



## NATIONAL GUIDELINE CLEARINGHOUSE™ (NGC) GUIDELINE SYNTHESIS

### MANAGEMENT OF OBSESSIVE COMPULSIVE DISORDER (OCD)

#### Guidelines

1. **American Psychiatric Association (APA).** [Practice guideline for the treatment of patients with obsessive-compulsive disorder](#). Arlington (VA): American Psychiatric Association (APA); 2007. 96 p. [570 references]
2. **National Collaborating Centre for Mental Health/National Institute for Health and Clinical Excellence (NCCMH/NICE).** [Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder](#). London (UK): British Psychological Society, Royal College of Psychiatrists; 2006. 350 p. (National clinical practice guideline; no. 31).

#### INTRODUCTION

A direct comparison of the American Psychiatric Association (APA) and National Collaborating Centre for Mental Health/National Institute for Health and Clinical Excellence (NCCMH/NICE) recommendations for the management of adults with OCD is provided in the tables below.

The guidelines differ somewhat in scope. In addition to addressing management of adults with OCD, the NCCMH/NICE also provides management recommendations for children with OCD, as well as for both children and adults with BDD. NCCMH/NICE also includes organization/policy recommendations. Both guidelines provide recommendations for areas of future research. These topics, however, are beyond the scope of this synthesis. For pediatric OCD treatment recommendations APA refers the reader to the practice parameter of the American Academy of Child and Adolescent Psychiatry.

The tables below provide a side-by-side comparison of key attributes of each guideline, including specific interventions and practices that are addressed. The language used in these tables, particularly that which is used in [Table 3](#), [Table 4](#) and [Table 5](#), is in most cases taken verbatim from the original guidelines:

- [Table 1](#) provides a quick-view glance at the primary interventions considered by each group.
- [Table 2](#) provides a comparison of the overall scope of both guidelines.
- [Table 3](#) provides a more detailed comparison of the specific recommendations offered by each group for the topics under consideration in this synthesis, including:
  - [Management](#)

- [Assessment](#)
- [General Management Recommendations](#)
- [Determination of Treatment Setting](#)
- [Choosing an Initial Treatment](#)
- [Psychological Treatment](#)
- [Pharmacological Treatment](#)
- [Adjunctive Treatment](#)
- [Follow-Up](#)
- [Education](#)
- [Table 4](#) lists the potential benefits and harms associated with the implementation of each guideline as stated in the original guidelines.
- [Table 5](#) presents the rating schemes used by both groups to rate the level of evidence and/or the strength of the recommendations.

A summary discussion of the [areas of agreement](#) and [areas of differences](#) among the guidelines is presented following the content comparison tables.

### Abbreviations

- APA, American Psychiatric Association
- BDD, body dysmorphic disorder
- CBT, cognitive behavioral therapy
- ERP, exposure and response prevention
- MAOI, monoamine oxidase inhibitor
- NCCMH/NICE, National Collaborating Centre for Mental Health/National Institute for Health and Clinical Excellence
- SRI, serotonin reuptake inhibitor
- OCD, obsessive compulsive disorder
- SSRI, selective serotonin reuptake inhibitor

<b>TABLE 1: COMPARISON OF INTERVENTIONS AND PRACTICES CONSIDERED</b> <i>("✓" indicates topic is addressed)</i>		
	<b>APA (2007)</b>	<b>NCCMH/NICE (2006)</b>
<b>Management</b>		
Assessment	✓	✓
General Management Recommendations	✓	✓
Determination of Treatment Setting	✓	✓
Choosing an Initial Treatment	✓	✓
<b>Specific Treatment Modalities</b>		

Psychological Treatment	✓	✓
Pharmacological Treatment	✓	✓
Adjunctive Treatment	✓	✓
<b>Follow-Up</b>	✓	✓
<b>Education</b>	✓	✓

<b>TABLE 2: COMPARISON OF GUIDELINE SCOPE</b>	
<b>Objective and Scope</b>	
<b>APA (2007)</b>	To provide recommendations for the treatment of patients with OCD
<b>NCCMH/NICE (2006)</b>	<p>To make recommendations for the identification, treatment and management of OCD and BDD. Specifically, it aims to:</p> <ul style="list-style-type: none"> <li>• Evaluate the role of specific psychological interventions in the treatment and management of OCD and BDD</li> <li>• Evaluate the physical management and role of specific pharmacological agents in the treatment of OCD and BDD</li> <li>• Evaluate the role of other biological interventions in the management of OCD and BDD</li> <li>• Integrate the above to provide best practice advice on the care of individuals with a diagnosis of OCD or BDD throughout the course of the disorder</li> <li>• Promote the implementation of best clinical practice through the development of recommendations tailored to the requirements of the National Health Service (NHS) in England and Wales</li> </ul>
<b>Target Population</b>	
<b>APA (2007)</b>	<ul style="list-style-type: none"> <li>• United States</li> <li>• Adult patients with OCD</li> </ul>
<b>NCCMH/NICE (2006)</b>	<ul style="list-style-type: none"> <li>• England and Wales</li> <li>• People with a diagnosis of OCD or BDD aged 8 years and over, and their families/carers</li> </ul>

<b>Intended Users</b>	
<b>APA (2007)</b>	Physicians
<b>NCCMH/NICE (2006)</b>	Advanced Practice Nurses Allied Health Personnel Emergency Medical Technicians/Paramedics Hospitals Nurses Patients Physicians Psychologists/Non-physician Behavioral Health Clinicians Social Workers

<b>TABLE 3: COMPARISON OF RECOMMENDATIONS</b>	
<b>MANAGEMENT</b>	
<b>Assessment</b>	
<b>APA (2007)</b>	<p><b>Using Rating Scales</b></p> <p>The psychiatrist should consider rating the baseline severity of OCD symptoms and co-occurring conditions and their effects on the patient's functioning, using a scale such as the 10-item Yale-Brown Obsessive Compulsive Scale (Y-BOCS), since this provides a way to measure response to treatment [I]. If a rating scale is not used, it is helpful to document the patient's estimate of the number of hours per day spent obsessing and performing compulsive behaviors, and the degree of effort applied to trying to escape the obsessions and to resisting the behaviors [I]. Recording actively avoided items or situations also provides a useful baseline against which change can be measured [I].</p>

### **Enhancing the Safety of the Patient and Others**

The psychiatrist should evaluate the safety of the patient and others **[I]**. This entails assessing the patient's potential for self-injury or suicide, since individuals with OCD alone or with a lifetime history of any co-occurring disorder have a higher suicide attempt rate than do individuals in the general population. Although acting on aggressive impulses or thoughts has not been reported in OCD, and patients rarely resort to violence when others interfere with their performing their compulsive rituals, it remains important to inquire about past aggressive behavior. OCD patients who fear loss of control may engage in extensive avoidance rituals in an effort to contain their symptoms.

The psychiatrist should understand that individuals with OCD are not immune to co-occurring disorders that may increase the likelihood of suicidal or aggressive behavior. When such co-occurring conditions are present, it is important to arrange treatments that will enhance the safety of the patient and others **[I]**.

Because OCD symptoms can also interfere with parenting, the clinician may have to work with the unaffected parent or social agencies to mitigate the effects of OCD symptoms on the patient's children **[II]**.

### **Completing the Psychiatric Assessment**

In completing the psychiatric assessment, the psychiatrist will usually consider all the elements of the traditional medical evaluation **[I]**. With regard to co-occurring conditions, the psychiatrist should pay particular attention to past or current evidence of depression, given its frequency and association with suicidal ideation and behaviors **[I]**. Exploration for co-occurring bipolar disorder and family history of bipolar disorder is also important in view of the risk of precipitating hypomania or mania with anti-OCD medications **[I]**. Other anxiety disorders are common in OCD patients, as are tic disorders, and may complicate treatment planning. Other disorders that may be more common and may complicate treatment planning include impulse-control disorders, anorexia nervosa, bulimia nervosa, alcohol use disorders, and attention-deficit/ hyperactivity disorder. Past histories of panic attacks, mood swings, and substance abuse or dependence are also relevant **[I]**.

It is important to document the patient's course of symptoms and treatment history, including psychiatric hospitalizations and trials of medications (with details on treatment adequacy, dose, duration, response, and side effects) and psychotherapies (with

	<p>details on the nature, extent, and response to all trials) <b>[I]</b>.</p> <p>The psychiatrist should also assess the patient's developmental, psychosocial, and sociocultural history, including his or her primary support group and sociocultural supports, potential psychosocial stressors, educational and occupational history (including military history), sexual history, and capacity to navigate developmental transitions and achieve stable and gratifying familial and social relationships <b>[I]</b>. In addition, the psychiatrist should evaluate how OCD has interfered with academic and vocational achievement as well as familial, social, and sexual relationships <b>[I]</b>. Having evaluated the symptoms and their effects on well-being, functioning, and quality of life, the psychiatrist should assess the role of the patient's social supports in facilitating treatment and in maintaining or exacerbating symptoms <b>[I]</b>.</p> <p>The psychiatrist should consider whether the OCD is a manifestation of a general medical condition <b>[I]</b>; document current medical conditions, relevant hospitalizations, and any history of head trauma, loss of consciousness, or seizures <b>[I]</b>; and record the presence and severity of somatic or psychological symptoms that could be confused with medication side effects <b>[I]</b>. Current medications and doses, including hormonal therapies, herbal or "natural" remedies, vitamins, and other over-the-counter medications, should be reviewed to assess the potential for pharmacokinetic and pharmacodynamic interactions with psychotropic drugs <b>[I]</b>. Allergies or sensitivities to medications should be recorded <b>[I]</b>. A mental status examination, including an evaluation of insight and judgment, should be performed to systematically collect and record data related to the patient's signs and symptoms of illness during the interview <b>[I]</b>.</p>
<p><b>NCCMH/NICE (2006)</b></p>	<p><b>Understanding</b></p> <p><b>GPP</b> - When assessing people with OCD or BDD, healthcare professionals should sensitively explore the hidden distress and disability commonly associated with the disorders, providing explanation and information wherever necessary. In particular, people with OCD who are distressed by their obsessive thoughts should be informed that such thoughts are occasionally experienced by almost everybody and, when frequent and distressing, are a typical feature of OCD.</p> <p><b>Recognition and Assessment</b></p> <p><b>GPP</b> - In people who have been diagnosed with OCD, healthcare professionals should assess the risk of self-harm and suicide, especially if they have also been diagnosed with depression. Part of the risk assessment should include the impact of their</p>

	<p>compulsive behaviours on themselves or others. Other comorbid conditions and psychosocial factors that may contribute to risk should also be considered.</p> <p><b>GPP</b> - If healthcare professionals are uncertain about the risks associated with intrusive sexual, aggressive, or death-related thoughts reported by people with OCD, they should consult mental health professionals with specific expertise in the assessment and management of OCD. These themes are common in people with OCD at any age, and are often misinterpreted as indicating risk.</p> <p><b>Families and Carers</b></p> <p><b>GPP</b> - Assessment and treatment plans for people with OCD or BDD should, where appropriate, involve relevant family members or carers. In some cases, particularly with children and young people, when the symptoms of OCD or BDD interfere with academic or workplace performance, it may be appropriate to liaise with professionals from these organisations. Assessment should include the impact of rituals and compulsions on others (in particular on dependent children) and the degree to which carers are involved in supporting or carrying out behaviours related to the disorder.</p> <p><b>GPP</b> - If dependent children are considered to be at risk of emotional, social, or mental health problems as a result of the behaviour of a parent with OCD or BDD and/or the child's involvement in related activity, independent assessment of the child should be requested. If this is carried out, the parent should be kept informed at every stage of the assessment.</p> <p><b>GPP</b> - In the treatment of people with OCD or BDD, especially when the disorder is moderate to severe or chronic, an assessment of their carer's social, occupational, and mental health needs should be offered.</p>
<p><b>General Management Recommendations</b></p>	
<p><b>APA (2007)</b></p>	<p><b>Psychiatric Management</b></p> <p>OCD seen in clinical practice is usually a chronic illness with a waxing and waning course. Treatment is indicated when OCD symptoms interfere with functioning or cause significant distress <b>[I]</b>. Psychiatric management consists of an array of therapeutic actions that may be offered to all patients with OCD during the course of their illness at an intensity consistent with the individual patient's needs, capacities, and desires <b>[I]</b>. It is important to coordinate the patient's care with physicians treating co-occurring medical conditions, other clinicians, and</p>

	<p>social agencies such as schools and vocational rehabilitation programs <b>[I]</b>. When OCD is of disabling severity, the psychiatrist may need to write on the patient's behalf to government agencies that control access to disability income, publicly financed health care, or government-supported housing; or to tax authorities, courts, schools, or employers <b>[I]</b>. OCD patients who are parents of young children may want advice regarding the genetic risk of OCD. It is important for clinicians to explain to such patients that the available data indicate an increased but modest risk of OCD in the children of affected individuals; patients wanting more information may be referred to a genetic counselor <b>[I]</b>.</p> <p><b>Establishing a Therapeutic Alliance</b></p> <p>Establishing and maintaining a strong therapeutic alliance is important so that treatment may be jointly, and therefore more effectively, planned and implemented <b>[I]</b>. Steps toward this end include tailoring one's communication style to the patient's needs and capacities, explaining symptoms in understandable terms, and being both encouraging and comforting <b>[I]</b>. The excessive doubting that is characteristic of OCD may require special approaches to building the alliance, including allowing the patient extra time to consider treatment decisions and repeating explanations (a limited number of times) <b>[I]</b>. In building the therapeutic alliance, the psychiatrist should also consider how the patient feels and acts toward him or her as well as what the patient wants and expects from treatment <b>[I]</b>.</p> <p><b>Establishing Goals for Treatment</b></p> <p>Clinical recovery and full remission, if they occur, do not occur rapidly. Thus, ongoing goals of treatment include decreasing symptom frequency and severity, improving the patient's functioning, and helping the patient to improve his or her quality of life <b>[I]</b>. Treatment goals also include enhancing the patient's ability to cooperate with care despite the frightening cognitions generated by OCD, minimizing any adverse effects of treatment (e.g., medication side effects), helping the patient develop coping strategies for stressors, and educating the patient and family regarding the disorder and its treatment <b>[I]</b>.</p>
<p><b>NCCMH/NICE (2006)</b></p>	<p><b>Continuity of Care</b></p> <p><b>GPP</b> - OCD and BDD are frequently recurring or chronic conditions that often affect some of the most intimate aspects of a person's life. Healthcare professionals should therefore ensure continuity of care and minimise the need for multiple assessments by different healthcare professionals.</p>

**GPP** - Because OCD and BDD may occur across a person's lifespan, particular care should be given to the provision of appropriate care at all ages and a seamless transition between services aimed at specific ages, such as the transition from services for young people to services for adults.

**GPP** - Careful consideration should be given to the effective integration and coordination of care of people with OCD and BDD across both primary and secondary care. There should be clear, written agreement among individual healthcare professionals about the responsibility for monitoring and treating people with OCD and BDD. A written copy of this agreement should be given to the patient. This should be in collaboration with the patient, and where appropriate

- The Care Programme Approach (CPA) should be used
- The patient's family or carers should be involved
- Healthcare professionals should liaise with other professionals involved in providing care and support to the patient

### **Religion and Culture**

**GPP** - Obsessive-compulsive symptoms may sometimes involve a person's religion, such as religious obsessions and scrupulosity, or cultural practices. When the boundary between religious or cultural practice and obsessive-compulsive symptoms is unclear, healthcare professionals should, with the patient's consent, consider seeking the advice and support of an appropriate religious or community leader to support the therapeutic process.

### **Families and Carers**

**GPP** - Because OCD and BDD often have an impact on families and carers, healthcare professionals should promote a collaborative approach with people with OCD or BDD and their family or carers, wherever this is appropriate and possible.

### **Stepped Care for Adults, Young People and Children with OCD or BDD**

The stepped-care model draws attention to the different needs of people with OCD and BDD, depending on the characteristics of their disorder, their personal and social circumstances, their age, and the responses that are required from services. It provides a framework in which to organise the provision of services in order to identify and access the most effective interventions (see Figure 1 in the original guideline document).

	<p><b>GPP</b> - Each PCT, mental healthcare trust, and children's trust that provides mental health services should have access to a specialist OCD/BDD multidisciplinary team offering age-appropriate care. This team would perform the following functions: increase the skills of mental health professionals in the assessment and evidence-based treatment of people with OCD or BDD, provide high-quality advice, understand family and developmental needs, and, when appropriate, conduct expert assessment and specialist cognitive behavioural and pharmacological treatment.</p> <p><b>GPP</b> - Specialist mental health professionals in OCD or BDD should collaborate with local and national voluntary organisations to increase awareness and understanding of the disorders and improve access to high-quality information about them. Such information should also be made available to primary and secondary healthcare professionals and to professionals from other public services who may come into contact with people of any age with OCD or BDD.</p> <p><b>GPP</b> - Specialist OCD/BDD teams should collaborate with people with OCD or BDD and their families or carers to provide training for all mental health professionals, cosmetic surgeons, and dermatology professionals.</p>
<p><b>Determination of Treatment Setting</b></p>	
<p><b>APA (2007)</b></p>	<p><b>Establishing the Appropriate Setting for Treatment</b></p> <p>The appropriate treatment setting may be the hospital, a residential treatment or partial hospitalization program, home-based treatment, or outpatient care. Treatment should generally be provided in the least restrictive setting that is both safe and effective <b>[I]</b>.</p> <p>Consequently, the appropriate treatment setting will depend on a number of factors:</p> <ol style="list-style-type: none"> <li>a. Hospital treatment may be indicated by suicide risk, an inability to provide adequate self-care, danger to others, need for constant supervision or support, an inability to tolerate outpatient medication trials because of side effects, need for intensive CBT, the presence of medical conditions that necessitate hospital observation while medications are initiated, or by co-occurring conditions that themselves require hospital treatment, such as severe or suicidal depression, schizophrenia, or mania.</li> <li>b. Residential treatment may be indicated in individuals with severe treatment-resistant OCD, who require multidisciplinary treatment in a highly structured setting</li> </ol>

	<p>that permits intensive individual and group CBT as well as psychopharmacologic management with close monitoring of treatment adherence over a period of several months.</p> <p>c. Partial hospitalization may be indicated by a need for daily CBT and monitoring of behavior or medications or a supportive milieu with other adjunctive psychosocial interventions, or to stabilize and increase the gains made during a period of full hospitalization. Goals of treatment include restoring the patient's ability to function in daily life without intensive monitoring; reduction of symptoms to a level consistent with outpatient treatment; prevention of relapse; and maintenance and improvement of social functioning.</p> <p>d. Home-based treatment may be necessary for patients with hoarding or, initially, for those with contamination fears or other symptoms so impairing that they cannot come to the office or clinic. Home-based treatment may also be indicated for individuals who experience symptoms primarily or exclusively at home.</p> <p>e. Outpatient treatment is usually sufficient for the treatment of OCD, but the intensity may vary from daily psychotherapy, such as intensive CBT, to treatment less than once a week (after achieving substantial symptom reduction and stabilization).</p>
<p><b>NCCMH/NICE (2006)</b></p>	<p><b>Intensive Treatment and Inpatient Services for People with OCD or BDD</b></p> <p><b>C</b> - People with severe, chronic, treatment-refractory OCD or BDD should have continuing access to specialist treatment services staffed by multidisciplinary teams of healthcare professionals with expertise in the management of the disorders.</p> <p><b>GPP</b> - Inpatient services, with specific expertise in OCD and BDD, are appropriate for a small proportion of people with these disorders, and may be considered when:</p> <ul style="list-style-type: none"> <li>• There is risk to life.</li> <li>• There is severe self-neglect.</li> <li>• There is extreme distress or functional impairment.</li> <li>• There has been no response to adequate trials of pharmacological/psychological/combined treatments over long periods of time in other settings.</li> <li>• A person has additional diagnoses, such as severe depression, anorexia nervosa, or schizophrenia that make outpatient treatment more complex.</li> <li>• A person has a reversal of normal night/day patterns that make attendance at any daytime therapy impossible.</li> <li>• The compulsions and avoidance behaviour are so severe or</li> </ul>

	<p>habitual that they cannot undertake normal activities of daily living.</p> <p><b>GPP</b> - A small minority of adults with long-standing and disabling obsessive-compulsive symptoms that interfere with daily living and have prevented them from developing a normal level of autonomy may, in addition to treatment, need suitable accommodation in a supportive environment that will enable them to develop life skills for independent living.</p>
<p><b>Choosing an Initial Treatment</b></p>	
<p><b>APA (2007)</b></p>	<p><b>Choosing an Initial Treatment Modality</b></p> <p>In choosing a treatment approach, the clinician should consider the patient's motivation and ability to comply with pharmacotherapy and psychotherapy <b>[I]</b>. CBT and SRIs are recommended as safe and effective first-line treatments for OCD <b>[I]</b>. Whether to utilize CBT, an SRI, or combined treatment will depend on factors that include the nature and severity of the patient's symptoms, the nature of any co-occurring psychiatric and medical conditions and their treatments, the availability of CBT, and the patient's past treatment history, current medications, capacities, and preferences. CBT alone, consisting of ERP, is recommended as initial treatment for a patient who is not too depressed, anxious, or severely ill to cooperate with this treatment modality, or who prefers not to take medications and is willing to do the work that CBT requires <b>[II]</b>. An SRI alone is recommended for a patient who is not able to cooperate with CBT, has previously responded well to a given drug, or prefers treatment with an SRI alone <b>[II]</b>. Combined treatment should be considered for patients with an unsatisfactory response to monotherapy <b>[II]</b>, for those with co-occurring psychiatric conditions for which SRIs are effective <b>[I]</b>, and for those who wish to limit the duration of SRI treatment <b>[II]</b>. In the latter instance, uncontrolled follow-up studies suggest that CBT may delay or mitigate relapse when SRI treatment is discontinued &lt;strong&gt;[II]. Combined treatment or treatment with an SRI alone may also be considered in patients with severe OCD, since the medication may diminish symptom severity sufficiently to allow the patient to engage in CBT <b>[II]</b>.</p> <p>Deciding whether to start or stop a psychotropic drug during pregnancy or breast-feeding requires making a risk-benefit calculation with the patient and her significant other; this process may be enhanced by providing clear information, seeking consultation from an obstetrician, and providing counseling over several sessions to help the patient come to terms with the uncertainty of the risks <b>[I]</b>.</p>

<p><b>NCCMH/NICE (2006)</b></p>	<p><b>Treatment Options for People with OCD or BDD</b></p> <p>Effective treatments for OCD and BDD should be offered at all levels of the healthcare system. The difference in the treatments at the higher levels will reflect increasing experience and expertise in the implementation of a limited range of therapeutic options. For many people, initial treatment may be best provided in primary care settings. However, people with more impaired functioning, higher levels of comorbidity, or poor response to initial treatment will require care from teams with greater levels of expertise and experience in the management of OCD/BDD.</p> <p>Irrespective of the level of care, the following recommendations should be taken into account when selecting initial treatments for people with OCD or BDD. The specific recommendations on how to provide these treatments follow in the subsequent sections of this synthesis.</p>
<p><b>Psychological Therapy</b></p>	
<p><b>APA (2007)</b></p>	<p><b>Choosing a Specific Form of Psychotherapy</b></p> <p>CBT that relies primarily on behavioral techniques such as ERP is recommended because it has the best evidentiary support <b>[I]</b>. Some data support the use of CBT that focuses on cognitive techniques <b>[II]</b>. There are no controlled studies that demonstrate effectiveness of dynamic psychotherapy or psychoanalysis in dealing with the core symptoms of OCD. Psychodynamic psychotherapy may still be useful in helping patients overcome their resistance to accepting a recommended treatment by illuminating their reasons for wanting to stay as they are (e.g., best adaptation, secondary gains) <b>[III]</b>. It may also be useful in addressing the interpersonal consequences of the OCD symptoms <b>[II]</b>. Motivational interviewing may also help overcome resistance to treatment <b>[III]</b>. Family therapy may reduce inter-family tensions that are exacerbating the patient's symptoms or ameliorate the family's collusion with symptoms <b>[III]</b>.</p> <p><b>Implementing a Treatment Plan</b></p> <p>When treatment is initiated, the patient's motivation and adherence may be challenged by factors such as treatment cost and medication side effects. It is essential for the psychiatrist to employ strategies to enhance adherence, as described above in Section I.B.1.h of the original guideline document <b>[I]</b>.</p> <p><b>Implementing Cognitive-Behavioral Therapies</b></p>

	<p>CBTs have been delivered in individual, group, and family therapy sessions, with session length varying from less than 1 hour to 2 hours. One group has explored a computer-based approach coupled with a touch-tone telephone system accessible 24 hours a day. CBT sessions should be scheduled at least once weekly <b>[I]</b>. Five ERP sessions per week may be more effective than once-weekly sessions but are not necessarily more effective than twice-weekly sessions <b>[II]</b>. The number of treatment sessions, their length, and the duration of an adequate trial have not been established, but expert consensus recommends 13-20 weekly sessions for most patients <b>[I]</b>. Clinicians should consider booster sessions for more severely ill patients, for patients who have relapsed in the past, and for patients who show signs of early relapse <b>[II]</b>. When resources for CBT are not available, the psychiatrist can suggest and supervise the use of self-help treatment guides and recommend support groups such as those accessible through the Obsessive Compulsive Foundation <b>[III]</b> (see Appendix in the original guideline document).</p> <p><b>NGC Note:</b> Refer to the <a href="#">Follow-Up</a> section of this synthesis for information on "Changing Treatments and Pursuing Sequential Treatment Trials."</p>
<p><b>NCCMH/NICE (2006)</b></p>	<p><b>Initial Treatment Options</b></p> <p><i>Adults</i></p> <p>The intensity of psychological treatment has been defined as the hours of therapist input per patient. By this definition, most group treatments are defined as low intensity treatment (less than 10 hours of therapist input per patient), although each patient may receive a much greater number of hours of therapy.</p> <p><b>C</b> - In the initial treatment of adults with OCD, low intensity psychological treatments (including ERP) (up to 10 therapist hours per patient) should be offered if the patient's degree of functional impairment is mild and/or the patient expresses a preference for a low intensity approach. Low intensity treatments include:</p> <ul style="list-style-type: none"> <li>• Brief individual CBT (including ERP) using structured self-help materials</li> <li>• Brief individual CBT (including ERP) by telephone</li> <li>• Group CBT (including ERP) (note, the patient may be receiving more than 10 hours of therapy in this format)</li> </ul> <p><b>C</b> - Adults with OCD with mild functional impairment who are unable to engage in low intensity CBT (including ERP), or for whom low intensity treatment has proved to be inadequate, should be offered the choice of either a course of an SSRI or more intensive CBT (including ERP) (more than 10 therapist</p>

hours per patient), because these treatments appear to be comparably efficacious.

**B** - Adults with OCD with moderate functional impairment should be offered the choice of either a course of an SSRI or more intensive CBT (including ERP) (more than 10 therapist hours per patient), because these treatments appear to be comparably efficacious.

**C** - Adults with OCD with severe functional impairment should be offered combined treatment with an SSRI and CBT (including ERP).

### **How to use Psychological Interventions**

#### *Training*

**GPP** - All healthcare professionals offering psychological treatments to people of all ages with OCD or BDD should receive appropriate training in the interventions they are offering and receive ongoing clinical supervision in line with the recommendations in *Organising and Delivering Psychological Therapies*, available from the [Department of Health Web site](#).

#### *Adults*

**B** - For adults with obsessive thoughts who do not have overt compulsions, CBT (including exposure to obsessive thoughts and response prevention of mental rituals and neutralising strategies) should be considered.

**C** - For adults with OCD, cognitive therapy adapted for OCD may be considered as an addition to ERP to enhance long-term symptom reduction.

**B** - For adults with OCD living with their family or carers, involving a family member or carer as a co-therapist in ERP should be considered where this is appropriate and acceptable to those involved.

**C** - For adults with OCD with more severe functional impairment who are housebound, unable or reluctant to attend a clinic, or have significant problems with hoarding, a period of home-based treatment may be considered.

**C** - For adults with OCD with more severe functional impairment who are housebound and unable to undertake home-based treatment because of the nature of their symptoms (such as contamination concerns or hoarding that prevents therapists' access to the patient's home), a period of CBT by telephone may

	<p>be considered.</p> <p><b>C</b> - For adults with OCD who refuse or cannot engage with treatments that include ERP, individual cognitive therapy specifically adapted for OCD may be considered.</p> <p><b>C</b> - When adults with OCD request forms of psychological therapy other than cognitive and/or behavioural therapies as a specific treatment for OCD (such as psychoanalysis, transactional analysis, hypnosis, marital/couple therapy) they should be informed that there is as yet no convincing evidence for a clinically important effect of these treatments.</p> <p><b>GPP</b> - When family members or carers of people with OCD or BDD have become involved in compulsive behaviours, avoidance or reassurance seeking, treatment plans should help them reduce their involvement in these behaviours in a sensitive and supportive manner.</p> <p><b>GPP</b> - Adults with OCD or BDD with significant functional impairment may need access to appropriate support for travel and transport to allow them to attend for their treatment.</p> <p><b>GPP</b> - Towards the end of treatment, healthcare professionals should inform adults with OCD or BDD about how the principles learned can be applied to the same or other symptoms if they occur in the future.</p>
<p><b>Pharmacologic Therapy</b></p>	
<p><b>APA (2007)</b></p>	<p><b>Choosing a Specific Pharmacological Treatment</b></p> <p>Clomipramine, fluoxetine, fluvoxamine, paroxetine, and sertraline, which are approved by the U.S. Food and Drug Administration (FDA) for treatment of OCD, are recommended pharmacological agents <b>[I]</b>. Although meta-analyses of placebo-controlled trials suggest greater efficacy for clomipramine than for fluoxetine, fluvoxamine, and sertraline, the results of head-to-head trials comparing clomipramine and SSRIs directly do not support this impression. Because the SSRIs have a less troublesome side-effect profile than clomipramine, an SSRI is preferred for a first medication trial <b>[I]</b>. Although all SSRIs (including citalopram and escitalopram) appear to be equally effective, individual patients may respond well to one medication and not to another. In choosing among the SSRIs, the psychiatrist should consider the safety and acceptability of particular side effects for the patient, including any applicable FDA warnings, potential drug interactions, past treatment response, and the presence of co-occurring general medical</p>

conditions **[I]**.

### **Implementing a Treatment Plan**

When treatment is initiated, the patient's motivation and adherence may be challenged by factors such as treatment cost and medication side effects. It is essential for the psychiatrist to employ strategies to enhance adherence, as described above in Section I.B.1.h of the original guideline document **[I]**.

### **Implementing Pharmacotherapy**

For most patients, the starting dose is that recommended by the manufacturer **[I]**. Patients who are worried about medication side effects can have their medication started at lower doses, since many SSRIs are available in liquid form or in pills that can be split **[I]**. Most patients will not experience substantial improvement until 4 to 6 weeks after starting medication, and some who will ultimately respond will experience little improvement for as many as 10 to 12 weeks. Medication doses may be titrated up weekly in increments recommended by the manufacturer during the first month of treatment **[II]**, or when little or no symptom improvement is seen within 4 weeks of starting medication, the dose may be increased weekly or biweekly to the maximum dose comfortably tolerated and indicated **[II]**. This maximum dose may exceed the manufacturer's recommended maximum dose in some cases**[III]**. The treatment trial is then continued at this dosage for at least 6 weeks **[II]**. Since available trial data suggest that higher SSRI doses produce a somewhat higher response rate and a somewhat greater magnitude of symptom relief, such doses should be considered when treatment response is inadequate **[II]**. Higher doses may also be appropriate for patients who have had little response to treatment and are tolerating a medication well **[I]**. If higher doses are prescribed, the patient should be closely monitored for side effects, including the serotonin syndrome **[I]**. Experience with pharmacotherapy in the elderly indicates that lower starting doses of medication and a more gradual approach to dose increase are often advisable **[I]**. Medication side effects should be inquired about and actively managed **[I]**. Useful strategies to manage medication side effects include gradual initial dose titration to minimize gastrointestinal distress **[I]**, addition of a sleep-promoting agent to minimize insomnia **[I]**, modest doses of modafinil to minimize fatigue or sleepiness **[III]**, and use of a low-dose anticholinergic agent to minimize sweating **[III]**. Sexual side effects may be minimized by reducing the dose **[II]**, waiting for symptoms to remit **[II]**, trying a once-weekly, one-day "drug holiday" before sexual activity< strong>**[II]**, switching to another SSRI **[II]**, or adding a pharmacological

	<p>agent such as bupropion <b>[II]</b>.</p> <p>The frequency of follow-up visits after a new pharmacotherapy is initiated may vary from a few days to two weeks. The indicated frequency will depend on the severity of the patient's symptoms, the complexities introduced by co-occurring conditions, whether suicidal ideation is present, and the likelihood of troubling side effects <b>[I]</b>.</p> <p><b>NGC Note:</b> Refer to the <a href="#">Follow-Up</a> section of this synthesis for information on "Changing Treatments and Pursuing Sequential Treatment Trials."</p>
<p><b>NCCMH/NICE (2006)</b></p>	<p><b>How to Use Pharmacological Interventions in Adults</b></p> <p>Current published evidence suggests that SSRIs are effective in treating adults with OCD or BDD, although evidence for the latter is limited and less certain. However, SSRIs may increase the risk of suicidal thoughts and self-harm in people with depression and in younger people. It is currently unclear whether there is an increased risk for people with OCD or BDD. Regulatory authorities recommend caution in the use of SSRIs until evidence for differential safety has been demonstrated.</p> <p><i>Starting the Treatment</i></p> <p>Common concerns about taking medication for OCD or BDD should be addressed. Patients should be advised, both verbally and with written material, that:</p> <ul style="list-style-type: none"> <li>• <b>C</b> - Craving and tolerance do not occur.</li> <li>• <b>C</b> - There is a risk of discontinuation/withdrawal symptoms on stopping the drug, missing doses, or reducing the dose.</li> <li>• <b>C</b> - There is a range of potential side effects, including worsening anxiety, suicidal thoughts and self-harm, which need to be carefully monitored, especially in the first few weeks of treatment.</li> <li>• <b>C</b> - There is commonly a delay in the onset of effect of up to 12 weeks, although depressive symptoms improve more quickly</li> </ul> <p><b>GPP</b> - Taking medication should not be seen as a weakness.</p> <p><i>Monitoring Risk</i></p> <p><b>GPP</b> - Adults with OCD or BDD started on SSRIs who are not considered to be at increased risk of suicide or self-harm should be monitored closely and seen on an appropriate and regular basis. The arrangements for monitoring should be agreed by the patient and the healthcare professional, and recorded in the</p>

notes.

**C** - Because of the potential increased risk of suicidal thoughts and self-harm associated with the early stages of SSRI treatment, younger adults (younger than age 30 years) with OCD or BDD, or people with OCD or BDD with comorbid depression, or who are considered to be at an increased risk of suicide, should be carefully and frequently monitored by healthcare professionals. Where appropriate, other carers—as agreed by the patient and the healthcare professional—may also contribute to the monitoring until the risk is no longer considered significant. The arrangements for monitoring should be agreed by the patient and the healthcare professional, and recorded in the notes.

**C** - For adults with OCD or BDD at a high risk of suicide, a limited quantity of medication should be prescribed.

**C** - When adults with OCD or BDD, especially those with comorbid depression, are assessed to be at a high risk of suicide, the use of additional support such as more frequent direct contacts with primary care staff or telephone contacts should be considered, particularly during the first weeks of treatment.

**C** - For adults with OCD or BDD, particularly in the initial stages of SSRI treatment, healthcare professionals should actively seek out signs of akathisia or restlessness, suicidal ideation and increased anxiety and agitation. They should also advise patients to seek help promptly if symptoms are at all distressing.

**C** - Adults with OCD or BDD should be monitored around the time of dose changes for any new symptoms or worsening of their condition.

#### *Choice of Drug Treatment*

##### SSRIs

**A** - For adults with OCD, the initial pharmacological treatment should be one of the following SSRIs: fluoxetine, fluvoxamine, paroxetine, sertraline or citalopram.

(Note: Citalopram does not have a UK Marketing Authorisation for use in OCD in adults at the date of publication [November 2005])

**C** - In the event that an adult with OCD or BDD develops marked and/or prolonged akathisia, restlessness or agitation

while taking an SSRI, the use of the drug should be reviewed. If the patient prefers, the drug should be changed to a different SSRI.

**GPP** - Healthcare professionals should be aware of the increased risk of drug interactions when prescribing an SSRI to adults with OCD or BDD who are taking other medications.

**GPP** - For adults with OCD or BDD, if there has been no response to a full course of treatment with an SSRI, healthcare professionals should check that the patient has taken the drug regularly and in the prescribed dose and that there is no interference from alcohol or substance use.

**C** - For adults with OCD or BDD, if there has not been an adequate response to a standard dose of an SSRI, and there are no significant side effects after 4-6 weeks, a gradual increase in dose should be considered in line with the schedule suggested by the Summary of Product Characteristics.

**GPP** - For adults with OCD or BDD, the rate at which the dose of an SSRI should be increased should take into account therapeutic response, adverse effects, and patient preference. Patients should be warned about, and monitored for, the emergence of side effects during dose increases.

**C** - If treatment for OCD or BDD with an SSRI is effective, it should be continued for at least 12 months to prevent relapse and allow for further improvements.

**GPP** - When an adult with OCD or BDD has taken an SSRI for 12 months after remission (symptoms are not clinically significant and the person is fully functioning for at least 12 weeks), healthcare professionals should review with the patient the need for continued treatment. This review should consider the severity and duration of the initial illness, the number of previous episodes, the presence of residual symptoms, and concurrent psychosocial difficulties.

**GPP** - If treatment for OCD or BDD with an SSRI is continued for an extended period beyond 12 months after remission (symptoms are not clinically significant and the person is fully functioning for at least 12 weeks), the need for continuation should be reviewed at regular intervals, agreed between the patient and the prescriber, and written in the notes.

**C** - For adults with OCD or BDD, to minimise discontinuation/withdrawal symptoms when reducing or stopping SSRIs, the dose should be tapered gradually over several weeks according to the person's need. The rate of

reduction should take into account the starting dose, the drug half-life, and particular profiles of adverse effects.

**C** - Healthcare professionals should encourage adults with OCD or BDD who are discontinuing SSRI treatment to seek advice if they experience significant discontinuation/withdrawal symptoms.

#### Other Drugs

**C** - The following drugs should not normally be used to treat OCD or BDD without comorbidity:

- Tricyclic antidepressants other than clomipramine
- Tricyclic-related antidepressants
- Serotonin and noradrenaline reuptake inhibitors (SNRIs), including venlafaxine
- MAOIs
- Anxiolytics (except cautiously for short periods to counter the early activation of SSRIs).

**C** - Antipsychotics as a monotherapy should not normally be used for treating OCD.

#### **Poor Response to Initial Treatment for Adults**

If initial treatment does not result in a clinically significant improvement in both symptoms and functioning, other treatment options should be considered. When additional treatment options also fail to produce an adequate response, multidisciplinary teams with specific expertise in OCD/BDD should become involved. Their role should include supporting and collaborating with those professionals already involved in an individual's care.

**GPP** - For adults with OCD or BDD, if there has not been an adequate response to treatment with an SSRI alone (within 12 weeks) or CBT (including ERP) alone (more than 10 therapist hours per patient), a multidisciplinary review should be carried out.

**C** - Following multidisciplinary review, for adults with OCD or BDD, if there has not been an adequate response to treatment with an SSRI alone (within 12 weeks) or CBT (including ERP) alone (more than 10 therapist hours per patient), combined treatment with CBT (including ERP) and an SSRI should be offered.

**C** - For adults with OCD or BDD, if there has not been an adequate response after 12 weeks of combined treatment with

CBT (including ERP) and an SSRI, or there has been no response to an SSRI alone, or the patient has not engaged with CBT, a different SSRI or clomipramine should be offered.

**C** - Clomipramine should be considered in the treatment of adults with OCD or BDD after an adequate trial of at least one SSRI has been ineffective or poorly tolerated, if the patient prefers clomipramine or has had a previous good response to it.

**GPP** - For adults with OCD or BDD, if there has been no response to a full trial of at least one SSRI alone, a full trial of combined treatment with CBT (including ERP) and an SSRI, and a full trial of clomipramine alone, the patient should be referred to a multidisciplinary team with specific expertise in the treatment of OCD/BDD for assessment and further treatment planning.

**GPP** - The assessment of adults with OCD or BDD referred to multidisciplinary teams with specific expertise in OCD/BDD should include a comprehensive assessment of their symptom profile, previous pharmacological and psychological treatment history, adherence to prescribed medication, history of side effects, comorbid conditions such as depression, suicide risk, psychosocial stressors, relationship with family and/or carers, and personality factors.

**C** - Following multidisciplinary review, for adults with OCD if there has been no response to a full trial of at least one SSRI alone, a full trial of combined treatment with CBT (including ERP) and an SSRI, and a full trial of clomipramine alone, the following treatment options should also be considered (note, there is no evidence of the optimal sequence of the options listed below):

- Additional CBT (including ERP) or cognitive therapy
- Adding an antipsychotic to an SSRI or clomipramine
- Combining clomipramine and citalopram.

**GPP** - Treatments such as combined antidepressants and antipsychotic augmentation should not be routinely initiated in primary care.

#### *How to use Clomipramine for Adults*

**GPP** - For adults with OCD or BDD who are at a significant risk of suicide, healthcare professionals should only prescribe small amounts of clomipramine at a time because of its toxicity in overdose (refer to the [Summary of Product Characteristics](#) for details about appropriate dosage). The patient should be

	<p>monitored regularly until the risk of suicide has subsided.</p> <p><b>C</b> - An electrocardiogram (ECG) should be carried out and a blood pressure measurement taken before prescribing clomipramine for adults with OCD or BDD at significant risk of cardiovascular disease.</p> <p><b>C</b> - For adults with OCD or BDD, if there has not been an adequate response to the standard dose of clomipramine, and there are no significant side effects, a gradual increase in dose should be considered in line with the schedule suggested by the <a href="#">Summary of Product Characteristics</a>.</p> <p><b>B</b> - For adults with OCD or BDD, treatment with clomipramine should be continued for at least 12 months if it appears to be effective and because there may be further improvement.</p> <p><b>C</b> - For adults with OCD or BDD, when discontinuing clomipramine, doses should be reduced gradually in order to minimise potential discontinuation/ withdrawal symptoms.</p>
<b>Adjunctive Treatments</b>	
<b>APA (2007)</b>	<p><b>Changing Treatments and Pursuing Sequential Treatment Trials</b></p> <p>Ablative neurosurgery for severe and very treatment-refractory OCD is rarely indicated and, along with deep brain stimulation, should be performed only at sites with expertise in both OCD and these treatment approaches <b>[III]</b>.</p>
<b>NCCMH/NICE (2006)</b>	<p><b>GPP</b> - Neurosurgery is not recommended in the treatment of OCD. However, if a patient requests neurosurgery because they have severe OCD that is refractory to other forms of treatment, the following should be taken into consideration:</p> <ul style="list-style-type: none"> <li>• Existing published criteria should be used to guide decisions about suitability.</li> <li>• Multidisciplinary teams with a high degree of expertise in the pharmacological and psychological treatment of OCD should have been recently involved in the patient's care. All pharmacological options should have been considered and every attempt should have been made to engage the individual in CBT (including ERP) and cognitive therapy, including very intensive and/or inpatient treatments.</li> <li>• Standardised assessment protocols should be used at pre- and postoperation and at medium- and long-term follow-ups in order to audit the interventions. These assessment protocols should include standardized measures of symptoms, quality of life, social and personality function, as</li> </ul>

	<p>well as comprehensive neuropsychological tests.</p> <ul style="list-style-type: none"> <li>• Services offering assessment for neurosurgical treatments should have access to independent advice on issues such as adequacy of previous treatment and consent and should be subject to appropriate oversight.</li> <li>• Post-operative care should be carefully considered, including pharmacological and psychological therapies.</li> <li>• Services offering assessment for neurosurgical treatments should be committed to sharing and publishing audit information.</li> </ul>
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<b>Follow-Up</b>	
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<b>APA (2007)</b>	<p><b>Changing Treatments and Pursuing Sequential Treatment Trials</b></p> <p>First treatments rarely produce freedom from all OCD symptoms. When a good response is not achieved after 13 to 20 weeks of weekly outpatient CBT, 3 weeks of daily CBT, or 8 to 12 weeks of SRI treatment (including 4 to 6 weeks at the highest comfortably tolerated dose), the psychiatrist should decide with the patient when, whether, and how to alter the treatment <b>[I]</b>. This decision will depend on the degree of suffering and disability the patient wishes to accept. However, it is important to consider that illness can bring secondary gains and that depressed mood can diminish hopefulness; the psychiatrist may have to address issues such as these when patients are not well motivated to pursue further treatments despite limited improvement <b>[I]</b>.</p> <p>When initial treatment is unsatisfactory, the psychiatrist should first consider the possible contribution of several factors: interference by co-occurring conditions, inadequate patient adherence to treatment, the presence of psychosocial stressors, the level of family members' accommodation to the obsessive-compulsive symptoms, and an inability to tolerate an adequate trial of psychotherapy or the maximum recommended drug doses <b>[I]</b>.</p> <p>When no interfering factor can be identified, augmentation strategies may be preferred to switching strategies in patients who have a partial response to the initial treatment <b>[II]</b>. The psychiatrist should first consider augmentation of SRIs with trials of different antipsychotic medications or with CBT consisting of ERP, or augmentation of CBT with an SRI <b>[II]</b>. Combined SRI and CBT treatment may be provided when the patient has a co-occurring disorder that is SRI-responsive <b>[I]</b> or has a partial response to monotherapy <b>[II]</b>. Combined SRI and CBT treatment may also reduce the chance of relapse when medication is discontinued <b>[II]</b>. Another option in the case of</p>
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partial response to ERP therapy is to increase the intensity of treatment (e.g., from weekly to daily sessions) [III]. Some evidence suggests that adding cognitive therapy to ERP may enhance the results, but this remains to be established [III].

Patients who do not respond to their first SRI may have their medication switched to a different SRI [I]. A switch to venlafaxine is less likely to produce an adequate response [II]. For patients who have not benefitted from their first SSRI trial, a switch to mirtazapine can also be considered [III]. The available evidence does not allow one to predict the chance of response to switching medications. SRI nonresponders, like partial responders, have responded to augmentation with antipsychotic medications [II] or CBT [II].

After first- and second-line treatments and well-supported augmentation strategies have been exhausted, less well-supported treatment strategies may be considered [III]. These include augmenting SSRIs with clomipramine, buspirone, pindolol, riluzole, or once-weekly oral morphine sulfate [III]. However, morphine sulfate should be avoided in patients with contraindications to opiate administration, and appropriate precautions and documentation should occur. If clomipramine is added, appropriate precautions should be utilized with regard to preventing potential cardiac and central nervous system side effects [I]. Less well-supported monotherapies to consider include D-amphetamine [III], tramadol [III], MAOIs [III], ondansetron [III], transcranial magnetic stimulation (TMS) [III], and deep brain stimulation (DBS) [III]. Intensive residential treatment or partial hospitalization may be helpful for patients with severe treatment-resistant OCD < strong> [II].

### **Discontinuing Active Treatment**

Successful medication treatment should be continued for 1 to 2 years before considering a gradual taper by decrements of 10% to 25% every 1 to 2 months while observing for symptom return or exacerbation [I]. Successful ERP should be followed by monthly booster sessions for 3 to 6 months, or more intensively if response has been only partial [II]. In medication discontinuation trials, rates of relapse or trial discontinuation for insufficient clinical response are substantial but vary widely because of major methodological differences across studies. Thus, discontinuation of pharmacotherapy should be carefully considered, and for most patients, continued treatment of some form is recommended [II]. The data suggest that CBT consisting of ERP may have more durable effects than some SRIs after discontinuation, but the observed differences in relapse rates could be explained by other factors.

**Poor Response to Initial Treatment for Adults**

If initial treatment does not result in a clinically significant improvement in both symptoms and functioning, other treatment options should be considered. When additional treatment options also fail to produce an adequate response, multidisciplinary teams with specific expertise in OCD/BDD should become involved. Their role should include supporting and collaborating with those professionals already involved in an individual's care.

**GPP** - For adults with OCD or BDD, if there has not been an adequate response to treatment with an SSRI alone (within 12 weeks) or CBT (including ERP) alone (more than 10 therapist hours per patient), a multidisciplinary review should be carried out.

**C** - Following multidisciplinary review, for adults with OCD or BDD, if there has not been an adequate response to treatment with an SSRI alone (within 12 weeks) or CBT (including ERP) alone (more than 10 therapist hours per patient), combined treatment with CBT (including ERP) and an SSRI should be offered.

**C** - For adults with OCD or BDD, if there has not been an adequate response after 12 weeks of combined treatment with CBT (including ERP) and an SSRI, or there has been no response to an SSRI alone, or the patient has not engaged with CBT, a different SSRI or clomipramine should be offered.

**C** - Clomipramine should be considered in the treatment of adults with OCD or BDD after an adequate trial of at least one SSRI has been ineffective or poorly tolerated, if the patient prefers clomipramine or has had a previous good response to it.

**GPP** - For adults with OCD or BDD, if there has been no response to a full trial of at least one SSRI alone, a full trial of combined treatment with CBT (including ERP) and an SSRI, and a full trial of clomipramine alone, the patient should be referred to a multidisciplinary team with specific expertise in the treatment of OCD/BDD for assessment and further treatment planning.

**GPP** - The assessment of adults with OCD or BDD referred to multidisciplinary teams with specific expertise in OCD/BDD should include a comprehensive assessment of their symptom profile, previous pharmacological and psychological treatment history, adherence to prescribed medication, history of side effects, comorbid conditions such as depression, suicide risk, psychosocial stressors, relationship with family and/or carers,

and personality factors.

**C** - Following multidisciplinary review, for adults with OCD if there has been no response to a full trial of at least one SSRI alone, a full trial of combined treatment with CBT (including ERP) and an SSRI, and a full trial of clomipramine alone, the following treatment options should also be considered (note, there is no evidence of the optimal sequence of the options listed below):

- Additional CBT (including ERP) or cognitive therapy
- Adding an antipsychotic to an SSRI or clomipramine
- Combining clomipramine and citalopram.

**GPP** - Treatments such as combined antidepressants and antipsychotic augmentation should not be routinely initiated in primary care.

#### *Choice of Drug Treatment*

##### SSRIs

**C** - If treatment for OCD or BDD with an SSRI is effective, it should be continued for at least 12 months to prevent relapse and allow for further improvements.

**GPP** - When an adult with OCD or BDD has taken an SSRI for 12 months after remission (symptoms are not clinically significant and the person is fully functioning for at least 12 weeks), healthcare professionals should review with the patient the need for continued treatment. This review should consider the severity and duration of the initial illness, the number of previous episodes, the presence of residual symptoms, and concurrent psychosocial difficulties.

**GPP** - If treatment for OCD or BDD with an SSRI is continued for an extended period beyond 12 months after remission (symptoms are not clinically significant and the person is fully functioning for at least 12 weeks), the need for continuation should be reviewed at regular intervals, agreed between the patient and the prescriber, and written in the notes.

**C** - For adults with OCD or BDD, to minimise discontinuation/withdrawal symptoms when reducing or stopping SSRIs, the dose should be tapered gradually over several weeks according to the person's need. The rate of reduction should take into account the starting dose, the drug half-life, and particular profiles of adverse effects.

	<p><b><u>Discharge After Recovery</u></b></p> <p><b>C</b> - When a person of any age with OCD or BDD is in remission (symptoms are not clinically significant and the person is fully functioning for 12 weeks), he or she should be reviewed regularly for 12 months by a mental health professional. The exact frequency of contact should be agreed between the professional and the person with OCD or BDD and/or the family and/or carer and recorded in the notes. At the end of the 12-month period if recovery is maintained the person can be discharged to primary care.</p> <p><b>GPP</b> - OCD and BDD can have a fluctuating or episodic course, or relapse may occur after successful treatment. Therefore, people who have been successfully treated and discharged should be seen as soon as possible if re-referred with further occurrences of OCD or BDD, rather than placed on a routine waiting list. For those in whom there has been no response to treatment, care coordination (or other suitable processes) should be used at the end of any specific treatment programme to identify any need for continuing support and appropriate services to address it.</p>
<p><b>Education</b></p>	
<p><b>APA (2007)</b></p>	<p><b>Enhancing Treatment Adherence</b></p> <p>Because the patient's beliefs about the nature of the illness and its treatments will influence adherence, providing patient and family education may enhance adherence <b>[II]</b>. Many patients with OCD benefit from educational materials and access to support groups provided by the Obsessive Compulsive Foundation (<a href="http://www.ocfoundation.org">www.ocfoundation.org</a>). When a patient has insufficient motivation to participate effectively in treatment, motivational interviewing or other psychosocial interventions designed to enhance readiness for change may be helpful <b>[II]</b>. Because medications used to treat OCD have side effects, particularly at high doses, adherence may be enhanced by informing the patient about any likely side effects, responding quickly to side effect concerns, and scheduling follow-up appointments soon after starting or changing medications <b>[I]</b>. In describing CBT, it is helpful to advise that it involves confronting feared thoughts and situations, though at a tolerable rate <b>[I]</b>. Practical issues such as treatment cost, insurance coverage, and transportation may need to be addressed. When a patient with OCD refuses or prematurely discontinues treatment, the clinician may wish to recommend that family members and others negatively affected by the OCD seek therapy to help develop strategies to mitigate the effect of the patient's OCD on their lives and to encourage the patient to obtain treatment <b>[II]</b>.</p>

## **Understanding**

**GPP** - People with OCD or BDD are often ashamed and embarrassed by their condition and may find it very difficult to discuss their symptoms with healthcare professionals, friends, family or carers. Healthcare professionals should help patients, and their families or carers where appropriate, to understand the involuntary nature of the symptoms by providing accurate information in an appropriate format on current understanding of the disorders from psychological and/or biological perspectives.

## **Information and Support**

**GPP** - Treatment and care should take into account the individual needs and preferences of people with OCD or BDD. Patients should have the opportunity to make informed decisions about their care and treatment. Where patients do not have the capacity to make decisions, or children or young people are not old enough to do so, healthcare professionals should follow the Department of Health guidelines.

**GPP** - Good communication between healthcare professionals and people with OCD or BDD is essential. Provision of information, treatment and care should be tailored to the needs of the individual, culturally appropriate, and provided in a form that is accessible to people who have additional needs, such as learning difficulties, physical or sensory disabilities, or limited competence in speaking or reading English.

**GPP** - Healthcare professionals should consider informing people with OCD or BDD and their family or carers about local self-help and support groups, and encourage them to participate in such groups where appropriate.

## **Families and Carers**

**GPP** - In the treatment and care of people with OCD or BDD, family members or carers should be provided with good information (both verbal and written) about the disorder, its likely causes, its course and its treatment.

## **How to Use Pharmacological Interventions in Adults**

### *Starting the Treatment*

Common concerns about taking medication for OCD or BDD should be addressed. Patients should be advised, both verbally and with written material, that:

	<ul style="list-style-type: none"> <li>• C - Craving and tolerance do not occur.</li> <li>• C - There is a risk of discontinuation/withdrawal symptoms on stopping the drug, missing doses, or reducing the dose.</li> <li>• C - There is a range of potential side effects, including worsening anxiety, suicidal thoughts and self-harm, which need to be carefully monitored, especially in the first few weeks of treatment.</li> <li>• C - There is commonly a delay in the onset of effect of up to 12 weeks, although depressive symptoms improve more quickly</li> <li>• <b>GPP</b> - Taking medication should not be seen as a weakness.</li> </ul>
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<b>TABLE 4: BENEFITS AND HARMS</b>	
<b>Benefits</b>	
<b>APA (2007)</b>	Appropriate treatment of OCD
<b>NCCMH/NICE (2006)</b>	Appropriate management of adults with OCD and BDD
<b>Harms</b>	
<b>APA (2007)</b>	<ul style="list-style-type: none"> <li>• The most common side effects of SSRIs include gastrointestinal distress (especially in the first weeks of treatment), agitation, insomnia or somnolence, increased tendency to sweat, and sexual side effects, including diminished libido and difficulty with erection and orgasm.</li> <li>• Concerns have been raised about the potential for increases in self-harming or suicidal behaviors in individuals treated with antidepressant medications, including SSRIs.</li> <li>• SSRIs may be associated with increased intra-operative blood loss in patients also taking nonsteroidal anti-inflammatory drugs and, along with clomipramine, may interact with anesthetics and opiate pain relievers.</li> <li>• In comparison to SSRIs, clomipramine is more likely to induce anticholinergic effects such as tachycardia, dry mouth, constipation, and blurred vision, although these typically diminish over time. Clomipramine is also more likely to induce delayed urination or, uncommonly, urinary retention. Histaminic blockade with clomipramine is associated with weight gain and sedation. Adrenergic blockade may lead to orthostatic hypotension and postural dizziness. Sodium channel blockade can induce cardiac arrhythmias or seizures (estimated to occur in 0.7% of</li> </ul>

	<p>patients treated with clomipramine at a dose of up to 300 mg/day for as many as 6 years).</p> <ul style="list-style-type: none"> <li>• A drug discontinuation syndrome consisting most often of dizziness, nausea/vomiting, headache, and lethargy, but also including agitation, insomnia, myoclonic jerks, and paresthesias, may occur if antidepressant medication is suddenly stopped.</li> <li>• The side-effect burden of MAOIs can be significant and includes potentially severe drug-drug interactions as well as cardiovascular problems and weight gain. To avoid drug-food interactions, dietary restrictions are needed during treatment with nonselective MAOIs or highdose selective MAOIs</li> <li>• Side effects of deep brain stimulation include brain hemorrhage, infection, and new onset-seizures as well as tingling, nausea, and diarrhea in one clinical trial</li> <li>• Side effects of cingulotomy include memory disturbance, apathy, urinary disturbances, headache, insomnia, and weight gain/loss</li> </ul>
<b>NCCMH/NICE (2006)</b>	<p>Adverse events associated with pharmacological therapy</p> <p>For further information, see the original guideline document and the "FDA Warning/Regulatory Alert" field in this summary.</p>

<b>TABLE 5: EVIDENCE RATING SCHEMES AND REFERENCES</b>	
<b>APA (2007)</b>	<p>Each recommendation is identified as falling into one of three categories of endorsement, indicated by a bracketed Roman numeral following the statement. The three categories represent varying levels of clinical confidence regarding the recommendation:</p> <p>[I] Recommended with substantial clinical confidence</p> <p>[II] Recommended with moderate clinical confidence</p> <p>[III] May be recommended on the basis of individual circumstances</p> <p><b>Type of Evidence Supporting the Recommendations</b></p> <p>The recommendations are based on the best available data and clinical consensus with regard to a particular clinical decision. The summary of treatment recommendations is keyed according</p>

	<p>to the level of confidence with which each recommendation is made (see the "Major Recommendations" field). In addition, the following coding system is used to indicate the nature of the supporting evidence in the references:</p> <p>[A] <i>Randomized, double blind clinical trial</i> A study of an intervention in which subjects are prospectively followed over time; there are treatment and control groups; subjects are randomly assigned to the two groups; both the subjects and the investigators are "blind" to the assignments</p> <p>[A--] <i>Randomized clinical trial</i> Same as above but not double blind</p> <p>[B] <i>Clinical trial</i> A prospective study in which an intervention is made and the results of that intervention are tracked longitudinally; study does not meet standards for a randomized clinical trial</p> <p>[C] <i>Cohort or longitudinal study</i> A study in which subjects are prospectively followed over time without any specific intervention</p> <p>[D] <i>Case-control study</i> A study in which a group of patients and a group of control subjects are identified in the present and information about them is pursued retrospectively or backward in time</p> <p>[E] <i>Review of secondary analysis</i> A structured analytic review of existing data (e.g., a meta-analysis or a decision analysis)</p> <p>[F] <i>Review</i> A qualitative review and discussion of previously published literature without a quantitative synthesis of the data</p> <p>[G] <i>Other</i> Textbooks, expert opinion, case reports, and other reports not included above</p>
<p><b>NCCMH/NICE (2006)</b></p>	<p><b>Evidence Categories</b></p> <p><b>I:</b> Evidence obtained from a single randomised controlled trial or a meta-analysis of randomised controlled trials</p> <p><b>IIa:</b> Evidence obtained from at least one well-designed controlled study without randomisation</p> <p><b>IIb:</b> Evidence obtained from at least one well-designed quasi-experimental study</p> <p><b>III:</b> Evidence obtained from well-designed non-experimental</p>

	<p>descriptive studies, such as comparative studies, correlation studies and case studies</p> <p><b>IV:</b> Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities</p> <p><b>Recommendation Grades</b></p> <p><b>Grade A</b> - At least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence level I) without extrapolation</p> <p><b>Grade B</b> - Well-conducted clinical studies but no randomised clinical trials on the topic of recommendation (evidence levels II or III); or extrapolated from level-I evidence</p> <p><b>Grade C</b> - Expert committee reports or opinions and/or clinical experiences of respected authorities (evidence level IV) or extrapolated from level-I or II evidence. This grading indicates that directly applicable clinical studies of good quality are absent or not readily available.</p> <p><b>Good Practice Point (GPP)</b> - Recommended good practice based on the clinical experience of the Guideline Development Group (GDG)</p>
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## **GUIDELINE CONTENT COMPARISON**

The American Psychiatric Association (APA) and the National Collaborating Centre for Mental Health/National Institute for Health and Clinical Excellence (NCCMH/NICE) present recommendations for the management of adults with OCD and provide explicit reasoning behind their judgments, ranking the level of evidence for each major recommendation.

The guidelines differ somewhat in scope. In addition to addressing management of adults with OCD, the NCCMH/NICE also provides management recommendations for children with OCD, as well as for both children and adults with BDD. These topics, however, are beyond the scope of this synthesis. For pediatric OCD treatment recommendations APA refers the reader to the practice parameter of the American Academy of Child and Adolescent Psychiatry.

### **Areas of Agreement**

*Assessment*

APA and NCCMH/NICE both stress the need for patients diagnosed with OCD to be assessed for the risk of self-harm and suicide, the presence of comorbid psychiatric and medical conditions, and any psychosocial factors that may contribute to risk or affect the treatment plan. The guidelines agree that when assessing for comorbid conditions, particular attention should be paid to past or current evidence of depression, given its frequency and association with suicidal ideation and behaviors.

### *General Management Recommendations*

APA and NCCMH/NICE agree that effective coordination of care between all parties involved in the patient's management is essential. NCCMH/NICE notes that there should be clear, written agreement among individual healthcare professionals about the responsibility for monitoring and treating the patient. Both groups also stress the need for appropriate continuity of care, which adjusts to the patient's needs and preferences during all stages of treatment. APA stresses the need for establishing a strong therapeutic alliance as well as setting realistic treatment goals. Both groups agree that promoting a collaborative approach with patients and their family/carers is recommended wherever this is appropriate and possible.

### *Determination of Treatment Setting*

The guidelines agree that outpatient treatment is usually sufficient for OCD, but that a more intensive treatment setting may be indicated in certain patients. APA provides indications for the initiation of home-based treatment, partial hospitalization, residential treatment, and hospital treatment. NCCMH/NICE notes that inpatient services, with specific expertise in OCD, are appropriate in certain circumstances, including when there is risk to life, severe self-neglect, and extreme distress or functional impairment.

### *Psychological Treatment*

The guidelines agree that the psychological intervention with the best evidentiary support is CBT that relies primarily on ERP, and that it should therefore be the first-line psychosocial intervention in the management of OCD. Both guidelines acknowledge that some data support the use of CBT that focuses on cognitive techniques, but that this should be reserved for patients who will not or cannot undergo ERP. There is also agreement that the effectiveness of other forms of psychological therapy, such as psychodynamic psychotherapy and psychoanalysis, as specific treatments for the core symptoms of OCD, has not been demonstrated. APA notes, however, that psychodynamic psychotherapy may still be useful in helping patients overcome their resistance to accepting a recommended treatment or in addressing the interpersonal consequences of the OCD symptoms.

In terms of the frequency of CBT sessions, APA recommends they be scheduled at least once weekly. They also note that five ERP sessions per week may be more effective than once-weekly sessions, but are not necessarily more effective than twice-weekly sessions. APA adds that while the number of treatment sessions, their length, and the duration of an adequate trial have not been established, expert consensus recommends 13-20 weekly sessions for most patients. NCCMH/NICE recommends that in the initial treatment of adults with mild OCD, low intensity treatment (including ERP), defined as less than 10 hours of therapist

input per patient, is appropriate. Low intensity treatments cited by NCCMH/NICE include brief individual CBT with ERP using structured self-help materials, brief individual CBT with ERP by telephone, and group CBT with ERP. A second-line option for these patients is either a trial of an SSRI or more intensive CBT with ERP (more than 10 therapist hours per patient). While that is a second-line option for adults with mild OCD, it is a first-line option for adults with moderate OCD. The combination of an SSRI and CBT with ERP is recommended for adults with severe OCD.

There is agreement between the guidelines that including the patient's family in the therapy process is recommended when it is appropriate and acceptable to those involved. The groups also address alternative therapy options, such as home-based treatment (by telephone if required), a computer-based approach coupled with a touch-tone telephone system, self-help treatment guides, and support groups.

### *Pharmacological Treatment*

APA and NCCMH/NICE agree that an SSRI is the preferred choice for a first medication trial in the pharmacologic management of OCD. While APA includes clomipramine in its recommended pharmacologic treatments, they note that in light of the fact that the SSRIs have a less troublesome side-effect profile, an SSRI is preferred for a first medication trial. NCCMH/NICE recommends that clomipramine be considered only after an adequate trial of at least one SSRI has been ineffective or poorly tolerated, if the patient prefers clomipramine, or has had a previous good response to it. They also provide specific recommendations pertaining to the prescription of clomipramine, including the need for vigilant monitoring in individuals at risk of suicide, due to its potential for toxicity in overdose.

In terms of choosing an SSRI, NCCMH/NICE recommends fluoxetine, fluvoxamine, paroxetine, sertraline or citalopram. APA addresses the same SSRIs plus escitalopram, and notes that although all SSRIs appear to be equally effective, individual patients may respond well to one medication and not to another. There is agreement between the guidelines that factors to be considered in choosing a medication include associated side effects, any applicable safety warnings (most notably the relationship between SSRIs and suicide risk), potential drug interactions, and the presence of comorbid conditions.

Both groups agree that a delay in response to medication is normal, and that a gradual increase in dose is appropriate for individuals who experience little or no symptom improvement after approximately 4 weeks. NCCMH/NICE notes that the rate at which the dose of an SSRI should be increased should take into account therapeutic response, adverse effects, and patient preference. The guidelines agree that medication side effects should be inquired about and actively managed, both during the initial prescription phase as well as during dosage changes.

In terms of follow-up after initiation of pharmacotherapy, APA notes that the indicated frequency will depend on the severity of the patient's symptoms, the complexities introduced by co-occurring conditions, whether suicidal ideation is present, and the likelihood of troubling side effects. NCCMH/NICE similarly

provides various risk monitoring recommendations for adults taking SSRIs according to the presence of comorbid depression and the risk of suicide.

### *Education*

APA and NCCMH/NICE agree that patients and their families/carers should be provided with accurate educational materials in an appropriate format about the nature of the illness and its treatments. Both groups also agree that educating patients about self-help and support groups and encouraging participation where appropriate is also important.

### *Adjunctive Treatments*

The guidelines agree that neurosurgery is rarely indicated in the management of OCD, but that when indicated, it should be performed only at sites with expertise in such techniques. NCCMH/NICE provides additional recommendations regarding the decision to perform neurosurgery.

### *Follow-Up*

Recommendations regarding the tapering of medications or total discontinuation of pharmacotherapy are fairly similar. NCCMH/NICE recommends that an effective SSRI treatment should be continued for at least 12 months after remission (symptoms are not clinically significant and the person is fully functioning for at least 12 weeks) to prevent relapse and allow for further improvements, at which time a review to determine need for continued treatment should be conducted. APA similarly recommends that successful medication treatment should be continued for 1-2 years before considering a gradual taper by decrements of 10%-25% every 1-2 months while observing for symptom return or exacerbation. They add that discontinuation of pharmacotherapy should be carefully considered, and for most patients, continued treatment of some form is recommended.

### **Areas of Differences**

There are no significant areas of differences between the guidelines.

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*This synthesis was prepared by ECRI on January 4, 2008. The information was verified by APA on January 23, 2008.*

Internet citation: National Guideline Clearinghouse (NGC). Guideline synthesis: Management of obsessive compulsive disorder (OCD). In: National Guideline Clearinghouse (NGC) [website]. Rockville (MD): 2009 Apr. [cited YYYY Mon DD]. Available: <http://www.guideline.gov>.



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Date Modified: 4/20/2009