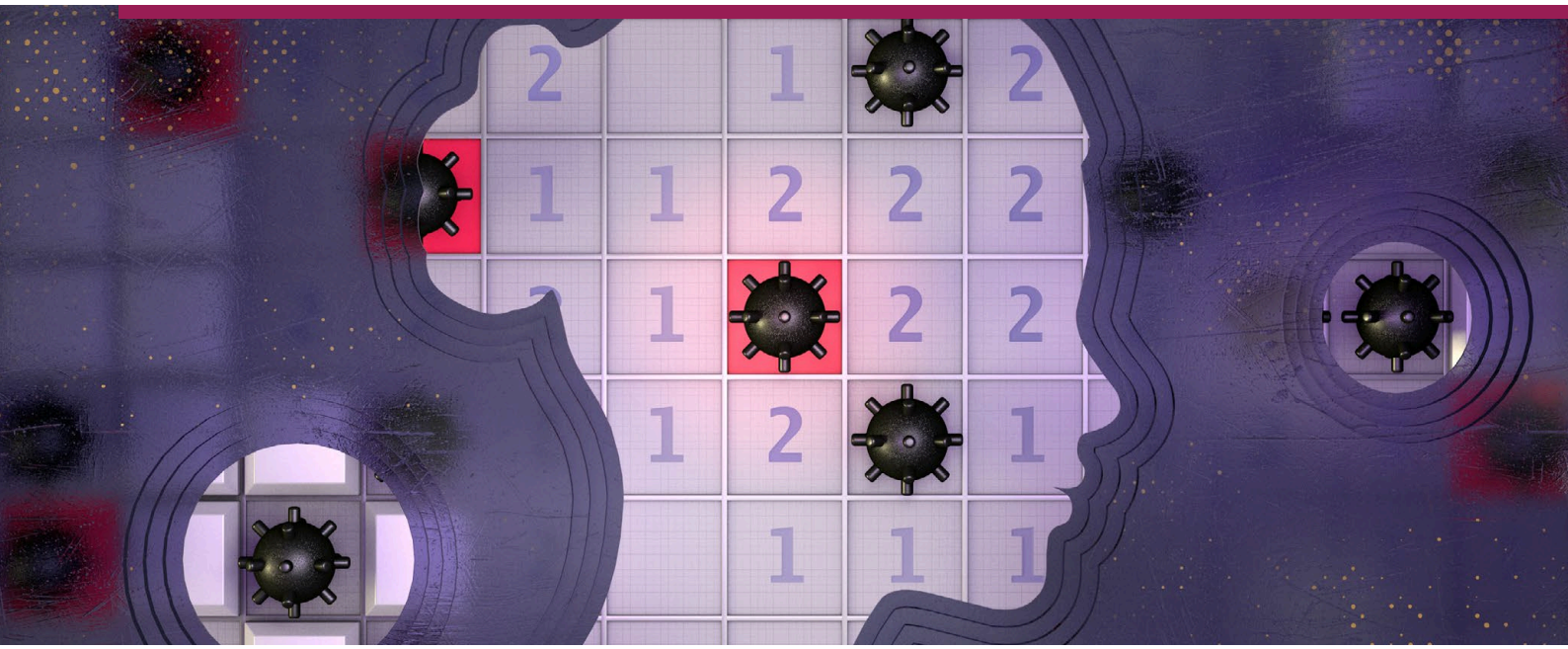


Recognising and managing OCD in primary care

Obsessive compulsive disorder (OCD) affects approximately 2% of the population and can have a significant impact on quality of life, including relationships, education and employment. Diagnosis in primary care can be challenging due to the variable nature of presentation and reluctance by many patients to report their symptoms. In addition, symptoms of OCD may be misunderstood, or attributed to another mental health or psychiatric condition.

In this article, we invited **Dr Caleb Armstrong**, Consultant Psychiatrist and Youth Forensics Specialist, **Anteris NZ**, to answer a series of questions about the understanding, recognition and management of OCD in primary care. The interview was conducted in May, 2022. Some responses have been edited for clarity or brevity.

KEY PRACTICE POINTS:

- OCD is associated with unwanted, repetitive, intrusive thoughts, images or impulses (e.g. contamination, losing control, harm) that are highly distressing, and often lead to the performance of compulsive behaviours (e.g. checking, hand washing, seeking reassurance, rumination) to resolve the anxiety caused by the obsessive thought(s)
- If OCD is suspected, an initial assessment in primary care should begin with broad questions to further elucidate the situation, e.g.:
  - *Do you ever find that certain thoughts or images keep coming into your head even though you try to keep them out?*
  - *What do you do to try to get rid of these thoughts?*
  - *Do you sometimes feel like you must do certain things over and over even though you do not want to?*
  - *Do repeating these actions seem reasonable to you or do they seem excessive?*
- Exclude other potential causes of the patient's symptoms, e.g. mood or anxiety disorders, psychotic disorder, anorexia nervosa, medicine adverse effects, substance misuse
- Assess the severity of symptoms and degree of functional impairment to help inform management decisions; tools such as the shortened version of the Yale-Brown Obsessive Compulsive Scale may assist with this
- Once a presumptive diagnosis of OCD has been made, the patient should ideally be referred for psychotherapy, but in the interim the general practitioner can advise on management techniques, recommend online CBT, e.g. Just a Thought, and consider initiating pharmacological treatment. Patients with severe OCD or complex co-morbidities should be referred more urgently.
  - *Mild to moderate OCD – psychotherapy alone is recommended, preferably exposure and response prevention therapy (ERP)*
  - *Moderate to severe OCD – pharmacological treatment is recommended in addition to psychotherapy; SSRIs are first-line (usually fluoxetine or sertraline), titrated as tolerated to a high dose*
- Tailor follow-up according to patient-specific factors; in general, a three-monthly review is appropriate, but monitoring may be less frequent if the patient has an established management plan, e.g. attending therapy. If suicidality, weight loss or other medical issues are involved, more frequent follow-up is required.
- Education about OCD and its treatment is an important part of management and people living with OCD, and their parents/caregivers, should be encouraged to join support groups

Understanding OCD

What is OCD and what is the difference between an obsession and a compulsion?

OCD is a common mental health disorder, part of a group of related disorders including **trichotillomania**, hoarding, excoriation disorder and body dysmorphic disorder.

While almost everyone may experience unwanted intrusive thoughts at some time, OCD is a disorder in which intrusive thoughts, images or impulses are highly repetitive, time consuming and distressing. As well as images, some people may experience smells, tastes or sounds which can repeat as if on a loop. People living with OCD generally describe trying to resist these obsessions to no avail, which often results in the performance of compulsive acts in an attempt to resolve the anxiety caused by having the obsession. Some people with OCD may present with no compulsive behaviours, a form of OCD referred to as "pure O". However, this may also mean that their compulsions are not overt, either to the clinician or themselves.

Distinct from the colloquial use of the word "obsession", **obsessions** in OCD are unwanted, are not preoccupations with real life problems, and are ego-dystonic, meaning that they go against the person's actual wishes and morals and are a source of great distress (in contrast to delusional beliefs).

Compulsive behaviours may be mental or physical, such as counting, checking, hand washing, praying, placing things in order or touching things a certain number of times, seeking reassurance, avoidance, mental reviewing, silent mantras, rumination. The key feature of a compulsion is that it's a behaviour performed to temporarily reduce the anxiety and distress caused by the obsession.

What type of symptoms do people with OCD have?

The stereotype for people living with OCD is an obsession with cleanliness/contamination and checking-based behaviours. However, there are a wide variety of obsessions and compulsions that people with OCD may display, therefore, keep an open mind for this diagnosis.

Contamination fears are common in people with OCD, and are often accompanied by severe avoidance of dirt, "germs" or environmental contaminants. Associated compulsions often involve excessive or repetitive cleaning, including hand washing.

However, other types of obsessions are also common in OCD, and include:

- Losing control, e.g. fear of blurting out obscenities or insults, stealing things, harming themselves or others
- Harm, e.g. fear of being responsible for something terrible happening, fear of harming others because of not being careful enough such as by dropping something on the ground that might cause someone to slip
- Religious obsessions, e.g. concern with offending God, excessive concern with morality
- Unwanted sexual thoughts, e.g. thoughts of sexual aggression, forbidden sexual behaviours and sexual abuse of children
- Perfectionism, e.g. concern about exactness, fear of losing things, inability to discard things
- General concerns such as sexual orientation, contracting an illness or terminal disease, superstitious ideas, a general feeling of something "just not being right"

Can you outline the current understanding of OCD pathophysiology?

The pathophysiology of OCD is thought to relate to changes in the activity of a circuit involving the orbitofrontal cortex, anterior cingulate cortex, dorsolateral prefrontal cortex and the head of the caudate nucleus and striatum (sometimes called the cortico-striatal-thalamic circuit).[a] Serotonin is highly important in regulating the activity of this network.

These brain regions work together to process incoming information, evaluate the importance of this in terms of threat or the need for a response and to choose a behavioural response.[a] It's thought that overactivity can lead to a feedback loop of sorts, with the signals amplifying within the loop until anxiety resulting from this becomes unbearable. Normalisation of the activity of these networks can be seen with successful psychological or pharmacological treatment of a patient with OCD.

"Metaphors that turn OCD into something strong and scary, a monster or a bully, are not necessarily helpful. To consider OCD as a brain "glitch" or a frightened child who needs firm boundaries may be more self-compassionate." – Marion Maw, an Administrator of Fixate

a. Aouizerate B, Guehl D, Cuny E, *et al*. Pathophysiology of obsessive–compulsive disorder. Progress in Neurobiology 2004;72:195–221. Doi:10.1016/j.pneurobio.2004.02.004

What risk factors influence the development of OCD?

Significant risk factors for the development of OCD include:[a]

Family history of OCD. Family history is often present, however, the genetics underlying OCD are unclear.

Younger age. Onset may occur at any age, however, there is a first peak onset between the ages of 8 and 12 years, and a second peak in the late teens and early 20's. The average age of onset is estimated to be 19 years, but diagnosis is sometimes delayed by many years.

Female sex. OCD is slightly more common in females than males, however, males are more likely to have early onset and severe symptoms.

Co-existing psychiatric disorder. It's common for OCD to co-exist with other psychiatric disorders; anxiety disorders usually develop first, impulse control disorders and substance use disorders are also often present prior to the onset of OCD, but mood disorders usually develop after.

a. Ruscio AM, Stein DJ, Chiu WT, *et al.* The epidemiology of obsessive-compulsive disorder in the National Comorbidity Survey Replication. Mol Psychiatry 2010;15:53–63. doi:10.1038/mp.2008.94

Can you explain more about the association between OCD and other mental health disorders?

"Nine in ten people diagnosed with OCD have at least one co-morbid psychiatric condition.[a] Studies have shown that 76% of people with OCD have an anxiety disorder, 63% have a mood disorder, particularly major depressive disorder (41%), 56% have an impulse control disorder and 39% have a substance use disorder.[a] Attention deficit hyperactivity disorder (ADHD), tic disorders and hypochondria are also common co-morbidities in people with OCD.[b] In children, Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) are common and typically require treatment independent of OCD.

OCD and autism spectrum disorders (ASD) often co-exist, and this can lead to symptoms of OCD being confused with autism spectrum traits. For instance, it's common for people with ASD to have special interests, and common for this to be referred to as the person's 'obsession'. However, an intense special interest in trains, for example, often brings a great deal of enjoyment to a person with ASD, whereas an obsession for a person with OCD, e.g. intrusive thoughts about having done something wrong, is often a cause of significant distress and warrants specific treatment.

a. Fenske JN, Petersen K. Obsessive-compulsive disorder: diagnosis and management. Am Fam Physician 2015;92:896–903.

b. Eskander N, Limbana T, Khan F. Psychiatric comorbidities and the risk of suicide in obsessive-compulsive and body dysmorphic disorder. Cureus 2020;12:e9805. doi:10.7759/cureus.9805.

How does OCD typically affect a person's quality of life?

"OCD often has a severe impact on people's lives due to the amount of time obsessions and compulsions occupy, and the shame, guilt and anxiety that people with OCD experience in response to their obsessions. It's not uncommon for people to experience severe consequences of this disorder before seeking help.

Quality of life. OCD usually has a significant impact on quality of life; obsessive thoughts and compulsive behaviours can be significant barriers to social functioning, negatively affect self-perception and may limit engagement in certain activities.[a]

Education. A 2018 study sponsored by the International OCD Foundation details the difficulties that children and adults with OCD may have with educational achievement, concluding: "*Based on a sample of more than 15,000 people with OCD, we showed that the disorder is associated with global academic impairment, spanning from compulsory to post-graduate education.*" [b]

Employment. Intrusive thoughts, images or impulses, and the compulsions carried out in response to these, can occupy a lot of time and energy and undermine participation in work, creating problems for people with OCD and their employers.

Relationships. OCD can undermine relationships, and considerable effort may need to be undertaken by family members to support a person undergoing treatment for OCD.

OCD increases the risk of suicidal thinking and completed suicide. This is partially due to high levels of co-morbidity with other mental health conditions, such as depression and anxiety, and substance use, which also increase the risk of suicide. Some people have intrusive images of suicide as part of their OCD. It's very important to regularly check for suicidal ideation in patients with OCD and ensure that co-morbid conditions are managed.

a. Remmerswaal KCP, Batelaan NM, Hoogendoorn AW, et al. Four-year course of quality of life and obsessive–compulsive disorder. Soc Psychiatry Psychiatr Epidemiol 2020;55:989–1000. doi:10.1007/s00127-019-01779-7.

b. Pérez-Vigil A, Fernández de la Cruz L, Brander G, et al. Association of obsessive-compulsive disorder with objective indicators of educational attainment: a nationwide register-based sibling control study. JAMA Psychiatry 2018;75:47. doi:10.1001/jamapsychiatry.2017.3523

What is perinatal OCD?

The incidence of OCD increases during the perinatal period and this can often be misdiagnosed as generalised anxiety disorder, perinatal depression or post-partum psychosis.[a] Understanding and recognising perinatal OCD is an important skill for clinicians when interacting with women who are pregnant or post-partum; fathers/partners can also experience perinatal OCD.[a] Dr Armstrong asked his colleague ***Dr Eileen Vuong****, Specialist and Consultant Psychiatrist and the Clinical Lead for the Perinatal and Infant Mental Health Service at Tauranga Hospital, to provide some additional insight on this topic.*

Perinatal OCD can occur in people with or without a known/prior OCD diagnosis. Typically, clinicians may observe an exacerbation or relapse of symptoms in the perinatal period, i.e. during pregnancy or post-partum. It isn't yet clear whether perinatal OCD is an entity on its own, however, it does appear that those with onset during the perinatal period have a better prognosis in terms of chronicity versus those with a pre-existing diagnosis.

Key risk factors include:

- Extremes of maternal age
- Assisted reproduction, e.g. IVF, surrogacy
- Primiparity
- Medical complications during pregnancy
- Traumatic or difficult delivery
- Health issues in the newborn
- Premorbid personality, e.g. obsessive compulsive personality disorder
- Family history of mood, anxiety or OCD disorders
- Limited social support

Perinatal OCD is often misdiagnosed as depression and anxiety, and mothers generally don't seek out treatment as they feel ashamed regarding the nature of their intrusive thoughts. Mothers may also fear that social services might become involved and remove the child if they reveal their thoughts. In perinatal OCD, intrusive thoughts often focus on causing harm to their baby, e.g. throwing the infant down stairs or sexually harming the infant, although it's extremely uncommon for such obsessions to be acted upon and these thoughts should usually be dealt with as a mental health problem rather than as a child protection issue. If clinicians aren't confident that they're able to distinguish between these two possibilities, the patient should be assessed by the crisis team urgently.

Obsessions typically represent a fear or worry that a mother doesn't want to have and that she wishes to avert at all costs. Obsessions are usually related to what's considered important and meaningful to an individual, and therefore it isn't surprising that many new mothers experience obsessional thoughts about potential threats to their babies.

Perinatal OCD can have a significant impact on the mother's wellbeing, negatively affecting mother-infant bonding and interaction and resulting in depression and social isolation. It can also impact the wellbeing of the partner and family/whānau, e.g. through seeking reassurance or engaging them in checking or other compulsive behaviours.

Perinatal OCD in the father/partner is also a very well recognised entity, and it's important for them to know that perinatal and infant mental health services provide care to all parents/primary caregivers.

Perinatal OCD is very treatable with therapeutic and medicine options which would be tailored by a perinatal psychiatrist according to the individual.

a. Hudepohl N, MacLean JV, Osborne LM. Perinatal obsessive–compulsive disorder: epidemiology, phenomenology, etiology, and treatment. Curr Psychiatry Rep 2022;24:229–37. doi:10.1007/s11920-022-01333-4

Detecting OCD in primary care

What are some of the biggest challenges for primary care clinicians in the detection of OCD?

Fear of being misunderstood and judged are just two of the many reasons why people living with OCD may delay accessing treatment, often until they have reached the stage of functional impairment. In addition, many people with intrusive or obsessive thoughts, and compulsive responses to these thoughts, do not recognise them as such, and therefore do not know they have OCD.

Reasons that may contribute to a delayed diagnosis of OCD include:

- Patient presentations can vary widely, from pure obsessions ("pure O") to classic contamination fears/compulsive cleaning which is often more obvious (although these may be hidden by the patient)
- Patients may be unaware that their symptoms are due to OCD or that they can be treated; some may think that their problem is self-induced or part of their personality, therefore don't see it as a medical condition to seek treatment for
- Patients may have a high degree of shame about their symptoms and be reluctant to disclose them, or may fear that others will not understand
- The presence of other psychiatric disorders in up to 90% of people with OCD may mean that these disorders become the primary target of treatment
- Colloquial use of OCD as a term to describe tidy people promotes misunderstanding of the real nature of OCD

How should a clinician begin the initial assessment of a patient with suspected OCD?

First of all, it's important to remember that OCD often has its onset in childhood or adolescence, and that it's a common condition, affecting at least 1% of the population, and maybe up to 3%. If there's anxiety or distress, but the patient is struggling to express their thoughts, it's useful to ask some broad questions. For example:

- Do you ever find that certain thoughts or images keep coming into your head even though you try to keep them out?
- What do you do to try to get rid of these thoughts?
- Do you sometimes feel like you have to do certain things over and over, even though you don't want to?
- Does repeating these actions seem reasonable to you, or do they seem excessive?

People experiencing OCD don't usually separate their concerns into real and unrealistic worries, but are awaware that others may regard their concerns as excessive and their precautions unnecessary. If worries appear to be based not on concerns in the present moment but on a chain of "what if's?" in the past or in the future, that's worth exploring further.

Patients may be quite adept at hiding the presence of symptoms, especially when they're relatively mild. The key symptoms and signs of OCD are the obsessions and compulsions themselves. It's also highly likely that a patient with OCD will have other mental health conditions, and these may contribute to disability and risk. Therefore, it's also worthwhile screening for symptoms of mood disturbance and suicidality, as well as substance use.

Health anxiety may be a clue to OCD:

If obsessive thoughts have a health theme, e.g. what if I have cancer?, might I have done something that harmed my unborn child?, the person will often seek reassurance from their health professional, perhaps repeatedly raising the same issue or asking for more tests. They may be vulnerable to intrusive thoughts which target health because of difficult health experiences in the past.

What techniques can help patients feel more able to share the nature of their intrusive thoughts?

An insight into the patient's thoughts and feelings is key for the diagnosis of OCD. An essential skill in the diagnostic workup is knowing how to ask for relevant information without making the patient feel judged or ashamed, particularly those who have illicit or explicit thoughts.

It's important to build trust over time. However, it may be too difficult for patients to disclose their thoughts – in fact, some people with harm-themed OCD may be unable to say their obsession aloud for fear of making the dreaded event happen. Sometimes patients find it easier to reveal their thoughts by filling out a form or writing it down (see below). Letting patients know that OCD can involve thoughts of a taboo theme may make them comfortable enough to share. The patient doesn't have to disclose the precise content of their intrusive thoughts but rather indicate the general nature.

If the patient doesn't want to disclose the nature of their thoughts, this may be due to them being of a sexual or violent nature. It's important to note that repetitive distressing thoughts on taboo subjects such as child abuse, violence or deviant sexual behaviour doesn't increase their risk of engaging in this behaviour – many people with such thoughts (for instance, women with thoughts of harming their newborn) are incredibly distressed because the thoughts represent what is most repugnant to them.

The following techniques may be useful:

- **GP Ice-breaker**. This is a tool that patients can use to communicate their distress by ticking boxes. It can be printed and given to the patient. This resource might serve as the basis for a conversation about referral to a therapist or psychiatrist.
- **"Living with me and my OCD"**. This is a documentary that the patient may watch to see whether they identify with the people's lived experience of OCD.

Diagnosing OCD in primary care

What is the general approach to making a diagnosis of OCD in primary care?

When establishing a diagnosis of OCD, it's important to first rule out other potential causes of the patient's symptoms, e.g. differential diagnoses (see next question), medicine adverse effects and substance misuse.

It's far more important to help people in distress than to be too concerned about whether you have made a correct diagnosis of OCD, particularly as a primary care clinician, and it can be difficult for expert psychiatrists to agree on diagnosis. However, most severe cases of OCD will be fairly unmistakable to professionals who work with a reasonable number of people with the condition.

In fact, it's much easier to make the opposite mistake of failing to recognise OCD and offer treatment for it.

What differential diagnoses should be considered in people with possible OCD?

There are several potential differential diagnoses for OCD. OCD can be mistaken for a psychotic disorder, as visions or other sensory disturbances may at first resemble hallucinations. However, it's often the case that these experiences are extremely distressing, and this may be more so than a true hallucination.

It can be important to ask about the patient's theory of why they are experiencing visions, for instance if they express the reason in terms of blameworthiness, or being a bad person, this may lead to suspecting OCD.

With respect to beliefs that may take on a delusional quality, it's important to note that people with a delusional disorder are often quite comfortable with their beliefs, however bizarre, and that people with OCD are often very troubled by the thoughts they're having. Nevertheless, it's not unknown for OCD to be mistaken for a psychotic illness.

Furthermore, other illnesses which may be co-morbid can cloud the presence of OCD, for example in depression, ruminations are quite common and share some characteristics with obsessions. People with OCD may become so paralysed with fear about the outcome of any of their actions that they freeze, and this can be mistaken for catatonic schizophrenia.

People with OCD commonly present with a high degree of anxiety; mood and anxiety disorders are part of the differential diagnosis for OCD. There is the possibility of OCD being confused with a simple phobia; where food is involved, anorexia nervosa may be a differential diagnosis.

Are there diagnostic tools for OCD that are suitable for use in primary care?

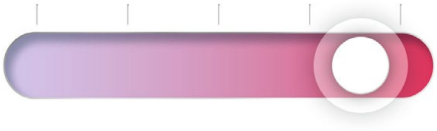
While diagnostic tools for use in primary care aren't widely available, the **Obsessive-Compulsive Inventory Revised (OCI-R)** has reasonable psychometric properties and can be useful in a general practice setting to help explore the patient's symptoms. Online resources for patients, e.g. self-assessment questionnaires, often require personal details or subscribing to emailing lists, which can be off-putting to many.

How do you assess the severity of OCD?

It is important to assess the severity of OCD to determine the degree of functional impairment and to help inform management decisions.

There are two important ways of assessing the severity of OCD – firstly, by asking the patient about the level of distress caused by their symptoms, and secondly, by looking at the restrictions on their lives. It's not uncommon for people with OCD to give up education, work, relationships and other important things in life, and to experience a high degree of functional impairment.

Formal assessment tools such as the **Yale Brown Obsessive Compulsive Scale (Y-BOCS)** can assess OCD severity in a standardised manner, but they're quite unwieldy. A **shortened scale** may be more appropriate for primary care but an enquiry into the patient's distress and day-to-day functioning is far more important. There are also online calculators, such as the **Y-BOCS calculator** which may be used during the consultation, alternatively a link can be given to the patient for completion after the appointment.



Managing a patient with OCD in primary care

What is the recommended management strategy for a patient with OCD?

Some people with OCD can be managed entirely in primary care, but this is the exception rather than the rule because of the difficulty posed by the high likelihood of co-morbid mental conditions. If the patient has two or more co-morbid mental health conditions and a severe level of distress or poor function, they should be referred for specialist treatment. Patient choice will often help to dictate whether this should start with psychotherapy or pharmacological treatment. Refer patients with acute suicide risk to a mental health service.

The ability of public mental health services to support people with OCD is limited. Regional mental health services are funded to look after the population with the most severe mental health problems, and the services aren't often a 'good fit' for people with OCD. Therefore, many will end up requiring the services of private psychiatrists and therapists. Private therapy is now more accessible than it used to be in rural areas due to the rise in telemedicine.

In general:

- **For people with mild to moderate OCD**, the treatment of choice is psychotherapy alone, preferably exposure and response prevention (ERP) therapy (see box)
- **For people with moderate to severe OCD**, the addition of pharmacological treatment is recommended, usually high dose SSRIs

N.B. Pharmacological treatment may be required initially to reduce anxiety enough to allow the patient to participate in therapy. Treatment must also address any co-morbidities, e.g. depression, anxiety, substance misuse.

Exposure and response prevention (ERP) therapy is a type of cognitive behavioural therapy that involves graded exposure to situations that make the person anxious or that trigger their obsessions. ERP teaches people to manage their anxiety without engaging in compulsive behaviours. It's the most recommended type of therapy for people with OCD.

Read more – **www.ocduk.org/overcoming-ocd/accessing-ocd-treatment/exposure-response-prevention/**

What about the management of OCD in young people?

Children and adolescents (aged < 18 years) with OCD have similar symptoms as adults but may not present in the same way. It's not unusual for children (and adults) to experience OCD-like tendencies to some degree during their life and so sometimes, it can be difficult to differentiate the early stages of compulsions from normal childhood routines. Parents may not always recognise what is happening with their child, and it can be difficult for a child to articulate their experience.

The early onset of OCD may indicate a worse prognosis; however, treatment is available for children and adolescents using similar principles as for adults, but tailored to their age and developmental stage. The main difference is the role of family. Family involvement in ERP can have a very important influence on the outcome for the child, and the family themselves may need support to recognise situations when they have been encouraging the patient to go with, rather than resist, their OCD.

⚠ *N.B. In some cases, OCD in children can be a more serious health concern.*

Involving family and support people in treatment

While bearing in mind privacy considerations, it's desirable to involve family members in the management of a patient experiencing OCD, and to check on their wellbeing too (if appropriate). Often the everyday routines of a family are severely disrupted by the consequences of unmanaged OCD. Excessive checking, washing, ordering or reassurance seeking can be difficult to deal with. A patient undergoing ERP therapy will often require the involvement of family members/support people. N.B. As genetic factors are involved with OCD, there may be other family members with OCD or associated conditions, e.g. other anxiety or mood disorders, ASD, ADHD or Tourette's syndrome.

The onset of OCD in children may be rapid and in rare cases it can be part of paediatric autoimmune neuropsychiatric disorder associated with streptococcal infection (PANDAS). Most hospitalisations associated with OCD occur in children. In children there is often a component of OCD related to eating and if this is the case, dangerous weight loss is possible, and hospitalisation may be required.

What can primary care do for a patient while they wait for an appointment with a psychologist or psychiatrist?

In many areas across New Zealand, there are significant waiting times to access publicly funded psychological or psychiatric services, or even sometimes private services. Online therapy courses for OCD may have a role in supporting patients while they await access to secondary care services.

General techniques can be recommended including:

Education and encouragement. Provide education about OCD so that the patient can understand what is happening to them; explain to patients that everyone has intrusive thoughts, it's normal, but the problem is in treating them as meaningful. A key management strategy is to learn to accept the occurrence of the thought/obsession and then to not engage in the compulsion. Provide encouragement and hope that over time this will get easier. Read more: **www.ocduk.org/ocd/understanding-ocd/**. People living with OCD and parents/caregivers supporting someone with OCD may benefit from hearing about the experiences and perspectives of their peers; encourage them to join support groups (see Resources section at the end of this article).

Referral to online CBT. There is increasing evidence for the efficacy of online therapy for people with OCD.[a, b] A New Zealand organisation, **Just a Thought**, hosts resources for a range of mental health conditions and offers free online CBT courses, including a **CBT course for OCD.** This course is a New Zealand adaptation of an Australian-based online CBT course for OCD. The Australian course by **This Way Up**, has been evaluated in a randomised controlled trial showing good efficacy.[a, b] The OCD course can be completed by the patient in a self-guided manner or through prescription by a clinician. Adherence rates are higher when a clinician prescribes the course and incorporates it into their follow-up consultations.

Pharmacological treatment. Some people with OCD will benefit from pharmacological treatment. Most general practitioners will not be used to initiating the high doses of selective serotonin reuptake inhibitors (SSRIs) that are required to treat people with OCD, but it can still be useful to start a patient on a SSRI at a standard dose to get the ball rolling (see next section). Sometimes general practitioners may be able to contact a GP liaison psychiatrist (if one is available locally) or the on-call psychiatrist for advice about treatment.

a. Mahoney AEJ, Mackenzie A, Williams AD, *et al*. Internet cognitive behavioural treatment for obsessive compulsive disorder: a randomised controlled trial. Behaviour Research and Therapy 2014;63:99–106. doi:10.1016/j.brat.2014.09.012

b. Luu J, Millard M, Newby J, *et al*. Internet-based cognitive behavioural therapy for treating symptoms of obsessive compulsive disorder in routine care. Journal of Obsessive-Compulsive and Related Disorders 2020;26:100561. doi:10.1016/j.jocrd.2020.100561

What pharmacological treatment is recommended for people with OCD?

Pharmacological treatment can be offered to patients with moderate to severe symptoms of OCD, or it may be required initially to reduce anxiety enough for patients to engage in therapy.

High dose SSRIs or clomipramine are generally recommended first-line for patients with moderate to severe symptoms of OCD. In general practice, it may be useful to start a patient on a SSRI at a standard dose whilst awaiting advice from a psychiatrist. Augmentation with an antipsychotic or more specialised treatments such as memantine* or riluzole* may be required for treatment resistant cases, however, this is really the province of specialist psychiatrists with an interest in OCD.

* Use is off-label and not funded for people with OCD

Is there a preference for any particular SSRI?

Fluoxetine and sertraline are best. Paroxetine can be used but it has a difficult discontinuation syndrome. Escitalopram and citalopram should be avoided as they are potentially cardiotoxic at the high doses which are needed to treat patients with OCD.

What dosing strategy is recommended?

A high dose strategy is best, e.g. 80 – 120 mg of fluoxetine, up to 400 mg of sertraline. While it's not usual practice for general practitioners to initiate these high doses of SSRIs required to cause remission, it can still be sensible to start a patient on a SSRI at a more usual lower dose.

Would you prescribe high dose SSRI treatment to a patient aged < 18 years?

SSRIs are not approved for use in people aged < 18 years, but if required, fluoxetine has traditionally been the first choice in this age group.

Prescribing SSRIs to young people is a complex issue but I would certainly prescribe SSRIs to patients with OCD aged under 18 years. Sertraline, fluoxetine and escitalopram are sometimes recommended for patients aged under 18 years for depression (*unapproved indication*).

What is considered an adequate response to pharmacological treatment and how and when is this assessed?

OCD is a waxing and waning disorder and response to treatment is often slow; a patient may have to take a SSRI for 8 – 12 weeks or longer before a response is observed. Response should be assessed throughout the course of the trial.

The best indicators of response are the patient's self-ratings of time spent focused on OCD concerns and the level of distress caused.

If there is adequate response to treatment, the medicine should be continued until the patient has been well for two years in most cases. Alternatively, the medicine may be gradually stopped once the patient has successfully completed a course of ERP.

If there is inadequate response to treatment after an appropriate trial, rather than switching to another medicine, seek psychiatric input – it may be as simple as needing to increase the dose or persisting with a longer trial.

Do you have any tips for helping patients engage in their management plan and adhere to treatment advice?

People with OCD like to have information about their condition, its treatment, and so on. In many cases, health professionals won't have time to answer all of their questions. I think that encouragement to join an OCD support group is a great way for people to find out what the experience of others has been with various management options. When a patient can see the general themes emerging – that pharmacological treatment and therapy help, that it's normal to have problems along the way during treatment and this doesn't mean that treatment won't work for them – they're often very reassured.

How often should a general practitioner follow up a patient with OCD?

This really depends on the situation; tailor follow-up according to individual patient-specific factors. If suicidality, weight loss or other medical issues are involved, frequent follow-up may be essential. If there is no specific management plan in place, three-monthly reviews may be most appropriate. For patients with an established management plan (e.g. attending therapy, taking pharmacological treatment), consider six-monthly reviews.

If a patient is not responding to treatment for OCD, also review the management of any co-morbidities that may be contributing to lack of treatment success.

Do you have any support group or resource recommendations for people living with OCD or for their family/whānau?

- **Fixate** is a New Zealand Facebook-based community for people living with OCD or supporting someone living with OCD. There is also an associated website **ocd.org.nz**, that contains book, podcast and website recommendations.

  "Within Fixate, members share their personal experiences while not offering others advice on what they should do – such conversations seem to help people to think through their own situation. As the internal voice of OCD is often very negative and self-critical, individuals may feel shame, guilt, frustration and despair. It can be a very lonely and hidden experience. When someone joins Fixate, it's often the first time that they've ever connected with someone who experiences OCD or who supports someone living with OCD. This normalisation of experiences through Fixate is an invaluable aspect of OCD-specific peer support." – Marion Maw, an Administrator for Fixate

- Perinatal Anxiety and Depression Aotearoa (PADA) has a **webpage** with resources about perinatal OCD, including a New Zealand-specific brochure for new parents
- The international weekly podcast, **The OCD Stories** has a recovery focus and a wealth of informative and inspirational interviews with clinicians who specialise in OCD treatment and with individuals sharing their lived experiences of OCD
- For parents of young children with anxiety or OCD – **www.anxioustoddlers.com**
- Public libraries often have self-help books on OCD, and if not are usually responsive to a request to purchase them

Families/whānau also need to learn about OCD, how to constructively support their relative to manage their OCD and how to gradually reduce family accommodation (enabling compulsive behaviours such as avoidance of feared situations, providing reassurance). Sometimes family members may attend a session with the therapist.

The following resources are a great way to learn:

- How families can support a family member – **theocdstories.com/episode/the-family-guide-to-getting-over-ocd-266/**
- How parents can modify their own behaviour to support their child – **www.anxioustoddlers.com/child-anxiety-and-ocd**
- The role of self-compassion in enabling someone to challenge their OCD – **theocdstories.com/episode/kim-quinlan-compassion-297/**
- Mindfulness used appropriately can be a useful tool to complement ERP therapy – **theocdstories.com/podcast/jon-hershfield-shala-nicely-meditation-and-mindfulness-for-people-with-ocd/**
- Acceptance Commitment Therapy as a framework for undertaking the challenges of ERP therapy with children and adolescents – **theocdstories.com/podcast/dr-lisa-coyne-act-and-erp-for-children-and-adolescents/**

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Hidden in plain sight

We invited Marion Maw, an Administrator of Fixate, to share her parental story of supporting someone experiencing OCD.

My parental radar began pinging while our daughter was still in primary school. My attempts to help her were ineffectual because I didn't understand what it was that I was seeing. The people I talked to during the following decade – her teachers, our GP and the school educational psychologist – listened and tried to help. My daughter tried valiantly to use the tools the school psychologist had suggested to manage anxiety, and believed that there was nothing further to be done, but I knew that the underlying distress had not resolved.

In hindsight, the narrow understanding and the unexamined beliefs I had about OCD meant that it was an answer that was "hidden in plain sight". I was puzzled by the nature of the things that she worried about, the perception of moral issues where I could see none, and this from a child who I knew to be kind and honest.

What I was seeing made no sense because I lacked the concept of intrusive thoughts. I didn't understand that the content of the obsessive thoughts was a red herring. Intrusive thoughts are the random creations of our minds constant brainstorming. But like a teasing sibling, sometimes an intrusive thought hits an area of vulnerability, something the person cares deeply about. It was precisely because our daughter is a kind and honest person that her mind got stuck on intrusive thoughts that she might have done something morally questionable.

Eventually I stumbled across a blog about moral scrupulosity OCD, and everything suddenly made sense. I began to gently suggest to my daughter that she was experiencing OCD, and that this was a treatable condition. The sense of moral responsibility she felt had become a terrible burden because of the associated anxiety, insomnia and exhausting hours of rumination and checking. But the idea that those moral concerns were themselves meaningless was nearly impossible to contemplate. It wasn't until her first year of university, when OCD had so taken over her life that she could not think about anything else, that she agreed to try seeing a private clinical psychologist, someone with specific expertise in OCD treatment.

Three years later, I'm passionate about raising awareness and understanding of OCD. Not only because of the unnecessary years of mental distress that our daughter experienced, but because of the effects it had on me as a parent and on our family life. Our daughter now has the tools she needs to manage OCD, and I now know how to support her rather than unintentionally make matters worse.