



## **Introduction to the Practice Guideline for the Treatment of Patients with Obsessive-Compulsive Disorder**

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## **Purpose of This Document**

This document is an introduction to Magellan Health Services' (Magellan) adopted clinical practice guideline (CPG) for the treatment of patients with Obsessive-Compulsive Disorder (OCD).

As with all CPGs, this adopted guideline and this Introduction are intended to augment, not replace, sound clinical judgment. As a matter of good practice, clinically sound exceptions to this practice guideline should be noted in the member's treatment record, documenting the clinical reasoning used in making the exception. Magellan periodically requests clinical files from providers in order to monitor compliance with adopted guidelines. Clear documentation of the rationale for exceptions to the guideline's recommendations should be present in the member's treatment record whenever there is evidence of deviation from the guideline.

Additionally, this guideline does not supersede Food and Drug Administration (FDA) determinations or other actions regarding withdrawal or approval of specific medications or devices, and their uses. It is the responsibility of the treating clinician to remain current on medication/device alerts and warnings that are issued by the FDA and other regulatory and professional bodies, and to incorporate such information in his or her treatment decisions.

The guideline Magellan has adopted to augment providers' clinical decision-making with those members who have Obsessive-Compulsive Disorder is the American Psychiatric Association's (APA) *Practice Guideline for the Treatment of Patients With Obsessive-Compulsive Disorder*, First Edition.<sup>1</sup> This APA guideline incorporates developments in pharmacotherapy and other areas of psychiatric management of individuals with OCD. The APA guideline is a research-based document that covers all areas of psychiatric management of patients with this disorder, from clinical features and epidemiology, to treatment approach and planning.

## **Additional Recommendations Based on Recent Literature Review**

The APA guideline is based on a literature review through December 2004. It was approved by the APA in October 2006 and published in July 2007. This guideline update is based on a literature review conducted by Magellan through March 2010. Key relevant recommendations from this more recent review of the literature are summarized here. Magellan encourages providers to be familiar with the information provided both in this introduction and the published adopted APA guideline.

## **Nosology, Symptom Structure and Risk Factors**

Since publication of the APA guideline and in preparation of the *Diagnostic and Statistical Manual of Mental Disorders V* (DSM-V), there has been considerable discussion in the clinical literature on the need to remove OCD from the anxiety disorders category and instead, consider it a disorder along a newly created spectrum of disorders sharing common features termed Obsessive-Compulsive Related Disorders (OCRDs) or Obsessive-Compulsive Spectrum Disorders (OCSDs). (Hollander et al., 2005; Durdle et al., 2008; Hollander et al., 2009; Fornaro et al. 2009; Ravindran et al., 2009)

In a clinical review by Hollander et al., authors discussed "possible similarities in phenomenology, co-morbidity, familial and genetic features, brain circuitry and treatment response between OCD and several related disorders that are characterized by repetitive thoughts or behaviors." (Hollander

et al., 2009, p.3) In addition, these authors reported that the original group of disorders examined for possible inclusion in DSM-V as an OCSD included “OCD, obsessive-compulsive personality disorder (OCPD), Tourette’s syndrome and other tic disorders, Sydenham’s chorea, Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS), trichotillomania (TTM), body dysmorphic disorder (BDD), autism, eating disorders, Huntington’s and Parkinson’s disease, impulse control disorder, as well as substance and behavioral additions.” (Hollander et al., 2009, p. 4) The breadth of the spectrum and conditions that should be included is still under investigation and researchers acknowledged this should be determined by the demonstration of a shared underlying pathophysiology and endophenotype. (Hollander et al., 2009; Ravindran et al., 2009; Durdle et al., 2008)

Another area of consideration is the proposed expansion of the Impulse-Control Disorder Not Otherwise Specified (NOS) diagnosis to include a group of new disorders called Impulsive-Compulsive Disorders. (Hollander et al., 2005) Hollander et al. revealed that four disorders were under review because they are associated with arousal and pleasure initially and then are subsequently performed to reduce dysphoria. These include Impulsive-Compulsive Buying Disorder, Impulsive-Compulsive Sexual Behavior, Impulsive-Compulsive Internet Usage and Impulsive-Compulsive Skin Excoriation. (Hollander et al., 2005)

Related to OCD diagnosis and classification, is another debatable issue regarding the factor structure of OCD symptoms. The research team of Bloch et al. conducted a meta-analysis that included 21 studies and 5,124 participants with OCD and an exploratory factor analysis of the 13 Yale-Brown Obsessive-Compulsive Scale Symptom Checklist (Y-BOCS) categories. (Bloch et al., 2008) Their findings showed that a four-factor structure explained a large proportion of the heterogeneity in the clinical symptoms of OCD (i.e., dimensions of symmetry, forbidden thoughts, cleaning and hoarding). The researchers concluded that the DSM-V diagnostic formulation of OCD should include specification of these four symptom dimensions. (Bloch et al., 2008)

Risk factors for OCD have been analyzed using epidemiological data in order to more readily identify and effectively treat persons affected with this illness. In 2007, Fontenelle and Hasler conducted a large qualitative systematic review of community samples (90 studies and 16 reviews) and analyzed the correlates and risk factors associated with the development of OCD. These included demographic characteristics, innate features (e.g., familial background and intelligence levels), environmental factors and psychiatric co-morbidities. (Fontenelle et al., 2007) Major findings of their review showed that late adolescence is a period of increased vulnerability to OCD and that it affects predominantly female adults and male children and adolescents. Other key risk factors identified were being unmarried, non-white or abusing drugs. Additionally, researchers reported that OCD was found to be a familial and genetic disorder when one considers symptom dimensions instead of categorical diagnosis and when the disorder begins at an early age. (Fontenelle et al., 2007)

## **Psychopharmacology**

The adopted APA guideline specifies that both serotonin reuptake inhibitors (SRIs) and cognitive-behavioral therapy (CBT) are safe and effective first-line treatments for OCD. The guideline notes that the choice of initial treatment modality is individualized and depends on the following factors: (1) the nature and severity of the patient’s symptoms (2) co-occurring psychiatric and medical conditions (3) the availability of CBT and (4) the patient’s past treatment history, current

medications, capacities and preferences. The guideline also indicates that clomipramine, a mixed serotonin and norepinephrine re-uptake inhibitor (SNRI) and selective serotonin re-uptake inhibitors (SSRIs) – specifically, fluoxetine, fluvoxamine, paroxetine and sertraline, are the recommended agents. However, the guideline notes that SSRIs are usually the preferred initial agents to be used because of their less troublesome side-effect profile. In addition to the guideline recommendations, other published information on SSRI treatment for OCD proposes their usage in significantly higher doses than those employed in depression and for at least six months or longer. (Marazziti et al., 2010)

Since release of the APA guideline, published meta-analytic findings continued to support SSRIs (i.e., citalopram, fluoxetine, fluvoxamine, sertraline and paroxetine) as a treatment for OCD. (Soomro et al., 2009) Findings from the 17 studies (3097 participants) that were reviewed in this analysis showed that all of these drugs had similar efficacy with a modest treatment effect overall. (Soomro et al., 2009) Additionally, other meta-analytic findings argued strongly for the efficacy of paroxetine and escitalopram, and to a somewhat lesser degree for fluoxetine, as a longer-term and maintenance treatment in the prevention of OCD relapse. Moreover, researchers suggested from their analysis, that worsening by five Y-BOCS points be considered a threshold for relapse in patient with OCD. (Fineberg et al., 2007)

Since clomipramine has such a well-established basis in the treatment of OCD, the team of Dell’Osso et al. conducted a critical review of studies in order to determine the anti-obsessional properties of another SNRI, venlafaxine. (Dell’Osso et al., 2006) In their critical review of research, the investigators noted that in two double-blind active-comparison studies, venlafaxine was found equally as effective as paroxetine and clomipramine in the short- and intermediate-term. Additionally, they identified one double-blind trial and two case reports where venlafaxine was shown to be particularly effective in OCD patients who had not responded to other SSRIs. These findings mirror the adopted guideline and its suggestion to consider switching to venlafaxine when the patient has an inadequate response to treatment with a single SSRI. Authors argued the need for more rigorous clinical trials to confirm the efficacy of venlafaxine in treating OCD due to its greater tolerability than clomipramine. (Dell’Osso et al., 2006)

Studies on augmentation strategies for treatment-resistant OCD were reviewed by Marazziti et al. They reported that about one-third of these patients may have a refractory condition and that the strongest predictor of poor response seemed to be the presence of higher Y-BOCS symptom checklist scores on hoarding obsessions and compulsions. (Marazziti et al., 2010) These authors and others indicated that clinical studies supported the use of haloperidol and risperidone added to an SSRI, but acknowledged that the data were mixed on the use of olanzapine as an augmenting agent to SSRIs in the treatment of OCD. (Bloch et al., 2006; Marazziti et al., 2010) Quetiapine added to an SSRI was also more recently studied where meta-analytic findings revealed that quetiapine as an additive to clomipramine, fluoxetine and fluvoxamine at the lowest doses was superior to placebo groups. (Denys et al., 2007)

## **Neurostimulation**

The APA guideline reviews the initial research investigating the efficacy of Deep Brain Stimulation (DBS) on the treatment of treatment-resistant OCD. At time of publication, the adopted guideline specifies that early case reports and preliminary studies are promising and further research should be

encouraged due “to the procedure’s reversibility and adjustability in comparison with ablative neurosurgery and the absence to date of serious side effects.” (p.56)

Since release of the guideline and based on a review of the peer-reviewed literature, Magellan considers DBS used in the treatment of treatment-resistant OCD to be an investigational treatment. This determination is based on an evaluation of the research findings where they did not support the effect of DBS on health outcomes, its safety and efficacy against existing alternative treatments, and its ability to demonstrate that benefits outweigh the risks. (Nuttin BJ et al., 2003; Greenberg et al., 2006; Mallet et al., 2008)

While there have been reported positive results in reducing symptoms of refractory OCD, these results have been associated with substantial risk of serious adverse events in patients with either VC/VS (ventral capsule/ventral striatum) or subthalamic nucleus stimulation implantation sites used for the treatment of refractory OCD. These include severe risk such as bleeding, infection or hemiparesis. More definitive tests of the safety, efficacy and tolerability of DBS will require larger controlled trials using matched healthy controls and double-blind on-off stimulation controls, other stimulation targets/surgical procedures and evaluation of long-term benefits. (Magellan, 2009)

The APA guideline also discusses early research on the use of Repetitive Transcranial Stimulation (rTMS) in the treatment of treatment-resistant OCD. The guideline notes that the four published trials evaluated had findings that were “inconsistent, perhaps because the studies differed in design, stimulation sites, duration, and stimulation parameters.” (p. 55)

A clinical review published subsequent to the adopted guideline indicated that these studies had stimulation parameters that varied as follows: (1) both right and left medial prefrontal cortex (PFC), (2) alternating left or right PFC, (3) bilateral stimulation of the supplementary motor area (SMA) and (4) left dorsolateral prefrontal cortex (DLPFC). (Pigot et al., 2008) In this report, the authors noted that the three sham-controlled trials in this group had negative results because the treatment courses may have been inadequate, underpowered (attributable to type II error) and not properly designed to control for co-morbid depression in the OCD patients. Additionally, the authors stressed that the “neural circuitry implicated in the pathogenesis of OCD is not exclusively cortical. Given that rTMS is a focal treatment that is known to result in cortical depolarization up to a depth of 2 cm, it is possible that prefrontal rTMS is insufficient to modify abnormal subcortical circuitry in OCD, despite known trans-synaptic effects.” (Pigot et al., 2008, p. 1451)

Another more recent study (n=20) by Kang et al. where sequential rTMS was performed alternating over the right DLPFC and SMA, showed no therapeutic effect for obsessive-compulsive symptoms. (Kang et al., 2009) However, newer stimulation parameters and treatment protocols (e.g., bilateral SMA) are now being studied in sham-controlled designs with more promising results and reduction in OCD symptomatology. (Mantovani et al., 2010)

## **Complementary and Alternative Medicine**

The only aspect of Complementary and Alternative Medicine (CAM) addressed by the APA guideline is yoga. The document briefly discusses the positive effects of a small study of Kundalini

yoga versus mental mindfulness and relaxation response management as an established alternative treatment to OCD.

The CAM therapy of electroacupuncture (EA) was more recently studied in the treatment of refractory OCD in a small (n=19) pilot, waitlist-controlled trial. (Zhang et al., 2009) All OCD patients participating had failed to fully respond to various classes of medications (i.e., anxiolytics, SSRIs/SNRI, mood stabilizers, first and second generation antipsychotics), CBT or both and still exhibited persistent symptoms. Patients in the treatment group receiving EA (12 sessions) additional treatment to their current treatment displayed significantly greater improvements in OCD symptoms. Researchers speculated that EA could enhance the release of several endogenous neuropeptides in the hypothalamus and limbic regions, including endorphin, which may be deficient in patients suffering with OCD. (Zhang et al., 2009)

## **Psychotherapy**

As noted earlier, the APA guideline recommends both SRIs and CBT as safe and effective first-line treatments for OCD. The guideline indicates that CBT used to treat patients with OCD rely primarily on exposure and response (aka relapse) prevention (ERP) or cognitive therapy (CT) techniques and acknowledges that the evidence base is strongest for ERP. Likewise, the guideline acknowledges supporting data on the use of CBT utilizing such techniques at identifying, challenging and modifying dysfunctional beliefs when combined with behavioral experiments or used in conjunction with ERP. A more recently published meta-analysis (seven studies) of CT, Behavior Therapy (BT) or CBT was consistent with the previous body of research in this area demonstrating their effectiveness and also showed that baseline level of OCD severity and depressive symptom level predicted the degree of response. (Gava et al., 2007)

Since the guideline's release, the research team of Rosa-Alcazar et al. reported that although several meta-analyses have shown the benefits of CBT, the differential effectiveness of various approaches have been inconclusive thus far. (Rosa-Alcazar et al., 2008) Results of this particular meta-analytic investigation of 19 studies showed that the treatment effect size estimates for exposure with response prevention (ERP) alone, cognitive restructuring (CR) alone and ERP plus CR were very similar. Also, their findings indicated that therapist-guided exposure was better than therapist-assisted self-exposure, and that exposure in vivo combined with exposure in imagination was better than exposure in vivo alone. Researchers have also noted that these techniques yield greater improvements for obsessions than for compulsions. (Rosa-Alcazar et al., 2008)

The APA guideline recognizes that there are limited clinical trial data on the efficacy of group behavioral therapies and acknowledges the need for additional research for this modality. Since then, a meta-analysis of 13 trials conducted by the team of Jónsson et al. examined the treatment effect sizes of group CBT/ERP against waitlist controls. Measuring clinical outcome using the Y-BOCS, their findings showed that group treatment is an effective treatment format in ERP or CBT for the treatment of OCD. However, researchers noted that these positive effects for CBT/ERP group treatment do not achieve change of the same magnitude as the individual formats of the respective treatments in previously reported studies. (Jónsson et al., 2008)

After publication of the APA guideline, formats have been developed for behavioral therapies using new technology and with reported positive results. Findings from one study of 72 patients who

received 10 weekly sessions of ERP delivered by telephone showed that clinical outcomes of this treatment was equally as effective as treatment delivered face to face. (Lovell et al., 2006) Similarly, findings from a British systematic review of four studies evaluating the effectiveness of computer-guided therapy (using the software program, *BTSsteps*), revealed that it was as good as therapist-led CBT for reducing time spent in rituals and obsessions. (Tumur et al., 2007) Moreover, these researchers found that computerized CBT showed improved outcomes in work functioning, home management, social activities and private leisure activities and was superior to relaxation therapy in the treatment of patients with OCD. (Tumur et al., 2007)

In children and adolescents, the APA guideline indicates that treatment should often start with CBT or with a combination of psychotherapy and an SRI. The guideline denotes ERP as an effective CBT approach for use in the pediatric population. More recently published meta-analytical findings continued to provide data supporting their value. (Barrett et al., 2008; Watson et al., 2008; Munoz-Salmando et al. 2008; In-Albon et al., 2007) The research team of Barrett et al. reported that results from exposure-based CBT trials have consistently shown remission rates ranging from 40 percent to 85 percent across studies. Authors also acknowledged that individual exposure-based CBT had the strongest evidence of efficacy followed by family-focused individual or group formats for the treatment of child and adolescent OCD. (Barrett et al., 2008)

### **Combined Treatment**

The APA guideline specifies that combined treatment (SRI and CBT) is more effective than monotherapy for some patients but that it is *not* necessary for all patients. Herein, the document notes that combined treatment should be considered for patients who have had an unsatisfactory response to monotherapy, who have co-occurring psychiatric conditions for which SRIs are effective, or who wish to limit the duration of medication treatment. Additionally, the guideline denotes that combined treatment may also be considered for patients with severe OCD, since the medication may diminish symptom severity and allow the patient to engage in CBT.

One randomized controlled trial looked at the effects of sequencing the provision of behavioral therapy to patients already receiving an adequate SRI dose. (Simpson et al., 2008) The study provided some 17 sessions of CBT (either twice weekly ERP or stress management) to 108 adult outpatients diagnosed with OCD while continuing SRI and adjuvant drug treatment (i.e., antipsychotics, benzodiazepine, mood stabilizer, stimulant and others). Results showed that the addition of ERP reduced OCD symptom severity more than the addition of stress management training in patients with clinically significant OCD despite an adequate SRI trial. Also, more patients who received ERP rather than stress management training were treatment responders and achieved minimal symptoms. Nonetheless, researchers concluded that the 17 sessions of CBT was not sufficient to help most of the patients in the study achieve minimal symptoms. (Simpson et al., 2008)

### **Obtaining Copies of the APA Guideline**

Copies of the Practice Guideline for the Treatment of Patients with Obsessive-Compulsive Disorder, First Edition may be obtained through the APA at [www.psych.org](http://www.psych.org), or by calling (800) 368-5777, or by U.S. mail at:

American Psychiatric Publishing, Inc.  
1000 Wilson Blvd., Suite 1825  
Arlington, VA 22209-3901

### **Provider Feedback**

Magellan welcomes feedback on our clinical practice guidelines. We take all suggestions and recommendations into consideration in our ongoing review of the guidelines. Questions or comments may be submitted via mail or e-mail to:

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