Bridging Perspectives: Navigating Tourette Syndrome and OCD

# Pharmacotherapy for OCD – a primer for non-prescribers

Elia Abi-Jaoude MD PhD, Staff Psychiatrist

Daniel Gorman MD, Staff Psychiatrist

The Hospital for Sick Children

University of Toronto

tourette canada

SickKids | Garry Hurvitz Centre for Brain & Mental Health

Tourette OCD Alberta Network

# Disclosures

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# Learning Objectives

1. To describe the evidence for pharmacotherapy for OCD
2. To describe the harms of medications commonly used for OCD
3. To be familiar with medications commonly used in OCD
4. To consider when medications might have a role in the management of OCD

# Treatment Approaches for Pediatric OCD

1. Psychoeducation and support
2. CBT / ERP
3. Pharmacotherapy

# Meta-analysis of CBT & SRI Pediatric OCD

## (McGuire et al., 2015)

| | **CBT** (10 studies) | **SRI** (7 studies) |
|---|---|---|
| **Response (%)** | 68 | 50 |
| **Response (RR)** | 2.72 (1.83, 4.04) | 1.80 (1.43, 2.26) |
| **Response (NNT)** | 3 | 5 |
| **Remission (%)** | 57 | 47 |
| **Remission (RR)** | 3.42 (2.11, 5.53) | 2.06 (1.03, 4.13) |
| **Remission (NNT)** | 3 | 5 |
| **Effect size (g)** | 1.21 (0.83, 1.59) | 0.50 (0.37, 7.33) |

# Psychopharmacology for Pediatric OCD

# Efficacy of SRIs for Pediatric vs. Adult OCD: Evidence from Meta-Analyses

| | Children & Adolescents | Adults |
|---|---|---|
| **Effect Size** | 0.4-0.5 | 0.3-0.4 |
| **Number Needed to Treat** | 5-6 | 6-7 |
| **Response Rate** | 50%<br>(twice the rate for placebo) | 33%<br>(twice the rate for placebo) |
| **Remission Rate** | 25-50%<br>(twice the rate for placebo) | ? |
| **Differences between SSRIs** | None | None |
| **SSRIs vs. Clomipramine (CMI)** | CMI may be superior, but studies are few and generally of poor quality | Small number of studies show a trend towards superiority of CMI, but it's not statistically significant |
| **SRI vs. CBT** | CBT+SRI ≥ CBT ≥ SRI | CBT+SRI ≥ CBT ≥ SRI |

Pediatric: *Geller et al., 2003; Bridge et al., 2007; Watson & Rees, 2008; Ipser et al., 2010* (Cochrane Review); *McGuire et al., 2015; Ivarsson et al., 2015; Öst et al., 2016; Locher et al., 2017; Cervin et al., 2024*

Adults: *Soomro et al., 2008* (Cochrane Review); *Skapinakis et al., 2016; Cohen et al., 2025*

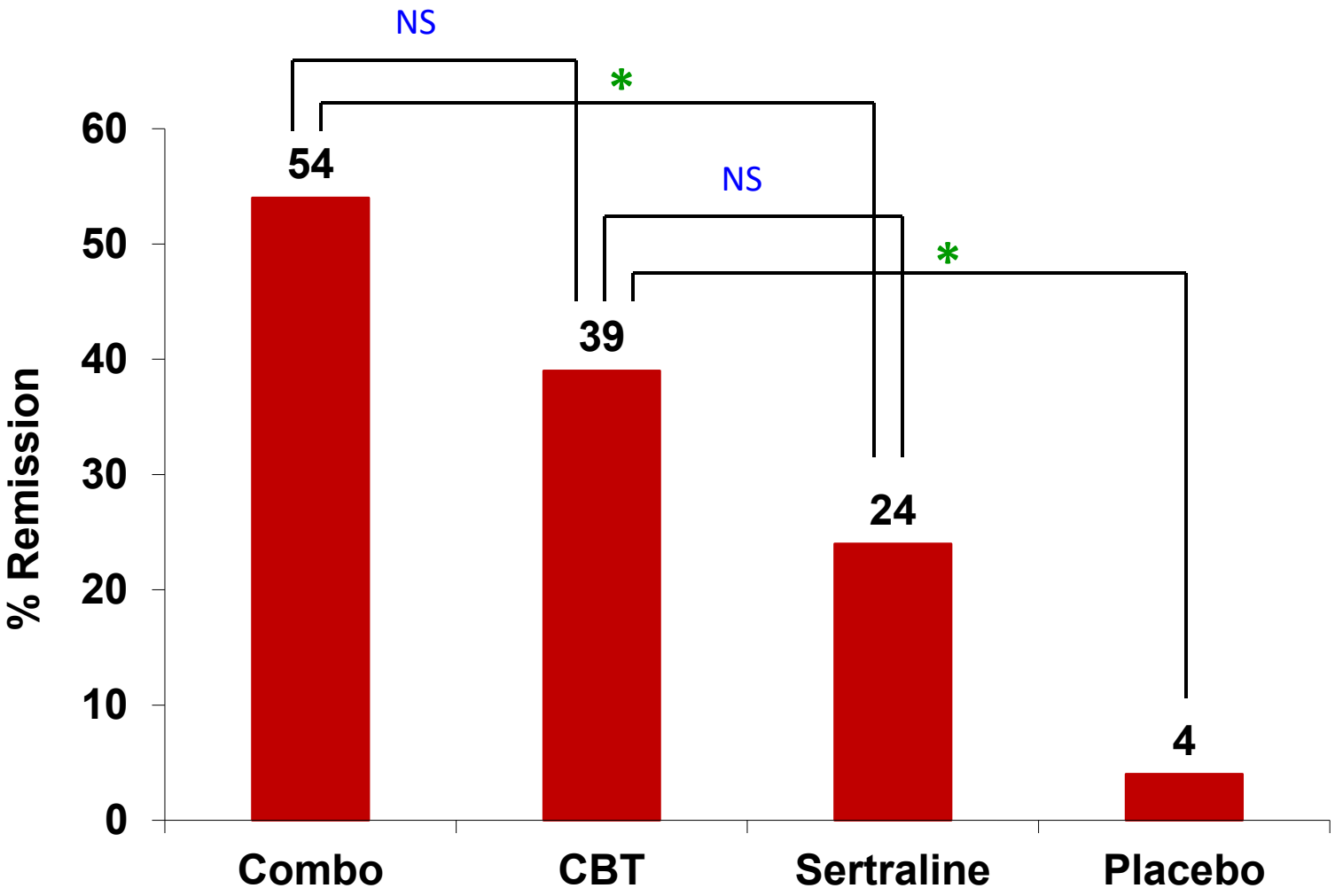
# Menu of Medications for OCD

- SSRIs
- Clomipramine
- Antipsychotics (for augmentation)

# Commonly Used SSRIs

- Sertraline
- Fluoxetine
- Fluvoxamine
- Citalopram
- Escitalopram

# Remission in POTS




NNT: COMB = 2, CBT = 3, SER = 6

# SRIs for OCD: Evidence from Meta-analyses

- Effect size = 0.5
- NNT = 5-6
- All SSRIs have comparable efficacy
- CBT has greater efficacy than SRIs
- Combined treatment is superior to SRI alone, but SRI adds little to CBT
- For SRI partial responders, adding CBT is superior to continuing SRI alone
- For CBT partial responders, continuing CBT is as beneficial as adding an SRI

*McGuire et al., 2015; Ivarsson et al., 2015; Romanelli et al., 2014; Ipser et al., 2009; Watson & Rees, 2008; Bridge et al., 2007; Geller et al., 2003*

# SSRI Harms

- Stomach upset
- Headaches
- Dizziness
- Activation (especially in younger children)
- Irritability
- Insomnia
- Somnolence
- ↓ or ↑ appetite
- Akathisia
- ↑ risk of suicidality
- Diaphoresis
- Sexual dysfunction
- ↑ prolactin
- Manic symptoms in predisposed patients
- Serotonin syndrome
- Flu-like symptoms during discontinuation
- QT prolongation with citalopram & escitalopram
- Withdrawal!

# Antipsychotic Augmentation of SRIs…

Evidence from meta-analyses:

- 14 placebo-controlled RCTs in adults, but none in children
- Overall, antipsychotic augmentation was significantly more efficacious than placebo (effect size = 0.6, NNT = 4.5)
- Risperidone, aripiprazole, and haloperidol were significantly superior to placebo (whereas olanzapine, quetiapine, and paliperidone were not)
- Unclear whether patients with comorbid tics respond better (*Bloch et al., 2006)* or worse (*Skapinakis et al., 2007)* to antipsychotic augmentation

*Dold et al., 2015; Veale et al., 2014; Komossa et al., 2010; Skapinakis et al., 2007; Bloch et al., 2006;*

# …Antipsychotic Augmentation

Caveats:

- No evidence of efficacy for antipsychotic augmentation in OCD patients who received <12 weeks of maximal SRI treatment (*Bloch et al., 2006*)
- Response rate was only 30% with antipsychotic augmentation, compared to 12.5% with placebo (*Dold et al., 2015*)
- Benefits of antipsychotic augmentation need to be weighed against the significant adverse effects

# Antipsychotic Harms

- Extrapyramidal symptoms
  - Acute dystonic reaction
  - Akathisia
  - Parkinsonism
- Tardive dyskinesia
- Metabolic
  - Wt gain
  - Hyperlipidemia
  - Hyperglycemia
- Hyperprolactinemia
- Sedation
- Dizziness
- Anticholinergic
  - Dry mouth
  - Constipation
  - Blurry vision
- QT prolongation
- Seizures
- Neutropenia
- Impaired impulse-control (aripiprazole)

# Take-Home Points

- CBT/ERP is generally the most effective treatment
- SSRIs can provide moderate benefit
- Other medication options have less evidence
- Medications can cause significant harms, often unrecognized
- Even for ‘treatment-resistant’ cases, ongoing psychotherapeutic intervention is worthwhile