OBSESSIVE COMPULSIVE AND RELATED DISORDERS TRANSCRIPT
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Dr Ian Collings. Consultant Psychiatrist & Honorary Clinical Senior Lecturer, Swansea Bay UHB; HEIW Medical Deanery Director of Medic Professional Support & Development.

0:01 **Chair** Good afternoon everybody and welcome to our live webinar on Obsessive Compulsive and Related Disorders. I would like to welcome once again our speaker Dr Ian Collings, Consultant Psychiatrist, who is going to elaborate on this very common condition that we see in general practice. I would now like to hand over to Dr Ian Collins to enlighten us on OCD. Thank you, Ian.

0:40 **Speaker:** Thanks so much, Nicola. Hello, everyone and thanks for taking the time in your lunch break to log in to this session. I am very happy to be talking to you about OCD and related disorders. I think this is about my fourth webinar now that I've delivered in the last 18 months or so on various issues related to mental health and I think I'm due to deliver a webinar on PTSD next month. So I'm really happy to be with you all to talk about OCD

1:21 **Speaker:** As you will probably no doubt know, we recently had an updated version of the international classification of diseases. We no longer using ICD10. We're now using ICD11. Psychiatrists get very excited about these diagnostic classifications, particularly when there's been an update. I suppose what's interesting around OCD is that's been moved out of the anxiety disorders section of ICD11 used to be in with the anxiety disorders in ICD10 and is now out on its own as a separate chapter, if you like, of ICD11 alongside some other related disorders. And I'm going to talk about some of those today.

2:16 **Speaker:** But I thought we'd start with a bit of audience participation, if you like, to get the sort of grey matter working. And I'm sure it's been working all day, but it would help to get some views on which of the following cases is most likely to warrant a referral to secondary care?

Is it Case 1? This is a seven year old boy who has been brought to your clinic by his concerned mother. She's worried he repeats a mantra every night before he goes to bed. He also likes to step over cracks in paving stones. When his Mum has asked him about these behaviours, he has explained that if he doesn't do them, something terrible will happen to her. When she tries to stop him doing these behaviours, he has a tantrum. Is that the one you're most likely to refer to secondary care?

Or is it Case 2? A 26-year-old woman with a recent history of OCD-like symptoms. She's repeated concerns related to coronavirus and sterilising various parts of her home. She feels very anxious and is convinced she will die of the virus. She has a history of self-harm by cutting her wrists, dating back to the age of 16. This has continued through the period. She has visible contact dermatitis on her hands from repeatedly using bleach.

Or is it Case 3? This is a 24-year-old gay man who is convinced he has large thighs. This is not obvious on clinical examination. He has stopped leaving the house and spends long periods of time inspecting them in the mirror, upwards of five hours per day. He has tried to cut parts of his thighs with a Stanley knife to reduce the size of them.

4:11 **Speaker:** So here are the three cases: the seven year old who has odd behaviour/odd mantra's (stepping over cracks of pavement), the 26 year old female with OCD symptoms related to pandemic or this gentleman in case three.

And I think Hillary was organising for a poll to come up. So if you vote on which would be the most likely to for you to refer to secondary care.

4:52 **Speaker:** OK, thank you very much, everyone. Great. Well, it looks like I don't need to do this session. Clearly, that's very straightforward. I mean, case one was basically me as a kid, and it's quite normal for kids to have quite obsessive ways of doing things. And if they don't do it, they worry that something bad will happen. And I basically presented like this as a kid and I kind of grow out of it. And the majority of kids will actually, though some will become adults with Obsessive Compulsive Disorder. A lot of people have felt like this through the pandemic, you know. Repeatedly sterilising their hands, washing surfaces, contact points in their house, a lot of people have been concerned, but this is clearly got a mixture of OCD and hypochondriasis, potentially on a background of deliberate self-harm. But this is the most concerning case, really. You know, he's a gay man's already, unfortunately, because he's a gay man that needs a higher risk of suicide and he's got Body Dysmorphic Disorder, used to be called body dysmorphic phobia. And we know that he's fixated on their size, but this is not obvious that one of the features of Body Dysmorphic Disorder and the perceived flaw that the person is focussed on actually is either not there or is very minimal and clearly has significant functional impairment. And that's one of the criteria to look to escalate. Second, you know, stop leaving the house. You've got a classic avoidance. He spends five hours a day look at its size in the mirror and he starts to cut as well. So new onset, deliberate self-harm. So he's by far the most risky and the most functionally impaired of the three patients. Clearly, he needs more he needs further support and more formal interventions by secondary mental health services. So, yes, that's great.

7:07 **Speaker:** OK, so as I mentioned, today in ICD 11 OCD is now in its own category with Body Dysmorphic Disorder and hypochondriacal disorder. I wanted to focus on these conditions today. All really characterised, if you like, by abnormal thinking patterns, anxiety and ritualistic or compulsive behaviours. Be that looking in the mirror for long periods of time, if you've got Body Dysmorphic Disorder to counting, checking, cleaning or whatever the ritual is when you think about OCD. Hypochondriacal disorder, again, used to be within the other Somatoform disorders in ICD 10. But again, because the features are very obsessive and anxiety driven, they are now with within this category, along with these other two. There's a couple of others, and I'll mention those right at the end, such as hoarding disorder. And I'll talk about that briefly.

And really, I'm going to focus on these three conditions. I'm going to talk about the main features. I'm going to talk a bit about the epidemiology, I'm going to give an overview of aetiology of these conditions and talk more about the management of these conditions as well.

8:32 **Speaker:** OCD. So there are really three cardinal features of Obsessive Compulsive Disorder. Firstly, the individual with OCD has the obsessions. These are thoughts. And they could also be sort of mental images or impulses. They are often repetitive, so they're

constantly whirring around in the patient's mind. They are very distressing. This is one of the key features of an obsession in OCD. The patient tries to resist and push the thoughts out of their head, which in turn sort of perpetuates the thoughts and makes them more intrusive. The obsessions in Obsessive Compulsive Disorder are hugely intrusive. But importantly, the patient accepts them and sees them as their own thoughts. And that's important to distinguish between OCD and perhaps somebody with psychotic symptoms that may be having thought insertion, for example, which is a delusion of thought control. It's not their thoughts in thought insertions So they have to be repetitive, distressing and there's resistance. But they're very much seen as their own thoughts. Those thoughts in themselves drive anxiety symptoms. So they drive feelings which predominantly are anxiety symptoms.

And, for those of you came to my last session a few months ago, I spoke about the sort of common anxiety disorders, the classic anxiety symptoms. And in OCD, the people that suffer with those anxiety symptoms fuelled by the obsessions, then engage in compulsions. So it's that classic Beck triad of thoughts, feelings and behaviours. You know, this fits that perfectly - that paradigm. And those compulsive acts don't necessarily have to be motor acts. So for example, one of the compulsive acts could be trying to neutralise one thought with another thought. For example, you get an obsessive thought, then you decide you count to ten or count the number of corners in a room. That is very much thought driven rather than a ritual motor behaviour such as cleaning or checking things, for example. So these compulsive acts are done to manage the anxiety associated with the obsessional thoughts and they are ritualistic and their repetitive. And they're not enjoyable. And whilst in the early days of the patient suffering from OCD, they may help to improve some of the anxiety associated with the obsessional thoughts, often by the time we see them in clinical practice, actually, even though they're engaging in those ritualistic, repetitive acts, they're not actually helping the anxiety at all. But they continue to do them, nevertheless. And they're done because (and this goes back to the child, the seven year old child) there's often a lot of catastrophising built into the obsessional thoughts and the ritualistic behaviour. So people believe that if they don't do these acts repetitively, something bad will happen to themselves or their family. And if the patient tries to resist doing these compulsions, that builds anxiety in itself. But, of course, it's that resisting of the compulsions that's actually one of the cornerstones of treatment of Obsessive Compulsive Disorder. But I'll talk about treatments in a bit.

13.01 **Speaker:** We all get obsessions or get thoughts coming into our heads (more so in the past 12-18 months). These are very distressing for us. We know we'd never act upon them and we're able to push those thoughts out of our head very easily and dismiss them and they don't keep popping back. So we all get these kinds of things. So to be diagnosed with OCD, you need to have these thoughts or these rituals for over an hour a day, or they need to cause significant stress or functional impairment. And typically, obsessional thoughts tend to be around checking things, cleaning, contamination, those kinds of themes. But remember, you can get obsessional thoughts related to violence (the mother wanting to harm her baby, for example) or sexual content to obsessional thoughts as well. So there are many different themes you can get within obsessional thoughts.

14:14 **Speaker:** In terms of epidemiology, men are equally affected as women, and it occurs in about one to 3% of adults. The Royal College of Psychiatrists figure is around 2% in the

U.K. Adults, as I mentioned before, who suffer with OCD frequently have those kinds of symptoms in childhood. And generally, if we were to differentiate males and females, men are more likely to engage in checking type behaviours. And women are more likely to engage in cleaning/washing type behaviours because of the themes of their obsessions. And of course, what often happens in these patients is this thing called obsessional slowness, whereby they will take forever engaging in the compulsion. So they're always late for everything and it's often something you might see in clinic. These people will turn up late for appointments. When I was working as a community mental health team clinician, I would often increase the appointment times for them. Sometimes with severe cases of OCD I would actually tell them their appointment time was at two o'clock and expect them to arrive at half past two when their appointment time really was. Because you get this obsessional slowness with OCD.

15:52 **Speaker:** These are the kinds of questions you would ask somebody if you feel they may have features suggestive of OCD. I'm not going to read through them all here, but it's questions like: Do you have frequent or unwanted thoughts that seem uncontrollable? What happens if you try to get rid of them? Questions around rituals and then more specific questions related to some of the themes like cleaning, checking, symmetry is another one getting everything in order, everything in symmetry. And then some questions relating to functional impairment.

16:37 **Speaker:** Generally, there are some theories around the aetiology of Obsessive Compulsive Disorder, but it still largely remains unclear. There's definitely a genetic component. So if you have family members who suffer from OCD, you are more likely to suffer from OCD yourself. And actually, it's about a 50% concordance rate for monozygotic twins or identical twins. Similar to schizophrenia, actually. You know, if you have an identical twin with OCD, you are about 50% more likely to develop OCD compared to 2-3% that you get in the general population. So there is that genetic predisposition with OCD.

17:35 **Speaker:** It also is related to anankastic personalities - also called - obsessive compulsive personalities. That tends to complicate it when you talk about obsessive compulsive personalities. That's why we use the term anankastic. Anankastic is a type of personality disorder, a Cluster C personality disorder, along the lines of anxious personality disorder, dependent personality disorder. And it's those personalities with features including wanting order. We all know people that like to have order in their lives. And I don't mean doing the same kinds of compulsions or having the kinds of obsessions as you get in OCD, but just having things neat and tidy and ordered and tidy desks and tidy houses and they don't like chaos. So it is related to those kinds of personality disorders. There's clearly an association between OCD and serotonin. And when we talk about the pharmacology of treatment of OCD, we will mostly talk about drugs that have an impact on the serotonergic system. And there's also this association of OCD with Tourette's. Tourette's is caused through a dysfunction in the basal ganglia. So some commonality in terms of where OCD arises and where Tourette's arises as well. About 60% of kids diagnosed with Tourette's will have obsessive compulsive type symptoms. Clearly, life events as well and traumatic events have an aetiological significance. I mean, we've seen it in the last 18 months. There's nothing like a global pandemic to potentially increase the prevalence of OCD and all mental disorders, quite frankly.

19:39 **Speaker:** And I've basically grouped both OCD and Body Dysmorphic Disorder into the same part of this presentation because the treatment is very similar for both conditions. And I'll talk about treatment shortly.

But let us first talk about Body Dysmorphic Disorder or Body Dysmorphic Phobia. I'm sure we've all encountered patients who appear to have an element of Body Dysmorphic Disorder. It's where the individual has a preoccupation with some flaw or defect or the size of a particular part of the body. And it is very much perceived. So often the clinician or loved ones, friends or family, will not see what they see. They will not see this flaw, this defect, this part is bigger or whatever. And if they do notice it, it would only be very minor to them. But more often, actually, they don't really see it at all. So the preoccupation is very much a perceived and it is very much a preoccupation. The patient becomes very self-conscious about their perceived flaw and sometimes develop referential ideas. So sometimes believe that other people are talking about them, specifically talking about this perceived bodily defect. And they're not delusions. We're not talking about referential delusions where people think, you know, the television or the radio is talking about them, for example. They're referential ideas. So they're amenable to rational discussion. And they're not sort of unshakeable like a delusional belief. If it was a delusional belief, we would have tipped into psychosis, which sometimes people with Body Dysmorphic Disorder can tip into. So you get this kind of feeling that people are talking about this flaw. And this is often where the functional impairment comes in. So the person will often repeatedly examine.

So you can see why Body Dysmorphic Disorder starts to fit in with OCD. You get this preoccupation. They're constantly thinking about a perceived flaw. So this is kind of obsessional and you've got this ritualistic behaviour. They're constantly examining themselves e.g. looking at themselves in the mirror. They may ask family and friends to try and get reassurance from them. You know, is this part of my body, this or that, or big or small? And sometimes the person with BDD will often use excessive camouflage. So they'll cover themselves up. They'll wear a hat all of the time, even indoors. They may wear excessive makeup, these kinds of things. And worst case, once the BDD starts getting really severe, they will start to avoid all kinds of situations where they can be scrutinised by others, where other people see them. So this is where you start getting the functional impairment because people are spending all day looking in the mirror at this perceived flaw. They are repeatedly examining themselves and they're avoiding social situations. So you can see how people with BDD, their lives get increasingly narrower, a bit like people with OCD. And this causes significant distress or impairment. So very similar features with OCD and BDD - that element of obsessional thinking, preoccupied, checking, ritualistic type behaviours.

23:37 **Speaker:** Around about the same prevalence as OCD. Again, similar in men and women and higher in some populations, for example, cosmetic surgery clinics. And, you know, I don't know the figures, but the proportion of people suffering from BDD and bypassing primary secondary care for treatment of the underlying condition and then going into cosmetic clinics for various bits of cosmetic interventions, the likelihood and the evidence suggests that the prevalence in those populations is much higher than the 0.7-7.5%.

24:19 **Speaker:** What about the aetiology of Body Dysmorphic Disorder? Like with OCD there's a genetic component. If you've got a first degree relative with Body Dysmorphic Disorder you are something like five to eight times more likely to suffer from Body Dysmorphic Disorder yourself. Again, there's the role of 5HT. Serotonin. An under expression of serotonin in certain pathways of the brain. And again, when we talk about pharmacological treatments, we'll understand why we often use the drugs we do use. There is a link between trauma, childhood trauma, physical, emotional, sexual abuse and later development of Body Dysmorphic Disorder. But, you know, you get that link with many mental disorders and childhood trauma. Obviously the most common or the strongest force, the strongest link is between these childhood trauma and personality disorders. But you do get that link between childhood trauma and Body Dysmorphic Disorder. And interestingly as well, evidence suggests that people with Body Dysmorphic Disorder have difficulties processing the visual information. That the things that they see in their body, they have distortions in how that visual information is processed. So they actually may see things as the rest of us seeing things, but how the brain then processes that perhaps makes their brain think that this part is bigger or there's a flaw there or a defect. And there's increasing evidence for this visual processing distortion in patients with Body Dysmorphic Disorder.

26:17 **Speaker:** And here are some questions that, you know, you might want to ask somebody with Body Dysmorphic Disorder:

- Do you worry about the way you look?
- What specific concerns do you have?
- On a typical day, how many hours a day is your appearance on your mind? (This is a great question to ask most patients who have mental health problems, actually)
- How many hours in a day you looking in the mirror or checking things?
- How does this affect your life?
- Does it make it hard to be your friends? (getting into that avoidance and that social isolation you get with Body Dysmorphic Disorder)

27:03 **Speaker:** OK, so we're going to shortly talk about the treatment of OCD and Body Dysmorphic Disorder. Firstly, I wanted to get your views on this patient and the treatment approach:

What would be the most appropriate first line treatment for a man with moderately severe OCD related to checking and counting? There is no suicidal ideation or significant functional impairment. He does not want to consider CBT or any other kind of talking therapy. So talking therapies are out. What do you feel would be the most appropriate treatment pharmacologically from moderately severe Obsessive Compulsive Disorder?

- Phenelzine
- Amitriptyline
- Clomipramine
- Mirtazapine or
- Sertraline

And hopefully the poll will come up. There we are. So that's absolutely right. Sertraline is the most appropriate treatment for this gentleman.

Sertraline is an SSRI, as you know, often cited as first line pharmacological treatment for OCD. Not first line treatment necessarily, but first line pharmacological treatment. It has the best evidence base, as do some of the other SSRIs. It just happens that Sertraline is probably the most easily tolerated. Clomipramine, for those of you who put Clomipramine down – yes that is a treatment for OCD. You're absolutely right. Because of the side effects, however, it probably wouldn't be a first line treatment. It would be a second or third line treatment. And then obviously Phenelzine being a monoamine oxidase inhibitor, and no one prescribes that anymore. And those others as well, not really indicated for Obsessive Compulsive Disorder.

29:18 **Speaker:** So what about treatments of OCD and Body Dysmorphic Disorder? So the NICE Guidelines haven't been updated actually for a number of years, they date from 2005 and they categorise OCD and Body Dysmorphic Disorder together. And the treatments are very much the same for both because of the similar features, but also the similar aetiologies, particularly around 5HT.

And as with all mental disorders and all disorders, the NICE guidelines refer to this stepped approach to care, whereby step one is about awareness, assessment of people that present with OCD, low level interventions, watchful waiting for less severe cases of OCD. And as you progress up the steps, the OCD is becoming more severe. There may be more associated functional impairment and distress. It may be increasingly associated with suicidal ideation and the risks are increasing. So obviously the more formal interventions are recommended, such as psychological interventions and pharmacological interventions.

It's really important in Obsessive Compulsive Disorder to assess for any co-morbidity and often treat that first. So the person may have OCD and they may be depressed, for example. And it's often a good idea to try and treat the depression because then the person may have a better response to treatment for OCD, be that pharmacological or psychological. And also substance misuse as well. People may often misuse substances (alcohol/drugs) to manage some of the distressing thoughts and feelings they get with Obsessive Compulsive Disorder.

And like with all anxiety disorders, it's absolutely imperative that psychological treatments be offered as first line treatment for OCD.

Now, I know that's easier said than done. I mean, that's easier said than done for me as a psychiatrist, actually, because we know that it's not easy to access psychological therapies. There are waiting lists. And there are a number of caveats that I would use whereby I would look to choose a pharmacological option ahead of a psychological option. And that is - severity. If the OCD was very severe, if the OCD was associated with significant risks to that person and if the OCD was causing significant stress or functional impairment, then it's probably prudent to try a two pronged approach of both pharmacological and psychological. But actually try and improve the symptoms of OCD before you start on the psychological therapy. So in that case, you would want to start a drug, a medication first line, because actually if the OCD is very severe and you go straight in with psychological therapy the patient’s going to find it very difficult to tolerate doing psychological therapy. It's not easy engaging in psychological work for Obsessive Compulsive Disorder.

Also, patient choice. Obviously, if a patient decides they would rather not deal with the condition through talking therapy, they may want to choose an antidepressant, first line, then that's their choice. Obviously, as part of informed consent, that is up to them. And actually, sometimes when there is a lack of appropriate services, you may want to want to help your patient in the short to medium term before they're able to access psychological therapies, particularly if it's something like a 12-18 month wait for psychological therapies, which is fairly commonplace. So these are the kinds of caveats that I would consider in terms of offering pharmacological treatments before psychological treatments.

33:40 **Speaker:** And what are those pharmacological treatments? Well, first line is an SSRI. It's really important, like with all anxiety disorders, when you treat them, the anxiety will get worse before it gets better. The obsessions will get worse before they get better. As will the compulsions. So it's really important to counsel the patient that this is likely. And sometimes, you know, if there is really going to be significant anxiety associated with starting an SSRI, I will often prescribe very small doses – 2mg of Diazepam for a week and no longer, to help that person with the anxiety. But an SSRI is first line. Clomipramine is second line. Then other agents, SNRIs, for example, Venlafaxine, Mirtazapine perhaps. Sometimes antipsychotics (but we're getting into the realms of secondary care now) can be used to treat OCD and BDD. Particularly if some of the behaviours and thinking patterns are almost verging on the delusional, it may be appropriate to consider antipsychotics. But they are way down the list of treatment options to reach for when you've got somebody with an OCD or BDD type presentation. So first line, SSRIs and anxiety often gets worse before it gets better.

35:10 **Speaker:** What about psychological treatment? This also is based on that stepped approach to care that I mentioned. There are really effective and useful support groups out there. I'll give you some links at the end for some OCD charities, for example, whereby patients can access support groups. Both face to face support groups and virtual support groups. And actually support groups can be not only helpful for the patient, but support groups can be helpful for the family members and the loved ones of the patient, because it can actually be very distressing to live with somebody with OCD. And it's actually can be very important to learn how to deal with the person with OCD that's living in your household. There's some really good guided self-help books out there. And I'll mention those at the end so you can sort of take a look at them.

And then in terms of formal psychological therapy, there are two main approaches to the treatment of OCD and BDD. Cognitive behavioural therapy underpins both of these treatments. The first one is exposure and response prevention, and the second one is cognitive therapy. What's the difference between exposure response prevention and cognitive therapy?

Well, exposure response prevention works on the premise of actually getting rid of the thoughts and the compulsions and exposure response prevention is very similar to like a graded desensitisation that you might get in a phobia, the treatment you might approach in a phobia. So you get the person to write down a list of their compulsions, for example. And, you know, at the bottom of the list is the compulsion that causes them the least anxiety if they don't do. And at the top of the list is the compulsion that causes the most anxiety if

they don't do. And you are getting to work through those compulsions and prevent a response to the obsession. So say, for example, you've got a checking obsession that you've got to check everything, if it doesn't, something terrible is going to happen in the house/someone's going to get hurt. And you go around the house 10, 20, 30 times checking everything. What are the things you check the most? Which ones cause you the most anxiety versus what are the things you check the least? Start off with the things you check the least and get the patient to try and resist doing that compulsion. And you get that classic response of the anxiety will go up, but if you're able to tolerate that and leave it long enough (and of course the therapist would have given that patient strategies to use to manage anxiety, relaxation techniques, progressive muscle, relaxation, guided imagery, those kinds of things) if you can tolerate that anxiety, anxiety always habituates. Anxiety always goes down. It's normal. You can't live in this heightened state. The anxiety will habituate. And that is the kind of underpinning, if you like, of exposure and response prevention. So it's a lot of behavioural experiments in exposure response prevention.

38:39 **Speaker:** Cognitive therapy doesn't tend to work so much on the behaviours. Cognitive therapy goes straight in for the thoughts and the therapist delivering cognitive therapy to a patient will help that patient manage those thoughts more effectively and deal with those. It's not about getting rid of the thoughts. It's about helping that patient get rid of those thoughts more effectively, so they don't they don't fuel anxiety and they don't fuel compulsive compulsions. Remember, not all patients suffer from both obsessions and compulsions. They may predominantly suffer from compulsion. Say, for example, you know, I mentioned before the mother who has recurrent obsessive ideas to harm her child. She knows she wasn't harming the child. There's absolutely no evidence that people with obsessional ideas related to causing harm, either physically, sexually or whatever, will act upon that. They are no more likely than the general population to act and to cause harm. But it's still very distressing. And actually, in those patients, the cognitive therapy can help. It's the patients whose lives are ruled by their compulsions, their ritualistic behaviours, that exposure response prevention can really support and benefit. I mean I once had a priest, actually who had OCD but the contents of his obsessions couldn't have been more antagonistic to his faith, because he had recurrent sexual themed obsessions, which were very distressing. And it was cognitive therapy that we were able to do with him to help him deal with those thoughts more effectively and not lead them to fuel that anxiety he was having.

40:38 **Speaker:** It's really important with OCD and BDD to support the family and the friends of those that suffer and give them the tools and the advice to help support their loved one with OCD and BDD. So encourage them to seek help themselves through self-help groups and research the condition to know what to do for the best.

It's really important to encourage family members not to reinforce behaviours. So if you're an OCD sufferer who's cleaned the kitchen floor 20 times and then you ask your loved one, is the kitchen floor looking clean or is there any dirt on the kitchen floor? The worst thing that a loved one can do is reinforce that by answering it. OK. It reinforces the behaviour. If you say yes, the person with OCD, their obsessions are just going to be running wild they're still going to carry on cleaning the floor anyway. If you say no, I mean, that's obviously going to be a lot worse. But getting people to reinforce or collude in some of these behaviours is

really quite damaging to the person with OCD. So you need to try and get the loved one to be very neutral around the individual's compulsive acts. And it's also really good to try and encourage family members to help the person confront anxiety provoking situations. Oh I need to clean the kitchen floor again or I need to go and check that the oven's off. No. Leave it. Come away with me. Spend 5/10 minutes, let the anxiety settle. It's good to get them to support in terms of tackling those anxiety-provoking situations.

It's not good for family members to physically try and stop people doing rituals. It's a bit like a kettle or a pan when it's boiling with a lid on. Something's going to give if you don't let that person do the rituals. And it's important to try and reassure family members that if their loved one is having obsessive thoughts related to violence or sexual themes, they're not going to act upon them. There's no evidence. They're just as likely to become violent or sexually violent as anyone in the general population. OCD doesn't increase the risk. So it does increase the risk of suicide like any mental disorder. But having the content related to sexual or physical violence does not increase the risk.

43:21 **Speaker:** Quickly going to talk about hypochondriasis. I don't like the term hypochondriasis because I think it's quite pejorative, actually. Hypochondriac has been sort of hijacked as quite a pejorative, offensive term to describe people. I'd rather call it health anxiety. However, I still have to call it hypochondriasis. And it's this persistent preoccupation with the serious progressive or life threatening illness and then because of that that persistent preoccupation, the patient engages in repetitive or excessive health related behaviours or avoidance behaviours. They can go one of two ways.

So the repetitive excessive health related behaviours would – and this is the classic one and is a real problem - continually researching their symptoms on the Internet. It is a huge thing. If you want to help the person with hypochondriasis, the first thing they need to do is stop going on the Internet every five minutes to look up what can cause this chest pain that I've got, for example? Obviously, other related behaviours are getting in family members to check them out or they check their bodies for lumps and bumps continuously. So, you know, you can see what it links in with Obsessive Compulsive Disorder. Or, of course, seeking out investigations, appointments with yourselves, etc, etc.

The opposite can happen with Hypochondriasis in that people can avoid health seeking behaviours so they can go the other way. They think they've got this terrible life limiting or life threatening condition, but they become reclusive, and they don't do anything about it. They don't go and see their doctor. So it can go one of two ways. The point with Hypochondriasis (because I think we've all got a bit Hypochondriacal probably the last 18 months) is it causes significant distress to the individual, like the person with OCD and BDD, they spend long periods of their day thinking about it, checking symptoms, etc, etc. And it does cause a lot of impairment. And that's where it becomes a problem, and that's where it becomes something you need to intervene with.

45:31 **Speaker:** Around about 1-5% prevalence, depending on which study you look at. Again, saving men and women. And similar sort of aetiological factors involved. If you've got a family history of hypochondriasis, you're more likely to develop it yourself. But also if you have a physical illness in childhood or if you had a parent who has a physical illness in

childhood, you're more likely to develop hypochondriasis yourself. If you've had a health scare, for example, a cancer scare where you've been sent for investigations because of a symptom and you've been sent for these symptoms that might be suggestive of red flags, you're more likely to develop health anxiety after that and also health related Internet behaviours. People just get into this cycle of checking every single ache or pain or symptom on the Internet. It becomes really kind of obsessive and they do it all the time. And that kind of leads to the development of a hypochondriacal or health anxiety disorder.

46:50 **Speaker:** Drugs don't work for Hypochondriasis. Self-help is the very first step that I would recommend to all patients so, guided self-help using a book rather than going on the Internet and checking various symptoms and then obviously a referral for CBT if it's excessive and severe.

47:12 **Speaker:** In IC11 under OCD and related disorders there are a couple of other disorders I just wanted to flag. Quite rare. Olfactory reference disorder is where you believe that you have a smell, a malodorous smell coming out of the body. Could be sort of body odour. It could be bad breath. Again, similar to BDD. It's not obvious to anyone else or may be ever so slightly obvious, but because of that, the person will become reclusive, will use various techniques to try and hide that smell, but will still smell the smell.

Then you've got hoarding disorder. Very similar features. Compulsions to hoard. Anxiety if you contemplate getting rid of things, tidying up.

And then the final category of disorders in this in this category is Body-focussed repetitive behaviour disorder. So I'm talking about people that pull their hair, trichotillomania, for example. I'm talking about people that maybe pull bits of skin off or bite their lip all the time. It's recurrent, it's obsessive, it's ritualistic. These kinds of behaviours are all in the same category of disorders.

48:22 **Speaker:** So just to summarise, I hope you found the session helpful. OCD and those other disorders I've spoken about have very many similar characteristics usually related to sort of maladaptive thinking patterns or ritualistic or excessive behaviours. They can be particularly disabling in severe cases leading to social isolation and complete withdrawal and a narrowing of their lives. They are likely to be increasing in prevalence, particularly in the last 18 months. But they often present late. The condition may have been ongoing for a while, sometimes years before it presents to yourselves as GPs. Psychological therapies are first line, though, I understand some of the constraints and some of the barriers, particularly in primary care to that. But they are easily treated if found and identified earlier. If later, they tend to become more chronic. You can improve symptoms with either anti-depressants or psychological treatment, but they tend to have a fairly chronic course.

49:41 **Speaker:** These are two books I'd recommend, actually, both by David Veale. I don't have shares in David Veale or in the company that makes these books. But David Veale is the lead clinician in the National Anxiety Disorders Residential Unit in the Royal Bethlem Hospital in London. I sent one patient there in my career actually, with very severe OCD who made really remarkable progress after that. And it's a unit that accepts referrals from right across the UK. It's a residential unit with intensive cognitive behavioural therapy approach.

But, you know, these are two really useful books. And I'll let you into a slight secret. I've really benefited by using the first book 'Overcoming Health Anxiety'. A sort of 'physician heal thyself' going on, particularly in the last 18 months. So it's a really useful book as is overcoming OCD.

And there are some really good websites out there that I would signpost post you to signpost your patients to. All have really good advice for both the sufferer and the carer, the loved one. And also opportunities to join self-help groups for patients as well.

So hope you found that helpful today. I'd be delighted in the last few minutes and to take any queries or take any questions you may have. And thanks very much. Thank you.

51:30 **Chair:** Thank you very much, Ian. If anyone has any questions, you can write them in the comment box on the right hand side of your screen. Nothing posted there at the moment. Also there's a link in the comment box for feedback questionnaire on this presentation. That would be very helpful to us if as many of you as possible could find the time to complete. Thank you.
We have just one comment from David Lupton saying 'Excellent, thank you'. 'A good and informative presentation, thank you from Khirya. So at the moment, no questions. So it sounds as though you've covered everything that needed to be covered at the moment. If we can get a couple of minutes. So just give people a bit of time to get their fingers on the keyboard.

I mean, how easy is it for people to be seen if we refer them? What's the sort of waiting list?

52:28 **Speaker:** I think that's the challenge, isn't it? I think, you know, a lot of mental health services, similarly to primary care actually have moved to a sort of hybrid model of working, whereby we offer both virtual appointments and face to face appointments. Face to face appointments tends to be reserved more for patients who are more severely ill, psychotic, etc, etc. But I think with the virtual way of working, I think in a sense that is taking down some barriers and enabled us to see patients more quickly with conditions. I mean, we obviously triage all of our patients that come and get referred into mental health. And if you've got a very uncomplicated OCD, but actually it's causing some level of functional impairment, they're going to be probably slightly further down, as it were, the waiting list than somebody with OCD and suicidal ideation, for example. But, you know, usually for somebody like that, hopefully within a few days or even weeks, and maybe we're talking about a couple of month mark for somebody with less complex presentations.

53:46 **Chair:** OK, we've got a couple of questions in. First from Terry Stewart. First of all he says: 'Thank you Ian – very clear' and then asks: Is he correct in thinking that higher doses of SSRI are needed in OCD?

54:00 **Speaker:** No. Normal doses of SSRIs. Your normal BNF range doses of SSRIs are fine with OCD and effective with OCD. What you tend to need to use high doses of SSRIs for is eating disorders actually. So often, for example, with bulimia you'll push the dose of Fluoxetine, for example, which is the main treatment pharmacological treatment for

bulimia, up to like 60 milligrams. So no normal doses are fine for OCD. Obviously normal therapeutic doses. But if you don't get a response on a lower dose, please push up to the higher dose, as it were, the higher dose within the range.

54:44 **Chair:** Catherine Connell asks do you find some SSRIs can cause sleep disturbance? If that happens, is that an indication to change to an alternative?

54:56 **Speaker:** Yes. Some SSRIs can cause sleep disturbance. And of course, we all, you know, advise our patients to take the SSRIs in the morning, preferably at the same time as they're eating breakfast, not on an empty stomach, because that reduces the side effects. However, it's often a good idea just to ask if a patient is complaining of sleep disturbance when they're taking their SSRI. Because the number of patients that I've asked that question to, they're actually taking them in the evening and no wonder they're having sleep disturbance. So that's usually a very good first question to ask before doing anything else. But ultimately, it depends on that risk benefit. That balance. If the patient is having significant benefit in terms of why you've started the SSRI, ie OCD but they're able to manage with a small amount of sleep disturbance, then it's probably wise to continue tentatively. If it's the opposite, however, they've had no benefit and they're having a significant amount of sleep disturbance, that it's wise to switch.

56:00 **Chair:** Terry's asking: Are relaxation techniques safe in OCD?

56:06 **Speaker:** Absolutely. And when a therapist works with somebody (and you know, you can teach relaxation techniques yourself) but when a therapist works with somebody in that that response prevention exposure response prevention work, they will often teach the individual relaxation techniques. Because, you know, if we're saying, like, make your kitchen floor dirty and don't clean it for ten minutes, but at the same time, your anxiety is going sky high, you need to be taught relaxation techniques to help manage that anxiety. Next week you have to wait 20 minutes before you clean your kitchen floor. These are just sort of simplistic examples of how you might approach it. But relaxation techniques really important to support people with the anxiety associated with OCD.

56:53 **Chair:** David is asking: Are there any issues giving SSRIs to the under 30s?

56:58 **Speaker:** No, there aren't any issues. Obviously, the increase in anxiety is really key. You need to be aware of that. You will have heard of the potential increased risk of suicidality with SSRIs, particularly with Paroxetine. I think it was about 5/10 years ago now, that faithful Panorama drama looking at Seroxat and the manufacturers of Seroxat that hid all of that information from clinical trials related to suicidality. Its complex. Suicidality related to any antidepressants or any anxiolytic treatment, because actually when you start improving somebody's mental health, if they already have suicidal ideation, one of the first things that often happens is their motivation improves so they're more likely to act upon their suicidal thoughts. But I would always use the mantra of ‘start low and go slow’ with antidepressants. I would always use the mantra of making sure the person knows they're going to get more anxious. And I would also say if they feel that their symptoms are getting worse, they're getting more thoughts of suicide than they need to talk to you about it. But

generally, I wouldn't not prescribe SSRIs in people under 30 because of risk of suicide. Again, it's risk versus benefits, like with all of our treatment decisions.

58:33 **Chair:** We've got just two last questions. I'll ask them both so that you can see because we're coming towards the end of our time. Gagan has asked: 'When do we refer a patient with OCD from primary to secondary care?' And Joel has asked: 'How long would you continue an SSRI for before stopping/weaning them down?'

58:56 **Speaker:** You refer a patient when they've stepped up that step model of care. If it's becomes severe OCD. If it's become very distressing for the patient. If it's become hugely functionally impairing for the patient and if it's associated with additional co-morbidities and high suicidal ideation, then you want to refer to secondary care. If you've tried everything in primary care and the person isn't getting better, also consider referring to secondary care.

How long would you continue an SSRI for before stopping/weaning down? Around the same time as you would for depression; uncomplicated first episode depression. You would look at about six months of continuing the antidepressants treatment once the person's better. Same approach really for uncomplicated presentation of anxiety or OCD. I mean, ideally you want to try and get to the root of the problem as well with OCD. So whilst the SSRI will treat the symptoms, you need to probably look at referring for psychological therapy to really treat the root cause as well, if possible.

1:00:06 **Chair:** Lovely, thank you very much, Ian. I think that completes the questions and thank you once again for a very comprehensive talk on a subject that we all find quite difficult to manage in primary care, but hopefully a little less troubled by it now. Thank you very much.