



Obsessive-Compulsive Disorder in Primary Care: Overview on Diagnosis and Management

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Article History	Abstract
Received: 06 June 2023 Revised: 05 Sept 2023 Accepted: 21 Oct 2023	<p>Background: Obsessive-Compulsive Disorder (OCD) is a debilitating condition marked by the presence of intrusive obsessions and repetitive compulsions. The primary care setting often serves as the first line of contact for individuals grappling with mental health issues, making it a crucial frontier in the early detection and management of OCD. Therefore, the accurate diagnosis of OCD in such settings is essential for effective management.</p> <p>Objective: This review article aims to provide a comprehensive overview of the diagnostic process for OCD, emphasizing the clinical presentation, differential diagnosis, and various diagnostic tools available. Additionally, it explores current strategies for managing OCD, including pharmacological and psychotherapeutic interventions.</p> <p>Methodology: For this review, a comprehensive literature search was conducted using Google Scholar and PubMed databases. Keywords such as "Diagnosis," "obsessive compulsive disorder," and "management" were employed to narrow down relevant studies. Both qualitative and quantitative research papers were included, while non-English publications and those lacking peer-review were excluded.</p> <p>Results: Core symptoms of OCD include obsessions and compulsions, with the Y-BOCS being a standard measure for diagnosis. Differential diagnosis is essential to distinguish OCD from other conditions. SSRIs have been recognized as first-line pharmacological treatments. CBT, particularly Exposure and Response Prevention, remains a potent psychotherapeutic intervention. Emerging treatments like DBS and TMS offer hope for those unresponsive to conventional treatments. Combination therapies have shown enhanced efficacy in certain cases.</p> <p>Conclusion: The meticulous diagnosis of OCD requires recognizing its core symptoms, ruling out other conditions, and leveraging validated clinical tools. A multi-faceted management approach combining pharmacological and</p>

CC License CC-BY-NC-SA 4.0	<i>psychological treatments ensures optimal patient outcomes, with ongoing research introducing promising new interventions.</i> Keywords: <i>Obsessive, Disorder, Mental-Care</i>
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1. Introduction

Obsessive-Compulsive Disorder (OCD) stands out as a complex and often misunderstood psychiatric disorder, influencing the daily lives of millions around the world. Characterized by persistent obsessions, which are unwelcome and intrusive thoughts, and compulsions, which are repetitive behaviors or mental acts performed in response to these thoughts, OCD consistently poses a challenge to affected individuals, causing significant distress and impeding their day-to-day functioning [1]. Alarming, while the lifetime prevalence of OCD is estimated to be between 2-3% in the general population, many sufferers remain undiagnosed or receive suboptimal care [2].

The primary care setting often serves as the first line of contact for individuals grappling with mental health issues, making it a crucial frontier in the early detection and management of OCD. Thus, primary care providers become instrumental in discerning the initial signs and symptoms of the disorder, paving the way for a more specialized intervention when needed [3]. While the underlying causes of OCD remain a blend of genetic, neurological, and environmental factors [4], the primary care provider's role in assessment, education, and initial management is undeniable.

If not addressed, OCD persists as a long-term ailment with fluctuating symptoms. A comprehensive review of prospective studies shows that close to half of the patients witness a cessation of symptoms, with Indian patients showing notably higher remission rates than their Western counterparts. Prompt recognition and suitable intervention can enhance recovery prospects. Although OCD is a prevalent mental disorder, many pursue treatment only after enduring years of pain. Individuals with OCD often conceal their symptoms due to feelings of humiliation and disgrace. Just under one-third of those with OCD get the right medication, and even fewer undergo proven psychotherapy. [5]

Frequent obsessions and compulsions in OCD patients often involve fears of contamination paired with actions like washing or cleaning, worries about causing harm to oneself or others paired with repetitive checking, unwanted aggressive or sexual thoughts accompanied by internal rituals, and the need for symmetry paired with actions like ordering or counting. Although reluctance to throw things away is typical for hoarding disorder, keeping items to avert potential harm is also found in OCD. These patterns are noticed globally, suggesting that OCD has consistent characteristics across different populations. However, OCD can also manifest in rarer symptoms such as an excessive concern with morality, intense jealousy, and even musical fixations. Another significant aspect of OCD is avoidance, where individuals might limit various activities to prevent triggering their obsessions. [7-11]

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) defines OCD as a disorder marked by obsessions, which are repetitive, unwanted urges or thoughts, paired with compulsions or behaviors that disrupt an individual's daily life. Often, it's associated with other neurological or mental health disorders. There's ongoing debate in research about which comes first: do compulsions lead to obsessions, or do obsessions drive compulsions as a way to reduce the anxiety from these irrational fears? Other symptoms that might appear include impulsive actions, outbursts of anger, aggressive tendencies, intrusive sexual thoughts, strict religious practices (known as scrupulosity), and obsessions related to food in eating disorders. Affected individuals might also develop anxieties about cleanliness, the possibility of contamination, an incessant need to check things, and a pursuit of perfect symmetry in their surroundings. [12-19]

OCD often starts in childhood, but it's most commonly diagnosed during the adolescent and early adult years, with the average age of onset falling between 22 to 36 years. Men tend to develop symptoms earlier than women. There's a genetic component to the predisposition for OCD, as evidenced by identical twins having a higher likelihood of both having the disorder compared to fraternal twins. Furthermore, immediate family members of those with OCD are more likely to develop the disorder themselves. Some research suggests that the various symptoms of OCD, like fears of contamination paired with cleaning rituals versus hoarding behaviors, might represent separate yet interconnected conditions. These might also have different genetic roots. Additionally, research has shown that the severity of specific OCD symptoms can fluctuate over time. [20]

OCD's impact is further intensified by the discrimination and stigmatization that many individuals with the condition, and psychiatric patients in general, face due to misunderstandings about the disorder. Despite this, OCD and related disorders are significant medical conditions. Several studies have light on the role of the amygdala and its connections to the 'fear circuits,' as well as other structural and

functional anomalies within specific neural pathways. These findings link the symptoms of OCD to its underlying neurobiology, paving the way for innovative therapeutic approaches. [21]

OCD frequently coexists with other mental health conditions. It's crucial to evaluate every OCD patient for potential accompanying psychiatric disorders, as these can influence treatment results if overlooked. Over half of the individuals seeking treatment for OCD also show signs of depression and anxiety. Notably, individuals diagnosed with OCD at a younger age, especially during childhood, display high incidences of conditions like attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), and tic disorders. [5]

Managing OCD often requires a multi-faceted approach that combines medications with other treatments, like cognitive behavioral therapy (CBT), patient education, and support groups. The primary treatment options often involve serotonin reuptake inhibitors (SRIs) and CBT. However, other medications such as anxiolytics and antipsychotics are also utilized. Properly identifying and treating OCD is vital not only for the well-being of the individual but also for optimizing healthcare resources by preventing unnecessary medical interventions. [21]

Recognizing OCD's varied manifestations and understanding its co-morbidities, like depression and anxiety disorders, is paramount in primary care settings. Additionally, appreciating the current diagnostic criteria, available therapeutic modalities (including cognitive behavioral therapy and pharmacological interventions), and the implications of untreated or inadequately treated OCD are critical for healthcare professionals [22]. This comprehensive overview seeks to arm primary care physicians with the necessary knowledge and tools to confidently identify, diagnose, and initiate management for OCD, ensuring that affected patients receive the best possible care.

Etiology:

The precise origin of obsessive-compulsive disorder (OCD) is still uncertain, but it's believed to be influenced by several factors. Genetics play a significant role, as 45 to 65% of OCD's variability can be traced back to genetic causes. Studies involving both mice and humans have shown that mutations in the NMDA can lead to behaviors reminiscent of OCD. Specifically, changes in the NMDA subunit "NR2" have been associated with fears of contamination and repetitive cleaning behaviors. Traits such as difficulty handling uncertainty, an exaggerated sense of duty, and magical thinking appear to make individuals more prone to obsessive-compulsive tendencies [23]

It is obvious that etiology of OCD can be complex and multifaceted, with various factors contributing to its onset and development, these factors can be:

1. **Genetic Predisposition:** There is a clear genetic component to OCD, suggesting that individuals may inherit a susceptibility to the disorder. A comprehensive meta-analysis reported that 45-65% of the variance in OCD can be attributed to genetic factors [4]. Additionally, first-degree relatives of those with OCD are at a higher risk of developing the disorder [24].
2. **Neurobiological Factors:** Imbalances in certain neurotransmitters, particularly serotonin, have been implicated in OCD. Neuroimaging studies have also identified abnormalities in certain brain regions, such as the orbitofrontal cortex, anterior cingulate cortex, and the basal ganglia, in individuals with OCD compared to controls [25]. In line with this, the dysfunction in the cortico-striato-thalamo-cortical (CSTC) circuit has been proposed as a potential underlying mechanism for OCD [26]. Furthermore, mutations in the NMDA receptor have been associated with OCD-like behaviors, with specific mutations in the NMDA subunit "NR2" linked to fears of contamination and compulsive cleaning behaviors [27].
3. **Environmental Factors:** Exposure to traumatic or stressful events, especially during childhood, has been identified as a potential risk factor for the development of OCD [28]. Childhood infections, particularly streptococcal infections, have also been proposed as a potential trigger in a subset of OCD cases, leading to the hypothesis of Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS) [29].
4. **Cognitive and Behavioral Theories:** From a cognitive-behavioral perspective, it's believed that individuals with OCD might misinterpret and assign too much significance to intrusive thoughts. This misinterpretation, combined with behavioral strategies to reduce the associated anxiety, may lead to the development and maintenance of compulsions [30]. Traits such as a heightened sense of responsibility, difficulty tolerating uncertainty, and belief in the importance of thoughts (thought-action fusion) have been implicated in predisposing individuals to OCD [31].

5. Psychological Factors: Early life experiences, particularly those involving control and powerlessness, may also contribute to the onset of OCD. Moreover, upbringing and parental attitudes might play a role, with overly punitive or protective parenting styles being potential contributors [32].

while there is no singular cause for OCD, an interplay of genetic, neurobiological, environmental, cognitive, and psychological factors likely contributes to its onset and progression.

Epidemiology:

Obsessive-compulsive disorder (OCD) has a lifetime prevalence of 1.6% to 2.3% and a point prevalence of 1%, with an average onset age of 19.5 years. Half of the individuals with OCD begin showing symptoms during childhood and adolescence, and it's rare for symptoms to first appear after the age of 40. Many people wait approximately 11 years before seeking treatment, possibly due to the embarrassment of their intrusive thoughts or behaviors. Almost 90% of individuals with OCD also have other psychiatric conditions, primarily anxiety disorders. While males tend to show symptoms earlier, more adult females have OCD, with postpartum females being twice as likely to develop it compared to the broader female population. [23]

Roughly 40% of OCD patients have a chronic form of OCD, and many try to hide their condition. The World Health Organization ranks OCD among the top ten most debilitating human disorders. The disorder can start in childhood, with around 80% of affected individuals showing symptoms by the age of 18. Researchers are exploring different subtypes of OCD based on their origins. For instance, there's a form of OCD in children known as Early Onset OCD, which is viewed from a neurodevelopmental angle. [12]

OCD typically has two peak ages of onset, with the average starting at age 19. Notably,

the younger the onset, the more severe the disorder tends to be. Unlike other anxiety conditions that often see a higher female prevalence, gender distribution in OCD is relatively equal. Various factors can influence OCD's manifestation, from biological and genetic predispositions to socio-cultural effects. There's a specific early-onset form possibly linked to streptococcal infections termed PANDAS, though it's not well-understood. Some manifestations of OCD, like poor-insight obsessive-compulsive disorder (PI-OCD), can further complicate diagnosis. When considering all OCD subtypes. Notably, OCD often runs in families. An episodic course of OCD sometimes overlaps with major depression, highlighting the importance of vigilant diagnosis. Some severe OCD cases may even experience suicidal thoughts, emphasizing the profound distress this disorder can cause. The potential shared neurobiological basis between depression and OCD suggests similar treatment strategies might be effective for both conditions. [21]

Diagnosis of Obsessive-Compulsive Disorder (OCD):

The accurate diagnosis of obsessive-compulsive disorder (OCD) is fundamental for appropriate treatment and management. Diagnosing OCD entails a comprehensive clinical evaluation, primarily based on the patient's reported symptoms, their obsessions, and compulsions.

Clinical Presentation: The hallmark symptoms of OCD are obsessions and compulsions. Obsessions are persistent and unwanted thoughts, images, or urges that cause significant anxiety or distress. Compulsions, on the other hand, are repetitive behaviors or mental acts that an individual feels driven to perform in response to an obsession. It's important to note that the behaviors are not connected in a realistic way to what they are designed to prevent or are clearly excessive. [1]

Diagnostic Criteria: The DSM-5 provides specific diagnostic criteria for OCD [1]:

- The presence of obsessions, compulsions, or both.
- The obsessions and compulsions are time-consuming or cause significant distress or impairment in social, occupational, or other essential areas of functioning.
- The symptoms are not attributable to physiological effects of a substance or another medical condition.
- The disturbance isn't better explained by another mental disorder.

Diagnostic Scale: Several standardized scales are utilized to assist in diagnosing and gauging the severity of OCD symptoms. The Yale-Brown Obsessive Compulsive Scale (Y-BOCS) is one such

widely accepted clinician-rated measure, which quantifies the severity and type of symptoms present. [33]

The Y-BOCS utilizes a scale ranging from 0 to 40, with 40 indicating the highest severity of symptoms.[23] Patients are asked to assess and score based on the intensity:

- The duration spent on obsessions and compulsions
- The disruption caused by obsessive thoughts
- The anguish from obsessive thoughts
- The effort to resist obsessions
- The ability to manage obsessive thoughts
- The duration dedicated to compulsive actions
- The disruption due to compulsive actions
- The emotional strain from compulsive behavior
- The effort to counteract compulsive behavior
- The control over compulsive actions.

Differential Diagnosis: OCD is distinct, but it can resemble other conditions. Conditions that are often mistaken for or can co-exist with OCD include generalized anxiety disorder, body dysmorphic disorder, hoarding disorder, trichotillomania, and exoriation disorder. The differential diagnosis ensures that these conditions aren't mistaken for OCD and vice versa. [1]

A crucial part of evaluating an OCD patient is distinguishing the OCD diagnosis from other conditions that might be responsible for the symptoms the patient exhibits. Detailed medical and psychological assessments are vital for accurate differentiation. The individual could be suffering from other anxiety-related conditions like generalized anxiety disorder, panic disorder, or various phobias. Depending on their symptoms and history, other potential diagnoses include depression, anorexia nervosa, bulimia nervosa, bipolar disorder, psychosis, tic disorders, substance abuse, hoarding, body dysmorphic disorder, trichotillomania, paraphilia, gambling issues, or specific personality disorders, such as obsessive-compulsive personality disorder. [12]

The diagnosis of OCD underwent a significant revision with its categorization under "OCD and related disorders" in the DSM-5 and ICD-11, removing it from anxiety disorders. This group encompasses various conditions like body dysmorphic disorder (BDD), trichotillomania (TTM), skin picking disorder, hoarding disorder, and some disorders induced by substances or other medical conditions. Additionally, the forthcoming ICD-11 will include tic disorders, hypochondriasis, and olfactory reference syndrome in this category. These disorders have been grouped based on common clinical attributes, such as repetitive behaviors, familial tendencies, and similar brain circuitry abnormalities. Notably, while hoarding disorder might not have many similarities with OCD, it's included due to its historical connection with OCD and obsessive-compulsive personality disorder. [5]

Pediatric Considerations: In children, a sudden onset of OCD symptoms might suggest a potential link to Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS). In such cases, a streptococcal infection may precede the onset of OCD, suggesting an autoimmune component. [29]

Research at the intersection of OCD and neurology has highlighted the emergence of obsessive-compulsive symptoms following streptococcal infections, termed pediatric autoimmune neuropsychiatric disorders associated with Streptococcus (PANDAS). This understanding was bolstered by initial studies linking obsessive-compulsive symptoms to Sydenham chorea, a result of childhood streptococcal infection, and subsequently in patients with rheumatic fever. While progress has been made in diagnosing PANDAS, understanding its autoimmune underpinnings, and finding specific treatments, the focus has expanded to pediatric acute-onset neuropsychiatric syndrome. This broader condition features the abrupt appearance of obsessive-compulsive symptoms, which can be triggered by various infections and external factors. [7]

Physical Examination and Lab Testing: Though OCD is primarily diagnosed through clinical evaluation, in some cases, a physical exam or lab tests might be done to rule out other problems that

could be causing the symptoms. Checking for substances or medications that could be contributing to symptoms might also be part of this process.

Patient and Family History: OCD has a genetic predisposition. A thorough family history can provide valuable insight into potential risks and comorbid conditions, helping clinicians to better understand the individual's symptoms and potential hereditary components. [24]

Evaluation of Comorbid Conditions: A substantial portion of individuals with OCD have one or more comorbid psychiatric disorders, such as anxiety disorders, mood disorders, and tic disorders. Such comorbidities might influence the course and treatment of OCD. [34]

When assessing a patient, clinicians should determine the age when symptoms first appeared and when OCD was diagnosed, as this information can provide insights into the potential outcome. It's common for OCD to manifest during childhood, making precise diagnosis crucial for effective treatment planning. Pediatric specialists might ask simple questions like, 'Do you constantly have troubling thoughts? Do you repeatedly do certain actions, even if they seem pointless?' An official diagnosis ideally utilizes structured interviews and widely accepted tools like the Children's Y-BOCS (CY-BOCS), known for its reliability. [35]

The diagnosis of OCD is a meticulous process that involves recognizing the core symptoms of obsessions and compulsions, ensuring these symptoms are not better explained by other conditions, and using validated clinical tools to support the diagnosis. A multi-dimensional approach considering clinical, familial, and, in some cases, physical elements ensure a comprehensive assessment and accurate diagnosis of OCD.

Management:

Managing Obsessive-Compulsive Disorder (OCD) necessitates a comprehensive approach, integrating both pharmacological and psychotherapeutic interventions to ensure optimal patient outcomes.

Creating a treatment strategy requires a precise diagnosis of OCD according to the DSM or ICD classification systems. It's advised to use a structured clinical interview when possible to gain a thorough understanding of the patient's challenges. After confirming the diagnosis, it's essential to conduct a comprehensive assessment of the patient's symptomatology. The behaviors of family members, who might unintentionally support the patient's compulsions, can impact the results negatively. For the most severe cases, an in-depth family evaluation might be necessary. Following this assessment, it's crucial to set both immediate and long-term treatment objectives. Ensuring that patients adhere to their treatment is a critical component of any treatment strategy. Patients should be informed about the potential delay in the therapeutic effects of medications and that consistent treatment over several months might be required for noticeable improvement. If considering psychotherapy, a basic overview of its principles should be shared with the patient. [5]

Pharmacological Treatments: Selective serotonin reuptake inhibitors (SSRIs) are the first-line pharmacological treatments for OCD. Drugs like fluoxetine, fluvoxamine, and paroxetine have demonstrated efficacy in mitigating the severity of OCD symptoms [36]. For those who don't sufficiently respond to SSRIs, clomipramine, a tricyclic antidepressant, might be beneficial [22].

Meta-analyses of randomized controlled trials (RCTs) indicate that selective-serotonin reuptake inhibitors (SSRIs) are notably more effective than a placebo in treating OCD. While SSRIs can cause various side effects, they are generally well-tolerated. Clomipramine, a serotonergic tricyclic antidepressant, is the only other medication proven to be consistently effective in treating OCD, showing significant efficacy over placebo in several studies. However, network meta-analysis comparing the efficacy of clomipramine with SSRIs has not demonstrated any advantage in effectiveness. Direct comparison trials generally report no significant difference in efficacy between clomipramine and SSRIs. Additionally, studies suggest that clomipramine is less tolerable than SSRIs, with its anticholinergic, cardiac, and neurological side effects potentially causing issues. The next table shows medications that have proven consistent efficacy when treating OCD patients alongside their suggested doses: [5,37]

Drug	Suggested Dose	Recommendation
Escitalopram	20-30 mg	A
Fluoxetine	60-80 mg	A
Fluvoxamine	200-300 mg	A
Paroxetine	40-60 mg	A
Sertraline	150-200 mg	A

Citalopram	40-60 mg	A
Clomipramine	150-225 mg	A

A: Consistent, good-quality patient- oriented evidence

Initial research on tricyclic antidepressants, which influence both serotonin and norepinephrine, indicated that inhibiting serotonin reuptake was essential for treating obsessive behaviors. The role of the serotonin system in treating OCD was further emphasized by the enhanced effectiveness of clomipramine and serotonin reuptake inhibitors (SRIs). Some researchers have proposed that a medication affecting both neurotransmitters might be more successful in patients who don't respond to standard treatments. This idea gains traction considering clomipramine, which has some influence on norepinephrine reuptake in comparison to selective serotonin reuptake inhibitors (SSRIs), seems to be more potent in certain analyses, even if direct comparisons don't always show this. For instance, when comparing several studies involving young OCD patients, clomipramine demonstrated superior results than some SSRIs. Nevertheless, SSRIs are still the preferred initial medication because they generally cause fewer side effects. [20]

Cognitive Behavioral Therapy (CBT): Among psychotherapeutic interventions, CBT stands out as particularly effective. Specifically, Exposure and Response Prevention (ERP), a subset of CBT, has shown promising results in helping patients confront their obsessions and resist the urge to perform compulsions [38].

When professionals inform patients and their families that they are dealing with a relatively prevalent disorder that is becoming better understood, and that there are treatments that can improve symptoms and enhance quality of life, it can bring significant comfort. It's important to address issues like societal biases, family misunderstandings, and the potential of close ones inadvertently worsening OCD symptoms. To ensure the best outcomes, it's beneficial to involve the family in treatment, especially when the patient is a child or teenager. [7]

Research has shown that Cognitive Behavioral Therapy (CBT) is beneficial for children with OCD. Effective CBT programs often incorporate psychoeducation, cognitive reshaping, and techniques to confront and resist obsessive-compulsive reactions. Some successful strategies for CBT in young OCD patients have been identified. For instance, a five-week program led to notable enhancements in a child's obsessive-compulsive assessment scores and overall functionality. Weekly sessions were determined to be as impactful as daily ones. Involving parents plays a significant role in the CBT process. The Positive Family Interaction Therapy model, which merges individual CBT for the child with family sessions, reported a high success rate compared to traditional methods. Given the challenges in accessing quality CBT, phone- and web-based programs have been explored and show promising results, often matching the effectiveness of traditional face-to-face sessions. Group CBT sessions have also proven to be effective. One study specifically looked at the impact of family-based CBT, focusing on exposure techniques, for younger children and found notable improvements in both clinical symptoms and daily functioning. [12, 39-42]

Deep Brain Stimulation (DBS): For individuals who do not respond to conventional treatments, deep brain stimulation (DBS) has emerged as a potential option. DBS involves surgically implanting electrodes into specific brain regions believed to be implicated in OCD [43].

Transcranial Magnetic Stimulation (TMS): Another novel approach is TMS, a non-invasive procedure that uses magnetic fields to stimulate nerve cells in the brain, potentially improving OCD symptoms [44].

Combination Therapy: There's evidence to suggest that combining pharmacological and psychological treatments can be more effective than either modality alone [45].

In 2004, a study titled the Pediatric OCD Treatment Study (POTS) was conducted. This trial involved 112 participants aged between 7 and 17 years. The study aimed to assess the effectiveness of an SSRI (sertraline), CBT, and their combination over a period of 12 weeks. The measure of improvement was the change in CY-BOCS scores during these 12 weeks, with scores below 10 indicating remission. All treatment methods showed better results than the placebo, with the combined approach (CBT and sertraline) leading to the highest remission rate at 53.6%. This was followed by CBT alone at 39.3%, sertraline alone at 21.4%, and placebo at 3.6%. While there wasn't a significant difference between the effects of CBT alone and sertraline alone, CBT did show a notable difference when compared to the placebo. Sertraline's effectiveness was not significantly different from that of the placebo. While there weren't any severe side effects reported, some minor ones such as nausea and diarrhea were more common in the treatment groups. [46]

In a review that analyzed, 27 studies from 2011 to 2016. It found that Significant developments in treatment include the increasing support for online-based cognitive behavioral therapies (CBT) conducted by trained professionals, which have shown notable reductions in OCD symptoms. While selective serotonin reuptake inhibitors (SSRIs) remain the primary pharmacologic intervention, recent data supports the supplementary use of neuroleptics and other treatments for cases resistant to conventional treatments. Moreover, some new agents are being tested for safety and efficacy, though results aren't conclusive yet. Thus, while CBT and SSRIs are still the recommended initial treatments, emerging evidence on other therapeutic approaches provides hope for treatment-resistant OCD cases. [47].

4. Conclusion

As always, the choice of treatment should be individualized, considering the patient's specific symptoms, severity of the disorder, and other concurrent health conditions. Regular monitoring and follow-up are crucial to assess the effectiveness of the chosen treatment strategy and make necessary adjustments.

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