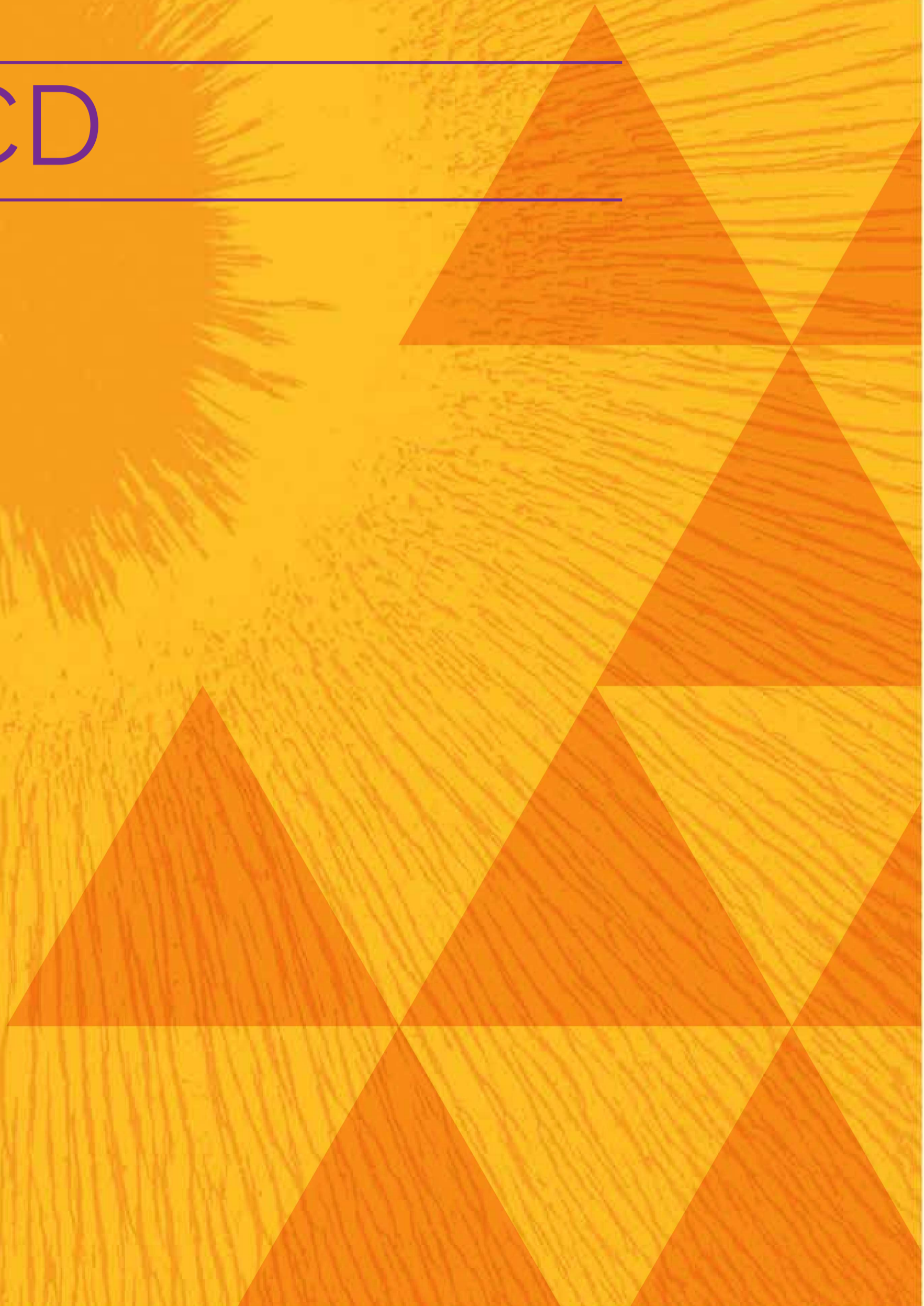

OCD



Obsessive compulsive disorder (OCD)

Clinical presentation

As mentioned in Chapter A4, OCD was classified as an anxiety disorder in the DSM-IV-TR, but the DSM-5 has separated OCD (and related disorders) into a separate category of disorder.

A person with OCD may be significantly distressed by their symptoms, and their ability to function may be impaired. They are plagued with persistent thoughts or impulses that are intrusive and unwanted (obsessions) and they may feel compelled to perform repetitive, ritualistic actions that are excessive and time consuming (compulsions). Symptoms of obsessions may include:

- Fear of germs, dirt, or poisons.
- Harm from illness or injury to self or others.
- Intrusive thoughts about sex or sexual acts.
- Excessive concerns with symmetry or orderliness.
- Needing to know or remember things.
- Hoarding or saving and collecting things.

Anxiety about obsessions may lead to vigilance about possible threats, and a compelling need for control. A person may feel annoyed, discomforted, distressed, or panic about their obsessions, and feel driven to perform repetitive mental or physical acts in response. Symptoms of compulsions may include:

- Excessive hand washing, showering, tooth brushing.
- Excessively checking locks, appliances, other safety items.
- Repeating activities or routines (e.g., opening a door, switching a light on and off).
- Applying rules to the placement of objects.
- Inability to throw out excessive collections of items (e.g., newspapers, clothes).

OCD may often go under-detected among people with AOD conditions. This is thought to be due to both a lack of training for AOD workers in the detection of OCD, and a lack of disclosure by clients who may experience shame and embarrassment, and be intent on hiding their symptoms [757].

Managing symptoms of OCD

Many people may have mild symptoms that are associated with stressful life events or situations which often improve without the need for specific treatments. However, those who experience the severity, distress and impairment associated with more chronic and enduring OCD may benefit from some form of treatment [758].

The techniques outlined in Table 41 may help AOD workers to manage clients with obsessive-compulsive symptoms, whether they are transient or more entrenched.

Table 41: Dos and don'ts of managing a client with obsessive compulsive symptoms

Do:

- ✓ Ignore strange or embarrassing behaviour if you can, especially if it is not serious.
- ✓ Approach the client in a calm, confident and receptive way.
- ✓ Move and speak at an unhurried speed.
- ✓ Be patient in order to allow the client to feel comfortable to disclose information.
- ✓ Minimise the number of staff present and attending to the client.
- ✓ Minimise surrounding noise to reduce stimulation.
- ✓ Reassure the client frequently (e.g., 'This won't take much longer').
- ✓ Explain the purpose of interventions.
- ✓ Remain with the client to calm him/her down.

Don't:

- × Crowd or pressure the client.
- × Become frustrated or impatient.
- × Laugh (or let others laugh) at the person.
- × Act horrified, worried or panic.
- × Confuse and increase the client's level of stress by having too many workers attempting to communicate with him/her.
- × Argue with the client's unusual beliefs or agree with or support unusual beliefs – it is better to simply say 'I can see you are anxious, how can I help you?'
- × Use 'no' language, as it may provoke hostility and aggression. Statements like 'I'm sorry, we're not allowed to do ____ but I **can** offer you other help, assessment, referral...' may help to calm the client whilst retaining communication.
- × Use overly clinical language without clear explanations.

Adapted from NSW Department of Health [277] and Clancy and Terry [296], Jenner et al. [123].

Treating OCD

Despite evidence from the general population indicating that roughly one in ten individuals with an AOD use disorder have OCD (see Chapter A2), the treatment of this comorbidity has not been rigorously investigated. Whether or not a person is in need of treatment will largely depend on the intensity and duration of symptoms, the impact of symptoms on their everyday life, whether or not there are any other comorbid conditions (e.g., depressive or anxiety disorders), and whether there have been any other treatment attempts in the past. As with all decisions to treat, this should be informed by the relevant evidence-base, and decisions made in partnership with the client.

Although there is very little evidence regarding the treatment of co-occurring AOD use and OCD, that which does exist suggests that treating both OCD and AOD use leads to better treatment outcomes than treating AOD use alone [759].

There are several treatment options available for the treatment of OCD, including psychotherapy, pharmacotherapy, e-health, physical activity, and complementary and alternative therapies. The evidence base surrounding each of these treatments is discussed below.

Psychotherapy

There is a significant body of research supporting the efficacy and effectiveness of CBT incorporating exposure and response prevention (ERP) for the treatment of OCD as a single disorder [760-768], including two reviews – one systematic and one meta-analysis [769, 770]. Research has found that the effect sizes for ERP are as large as pharmacological treatments [765], with lower rates of relapse [766, 771, 772]. As such, CBT incorporating ERP is recommended as a first line of treatment for single disorder OCD by clinical practice guidelines [773-775].

ERP involves repeated, prolonged and systematic confrontation with certain objects or situations that trigger obsessional responses (exposure), and resisting the compulsive urges that arise in response to the triggers (response prevention) [776]. The nature of the exposure therapy can be in vivo (i.e., physically touching a light switch) or in the imagination (i.e., confronting images of loved ones dying). ERP concurrently weakens the association between the obsessional triggers and anxiety arousal, and compulsive rituals and anxiety reduction (i.e., ERP seeks to weaken the idea that anxiety will only reduce once compulsions are performed [777]). Additional cognitive therapy can help clients address thought patterns that may be underlying their obsessional fear [776]. Although ERP is considered to be the treatment of choice for OCD [775, 778], it has been suggested that the efficacy is highly dependent on ERP being delivered consistent with clinical guidelines [778].

The UK NICE guidelines recommend that low intensity CBT with ERP (i.e., consisting of up to 10 practitioner hours per client) be offered to clients with mild functional impairment and those who express a preference for a low intensity approach [775]. Low intensity treatments may include brief individual CBT with ERP, using structured self-help materials; brief individual CBT with ERP by telephone; or group CBT. Those with mild functional impairment who are unable to engage in low intensity CBT, or have a proven inadequate response to low intensity treatment, should be offered a choice of either a course of SSRI or more intensive CBT with ERP (i.e., more than 10 practitioner hours per client), as these treatments have been shown to have comparable efficacy. Similarly, the UK NICE guidelines recommend that people with OCD with moderate functional impairment should be offered a choice between SSRIs or more intensive CBT with ERP [775]. Despite evidence of its efficacy, ERP is not always the first line of treatment provided to clients with OCD. This is likely due to a combination of factors, including the ease with which medication is prescribed and is available over ERP; the fact that many workers are either unfamiliar with, or reluctant to perform ERP; and the reluctance of some people with OCD to engage with ERP due to the anxiety-evoking nature of the treatment [769].

There are currently no integrated treatments for co-occurring OCD and AOD use disorders and only one RCT has examined the concurrent treatment of OCD among people attending residential rehabilitation for their AOD use [779]. Clients who received concurrent ERP for their OCD remained in treatment longer, and had lower OCD symptom severity and higher abstinence rates during treatment and at the 12-month follow-up, compared to those who received AOD treatment alone or AOD use plus progressive muscle relaxation. Based on the evidence provided from this RCT [779], and evidence pertaining to the treatment of OCD and AOD use as single disorders, Klostermann and Fals [759] recommend five steps for treating people with comorbid OCD and AOD use. The five steps include:

- Assessment of both OCD and AOD use: This can be difficult if clients are attempting to conceal their symptoms for fear of embarrassment, and OCD can often be confused with other psychiatric illnesses (e.g., phobia, depression, and psychosis).
- Assessment of symptom type and quality using validated assessment tools: For example intrusive thoughts, feelings and behaviours, detailed description of the anxiety-provoking stimuli typically experienced, and the ritualistic behaviours performed in response.
- Psychoeducational therapy.
- Creation of a stimulus hierarchy: Listing obsessions, compulsions and anxiety-provoking stimuli, which are then rated based on the amount of anxiety generated.
- Treatment: Concurrent delivery of ERP and AOD use treatment.

Although the findings of Fals-Stewart and Schafer [779] are promising, more evidence is clearly needed. In particular, the cyclical nature between OCD and AOD use suggests there is a need for the development of integrated treatments that simultaneously address both disorders [769, 780]. Stewart and O'Connor [780] suggest that such an integrated approach may consist of psychoeducation to explore the cyclical relationship between OCD symptoms and AOD use; targeting AOD use during ERP treatment if it is identified as a safety behaviour (a behaviour that temporarily relieves the distress associated with obsessions); and therapeutic work focused on increasing self-efficacy, in order to help the client believe they can cope without AOD use [780].

Pharmacotherapy

There has been little research examining the efficacy of pharmacotherapy interventions among people with comorbid OCD and AOD use. A Cochrane review of pharmacotherapy for anxiety and comorbid alcohol use disorders found no rigorously conducted trials of medication treatment for comorbid alcohol misuse and OCD [708]. In view of the lack of evidence for pharmacological interventions for comorbid OCD and AOD use, workers may be guided by the body of research that has been conducted for single disorder OCD.

Systematic reviews and meta-analyses of RCTs examining pharmacotherapy treatments for single disorder OCD have found that the SSRIs (citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, and sertraline), and the TCA antidepressant clomipramine, to be associated with reductions in symptom severity and improvements in health-related quality of life [781, 782]. Evidence-based guidelines for the treatment of single disorder OCD recommend that SSRIs be used as the first line of pharmacotherapy, and further suggest that the combination of psychological and pharmacological treatments is likely to be superior to either approach in isolation, though this has yet to be confirmed [758]. The current evidence for a combined approach is conflicting, with some studies finding an enhanced effect from the combination of both psychotherapy and pharmacotherapy (e.g., fluvoxamine enhancing ERP [783], and CBT [784], ERP and SSRIs being superior to SSRIs alone [785], ERP/CBT plus SSRIs being superior to SSRI alone [786]), which is not supported in others (e.g., d-cycloserine hastens the response to CBT, but overall effectiveness of CBT is not enhanced [787-789]). Table 42 provides a list of SSRIs for the pharmacological treatment of single disorder OCD.

Table 42: Selective serotonin reuptake inhibitor (SSRI) medications

Drug name	Brand names
Fluoxetine	Lovan, Prozac, Zactin
Paroxetine	Aropax, Paxtine, Paroxo
Sertraline	Zoloft, Eleva, Seralin
Fluvoxamine	Luvox, Faverin, Voxam
Citalopram	Cipramil, Celapram, Celica
Escitalopram	Lexapro, Escicor, Esipram

Adapted from Australian Government Department of Health [630]. For a full list of generic brands available, see the Therapeutic Goods Administration website (<https://www.tga.gov.au/>).

E-health interventions

Although there have yet to be any e-health interventions developed specifically for comorbid OCD and AOD use, there have been several e-health interventions developed for OCD as a single disorder. Research examining computerised CBT programs for OCD have found evidence of effectiveness [790-794], with effects similar to those found in clinician-delivered CBT sustained to three and four months [790, 793, 795, 796]. There is also evidence to suggest a dose-response relationship in regards to computerised CBT programs, with greater symptom improvements found among those who have completed more homework [792]. However, studies have found that clinician-assisted programs with limited contact are associated with better outcomes than completely computerised programs with no human contact, and the addition of a therapist coach has been linked to treatment adherence and lower dropout rates [797].

A small number of e-health programs based on ERP have also been developed. It has been suggested that the complex nature of OCD coupled with the exposure-based intervention may have deterred researchers from translating treatments into online interventions [798]. Furthermore, the findings from studies examining the efficacy of computerised ERP interventions have been mixed. A computerised ERP intervention called *BT Steps/OC Fighter* was found to be less efficacious in reducing OCD symptoms than a more expensive clinician-delivered ERP, but more efficacious than relaxation training [792]. The findings from this study suggest that the primary benefit of having a clinician was to ensure people maintain their engagement in the exposure process [769]. Given these findings, the UK NICE Guidelines recommend that *BT Steps/OC Fighter* should not be used in the treatment of OCD [444].

Another ERP program, *ICBT*, has been found to be more efficacious in reducing OCD and depressive symptoms, and improving general functioning compared to active control (online, non-directive supportive therapy) [793]. Although encouraging, further research is needed in the area of *ICBT* and OCD [798].

Physical activity

There is preliminary evidence to suggest that physical exercise may be beneficial for people with single disorder OCD. One pilot study of people with OCD maintained on SSRIs found an improvement in self-reported OCD symptoms and depression after six weeks of a walking intervention, which remained stable for one month post-treatment [799]. A second study found that the combination of a 12-week moderate aerobic exercise program with psychotherapy or pharmacotherapy reduced OCD symptom severity, which was maintained at 6-month follow-up [800]. The study found that significantly lower OCD symptoms, anxiety, and negative mood levels were reported immediately following each 20-40 minute exercise session, compared to the beginning of the session [801]. However, there is no evidence to date on the efficacy of physical exercise for the treatment of comorbid OCD and AOD use disorder specifically.

Complementary and alternative therapies

As mentioned previously, SSRIs have been associated with various dose-dependent side effects, including nausea, diarrhoea, dizziness, headaches, insomnia, sedation, anxiety, sexual dysfunction, and decreased libido [802]. As the dose required for a clinically significant improvement in OCD symptoms is typically higher than is required in the treatment of depressive disorders, the potential for unwanted side effects is substantially increased [803]. As such, several studies have examined alternative therapies in the treatment of single disorder OCD.

In a systematic review of these approaches, there was some evidence that mindfulness meditation, electroacupuncture, yoga, nutrient glycine, borage, and milk thistle may have a positive impact on OCD symptoms [804]. However, it is important to note that a number of these studies used methodologically weak designs, and none examined use of these therapies among people with comorbid OCD and AOD use.

Summary

There are currently no integrated treatments for co-occurring OCD and AOD use disorders, and evidence from only one RCT among people with comorbid OCD and AOD use favouring the concurrent treatment of these disorders [779]. Although there is limited evidence for the treatment of comorbid OCD and AOD use, results from single disorder OCD studies suggest there is strong and consistent evidence to recommend the use of ERP or CBT as the first line of treatment in single disorder OCD. Box 18 illustrates the continuation of case study F, following Jenny's story after the identification of her OCD had been made.

Box 18: Case study F: Treating comorbid OCD and AOD use: Jenny's story continued

Case Study F: Treating comorbid OCD and AOD use: Jenny's story continued

The AOD consultant liaison nurse arranged for Jenny to see both a mental health and AOD worker. With Jenny's involvement, they devised a treatment plan. This involved consultation with Jenny's GP, a home visit by a psychologist, comprehensive assessments, and concurrent treatment of Jenny's OCD and alcohol and benzodiazepine use. Although Jenny's AOD treatment was managed by the AOD service and her GP, it became evident that the supply of drugs from the Internet contained medication of varying dosage and qualities, which made it very difficult for clinicians to establish the quantity Jenny had been consuming.

Jenny received concurrent treatment of both pharmacotherapy and CBT with ERP, which addressed her OCD and alcohol and benzodiazepine use. In addition to the gastritis, Jenny had problems with her liver function, which required long-term follow up with a hepatologist. Jenny's treatment for her OCD and AOD use took place over several months and included exposure to her previously avoided situations. When this phase of treatment was completed, a longer-term process of monitoring and support was put in place to ensure that her treatment gains were maintained.

Key points:

- OCD is a condition with a much higher prevalence than had previously been assumed, but symptoms can be mistaken for anxiety.
- People with OCD commonly use substances that reduce their levels of anxiety, but may not necessarily reveal their use of AOD to health professionals.
- There are considerable problems associated with the use of medications obtained from the internet.
- There is a need to monitor ongoing physical health complications of comorbid disorders.