Health essays - treatment ocd disorder

Treatment OCD Disorder

Introduction

My research intention is to compose a literature review aimed at finding the best existing method for the treatment of Obsessive-Compulsive disorder (OCD).

OCD is an anxiety disorder characterized by intrusive and distressing thoughts, urges and images as well as repetitive behaviours aimed at decreasing the discomfort caused by these obsessive thoughts.

So in order to achieve my research intention I will be comparing and analysing a wide assortment of current and previous literature to distinguish the most favourable treatment method, where advantages outweigh all disadvantages.

The key features of OCD as already discussed, include obsessional doubt, the need to feel in control, and risk aversion, and these features have significant impact on the successful application of both pharmacological and behavioural treatments.

Treatment History of Obsessive-compulsive disorder

Until the 1960’s OCD was considered a refractory psychiatric condition, neither psychotherapy nor a variety of pharmacological treatments had proven successful with the symptoms, however since around 1975, much progress has been made in improving the effectiveness of these treatments. Prior to 1980, OCD was unresponsive to psychotherapy, anxiolytic drugs, and anti-psychotic drugs and had a poor record of success. Today although

treatment of this disorder remains challenging, the effectiveness of both behavioural and pharmacological therapies has been significantly improved.

Treatments

There are many methods available for the treatment of obsessive-compulsive disorder (OCD) arguably the most popular of these being administration of antidepressants, either taken singularly or a combination of 2. Also Psychotherapy strategies including both behavioural and cognitive treatments where it is common (and often claimed to achieve better results) for the two to be combined, this is known as Cognitive Behavioural Therapy (CBT).

I will then go on to investigate Combination treatments. This being the combination of antidepressants and a CBT treatment to see if a combination of the two is more successful than using either alone.

Alternative strategies are available for OCD sufferers and although these are not as successful as some of the already discussed, they are worth mentioning as they can provide relief to patients, also when added to another more established treatment better results may be achieved.

I will also be touching on psychosurgery (also known as neurosurgery), and Electro Convulsive therapy, which although are only used in the most extreme cases, are still worth mentioning as, when used, have shown significant efficacy in the treatment of OCD.

Pharmacotherapy, the uses of antidepressants for the treatment of Obsessive-compulsive disorder.

Currently in the UK only 5 drugs are licensed for the treatment of OCD, They include the Tricyclic antidepressant (TCA) Clomipramine and the Selective Serotonin reuptake inhibiting (SSRI) antidepressants Fluoxetine, Sertraline, Paroxetine, and Fluvoxamine which can be collectively labelled as STI's, these STI's represent the cornerstone of Pharmacological treatment in patients with OCD. A good reason for using antidepressants in OCD treatment is that very often there will be underlying depressive disorder.

There is a substantial amount of evidence derived from a large number of placebo-controlled clinical trials, to indicate that drugs, which preferentially block the re-uptake of Serotonin, are effective in ameliorating the symptoms of OCD.

The evidence in favour of other antidepressants without potent serotonergic properties is poor.

Clomipramine was the first agent to receive food and drug administration (FDA) approval for the treatment of OCD, and was also the first medication to demonstrate consistent efficacy in the treatment of patients with OCD (Clomipramine collaborative study group) it has been the most extensively studied medication for the treatment of OCD.

Studies in OCD treatment that have compared two antidepressants have been very small and yet an apparent superiority of Clomipramine emerges.

In a small three-way study by Thoren et al (94), which compared Clomipramine with Nontriptyline and Placebo, found there was significant

effect for Clomipramine but Nontriptyline appeared no different from Placebo. However a significant difference between active treatments is not normally expected unless very large numbers are included in studies.

Clomipramine which affects both 5-HT and non adrenalin may be more effective than SSRI’s although does have more side effects which is the biggest disincentive, these include constipation, dry mouth, tremor and weight gain, however these side effects can be used to advantage in patients who cannot deal with the agitation of the SSRI’s

During trials, drop out rates due to side effects from Clomipramine are consistently higher than for the SSRI’s. (Pata et al 90)

Although there are only rare reports of less efficacy, the issue of how long to maintain treatment before a trial off medication has not been well explored. The only data that exists in this area comes from 3 rather small-blinded discontinuation studies. All were done with Clomipramine. (Pato, Zohar, Kadouch, Zohar & Murphy 1988) in each case, the majority of the patients upwards of 90% had their symptoms return within 4-7 weeks of discontinuing medication.

The efficacy of SSRI’s versus those of the TCA’s, for these indications is unstudied, further research is required fully to assess the place of the SSRI’s in the treatment and understanding of OCD.

Fluvoxamine has been shown to be significantly better than Placebo and equal in efficacy to Tricyclic’s such as Clomipramine however Fluvoxamine

compared to Clomipramine is found to have fewer side effects and is a first line agent in the treatment of OCD.

More than 50% of patients with OCD are significantly improved after a trial with Fluvoxamine, however not all patients benefit from this treatment- In a single-blind study of Fluvoxamine 6 of 10 in patients with severe OCD were ‘ responders’ on the basis of a clinical rating of ‘ much’ or very ‘ much’ improved.

The most commonly reported side effects for Fluvoxamine are daytime drowsiness, nausea, insomnia, and headache. However these seem to be common side effects of all the SSRI’s.

The effects of Fluoxetine in OCD have been studied in a number of single blind and open trials, and the results indicate that Fluoxetine is effective in reducing the symptoms of OCD; these results also appear to be dependent of the drugs antidepressant effect. (Liebowitz et al 1990, Riddle et al 1990)

While these studies suggest that drugs with Serotonin re-uptake blocking properties are effective in OCD, they do not bear on which of these drugs may be more effective or better tolerated. Although no such comparative trials have been published, Jenike and associates (1990) indirectly compared Fluoxetine with Clomipramine in OCD symptoms in a recent meta-analysis. The data came from two separate open studies of each compound in OCD, and the special statistical techniques used suggested that Clomipramine had a slightly superior therapeutic effect. Fluoxetine however was considerably bettered tolerated. Fewer data is available on Fluoxetine, ideally more research is needed to better understand its place in OCD treatment.

Paroxetine efficacy reports back to Wheaden et al (1993) however a more recent study (Zohar et al 1996) reported that in a 12 week acute trail comparing patients on Paroxetine, Clomipramine and Placebo, only 16% of Paroxetine patients had drug related adverse experiences, compared to 28% on Clomipramine, and although generally well tolerated, there have been some reports of severe withdrawal symptoms, even when done gradually. This however may be related to the fact Paroxetine is a newer FDA approved agent for OCD, and there have not been as many published findings of its efficacy compared to other agents available.

Sertraline has generally shown significant improvement in OCD symptoms when compared to placebo (Greist et al 95), and although Sertraline does have the smallest effect size, with regard to side effects it is well tolerated. However unlike Fluoxetine, Fluvoxamine and Paroxetine there are no head to head trials comparing it to other antiobsessionals.

Some advantages of the SSRI’s are that they have fewer clinically meaningful interactions, for example, they do not potentiate the effects of alcohol, or other sedatives- (Cooper et al 1989), however as not all of the SSRI’s have been tested with all drugs generalisations are difficult.

One meaningful global measure of how well medications are tolerated is the number of patients who have dropped out of double-blind trials because of adverse effects. Most double blind studies of SSRI’s have had more dropouts among patients treated with tricyclic antidepressants such as Clomipramine. Within the SSRI’s the highest dropout rate was associated with Fluvoxamine and the lowest with Paroxetine. While the number of dropouts provides

useful information, this variable is also important for the examination of specific side effects.

When considering a combination of 2 types of drugs there is rarely any rationale for prescribing together more than one drug from the same general class.

Fatalities have been reported following the combination of Clomipramine and Tranylcypromine. Other combinations can lead to adverse effects.

TCA’s and SSRI’s have been tried together but there is a high risk of adverse interactions. If the two-antidepressant classes were to be co prescribed the safest choice would appear to be Citalopram, or low dose Sertraline that have little or no effect on the metabolism of TCA. (Taylor 95)

‘ Triple therapy’ has also been tried, one example being Clomipramine, Tryptophan and Lithium.

When considering Pharmacotherapy treatment failure, comparative dropout rates rather than number of intensity of side effects, may be a good indirect measure of the tolerability of the medication, the results in this regard have been mixed but very interesting.

In comparative studies between Fluvoxamine and Clomipramine (Freeman et al 1994, Koran et al 1996) dropout rates were virtually identical with both medications around 15%. However in the meta-analysis conducted by Greist et al 1995 they note that analysis of the pooled multicenter studies revealed the lowest rates of dropout in the Clomipramine group at 12%, followed by Fluvoxamine at 24%.

There are some data on the characteristics of patients who are more resistant to treatment or poor treatment responders, but more work is needed in this area. For example, many OCD patients have shown poor response to Pharmacotherapy in some studies. (Jenike 93, Riccardi et al 92), and more recently (Black, Manahan, Clancy, Baker, and Gabel 97)

Psychotherapy in the treatment of Obsessive-Compulsive disorders a Cognitive-Behavioural approach.

Research has shown that psychological and social treatment can produce definite and measurable benefits (Kingdon et al 1994).

Cognitive behavioural therapy leads to marked improvement in the large majority of clients with OCD who complete the treatment, and has been estimated that between 80/90% of patients will respond to CBT (Abramowitz 97)

In Meyers (1966) treatment plan hospital staff actually stopped the patients from performing rituals-this treatment procedure was labelled ‘ exposure and response prevention’ (EX/RP). However this kind of intervention is no longer typical or recommended. Actual physical prevention is too coercive to be acceptable-and reliance upon this technique may limit generalizability to non-therapy situations in which staff are non-present to prevent rituals. Although exposure reduces obsessional distress it is not so effective in reducing compulsions.

Exposure and response prevention (EX/RP) is the psychological treatment of choice for OCD. Although other interventions (Cognitive approaches) have

received some attention in the literature EX/RP has received by far the strongest empirical support for treating.

Despite documented efficacy of EX/RP treatment 25% of individuals with OCD decline to accept this form of CBT. Efforts to understand the factors influencing acceptability of exposure treatment are indicated so that more clients may profit from this powerful remedy.

Separate effects of exposure and response prevention for OCD have been examined, treatment that combined both exposure and response prevention was found to be more effective. (Foa, Steketee, Grayson, Turner, & Latimer 1984)

With non-ritualisers, exposure did not prove particularly effective. Emmelkamp & Kwee (1977) noted only 1 of 3 patients showing improvement after 5 one-hour sessions. Although exposure reduces obsessional distress it is not as effective as reducing compulsions. It is generally held that patients with obsessions alone, rather than obsessions and compulsions are more difficult to treat using conventional behavioural procedures. However recent research is inconsistent with this view as patients in 2 studies evidenced some improvement in compulsive behaviour with this technique. (Marks, Crowe, Young & Dewhurst 69)

CBT has been found to be more helpful than drugs for individuals who complete it. About 75% of clients who complete CBT do well both immediately after treatment and in the long run, showing lasting improvement of about 65% fewer symptoms on average-also no side effects.

Drugs, mainly antidepressants in this condition, are easy to administer and are more rapidly effective than the main forms of behaviour therapy, response prevention and gradual exposure. However unlike drug treatment, once behaviour therapy has been used and shown to be effective, relapse is much less likely to occur even after treatment is withdrawn completely.

A number of other exposure-orientated procedures, such as paradoxical intention, imaginal flooding, satiation, and aversion relief have been found relatively unsuccessful with OCD. Procedures aimed at blocking or punishing obsessions and compulsions such as though stopping, aversion therapy, and covert sensitisation have also been relatively unsuccessful with OCD. (Emmelkamp & Kwee 1977, Kenny, Mowbray & Lalani 1978) Conversely Victor Meyer treated clients with OCD with prolonged exposure to situations of objects that evoked obsessional distress and prevention of rituals-the treatment was very successful in 10 of its 15 cases. (Meyer 1966, Meyer & Levy 1973, Meyer, Levy & Schnurer 1974)

Another downfall that the literature indicates is that OCD patients who have additional psychological problems are less likely to respond favourably to CBT, these include depression, anxiety or poor judgement, and unfortunately these often coexist with OCD symptoms.

Combination treatments, Antidepressants & CBT in Obsessive-Compulsive disorder.

As already discussed, effective treatments for OCD consist mainly of Cognitive behavioural therapy and antidepressants. In order to maximise the effects of treatment, antidepressants and CBT are frequently combined in

clinical practice, despite the fact that scientific support for this is surprisingly thin.

Preliminary findings of a controlled, double blind, multicenter comparison of Clomipramine, exposure therapy and their combination indicate that exposure therapy have stronger effects than Clomipramine-both procedures combined are equivalent to exposure therapy alone. (Foa et al 93) Also Combination of EX/RP was not enhanced by the addition of cognitive therapy (Emmelkamp & Beens 1991).

However findings by Van Oppen et al (95) show that cognitive approaches compared to EX/RP indicated that cognitive therapy alone was as effective as exposure therapy.

A recent meta-analysis (Van Balkom et al 94) showed that CBT was superior to antidepressants on self-ratings, also compared with CBT; antidepressants have a higher dropout rate and higher relapse rate after stopping treatment. Thus when given alone CBT is more effective than antidepressants. However meta-analysis have shortcomings, firstly since studies are combined, there is always a mixture of the specific study details such as the way in which treatments were implemented, also studies differ in length, therapist involvement, and strictness of ritual control, leaving many reasons to believe that the results of meta-analysis are not conclusive.

Conversely one large multicenter study carried out by the national institute of mental health compared 2 forms of psychotherapy with antidepressant drug treatment, all treatments were approximately equally effective over the period of study when mildly ill people were assessed, however, with more

severely ill patients, drug treatment was clearly superior to psychotherapy. (Elkin et al 1989)

Third line treatments-Electro compulsive therapy and Psychosurgery for Obsessive-compulsive disorder.

If psychosocial and pharmacological treatments do not work, third-line treatment includes Psychosurgery and electro convulsive therapy (ECT).

Although rarely used electro convulsive therapy (ECT) has been shown to be of benefit in some who failed to respond adequately to Pharmacological or Psychotherapy interventions (Strober et al 98). In many cases there will be temporary amnesia post treatment and mild headache but otherwise ECT is free from side effects. This makes it distinct from the anti-depressants, and it is for this reason that ECT is still used. Studies using ECT however lack any control data that allow a conclusion to be reached about its efficacy.

Psychosurgery like ECT has aroused a great deal of controversy.

Results suggest that 25-30% of the patients who previously were unresponsive to medication and behavioural treatments are significantly improved after psychosurgery, although should always be considered as a last resort, studies suggest that complications are relatively rare and that neuropsychological and personality functioning is not adversely effected by psychosurgery

Some Conclusions.

In sum, there are 2 very good treatments for OCD. CBT seems to produce more improvement than medication, and improvements are more lasting after treatment is stopped. Medication however does take less time and effort in the short run than CBT but may have to be continued indefinitely.

Medication is not emotionally challenging but you must tolerate side effects, EX/RP requires determination and is emotionally challenging.

With regards to treatment failure Foa et al (1983) argue that it is only when investigation is carried out of the differences between those who succeed and those who fail, that light can be thrown on the mechanisms involved in the treatment and more effective treatment strategies be developed, as it is evident that new and more effective pharmacological and psychotherapy strategies are needed for the treatment-refractory OCD patient.