

Obsessive-compulsive disorder: Under-recognized and responsive to treatment

Mood or anxiety concerns, when explored, may reveal associated OCD symptoms. Pharmacotherapy and cognitive behavioral therapy have proven effective.

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THE CASE

Ms. L is a 26-year-old woman in acute distress because of a recurrent thought. She worries: "What if I sexually molest my son?" She says she has no desire to act on this recurring thought and recognizes that it is unlikely to be true. The thought is so upsetting, however, that she has begun having panic attacks and avoids being left alone with her child.

She also reports past episodes of thoughts that she may be homosexual and thoughts that something catastrophic happened without her awareness (eg, that she unknowingly ran over someone while driving). She has attempted self-management, including trying to reason with herself, trying to stop thinking the thoughts, and seeking reassurance from her boyfriend and medical providers.

These compulsive behaviors lowered her distress temporarily, thereby reinforcing her need to check and seek reassurance.

HOW WOULD YOU PROCEED WITH THIS PATIENT?

Obsessive-compulsive disorder (OCD) is a common psychiatric disorder with a 12-month prevalence of 1.2% in the United States and internationally.¹ Like other psychiatric disorders, patients with OCD present more often to primary care than specialty settings.² Despite high distress and impairment levels, individuals with OCD are often undiagnosed and do not receive evidence-based care.^{3,4} This can be particularly problematic in fast-paced primary care settings due to high medical utilization and increased costs associated with OCD.⁵

A TIME-CONSUMING DISORDER ASSOCIATED WITH DISTRESS

OCD is characterized by obsessive thoughts and/or compulsions.¹

■ **Obsessions are repeated, unwanted, distressing thoughts** or images (eg, of being contaminated by dirt/germs, fears of causing harm to others without wanting to). Individuals with OCD attempt to avoid these thoughts by suppressing or neutralizing them.

■ **Compulsions are mental or behavioral rituals** that the individual feels compelled to perform to reduce distress or prevent a feared consequence (eg, hand-washing, checking

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locks, counting). Compulsions are not reasonable safety efforts, but are instead out-of-proportion reactions to the situation.

Onset of OCD usually occurs by young adulthood, but may be present in children. Pregnancy and postpartum periods may be associated with increased risk for symptoms.⁶ The course is typically chronic if left untreated, although symptoms can occur episodically.¹

Intrusive thoughts and compulsive behaviors are surprisingly common in the general population. One study found that most individuals in a non-clinical sample reported having occasional intrusive thoughts such as whether they may have accidentally left the stove on, running their car off the road, or engaging in a “disgusting” sex act.⁷ With OCD, however, obsessions and compulsions are time-consuming and associated with distress and/or impairment.¹

For example, an individual with OCD may restrict their diet due to fears of handling foods that other people may have touched or may limit contact with people for fear they will lose control and act violently. This is partly the result of overestimating the significance of the thoughts.⁸ Individuals with OCD may believe that the thoughts mean something negative about them (eg, that they are immoral) or could lead to serious consequences (eg, thinking about a car accident makes it more likely to occur).

Distinguishing features of OCD

OCD is commonly misdiagnosed,⁹ which may contribute to the long duration of untreated illness (average 17 years).¹⁰ In one study, primary care providers were given vignettes describing OCD symptoms; half of these cases were misidentified.⁹ Certain types of obsessions (eg, aggression, fear of saying certain things, homosexuality, pedophilia) were misdiagnosed 70% to 85% of the time.⁹

Although OCD shares characteristics with other disorders, several features can help family physicians correctly identify OCD. Fears associated with OCD are usually not about everyday concerns or worries. For example, a patient with social anxiety disorder may report fear of embarrassing themselves in public, whereas a patient with OCD may report fear that they will lose control and do something outlandish such as start swearing loudly.

Additionally, obsessions and compulsions in OCD are not exclusively tied to a traumatic experience as in posttraumatic stress disorder. Someone with OCD who has harm-related or sexual obsessions (eg, homosexuality) will report that this is *not* consistent with their interests and desires. Furthermore, a small subset of people with OCD may have poor insight, meaning they have low self-awareness of the nature of their obsessions or compulsions, but they do not experience psychotic symptoms.

HOW TO MAKE THE DIAGNOSIS

A clinical interview is an essential component of assessing OCD in primary care. Ask patients who have mood or anxiety concerns about OCD symptoms, due to the high comorbidity rates of these entities.¹ If a family history of OCD is known, assess the patient for this disorder, as higher rates exist among family members.¹⁰ Although primary care providers should indeed screen for OCD and provide provisional diagnoses as warranted, additional assessment by a behavioral health practitioner is recommended, given their specialty training in this area.

Patients with OCD are often reluctant to disclose intrusive thoughts due to perceiving them as shameful or unacceptable. Consider asking direct questions to facilitate the evaluation:

- “Do you ever feel bothered by unwanted or unusual thoughts that you cannot get out of your mind even though you try to?”
- “Do you feel that you have to do anything to get rid of these thoughts or prevent something bad from happening?”
- “Will you feel very uncomfortable if you don’t do something a specific way?”

Evidence-based self-report measures are also available. The Yale-Brown Obsessive Compulsive Scale (Y-BOCS)¹¹ has become the gold standard psychometric measure for OCD. The updated version (Y-BOCS-II)¹² and child/adolescent version (CY-BOCS)¹¹ are also available.

TREATMENT: A TANDEM APPROACH IS MOST EFFECTIVE

Offer patients with OCD both medication options and cognitive-behavioral therapy (CBT). Selective serotonin reuptake inhibitor (SSRI) medications are effective first-line treatments.¹³ Treatment with clomipramine has yielded treatment outcomes similar to those seen with SSRIs; however, SSRIs are generally better tolerated.¹⁰ For treating OCD, evidence is lacking to support use of one SSRI over another.¹⁰ Medium- to upper-dose ranges are recommended for all SSRIs.¹⁴

Patient characteristics (eg, comorbid depression, level of adherence to treatment) may also help guide prescribing choices.¹⁰ For patients not responding to pharmacologic treatment in 8 to 12 weeks, consider referral to a psychiatrist.¹⁴

For OCD, CBT provided by a trained specialist typically involves exposure with response prevention (ERP). This entails confronting difficult thoughts and feared situations through exposure therapy and learning to reduce compulsive and excessive safety behaviors (eg, thinking about being contaminated by germs and then refraining from washing hands). Research suggests that CBT with ERP produces outcomes equivalent or superior to those achieved with pharmacotherapy.¹³ In addition to finding large effect sizes, clinical trials have demonstrated a treatment response of 86% in those completing CBT with ERP, compared with 48% of those receiving clomipramine.¹⁵ And Y-BOCS symptom scores have been reduced by 50% to 60% with CBT and ERP.¹⁶

HOW BEST TO NAVIGATE COORDINATION-OF-CARE ISSUES

When selecting a psychotherapy treatment provider for a patient with OCD, ask whether they are trained in ERP. If a trained psychotherapist is not available in the local health care system, you may refer to the International OCD Foundation (iocdf.org), which maintains an online directory of psychotherapists specializing in OCD.

Primary care physicians can also work with psychiatrists or psychotherapy providers to develop shared treatment plans. Part of

this plan may involve reducing excess medical utilization and checking/reassurance (eg, requesting repeat medical tests). When there is concern about safety issues (eg, intrusive homicidal or suicidal thoughts), a risk assessment is strongly recommended.

CASE

An on-site psychologist evaluated Ms. L and diagnosed OCD. Ms. L had talked to the doctor about the possibility of medication, but she preferred to try behavioral treatment first. Ms. L agreed to participate in CBT with ERP. Treatment included imaginal and situational exposure exercises to decrease emotional reactivity associated with the thoughts, and to challenge beliefs that the thoughts are meaningful (eg, that having the thought means that she may act on it or that she is an unfit mother).

For example, Ms. L practiced repeating the thoughts aloud and going into feared situations (eg, being alone with her child). This was paired with response prevention, meaning that Ms. L was instructed to avoid checking with, or seeking, reassurance from others. She engaged in 4 ERP sessions in the primary care setting, and treatment led to significant symptom improvement that was maintained at follow-up with her primary care provider 6 and 12 months later. **JFP**

CORRESPONDENCE

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