

# TREATING

## OBSESSIVE-COMPULSIVE DISORDER

A Quick Reference Guide



Based on *Practice Guideline for the Treatment of Patients With Obsessive-Compulsive Disorder*, originally published in July 2007. A guideline watch, summarizing significant developments in the scientific literature since publication of this guideline, may be available in the Psychiatric Practice section of the APA web site at [www.psych.org](http://www.psych.org).

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# Introduction

“Treating Obsessive-Compulsive Disorder: A Quick Reference Guide” is a synopsis of the American Psychiatric Association’s *Practice Guideline for the Treatment of Patients With Obsessive-Compulsive Disorder*, which was originally published in *The American Journal of Psychiatry* in July 2007 and is available through American Psychiatric Publishing, Inc. The psychiatrist using this Quick Reference Guide (QRG) should be familiar with the full-text practice guideline on which it is based. The QRG is not designed to stand on its own and should be used in conjunction with the full-text practice guideline. For clarification of a recommendation or for a review of the evidence supporting a particular strategy, the psychiatrist will find it helpful to return to the full-text practice guideline.

## Statement of Intent

The Practice Guidelines and the Quick Reference Guides are not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual patient and are subject to change as scientific knowledge and technology advance and practice patterns evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome for every individual, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgment regarding a particular clinical procedure or treatment plan must be made by the psychiatrist in light of the clinical data presented by the patient and the diagnostic and treatment options available. The development of the APA Practice Guidelines and Quick Reference Guides has not been financially supported by any commercial organization.

## OUTLINE

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## A. Psychiatric Management

### 1. Establish and maintain a therapeutic alliance.

- Tailor communication style to the patient's needs and abilities.
- Allow patients with excessive worry or doubting time to consider treatment decisions. Repeat explanations if necessary.
- Attend to transference and countertransference, which may disrupt the alliance and adherence.
- Consider how the patient's expectations are affected by his or her cultural and religious background, beliefs about the illness, and experience with past treatments.

### 2. Assess the patient's symptoms.

- Use DSM-IV-TR criteria for diagnosis.
- Consider using screening questions to detect commonly unrecognized symptoms (Table 1).
- Differentiate OCD obsessions, compulsions, and rituals from similar symptoms found in other disorders (Table 2).

**TABLE 1. Example Obsessive-Compulsive Disorder Screening Questions**

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Do you have unpleasant thoughts you can't get rid of?

Do you worry that you might impulsively harm someone?

Do you have to count things, wash your hands, or check things over and over?

Do you worry a lot about whether you performed religious rituals correctly or have been immoral?

Do you have troubling thoughts about sexual matters?

Do you need things arranged symmetrically or in a very exact order?

Do you have trouble discarding things, so that your house is quite cluttered?

Do these worries and behaviors interfere with your functioning at work, with your family, or with social activities?

**TABLE 2. Symptoms of Other Psychiatric Disorders to be Differentiated From the Obsessions, Compulsions, and Rituals of Obsessive-Compulsive Disorder (OCD)**

| Disorder                     | Symptom  | How the Symptom Differs From Symptoms of OCD   |
|------------------------------|--|--|
| Bipolar disorder             | Manic delusions  | The content of the delusions is usually related to grandiosity.  |
| Body dysmorphic disorder     | Recurrent and intrusive preoccupation with a perceived bodily defect   | The preoccupation is limited to the body.  |
| Depressive disorders         | Depressive ruminations   | Unlike OCD obsessions, depressive ruminations are experienced as consistent with one's self-image and usually concern self-criticism, failures, guilt, regret, or pessimism about the future. Unlike obsessions, depressive ruminations do not lead to compulsive rituals. |
| Eating disorders             | Intrusive thoughts and unhealthy behaviors regarding weight and eating | The thoughts and behaviors are limited to weight and eating.   |
| Generalized anxiety disorder | Worry  | Unlike with OCD, worry does not lead to compulsive rituals.  |
| Hypochondriasis              | Fear or belief regarding serious disease                               | In OCD, such fear arises from an external stimuli (e.g., that causes contamination) rather than misinterpretation of an ordinary bodily sign or symptom.   |

**TABLE 2. Symptoms of Other Psychiatric Disorders to be Differentiated From the Obsessions, Compulsions, and Rituals of Obsessive-Compulsive Disorder (OCD) (continued)**

| Disorder   | Symptom   | How the Symptom Differs From Symptoms of OCD   |
|--|---|--|
| Obsessive-compulsive personality disorder (OCPD) | Hoarding, scrupulosity, perfectionism, preoccupation with rules and order | In OCD, obsessions and compulsions usually focus on specific feared events; in OCPD, thoughts and behaviors are globally colored by traits such as perfectionism and preoccupation with rules. |
| Paraphilias                                      | Intrusive sexual thoughts and urges                                       | OCD obsessions are resisted, are morally abhorrent to the individual, and lead to avoidance.   |
| Postpartum depression                            | Urges to harm an infant   | OCD thoughts and urges do not emerge from depressed mood or psychosis and are resisted.  |
| Posttraumatic stress disorder                    | Intrusive thoughts and images   | The thoughts replay actual events rather than anticipate future events as in OCD.  |
| Schizophrenia                                    | Schizophrenic delusions   | The content is usually bizarre or related to persecution, grandiosity, passivity experiences, or ideas of reference.   |
| Tourette's disorder                              | Complex vocal or motor tics   | Tics, unlike compulsions, are not preceded by thoughts nor aimed at relieving anxiety or preventing or undoing an event.   |

### 3. Consider rating the patient's symptom severity and level of functioning.

- Recording baseline severity provides a way to measure response to treatment.
- A useful symptom scale is the Yale-Brown Obsessive Compulsive Scale (Y-BOCS), which is available on web sites such as <http://healthnet.umassmed.edu/mhealth/YBOCRatingScale.pdf> or <http://www.peaceofmind.com/YBOCS.pdf>.
- Useful self-rated depression scales include the Patient Health Questionnaire (PHQ-9), the Beck Depression Inventory–II (BDI-II), the Zung Depression Scale, and the patient versions of the Inventory of Depressive Symptoms (IDS) or the Quick-IDS.
- A useful disability rating scale is the Sheehan Disability Scale (SDS).
- A useful quality-of-life scale is the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q) or the more detailed World Health Organization Quality of Life Survey (WHQOL-100).

### 4. Enhance the safety of the patient and others.

- Assess for risk of suicide, self-injurious behavior, and harm to others.
- Collateral information from family members and others can be helpful.
- Take into consideration factors associated with increased risk of suicide, including specific psychiatric symptoms and disorders (e.g., hopelessness, agitation, psychosis, anxiety, panic attacks, mood or substance use disorders, schizophrenia, borderline personality disorder) and previous suicide attempts. See APA's *Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors*.
- Evaluate the patient's potential for harming others, either directly or indirectly (e.g., when OCD symptoms interfere with parenting).



## 5. Complete the psychiatric assessment.

- See APA's *Practice Guideline for the Psychiatric Evaluation of Adults*.
- Assess for common co-occurring disorders, including mood disorders, other anxiety disorders, eating disorders, substance use disorders, and personality disorders.

## 6. Establish goals for treatment.

- 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.
- Reasonable treatment outcome targets include less than 1 hour per day spent obsessing and performing compulsive behaviors, no more than mild OCD-related anxiety, an ability to live with OCD-associated uncertainty, and little or no interference of OCD with the tasks of daily living. Despite best efforts, some patients will be unable to reach these targets.

## 7. Establish the appropriate setting for treatment.

- In general, patients should be cared for in the least restrictive setting that is likely to be safe and to allow for effective treatment.
- Outpatient treatment is usually sufficient. More intensive settings (e.g., hospitalization, residential treatment, or partial hospitalization) may be needed by patients who have significant suicide risk, pose a danger to others, are unable to provide adequate self-care, have co-occurring psychiatric and general medical conditions, or need intensive treatment or monitoring.
- Home-based treatment may be needed by patients who are unable to visit an office or clinic because of impairing fears or other symptoms.

## 8. Enhance treatment adherence.

- Recognize that the patient's fears, doubting, and need for certainty can influence his or her willingness and ability to cooperate with treatment and can challenge the clinician's patience.
- Provide education about the illness and its treatment, including expected outcomes and time and effort required.
- Inform the patient about likely side effects of medications, inquire about side effects the patient may be unwilling to report (e.g., sexual side effects), respond quickly to concerns about side effects, and schedule follow-up appointments soon after starting or changing medications.
- Address breakdowns in the therapeutic alliance.
- Consider the role of the patient's family and social support system.
- When possible, help the patient to address practical issues such as treatment cost, insurance coverage, and transportation.

## B. Choice of Initial Treatment

**First-line treatments for OCD are cognitive-behavioral therapy (CBT) and serotonin reuptake inhibitors (SRIs).**

- SRIs include clomipramine and all of the selective serotonin reuptake inhibitors (SSRIs). Clomipramine, fluoxetine, fluvoxamine, paroxetine, and sertraline are approved by the U.S. Food and Drug Administration for treatment of OCD.
- Strong evidence, including from controlled trials, supports using CBT that relies primarily on the behavioral technique of exposure and response prevention (ERP).

→ **Choice of initial treatment modality is individualized and depends on factors including the following:**

- The nature and severity of the patient's symptoms.
- Co-occurring psychiatric and medical conditions.
- The availability of CBT.
- The patient's past treatment history, current medications, capacities, and preferences.

→ **CBT alone is recommended 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.**

- In ERP, patients are taught to confront feared situations and objects (i.e., exposure) and to refrain from performing rituals (i.e., response prevention). The goal is to weaken the connections between feared stimuli and distress and between carrying out rituals and relief from distress.
- Cognitive techniques such as identifying, challenging, and modifying dysfunctional beliefs (e.g., magical thinking, inflated sense of responsibility for unwanted events, overestimation of the probability of feared events, "thought-action fusion," perfectionism, belief that anxiety will persist forever, and need for control) may be effectively combined with ERP.
- The patient must be willing to do the work that CBT requires (e.g., regular behavioral homework).
- Psychodynamic psychotherapy may be useful in helping patients overcome their resistance to accepting a recommended treatment and addressing the interpersonal consequences of OCD symptoms.
- Motivational interviewing may also help overcome resistance to treatment.

**An SRI alone is recommended for a patient who has previously responded well to a given drug or who prefers treatment with an SRI alone.**

- Starting with an SRI alone may enhance cooperation with treatment by diminishing symptom severity. Thus, an SRI alone may also be considered in patients who have severe OCD or are not otherwise able to cooperate with the demands of CBT.
- An SRI alone may also be necessary if CBT is not accessible or available.
- Because the SSRIs have a less troublesome side effect profile than clomipramine, an SSRI is preferred for a first medication trial.
- Factors to consider when choosing among the SSRIs include safety, side effects and their acceptability to the patient, and potential interactions with other medications the patient may be taking.

**Combined treatment (SRI and CBT) is more effective than monotherapy for some patients but is not necessary for all patients.**

- Combined treatment should be considered for patients who have had an unsatisfactory response to monotherapy, who have co-occurring psychiatric conditions for which SRIs are effective, or who wish to limit the duration of medication treatment.
- Combined treatment may also be considered for patients with severe OCD, since the medication may diminish symptom severity and allow the patient to engage in CBT.

## C. Implementation of Treatment

→ **Initiate pharmacotherapy at the dose recommended by the manufacturer (for most patients) and titrate to a maximally tolerable dose (Table 3).**

- Patients who are worried about side effects can be started at half-doses or less.
- Lower doses and more gradual titration may be needed for patients with co-occurring anxiety disorders and for elderly patients.
- Evidence suggests that higher SSRI doses produce a somewhat higher response rate and somewhat greater magnitude of symptom relief.
- Some patients may benefit from even higher doses than those shown in the last column of Table 3. Monitor such patients closely for side effects including serotonin syndrome.
- There is no apparent relationship between OCD treatment outcome and plasma levels of SRIs.

→ **Continue pharmacotherapy for 8–12 weeks, including 4–6 weeks at a maximally tolerable dose.**

- Most patients will not experience substantial improvement until 4–6 weeks after starting medication, and some who will ultimately respond will experience little improvement for as many as 10–12 weeks.
- Patients who have not responded to a known effective dose after 10–12 weeks may respond at higher doses.
- Some clinicians prefer to titrate doses more rapidly (in weekly increments to the maximum recommended dose if this is comfortably tolerated) rather than waiting for 1–2 months before each dose increment.

**TABLE 3. Dosing of Serotonin Reuptake Inhibitors (SRIs) in Obsessive-Compulsive Disorder**

| SRI                     | Starting Dose and Incremental Dose (mg/day) <sup>a</sup> | Usual Target Dose (mg/day) | Usual Maximum Dose (mg/day) | Occasionally Prescribed Maximum Dose (mg/day) <sup>b</sup> |
|-------------------------|--|----------------------------|-----------------------------|--|
| Citalopram              | 20   | 40–60                      | 80                          | 120  |
| Clomipramine            | 25   | 100–250                    | 250                         | — <sup>c</sup>   |
| Escitalopram            | 10   | 20                         | 40                          | 60   |
| Fluoxetine              | 20   | 40–60                      | 80                          | 120  |
| Fluvoxamine             | 50   | 200                        | 300                         | 450  |
| Paroxetine              | 20   | 40–60                      | 60                          | 100  |
| Sertraline <sup>d</sup> | 50   | 200                        | 200                         | 400  |

<sup>a</sup>Some patients may need to start at half this dose or less to minimize undesired side effects such as nausea or to accommodate anxiety about taking medications.

<sup>b</sup>These doses are sometimes used for rapid metabolizers or for patients with no or mild side effects and inadequate therapeutic response after 8 weeks or more at the usual maximum dose.

<sup>c</sup>Combined plasma levels of clomipramine plus desmethylclomipramine 12 hours after the dose should be kept below 500 ng/mL to minimize risk of seizures and cardiac conduction delay.

<sup>d</sup>Sertraline, alone among the selective serotonin reuptake inhibitors, is better absorbed with food.

### Manage medication side effects.

- A first step is to consider if lowering the drug dose may alleviate the side effect without loss of therapeutic effect.
- Clomipramine is likely to induce anticholinergic effects, although these typically diminish over time. Side effects may include delayed urination, weight gain and sedation, orthostatic hypotension and postural dizziness, and cardiac arrhythmias and seizures. Starting at a dose of 25 mg/day or less will increase early tolerability.
- Common side effects of SSRIs and management strategies are described in Table 4. Sexual side effects may affect one-third or more of patients taking SSRIs.

- Carefully monitor patients taking SSRIs for suicidal thoughts and suicidal or other self-harming behaviors, particularly during the early phases of treatment and after dosage increases.
- A discontinuation syndrome consisting of dizziness, nausea/vomiting, headache, and lethargy but also agitation, insomnia, myoclonic jerks, and paresthesias may occur if medication is suddenly stopped. The syndrome may occur with any SRI but is most often seen with paroxetine or the serotonin-norepinephrine reuptake inhibitor venlafaxine. A slow taper over several weeks or more will minimize the likelihood of discontinuation symptoms.

**TABLE 4. Management Strategies for Common Side Effects of Selective Serotonin Reuptake Inhibitors (SSRIs)**

| <b>Side Effect</b>        | <b>Management Strategies</b>   |
|---------------------------|--|
| Fatigue or sleepiness     | <ul style="list-style-type: none"> <li>• Add modest doses of modafinil.</li> </ul>   |
| Gastrointestinal distress | <ul style="list-style-type: none"> <li>• Start with low doses.</li> <li>• Advise that mild queasiness or nausea will usually disappear within 1–2 weeks at a constant dose.</li> </ul>   |
| Insomnia                  | <ul style="list-style-type: none"> <li>• Recommend taking the medication in the morning.</li> <li>• Recommend sleep hygiene measures.</li> <li>• Add a sleep-promoting agent.</li> </ul>   |
| Sexual side effects       | <ul style="list-style-type: none"> <li>• Reduce the dose to that which is minimally effective.</li> <li>• Wait for the symptom to remit.</li> <li>• Recommend a once-weekly, one-day “drug holiday” before engaging in sexual activity (not effective for fluoxetine).</li> <li>• Switch to another SSRI.</li> <li>• Add a counteracting pharmacological agent (e.g., bupropion).</li> </ul> |
| Sweating                  | <ul style="list-style-type: none"> <li>• Add a low-dose anticholinergic agent such as benztropine.</li> <li>• Add clonidine, cyproheptadine, or mirtazapine.</li> </ul>  |

→ **Provide CBT at least once weekly for 13–20 weeks.**

- The literature and expert opinion suggest that 13–20 weekly sessions with daily homework (or 3 weeks of weekday daily CBT) is an adequate trial for most patients. More severely ill patients may require longer treatment and/or more frequent sessions.
- Consider booster sessions for more severely ill patients, patients who have relapsed in the past, and those who show signs of early relapse.
- The psychiatrist may conduct the CBT or refer the patient for this or another adjunctive psychotherapy.

→ **Monitor the patient's psychiatric status in follow-up visits.**

- The frequency of follow-up visits may vary from a few days to 2 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 troublesome side effects.
- The patient should be encouraged to telephone between visits if medication questions arise. If telephone calls become reassurance rituals, work with the patient and the patient's family to limit call frequency, using treatment as for any other ritual.

## **D. Changing Treatment**

→ **Decide when, whether, and how to alter the therapeutic plan for patients who have continued OCD symptoms despite treatment.**

- First treatments rarely produce freedom from all OCD symptoms, and there is typically opportunity for improvement.



- Decisions about altering treatment may depend on the degree of residual symptoms that a patient is willing to accept.
- When patients are not motivated to pursue further treatments despite limited improvement, consider if depressed mood is diminishing hopefulness or if illness is associated with secondary gain.

→ **Consider whether other factors are contributing to limited improvement and address them:**

- Problems in the therapeutic alliance
- Interference of co-occurring conditions such as panic disorder, major depression, a substance use disorder, or severe personality disorder
- Inadequate adherence to treatment or failure to tolerate an adequate trial of psychotherapy or medication at the recommended dose
- Psychosocial stressors
- Family accommodation to symptoms

→ **Consider extending or intensifying the psychotherapeutic or pharmacological intervention.**

→ **If the patient continues to have an inadequate response to treatment, consider the following alternatives:**

- Providing combined treatment (SRI and CBT)
- Augmenting an SRI with an antipsychotic medication
- Switching to a different SRI
- Switching to venlafaxine

**After the above treatments and augmentation strategies have been exhausted, consider less well supported strategies.**

- Augmentation of SSRIs with clomipramine, buspirone, pindolol, riluzole, or once-weekly morphine sulfate may be helpful for some patients. 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 used to prevent potential cardiac and central nervous system side effects.
- Monotherapy with D-amphetamine, tramadol, monoamine oxidase inhibitors, ondansetron, transcranial magnetic stimulation, or deep brain stimulation may be considered in selected circumstances.
- Intensive residential treatment or partial hospitalization may be helpful for patients with severe treatment-resistant OCD.
- 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.

## **E. Discontinuing Treatment**

**Because relapse appears to be common, continue treatment of some form for most patients.**

- Continue successful medication treatment 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.
- Follow successful CBT consisting of ERP by monthly booster sessions for 3–6 months, or more intensively if response has been only partial.