Treating OCD during COVID-19: Pharmacotherapy and combined treatments

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ROGERS Behavioral Health

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Disclosures

The presenters have each declared that s/he does not, nor does her/his family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation. The presenters have each declared that s/he does not have any relevant non-financial relationships. Additionally, all planners involved do not have any financial relationships.

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Learning objectives

Upon completion of the instructional program, participants should be able to:

1. Describe at least two pharmacological interventions found efficacious for OCD both alone and in combination with CBT for OCD across the developmental spectrum;
2. Describe at least two ways to modify the delivery of pharmacological interventions for OCD in light of the current need to switch to a tele-psychiatry format to minimize objective risks to patients, families, and treatment providers;
3. Identify one way that you can optimize pharmacotherapy treatment outcomes as delivered both as monotherapy as well as in combination with CBT involving ERP by addressing patient and family reservation, management of non-adherence, and safety planning.

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What we'll cover in this webinar

1. **Pharmacotherapy and combined treatments for OCD across the developmental spectrum**
   - Theoretical rationale and empirical foundation
   - Optimized treatment delivery
2. **Modifications to ERP in light of COVID-19**
   - Telepsychiatry
   - Getting essential patient data in light of limitations related to remote treatment
   - Coordination of care with ERP and other providers
3. **Addressing patient and family concerns**
   - Reluctance to initiate pharmacotherapy or to permit upward titration
   - Managing effect/side effect balance remotely
   - Emergency and safety planning
   - Identifying patients for whom pharmacotherapy initiation or medication changes may not be advised

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Pharmacotherapy and combined treatments for OCD across the developmental spectrum

- Theoretical rationale and empirical foundation
- Optimized treatment delivery

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Practice parameters

Information in this lecture is based on research in adults, children and adolescents, research in adults extrapolated to children, expert consensus, and clinical judgment.

APA – Treatment of OCD

- Updated guidelines *(APA, 2007)*
- Guideline Watch *(APA, 2013)*

AACAP – Pediatric OCD

- Practice parameters established *(AACAP, 1998)*
- Research Consortium Treatment Guidelines
  - Updated *(AACAP, 2012)*
  - Not as specific as adult recommendations

PANS/PANDAS

- Research Consortium Treatment Guidelines *(Thienemann et al, 2017)*

AMERICAN PSYCHIATRIC ASSOCIATION

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

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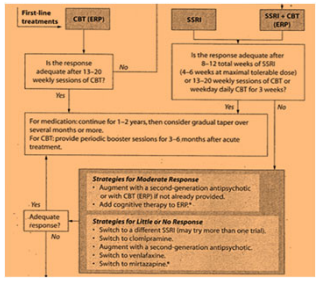
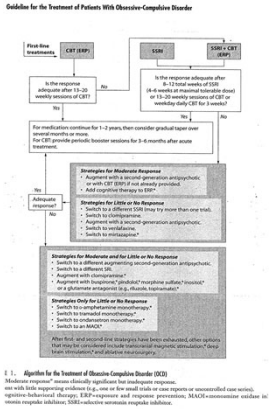
APA Practice Parameters





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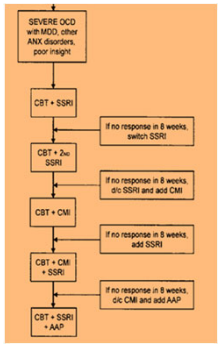
Pediatric OCD Algorithm



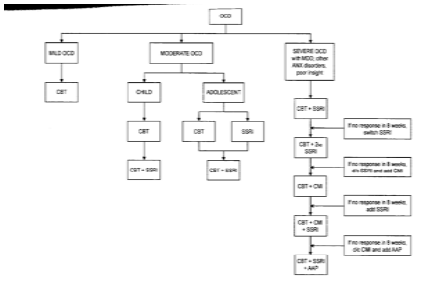


Figure 21.1 A treatment algorithm for obsessive-compulsive disorder (OCD) in children and adolescents.
CBT = cognitive-behavioral therapy; SSRI = selective serotonin reuptake inhibitor; MDD = major depressive disorder; ANX = anxiety disorder; CMI = clomipramine; AAP = atypical antipsychotic. Adapted from Geller DA and Spencer T. Obsessive-compulsive disorder. In Martin A, Scahill L, Charney DS, and Leckman JF (Eds.). *Pediatric Psychopharmacology Principles and Practice.* New York: Oxford University Press, pp. 511–525, 2003.

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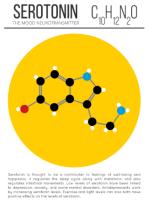
Basic psychopharmacology

Medications with **serotonergic** activity considered most useful

- Multiple RCT's in adults show reduction in OCD symptoms vs. placebo for SSRI's and TCA
- Over 20 studies report that serotonergic drugs helpful in short to medium-term in children/adolescents

Multiple augmentation strategies for treatment-resistant OCD

- Use other medication classes to mediate other CNS receptors and augment/enhance serotonin
- More recent research suggests role of glutamate in OCD



Reinblatt, SP, Riddle, MA (2007) The pharmacological management of childhood anxiety disorders: a review. Psychopharmacology 191: 67-86.

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FDA approved SSRI's for OCD

FDA approved for adults:

- Fluoxetine, Fluvoxamine, Paroxetine, Sertraline

FDA approved SSRIs for pediatric OCD:

- Sertraline (Zoloft) – age 6 and over
- Fluoxetine (Prozac) – age 7 and over
- Fluvoxamine (Luvox) – age 8 and over

Significant portion of psychiatric medications are prescribed "off-label" for use in pediatric population

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SRIs in adult OCD: Dosing guidelines

SRI	Starting (a)	Usual Target	Usual Max	Occasional (b)
Clomipramine	25	100-250	250	_(c)
Escitalopram	10	20	40	60
Fluoxetine	20	40-60	80	120
Fluvoxamine	50	200	300	450
Paroxetine	20	40-60	60	100
Sertraline (d)	50	200	200	400

a-Some patients may need to start at half this dose or less to minimize undesired side effects such as nausea or to accommodate anxiety about taking medications.
b-These doses are sometimes used for rapid metabolizers or for patients with no or mild side effects and inadequate therapeutic response after 8 weeks or more at the usual maximum dose.
c-Combined plasma levels of clomipramine plus desmethylclomipramine 12 hours after the dose should be kept below 500 ng/mL to minimize risk of seizures and cardiac conduction delay.
d-Sertraline, alone among the SSRIs, is better absorbed with food.

from American Psychiatric Association. Practice guideline for the treatment of patients with obsessive-compulsive disorder. American Psychiatric Association; Arlington, VA: 2007)

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Pediatric dosing guidelines

Drug	Starting Dose (mg) Pre-Adolescent	Starting Dose (mg) Adolescent	Typical Dose Range (mg)
Clomipramine	6.25-25	25	50-200
Fluoxetine	2.5-10	10-20	10-80
Sertraline	12.5-25	25-50	50-200
Fluvoxamine	12.5-25	25-50	50-300
Paroxetine	2.5-10	10	10-60
Citalopram	2.5-10	10-20	10-60*
Escitalopram	5	10	10-40

American Academy of Child & Adolescent Psychiatry. Practice parameter for the assessment and treatment of children and adolescents with obsessive-compulsive disorder. Journal of Am Acad of Child & Adolescent Psychiatry; 51 (1): 107.

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Strategies for treatment resistant OCD

Can add another SRI or switch to a different antidepressant with a different MOA

- **Switch** to a different SSRI
- Clomipramine (Anafranil)
- Venlafaxine (Effexor)
- Duloxetine (Cymbalta)

Augmentation strategies – goal is to enhance serotonin function or modulate glutamate receptors

- Atypical anti-psychotics
- Gabapentin (Neurontin)
- Ondansetron (Zofran)
- Glutamate modulators – riluzole (Rilutek), topiramate (Topamax), memantine (Namenda)

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Next step: Clomipramine (Anafranil)

- Only FDA approved TCA in pediatric OCD (10 years and older)
- Can be used as **single agent or as augmentation agent** with SSRIs
  - Meta-analysis showed increased efficacy of clomipramine over SSRI in adult placebo-controlled trials (Ackerman et al 2002)
- Typically used after at least **two SSRI failures**
  - Is clomipramine more effective than SSRI's? (see study)
- Requires physical exam and lab work prior to initiation
  - This may limit use when having to do telemedicine
  - Typically get baseline pulse, B/P, and EKG
  - Get family history of heart disease

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Next steps: Another antidepressant

- Selective Norepinephrine Reuptake Inhibitors (SNRIs)
  - Modulate **serotonin** and norepinephrine
  - No FDA Approved SNRIs for OCD
  - SNRIs
    - Duloxetine (Cymbalta)
    - Venlafaxine (Effexor)
    - Desvenlafaxine (Pristiq)
- Atypical Antidepressants
  - May modulate **serotonin**, norepinephrine, and dopamine
- Used as single agent or as augmentation strategy with SSRI

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Augmenting with atypical antipsychotics

- Atypicals are **serotonin** and dopamine receptor antagonists
- Several RCT's and a meta-analysis in adults support augmentation with AA
- Atypical anti-psychotics with evidence:
  - Aripiprazole (Abilify)
  - Olanzapine (Zyprexa)
  - Quetiapine (Seroquel)
  - Risperidone (Risperdal)
- May help with comorbid tic disorders, anxiety disorders, mood disorders, pervasive developmental disorders

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Split treatment

- Psychiatrist is prescribing medication while another health professional is administering psychotherapy
- Very little data on frequency or outcomes of split vs integrated treatment in outpatient treatment
- U.S. claims data examined form a national managed mental health care organization found that, of 1517 pts receiving both medication and psychotherapy, 79% (n = 1,326) were in split treatment *(Essock & Goldman, 1995)*
- 1997 survey of psychiatrists' practices found only 29% of their patients were in psychotherapy with another professional *(APA, 1997)*
- No study of short- or long-term outcomes in split vs integrated care

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Communication in split treatment

Multiple surveys have shown that prescribing psychiatrist and therapists do not routinely communicate about patient care

- 5-month study of psychiatric residents and therapists showed contact occurred in just over half of the patients in a 5-month period *(Hansen-Grant & Riba, 1995)*
- In private practice psychiatrists, no communication occurred between professionals in 25% of cases of pts treated for more than 6 months *(Kalman et al, 2012)*
- Communication with medical providers was reported 'a few times per year' among more than 60% of school-based providers *(Bradley-Klug et al, 2013)*
- No published studies in which neutral observers tabulate # of contacts between psychiatrists and therapists

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Key things to communicate <u>from psychiatrists</u>

- Psychiatric hospitalizations
- Medication changes (including discontinuation of medications)
- Major changes in diagnosis
- Comorbidities
- Major changes in symptoms
  - Substance use
  - Psychosis
  - Safety issues
- Safety concerns
  - New-onset or marked exacerbation of suicidal thinking or risk
  - Safety planning

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Key things to communicate <u>from therapists</u>

- Changes in environmental stressors (e.g., quarantine, loss of job)
- Significant changes in treatment planning or modality (from in-person to telehealth)
- Behaviors or reports indicating medication side-effects (or effects)
- Endorsed changes in medication compliance
- Major changes in symptoms
  - Substance use
  - Psychosis
  - Safety issues
- Safety concerns
  - New-onset or marked exacerbation of suicidal thinking or risk
  - Safety planning

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Team approach

- It takes a team to help patient reduce OCD symptoms
- Relationship between therapist and psychiatrist
  - Therapist is often the first provider patients/families form therapeutic alliance with to treat OCD
  - Therapists can help patients/families understand options to treat OCD
  - Therapy helps mediate suicidal ideations and OCD symptoms during medication initiation, cross-tapering and discontinuation
  - Critical to increase communication to help ensure that clinicians are not unintentionally reinforcing OCD symptoms

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Therapists should work with a psychiatrist who follows evidence-based prescribing

Evidence-based OCD medications

- First line: SSRIs, often need high doses for OCD
- SNRIs are NOT first line (third line, serotonin action key)
- Antipsychotic monotherapy is NOT recommended (but augmenting an SSRI is reasonable)
- Benzodiazepines are NOT effective for OCD (especially in kids!), are habit-forming, and interfere with therapy (learning)

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Therapist-informed prescribing

- Are they making progress in therapy?
- If not, why not?

  Can guide choice of augmentation:
  - Overwhelming **fear**
  - Poor **attention** (ADHD?)
  - Low **motivation** (depression?)
  - Getting **stuck**
  - Poor **insight**
  - **Oppositionality**

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Modifications to ERP in light of COVID-19

- Telepsychiatry
- Getting essential patient data in light of limitations related to remote treatment
- Overcoming telehealth-related barriers to communication

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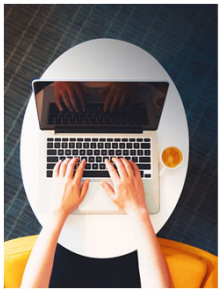
Telepsychiatry

- The taxonomy of telehealth *(Bashshur et al., 2016)*
  - Communication (patients)
  - Establishing policy
  - Collaborating (providers)
  - Seeking reimbursement
- Dimensions of telepsychiatry
  - Functionality (consultation, diagnosis, prescription, monitoring)
  - Applications (discipline, conditions, ERP/CBT)
  - Technology (platform/connectivity, equipment, location)



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Does it work?

Internet-delivered family-based CBT for youth with OCD

- Child *(Comer et al., 2017)*
  - RCT (*N*=22, 4-8yo)
    - Strong family engagement
    - High parent satisfaction
    - 90% completion rate

	Internet-based	Clinic-based
Post-treatment	72.7%	60%
6-month follow-up	80%	66.7%

- Adolescent *(Storch et al., 2011)*
  - RCT (*N*=31, 7-16yo)
    - Significant reductions in functional impairment and family accommodation
    - High parent satisfaction
    - 94% completion rate

	Internet-based	Waitlist
Post-treatment	81%	13%
3-month follow-up	71%	-

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Getting information: A two-fold problem

Gathering meaningful data

'Phases' of data collection:

- Screening
- Baseline
- Progress monitoring
- Transition/Termination

Communication barriers

Four main types of communication:

- Verbal
- Nonverbal
- Written
- Visual

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Telepsychiatry: Screening data

Did you ever wonder…

- How did telehealth researchers find participants for their studies?
  - They looked at *the patients physically coming into their clinic*, and screened them to see whether they were appropriate for telehealth…

- How are YOU going to screen clients (who <u>can't</u> walk into your clinic) for telehealth?
  - Age/Social support
  - Symptoms not life-threatening
  - No significant behavioral dysreg
  - No complex med comorbidities
    - Including recent suicide attempts

(Thomas et al., 2018)

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Telepsychiatry: Baseline data

Way back in 2019, how did you…

- Determine symptom severity?
- Determine level of adaptive functioning?

Fast-forward to 2020…

- Electronic medical record
  - If previous treatment history
- Virtual interview
  - Self- (and parent if applicable)
  - Triangulate with school or OP
- eMeasures

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Telepsychiatry: Progress monitoring data

How (and to whom) are you communicating change:

…in symptom severity?

…in medication or dosage?

…in hierarchy progress?

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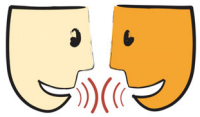
Speaking of communication…

Comparing types of communication:

- ***Verbal:*** High effort, Low information density
- ***Nonverbal:*** Low effort, High information density
- ***Written:*** High effort, Low information density
- ***Visual:*** Low effort, High information density



Telepsychiatry presents a barrier to communication

- Unfortunately, instead of changing our approach, our knee-jerk reaction is often to "try harder" – doing more of what isn't working (sound familiar?)

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(Overcoming) communication barriers

- "Information density"?!

  Remember the relationship between treatment dosage, symptom severity (or functional impairment) and treatment response *(Nadeau et al., 2017)*

- To maintain high "dosage" of treatment information, our focus must shift to more efficient means of communication…

	Commonality	Information Density
Highest	Verbal	Visual
	Written	Nonverbal
	Nonverbal	Written
Lowest	Visual	Verbal

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Telepsychiatry communication techniques

Increase…

Visual *(Individualized, attractive)*
- Graphic organizers (Psychoeducation!)
- Flowcharts (Hierarchies!)
- Pictures/charts (SUDS!)

Nonverbal *(Frequent, varied)*
- Active listening!
- Gestures (can you see these?)
- EXPOSURES!

Decrease…

Written *(Concise, direct)*
- Exposure / 'worry' scripts
- Vignettes
- Bibliotherapy

Verbal *(Brief and clear)*
- Oral instruction
- Stories/examples
- Narrative psychoeducation

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The active ingredients don't change…

Psychoeducation:
What you're learning and why
- Rationale and expectations

Hierarchy-building:
How you're going to learn it
- Gross (triggers) and fine (knobs) adjustment

Quantifying anxiety:
How you'll know it's working
- Subjective Units of Distress Scale (SUDS)

Exposures:
The curriculum
- Gradual in nature, Powerful in content, Repeated to mastery

Relapse Prevention:
Reviewing what you've learned
- Checking for generalization and consolidation

(Himle & Franklin, 2009)

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Addressing patient and family concerns

- Reluctance to initiate pharmacotherapy or to permit upward titration
- Managing effect/side effect balance remotely
- Emergency and safety planning
- Identifying patients for whom pharmacotherapy initiation or medication changes may not be advised

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Managing medication side effects virtually

Eliciting help of parent or support person
- Observations of patient's physical state

Vitals signs
- Patient uses own equipment for B/P and weight
  - Leverage technology, such as Apple watch
- Pregnancy tests, if needed, can be done at home

Labs
- Consider the necessity
- Send outside of peak times

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Managing medication anxiety

How do you discuss potential side effects with parents? kids?

- Anxious kids often have anxious parents.
- Anxious people don't benefit from knowing everything that could go wrong…or you are practically guaranteeing that it *will* go wrong.
- State common and dangerous side effects to monitor (not every possible effect ever reported)

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Therapist-assisted medication initiation

- Kids are often resistant to taking medicationss
- Fears about harm, change, stigma
- The therapist can assist in challenging and overcoming this fear

Cognitively: Is that your OCD talking? Given what you've learned about exposures, how do we fight an OCD fear of taking meds?

Behaviorally: Exposures to taking medication (at home or with the therapist)

- Hold the bottle
- Hold the pill
- Lick the pill
- Take half the pill…

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Therapist-aided adherence

- Anxious kids and parents tend to attribute every little change to a medication side effect

  "Life goes up and down regardless of the meds, so its important not to jump on every little blip with a med change. Let's watch and see!"

- Kids (people) confuse somatic anxiety symptoms with side effects

  "Sometimes kids have stomachaches, headaches, 'unreal' feelings, etc. when they feel anxious. Could that be your anxiety making you feel that way?"

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Response rates

Across studies, typical response rate to serotonergic drugs is 42-53%

- Response = a reduction of 25-40% in severity of symptoms
  - ≥ 25% to 35% reduction in Y-BOCS score
- Pediatric placebo response rate is 8-37%

Snyder, JL: Child and Adolescent Psychiatry: The Essentials. Edited by Cheng K, Myers KM. Philadelphia, PA, Lippincott Williams & Wilkins, 2005, pp 103-150.

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Safety and emergency planning

Research findings:

Suicidal ideation associated with:

- Symmetry/ordering
- Sexuality/religiosity
- "Miscellaneous" OCD symptom clusters
- General depressive and anxiety symptoms
- Older age
- Functional impairment

(Storch et al., 2015)

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Crisis planning and telepsychiatry

Telehealth increases "load" of treatment for parents/caregivers

- Caregiver perceptions of burden were associated with:
  - Parent-rated child functional impairment
  - Family accommodation
  - OCD symptom severity
- Caregivers may require additional support with:
  - How to handle requests for accommodation
  - Addressing distress/consequences of not accommodating
  - Remembering that accommodation reinforces OCD symptomology

(Wu et al., 2018)

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Time for questions and answers…

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Additional resources

APA [Psychiatric] Telepsychiatry Toolkit
www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit

APA [Psychological] Telepsychology Practice Guidelines
www.apa.org/practice/guidelines/telepsychology

HHS COVID-19 Updates
www.hhs.gov/about/news/coronavirus/

IOCDF Teletherapy and COVID-19
www.iocdf.org/covid19/information-for-therapists/

Rogers Behavioral Health "Connect Care"
www.rogersbh.org/connectcare

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Where to get additional information…

https://www.coronavirus.gov

https://www.nih.gov/health-information/coronavirus

https://iocdf.org/covid19

https://adaa.org/finding-help/coronavirus-anxiety-helpful-resources

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About the presenters…

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Stephanie C. Eken, MD, FAAP, is a board-certified child and adolescent psychiatrist, adult psychiatrist and pediatrician. Dr. Eken serves as the regional medical director for the Rogers Behavioral Health System. In addition, she provides medical leadership for Rogers' pediatric OCD and Anxiety services.

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