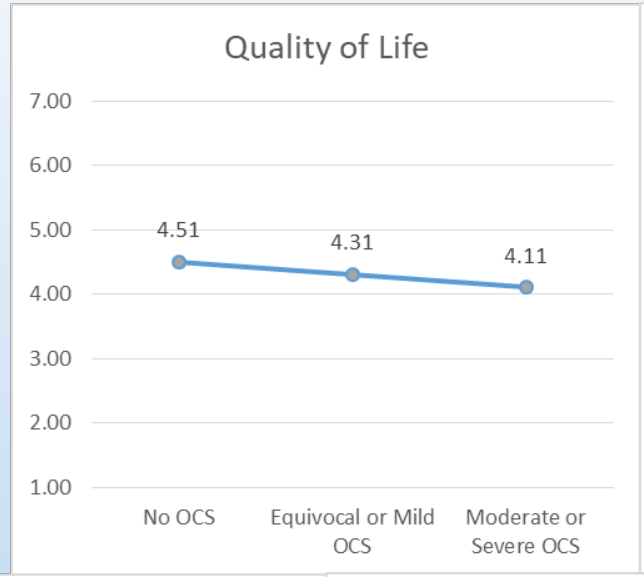
Prevalence of OCD/S Among Those Receiving Treatment in MA-based FEP Programs? (N=425)*

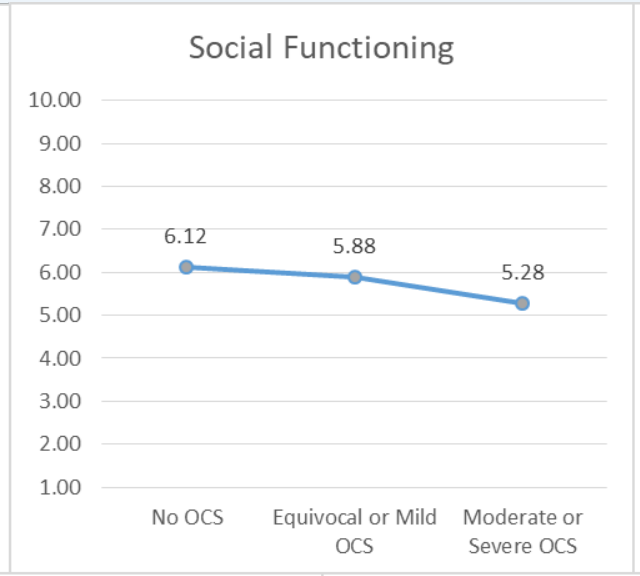


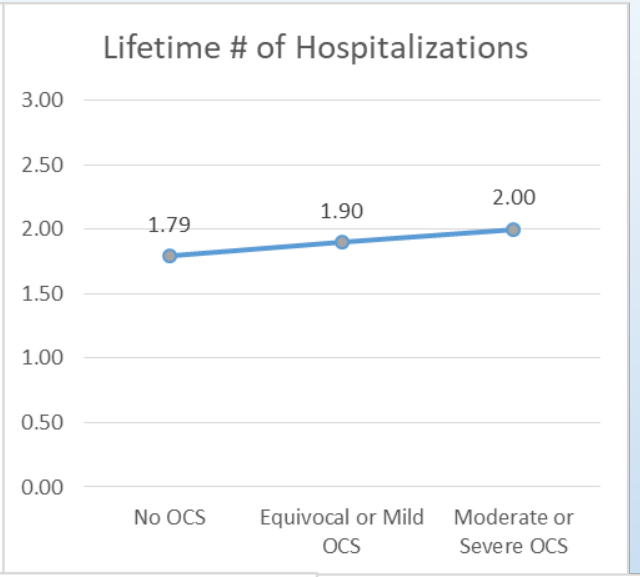
Unpublished data courtesy of MA DMH, MAPNET, and The LEAP Center

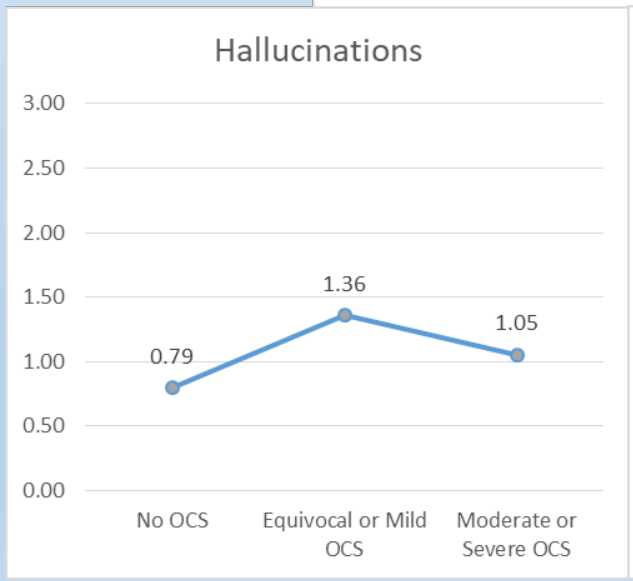
*N = 370 for OCD Dx

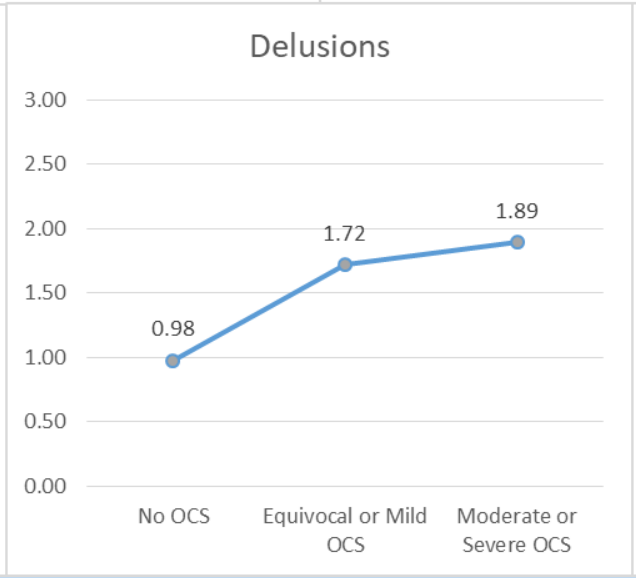
Correlates of OC Sxs in FEP Sample (N = 425)

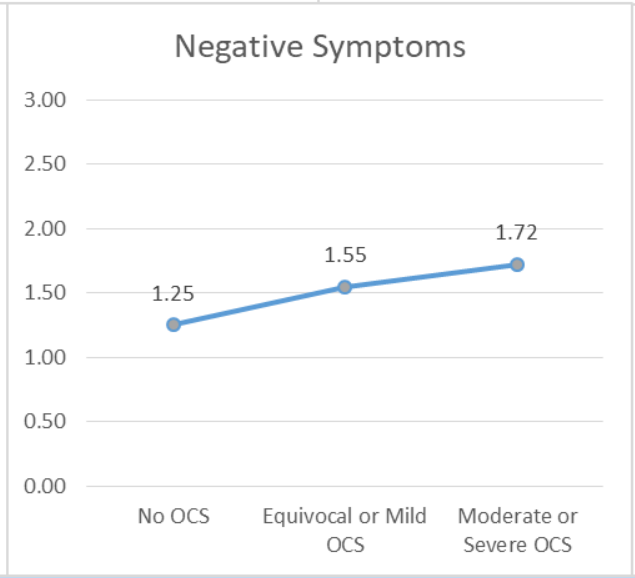


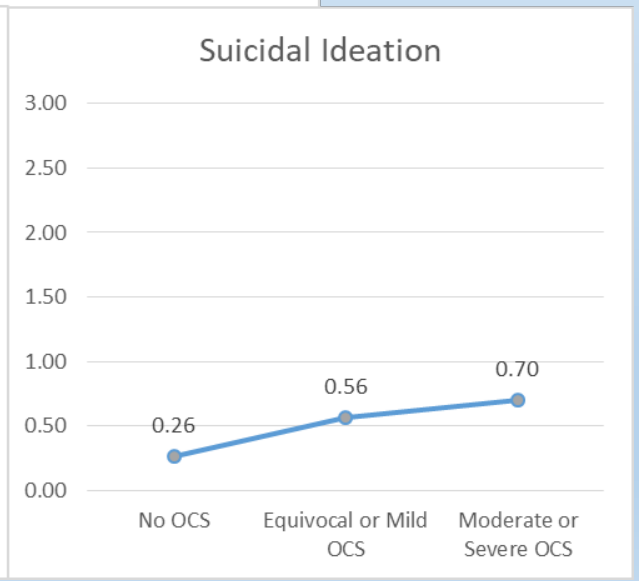












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Differential Diagnosis: Considerations

- Age of onset similar for SZ and OCD, but slightly younger for OCD, pay attention to temporal relationship of OCD/S starting after antipsychotic initiation
- Common OCD themes are: contamination/cleaning, symmetry/arranging, forbidden thoughts (aggressive, sexual, religious, and somatic)/checking, and hoarding vs. delusional content (persecutory, referential, somatic, erotomania, and grandiosity)
- Insight may not be helpful to distinguish since 5–25% of adults with OCD have only partial/no insight

Differential Diagnosis: Considerations (con’t)

- Consider bizarreness and whether viewed as product of own mind
- Evaluate whether there was a prodromal period in which social functioning declined before symptom onset
- Examine overlap between delusional content and OC sx content—OC content can not be exclusively related to delusion for an OCD dx
- Is there a clear link between repetitive behaviors and obsessions?

Identify Obsessions and Compulsions: Y-BOCS

Current Past

AGGRESSIVE OBSESSIONS

___ ___ Fear might harm self
___ ___ Fear might harm others
___ ___ Violent or horrific images
___ ___ Fear of blurting out obscenities or insults
___ ___ Fear of doing something else embarrassing*
___ ___ Fear will act on unwanted impulses (e.g., to stab friend)
___ ___ Fear will steal things
___ ___ Fear will harm others because not careful enough (e.g. hit/run motor vehicle accident)
___ ___ Fear will be responsible for something else terrible happening (e.g., fire, burglary

Other:

CONTAMINATION OBSESSIONS

___ ___ Concerns or disgust w\ with bodily waste or secretions (e.g., urine, feces, saliva Concern with dirt or germs
___ ___ Excessive concern with environmental contaminants (e.g. asbestos, radiation toxic waste)
___ ___ Excessive concern with household items (e.g., cleansers solvents)
___ ___ Excessive concern with animals (e.g., insects)
___ ___ Bothered by sticky substances or residues
___ ___ Concerned will get ill because of contaminant
___ ___ Concerned will get others ill by spreading contaminant (Aggressive)
___ ___ No concern with consequences of contamination other than how it might feel

CLEANING/WASHING COMPULSIONS

___ ___ Excessive or ritualized handwashing
___ ___ Excessive or ritualized showering, bathing, toothbrushing grooming, or toilet routine Involves cleaning of household items or other inanimate objects
___ ___ Other measures to prevent or remove contact with contaminants
___ ___ Other

CHECKING COMPULSIONS

___ ___ Checking locks, stove, appliances etc.
___ ___ Checking that did rot/will not harm others
___ ___ Checking that did not/will not harm self
___ ___ Checking that nothing terrible did/will happen
___ ___ Checking that did not make mistake
___ ___ Checking tied to somatic obsessions
___ ___ Other:

REPEATING RITUALS

___ ___ Rereading or rewriting
___ ___ Need to repeat routine activities jog, in/out door, up/down from chair)
___ ___ Other _____

OCD in Adolescents/Young Adults

OCD in adolescents

- Prevalence of OCD 1-2 %, Bimodal age of onset: preadolescence and early adulthood. 7-8 years from onset of symptoms to treatment.
- Not all pediatric cases progress to adulthood (Stewart, 2004; Micali, 2010)
- Child/Adolescent OCD with higher rates of aggressive/harm obsessions, compulsions without obsessions, atypical rituals (blinking, breathing), mental rituals.
- Insight as a specifier. Poor insight is not uncommon in peds/adolescent OCD (45% of the sample in Storch, 2007 study) vs adult OCD with more preserved.
- Comorbidities: tics (common), ADHD (30-50%) other anxiety disorders (social anxiety, GAD, separation anxiety), mood disorders (common), ASD (true comorbidity exists but not common 5%)

Medication treatment of OCD in adolescents/young adults

- SSRIs as first line.
- Clomipramine (consider after 2 failed SSRIs)
- FDA approved for children and adolescents: Fluoxetine, Fluvoxamine, Sertraline and Clomipramine. (Paxil is FDA approved for adults only *avoid in child/adolescent for increased risk of suicidality)
- Mild to moderate symptoms: start with CBT, moderate to severe symptoms CBT + SSRI. (CBT+SSRI > SSRI alone, or CBT alone. (ES for CBT 0.97, sertraline 0.67, combined 1.4). Remission rates (CY-BOCS <10): Combined > CBT alone > SSRI alone > placebo (POTS/Pediatric OCD treatment study, JAMA, 2004)
- CBT – cognitive reappraisal + exposure/response prevention (ERP > cognitive)
- SSRI dose – response relationship is well established in adult OCD (Bloch, 2010), however the literature is less clear for peds/adolescent with main concern for tolerability.

Medication treatment of OCD in adolescents/young adults

- Symptoms despite treatment: 40-60% reports residual symptoms leads to augmentation. Up to 1/3 of child/adolescent OCD cases don't respond to first line treatment.
- SSRI dose escalation? Modest but significant advantage to use high dose SSRI in adult studies, pediatric studies are lacking.
- Clomipramine? Serotonin-Selective Tricyclic Antidepressant first agent approved, gold standard but unclear if it is more compared to SSRIs. 3mg/kg.
- Consider clomipramine after 2 failed SSRI trials. Clomipramine augmentation for SSRI partial responders; monitor EKG (*may see drastic level increase w/p450 inhibitors, Luvox, Prozac, lower doses on clomipramine 25-75mg)
- AP augmentation: Antipsychotic augmentation: Adult studies with risperidone, aripiprazole, olanzapine, quetiapine, haloperidol. Co-morbid tics with good response. 1/3 of refractory cases responds to AP augmentation (Bloch, 2016)

Treatment refractory OCD: truly refractory?

- Treatment refractory: 2 failed SSRI trials, or 1 SSRI and clomipramine and failure of adequately delivered CBT/ERP
- Is the diagnosis correct? perseverative behavior/restricted interest of ASD, complex tics, ruminations with depression, emerging psychosis
- Are the first line treatment optimally provided?

-> Failed treatment vs treatment intolerant: SSRIs utilized low dose due to side effects or child/parental anxiety? : Subtherapeutic SSRIs don't work for OCD. Increase SSRI tolerability by parental education, slow titration, managing side effects with Rx.

-> Med compliance? at adequate and maximum tolerated dose (12 weeks total, 8 weeks at maximal dose)

-> Is CBT ERP based?

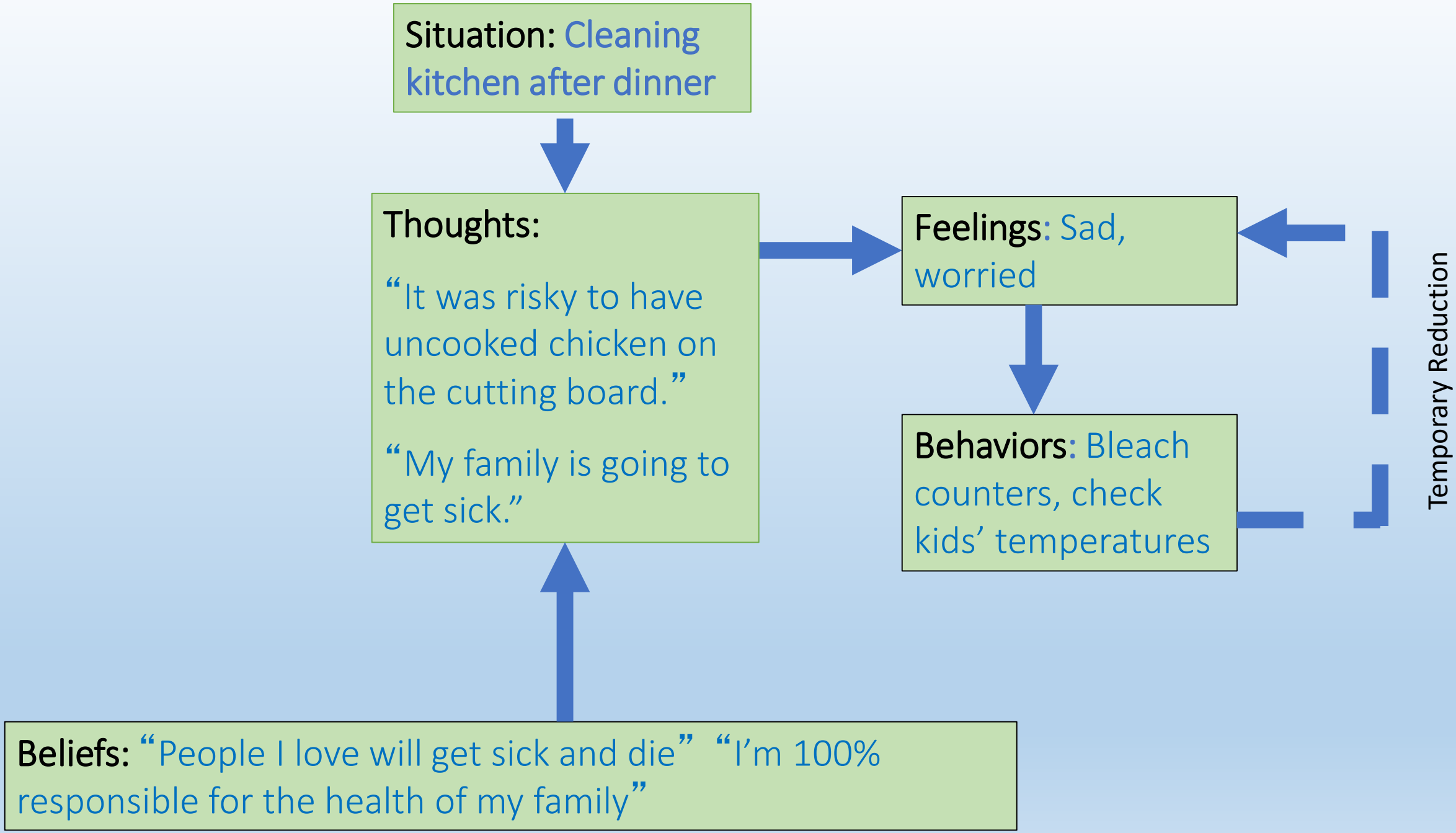
-> Assess for comorbidities, level of insight, level of parental accommodation, treatment engagement and compliance

*Mancuso, JAACAP, 2010; Bloch, JAACAP, 2015

Components of CBT for OCD

- Exposure and response prevention (ERP)
- Cognitive techniques
  - Cognitive restructuring

    responsibility/threat estimation - importance and control of thoughts - perfectionism/certainty
  - Addressing meta-cognitive beliefs (i.e., thought-action fusion)
  - Acceptance/mindful awareness of thoughts without acting on them
- Stronger ERP treatment effects for presentations which include compulsions vs. pure obsessions (but do not overlook mental compulsions)

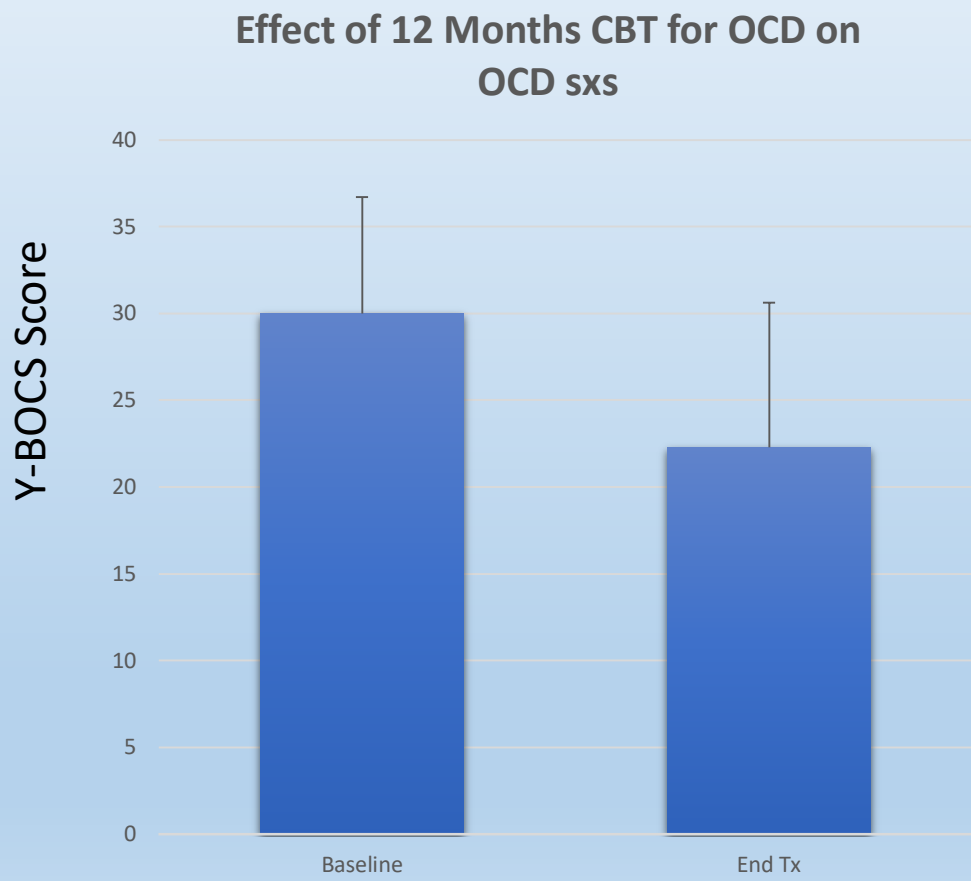

Situation: Cleaning kitchen after dinner
Thoughts:
"It was risky to have uncooked chicken on the cutting board."
"My family is going to get sick."
Feelings: Sad, worried
Behaviors: Bleach counters, check kids' temperatures
Temporary Reduction
Beliefs: "People I love will get sick and die" "I'm 100% responsible for the health of my family"

Exposure Hierarchy: Contamination

	SUDS	Compulsions/safety behaviors to prevent
Touch toilet rim in public bathroom-bare hand—15 mins	100	No washing/rubbing for 3 hours after; No stall selection
Touch public bathroom door handle-bare hand	90	
Touch toilet rim in public bathroom—with gloves—30 mins	85	No taking gloves off for 2 hours after
Touch public bathroom door handle—with gloves	50	
Handle toys on shelf at Walmart 20 mins	45	No washing for 3 hrs after; Need to touch toys that are not neatly placed
Hold grocery cart handle while shopping for 45 minutes	40	No washing steering wheel
Eat lunch from a salad bar	35	No beverage; no teeth brushing for 2 hrs after

Open trial of CBT for comorbid OCD and Schizophrenia (n = 21)

- Included participants with moderate OCD (YBOCS GE 16) and schizophrenia
- Offered 1 year of CBT focused on ERP and cognitive techniques
- 52% patients were rated as much/very much improved, 33% as responders and 19% as remitters
- GAF and insight to illness also improved



Tundo et al. (2012) *Psychother Psychosom*

Safety and Tolerability of CBT for OCD with Psychosis

- Although clinicians express concerns about ERP exacerbating psychotic sxs, not supported by the data

- Drop-out rates similar for CBT for OCD with vs. without schizophrenia

Tundo et al., (2016) *World Psychiatry*

Case Examples

Take home points..

- Screen for OCD in psychotic disorders (YBOCS/CYBOCS) and consider emerging psychosis in OCD w/delusions.
- ERP increases distress for a short period of time, but untreated OCD is highly distressing (vulnerability stress model in psychosis).
- We may not know longitudinal course, but we should treat expressed illness (OCD in CHR or psychosis in OCD).
- Considerations for differential diagnosis:
  - Pervasive delusions vs delusions only in relation to obsessional fears?
  - Presence of compulsions?
  - Presence of other symptoms of primary psychosis (negative, cognitive symptoms)?
  - Transient vs persistent delusional level conviction?
  - Illness progression?