

TAKE-HOME NOTES:

The assessment and management of obsessive-compulsive disorder: Part 2

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Obsessive compulsive disorder (OCD) is a prevalent, chronic and disabling disorder characterised by obsessional thoughts and compulsive behaviours.

Although effective psychological and pharmacological treatments are available, delays in diagnosis and treatment of the disorder occur. Better recognition and improved access to evidence-based treatment are needed.

The cornerstone of psychological treatment for OCD is prolonged, graded exposure in real life to the feared obsessions, combined with self-imposed response prevention. This treatment is usually referred to as ERP. Although there are many papers concerning the addition of cognitive techniques to ERP, there is little evidence to support anything other than the usage in patients who prove resistant to ERP.

OCD responds well to drugs that inhibit the synaptic reuptake of serotonin. These are:

- the selective serotonin reuptake inhibitors (SSRIs)
- the tricyclic antidepressant clomipramine.

The current available evidence suggests that pharmacological and psychological treatments are equally effective and there is no clear evidence that a combination is superior to monotherapy.

There are few studies addressing the issue of combining SSRIs and CBT versus monotherapy. These studies have had limitations in terms of sample size and design. However, the available data suggests that a combination of SSRIs and CBT is superior to monotherapy in some OCD patients.

The main pharmacological options for treatment-resistant OCD are:

- switching to another SSRI or clomipramine
- increasing the dose
- adding an antipsychotic.

Research has also been carried out on the efficacy of non-pharmacological interventions such as ECT, ablative stereotactic neurosurgery, DBT and the use of novel agents such as immune system modulating drugs.

Guidelines on the treatment of OCD have recently been published by:

- the National Institute of Clinical Excellence (now National Institute of Health and Clinical Excellence)
- the British Association for Psychopharmacology
- the American Psychiatric Association.

Reflection

(1.3) In order to understand how ERP works, we need first to look at why people perform compulsive acts. What is your understanding of the process of compulsive behaviour?

(2.2) What would you normally choose as a first line pharmacological treatment for OCD, SSRIs or clomipramine? What would be the reasons for your choice?

(2.6) What side effects can you think of that are associated with SSRIs?

(2.8) What management approaches might you consider in order to combat or prevent the side-effects of SSRIs?

(2.9) Which pharmacological treatments might you consider for managing OCD in the long term?

(3.2) Think about your own approach. How you would manage a treatment-resistant OCD patient?

(4.8) What treatment might you recommend for: patients with moderate functional impairment; patients who cannot engage in this type of therapy; patients for whom the therapy proves unsuccessful?

Tables and figures

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[\(4.5\) Figure 5: Stepped Care Model](#)

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