Psychiatric NP Cheat Sheet: Obsessive-Compulsive Disorder (OCD)

🧠 Diagnostic Criteria (DSM-5)

🔍 Core Features

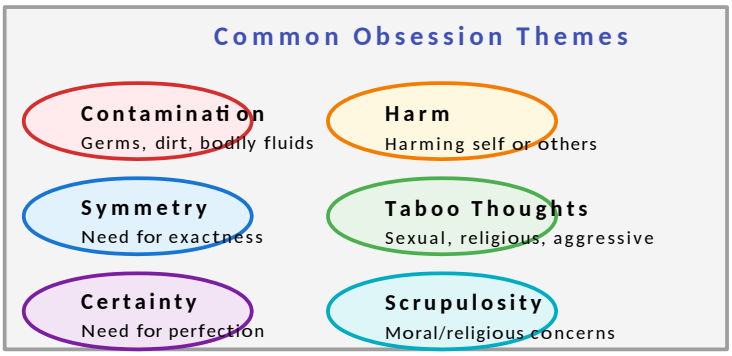
- **Obsessions:** Recurrent and persistent thoughts, urges, or images experienced as intrusive and unwanted, causing anxiety or distress
- **Compulsions:** Repetitive behaviors or mental acts performed in response to obsessions or according to rigid rules
- Person attempts to ignore/suppress obsessions or neutralize them with compulsions
- Obsessions/compulsions are time-consuming (>1 hour daily) or cause significant distress/impairment
- Not attributable to substance, medical condition, or better explained by another disorder

🔍 Specifiers

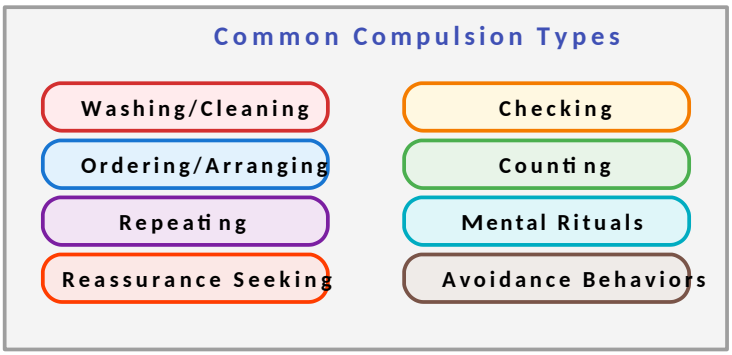
- **With good insight:** Recognizes beliefs are definitely or probably not true
- **With fair insight:** Recognizes beliefs are possibly not true
- **With poor insight:** Believes obsessions are probably true
- **With absent insight/delusional beliefs:** Completely convinced beliefs are true
- **With tic-related:** Current or past history of a tic disorder

🔄 OCD Symptom Patterns

💭 Common Obsession Themes



🔄 Common Compulsion Types



📊 Assessment Tools

Screening/Severity Measures

- **Yale-Brown Obsessive Compulsive Scale (Y-BOCS):** Gold standard, clinician-rated
  - 0-7: Subclinical
  - 8-15: Mild
  - 16-23: Moderate
  - 24-31: Severe
  - 32-40: Extreme
- **Florida Obsessive-Compulsive Inventory (FOCI):** Brief self-report

- **Obsessive-Compulsive Inventory-Revised (OCI-R):** 18-item self-report

🔬 Differential Diagnosis

Medical Conditions

- Traumatic brain injury
- Stroke
- Seizure disorders
- Parkinson's disease
- Huntington's disease
- Brain tumors
- Sydenham's chorea
- PANDAS/PANS

Psychiatric Conditions

- Anxiety disorders
- Major depressive disorder with rumination
- Tic disorders/Tourette syndrome
- Autism spectrum disorder
- Body dysmorphic disorder
- Hoarding disorder
- Illness anxiety disorder
- Schizophrenia spectrum disorders

💊 Substance-Induced Considerations

- **Stimulants:** Cocaine, amphetamines, methamphetamine
- **Medications:** Some antipsychotics, anticonvulsants
- **Withdrawal:** Alcohol, benzodiazepines

🔬 Recommended Workup

Initial Evaluation

- 🩸 **Laboratory:** CBC, CMP, TSH, B12, folate, urine toxicology
- 🧠 **Consider:** Neuroimaging if neurological symptoms present

- 📋 **Screening tools:** Y-BOCS, OCI-R
- 📝 **History:** Detailed symptom history, onset, course, comorbidities
- ⚠️ **Risk assessment:** Suicidality, functional impairment
- 🔍 **Rule out:** Medical conditions, substance-induced symptoms

💊 Treatment Approaches

🗣️ Psychotherapy

First-Line Treatment

- **Exposure and Response Prevention (ERP):** Gold standard treatment
  - Involves exposure to feared stimuli while preventing compulsive responses
  - Typically 12-20 sessions
  - 60-80% response rate

Second-Line/Adjunctive Treatments

- **Cognitive-Behavioral Therapy (CBT):** Addresses dysfunctional beliefs
- **Acceptance and Commitment Therapy (ACT):** Focuses on acceptance of intrusive thoughts
- **Mindfulness-Based Cognitive Therapy (MBCT):** Enhances awareness without judgment
- **Group therapy:** Provides support and reduces isolation
- **Family therapy:** Addresses accommodation and family dynamics

💊 Pharmacotherapy (Pittenger & Bloch, 2014)

First-Line Medications

- **SSRIs:**
  - Fluoxetine: 20-80 mg/day (FDA-approved)
  - Fluvoxamine: 100-300 mg/day (FDA-approved)
  - Sertraline: 50-200 mg/day (FDA-approved)
  - Paroxetine: 20-60 mg/day (FDA-approved)
  - Escitalopram: 10-40 mg/day
- Higher doses often needed than for depression
- Longer trial duration (10-12 weeks)

Second-Line Medications

- **Clomipramine:** 150-250 mg/day (FDA-approved)
  - More side effects than SSRIs
  - Requires ECG monitoring
- **Venlafaxine:** 150-375 mg/day
- **Mirtazapine:** 15-45 mg/day

Augmentation Strategies

- **Antipsychotics:**
  - Risperidone: 0.5-3 mg/day
  - Aripiprazole: 2.5-15 mg/day
  - Quetiapine: 25-300 mg/day
- **Glutamate modulators:**
  - Memantine: 5-20 mg/day
  - N-acetylcysteine: 1200-3000 mg/day
- **Other options:**
  - Lamotrigine: 25-200 mg/day
  - Topiramate: 25-200 mg/day
  - Ondansetron: 4-8 mg BID-TID

🔄 Treatment Algorithm

OCD Treatment Algorithm

🔍 Special Considerations

🤰 Pregnancy/Postpartum

- OCD may worsen during pregnancy or postpartum
- Careful risk-benefit analysis required for medications
- SSRIs generally considered safer options if medication needed
- Paroxetine: Avoid in pregnancy (cardiac malformations)
- Clomipramine: Higher risk of adverse effects
- ERP remains first-line treatment
- Postpartum onset may involve intrusive thoughts of harming infant

👵 Elderly

- Late-onset OCD possible but uncommon
- Medical comorbidities may complicate treatment
- Start low, go slow with medications
- Increased risk of drug interactions
- Cognitive impairment may affect therapy approach
- Adapt ERP for cognitive limitations if needed

🧒 Children/Adolescents

- Peak age of onset: 10-12 years
- May present with more magical thinking
- Family accommodation common

- ERP is first-line treatment
- Family involvement essential
- SSRIs FDA-approved for pediatric OCD:
  - Fluoxetine (7+ years)
  - Sertraline (6+ years)
  - Fluvoxamine (8+ years)
  - Clomipramine (10+ years)
- Consider PANDAS/PANS in acute-onset cases

📋 Monitoring

Follow-Up Schedule

- 🗓️ **Initial phase:** Every 2-4 weeks
- 🗓️ **Medication adjustments:** Every 2-4 weeks
- 🗓️ **Maintenance phase:** Every 1-3 months

Monitoring Parameters

- 📊 **Symptom severity:** Y-BOCS or other validated measures
- ⚠️ **Side effects:** Sexual dysfunction, GI issues, activation
- 🔄 **Treatment adherence:** Assess barriers and address concerns
- 🧠 **Functional improvement:** Work, relationships, avoidance behaviors
- ⚠️ **Suicidality:** Regular assessment
- 👪 **Family accommodation:** Assess and address

🔄 Comorbidities

Common Comorbidities (Torres et al., 2016)

- **Major depressive disorder:** 30-40%
- **Anxiety disorders:** 30-60%
- **Tic disorders/Tourette syndrome:** 20-30%
- **ADHD:** 10-30%
- **Autism spectrum disorder:** 5-10%
- **Body dysmorphic disorder:** 10-15%
- **Eating disorders:** 5-10%

Treatment Implications

- Address both OCD and comorbid conditions
- Consider integrated treatment approaches
- Medication selection may target multiple conditions
- Depression may require higher SSRI doses
- Tic disorders may benefit from antipsychotic augmentation
- ADHD treatment may worsen OCD (stimulants)

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