Diagnosis and Treatment of Obsessive-Compulsive Disorder in the Inpatient Unit

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Introduction: Obsessive compulsive disorder (OCD) can be severely debilitating, with some individuals' lives becoming consumed by their compulsions. Their response to treatment can be frustratingly slow, but the advantage of inpatient units is the opportunity for intensive daily treatment, which can accelerate this improvement.

Diagnosis:
Obsessions: Distressing recurring thoughts, images, or urges
Compulsions: Repetitive, ritualistic behaviors that the person feels driven to perform in response to obsessions.

Common obsessions
-Contamination: Worries about germs, dirt, toxins. "If I touch that doorknob, I might get a deadly disease."
-Fear of harm to oneself or others. "I might have left the stove on and now the house might burn down."
-Need for symmetry or exactness. "All the pencils on my desk need to be perfectly parallel."
-Religious or moral fears, often referred to as "scrupulosity." "What if I have bad thoughts during my prayers?"
-Unwanted sexual or violent thoughts: "What if I harm my child?" or "What if I act on a taboo sexual urge?"

Common compulsions
-Washing and cleaning: e.g., hand-washing many times in a row or excessive showering.
-Checking: Repeatedly checking something to make sure it's off, locked, safe, etc., like a stove or doors.
-Repeating: Doing something over and over a certain number of times or until it feels "just right," like going in and out of a door several times.
-Ordering/arranging: E.g., Arranging books by size or color, or ensuring shoes are paired perfectly.
-Mental rituals: Counting, praying, or repeating certain words in one's mind to counteract or neutralize a distressing thought. E.g., Counting to ten every time one has a bad thought.

Treatment:
- **Cognitive Behavior Therapy with Exposure Response Prevention (CBT-ERP):** A therapeutic approach that involves gradually exposing individuals to their feared objects or obsessive thoughts, teaching them to refrain from their habitual compulsive responses.
- **Medications:** Close monitoring in an inpatient setting allows for faster dose increases, especially since doses for OCD often lean towards the higher side.
    - SSRIs, e.g., fluoxetine (Prozac) 40-80 mg daily, fluvoxamine (Luvox) 200-300 mg daily, sertraline (Zoloft) 200-300 mg, paroxetine (Paxil) 40-60 mg daily.
    - Clomipramine (Anafranil) 100-250 mg daily.
- **Combination of CBT-ERP and medication:** Offers the best outcomes.
- **Track progress** with the Yale-Brown Obsessive Compulsive Scale (YBOCS).

Treatment resistant OCD:
- Switch to different SSRI or switch to clomipramine or venlafaxine.
- Increase the dose of the SSRI to very high doses, eg., fluoxetine up to 120 mg daily or sertraline up to 400 mg.
- Augment with second-generation antipsychotics: aripiprazole (titrate to 15-30 mg daily), olanzapine (5-10 mg daily), risperidone (2-6 mg daily)
- Augment an SSRI with clomipramine
- Augment an SSRI with one of a range of glutamate modulators, such as lamotrigine, pregabalin, topimamate, memantine, amantadine, riluzole.

Interventions for Refractory OCD:
- **Transcranial magnetic stimulation:** Depending on your facility's resources.

- **Surgical Interventions:** liaise with neurosurgical teams regarding potential suitability for deep brain stimulation, cingulotomy or anterior capsulotomy.