The Expert Consensus Guideline Series:

Treatment of Obsessive-Compulsive Disorder

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The Expert Consensus Panel for Obsessive-Compulsive Disorder

The following participants in the Expert Consensus Survey were identified from several sources: participants in a recent NIMH consensus conference on OCD; participants in the International Obsessive Compulsive Disorders Conference (IOCDC); members of the Obsessive-Compulsive Foundation Scientific Advisory Board; and other published clinical researchers. Of the 79 experts to whom we sent the obsessive-compulsive disorder survey, 69 (87%) replied. The recommendations in the guidelines reflect the aggregate opinions of the experts and do not necessarily reflect the opinion of each individual on each question.

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Guideline 1: Selecting the Initial Treatment Strategy

1A. Treatment Choice by Severity of Illness and By Age

Summary: The experts usually prefer to begin the treatment of OCD patients with either CBT alone or with a combination of CBT and medication (CBT+SRI). The likelihood that medication will be included in the recommendation varies with the severity of the OCD and the age of the patient. In milder OCD, CBT alone is the initial choice. As severity increases, the experts are more likely to add medications to CBT as the initial treatment or to use medication alone. In younger patients, the experts are more likely to use CBT alone.

	Adult OCD		Adolescent OCD		Prepubertal OCD	
	Milder*	**More Severe***	**Milder**	**More Severe**	**Milder**	**More Severe**
First Line	CBT** first	CBT+SRI*** SRI first	CBT first	CBT + SRI	CBT first	CBT first
Second line	CBT+SRI SRI first	CBT first	CBT + SRI SRI first	CBT first SRI first	CBT+SRI SRI first	CBT+SRI SRI first

*Mild OCD (Yale-Brown Obsessive-Compulsive Scale 10-18) causes distress but not necessarily dysfunction; help from others is usually not required to get through the day. Moderate OCD (YBOCS 18 -29) causes both distress and functional impairment. Severe OCD (YBOCS = 30 or above) causes serious functional impairment requiring significant help from others.

**CBT: cognitive-behavioral therapy

***SRI (serotonin reuptake inhibitor) refers to the five compounds clomipramine, fluoxetine, fluvoxamine, paroxetine, and sertraline; SSRI (selective SRI) refers to all but clomipramine.

1B. Other Factors That Affect the Choice of Treatment

Summary: We also asked the experts a series of questions concerning the relative efficacy, durability, speed, tolerability and acceptability of CBT alone, medication alone, and combined treatment (CBT + SRI). Table 1B examines to what extent each treatment is rated as first, second, or third line across these dimensions for patients with either mild or severe OCD. Combined treatment is the experts' favorite in most comparisons suggesting that overall it may be the most acceptable and successful treatment approach for the majority of adult patients.

	Efficacy		Speed		Durability		Tolerability		Acceptability	
	Milder	**Severe**	**Milder**	**Severe**	**Milder**	**Severe**	**Milder**	**Severe**	**Milder**	**Severe**
CBT + SRI	First	First	First	First	First	Second	First	First	First	First

CBT	First	Second	First	Second	First	Second	First	Second	First	Second
Medication	Second	Second	Second	Second	Second	Third	Second	First	Second	First

Efficacy represents the likelihood of meaningful symptom remission.

Speed refers to how quickly symptom remission begins.

Durability refers to the probability of symptom recurrence when treatment is withdrawn.

Tolerability is the degree to which patients find the treatment to be free of major or prohibitive side effects.

Acceptability refers to positive patient expectations that influence choice of treatment.

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Guideline 2: Selecting Specific Cognitive-Behavioral (CBT) Techniques

Editors note: Table 2A describes the specific CBT treatment strategies that were endorsed by the experts and table 2B describes the level of care and intensity of services for CBT. Cognitive-behavioral therapy involves the combination of behavior therapy (E/RP) and Cognitive Therapy (CT). Behavior therapy for OCD (BT in CBT) most specifically involves Exposure (E) and Response or Ritual Prevention (RP). **Exposure** (E) capitalizes on the fact that anxiety usually attenuates after sufficient duration of contact with a feared stimulus. Thus, patients with obsessions related to germs must remain in contact with "germy" objects until their anxiety is extinguished. Repeated exposure is associated with decreased anxiety until, after multiple trials, the patient no longer fears contact with the specifically targeted stimulus. In order to achieve adequate exposure, it is usually necessary to help the patient block the rituals or avoidance behaviors, a process termed **response or ritual prevention** (RP). For example, patients with germ worries must not only touch "germy things," but must also refrain from ritualized washing until their anxiety diminishes, a process termed **exposure and response prevention** (E/RP). **Cognitive therapy** (CT), which may be added to E/RP, addresses such things as faulty estimation of danger or the exaggerated sense of personal responsibility often seen in OCD patients. Other techniques such as thought stopping and distraction (which involve suppressing or "switching off" OCD symptoms) and contingency management (which emphasizes rewards and costs as incentives for ritual

prevention) are generally thought to be less effective than standard CBT.

2A. Selecting a CBT Strategy (***bold italics*** = treatment of choice)	**Summary**: The experts consider the combination of exposure and response prevention as the optimal behavioral psychotherapy for OCD, while cognitive therapy may provide additional benefit by directly targeting distorted "OCD beliefs" and/or by improving compliance with E/RP.	
	Obsessions	**Compulsions**
First line	Exposure plus response prevention (E/RP) E/RP + Cognitive Therapy (CT)	***E/RP*** E/RP + CT
Second line	CT Exposure	Response Prevention CT Exposure

Further recommendations:

Cognitive therapy may be more useful for pathological doubt, aggressive obsessions, and scrupulosity or other "OCD beliefs" as contrasted to "urge" like symptoms such as arranging or touching rituals. Habit reversal, which depends primarily on establishing a set of competing responses, may be especially useful for tic-like compulsions.

Patients with little insight do not do as well with any of the specified treatment interventions. CT may help sharpen insight, however.

2B. Level of Care for CBT (***bold italics*** = treatment of choice)	**Summary**: The experts' recommend beginning treatment with weekly, individual CBT sessions and may also use between session homework assignments or therapist assisted out-of -office (in vivo) exposure and response prevention. Group CBT or behavioral family therapy are second line alternatives. The experts recommend 13-20 sessions as the appropriate number of CBT treatments for

	the typical patient. When speed is of the essence or OCD is particularly severe in adults, intensive CBT (daily CBT for 3 weeks) may be preferable.	
	First line	**Second line**
Intensity and setting	Weekly office + E/RP homework Weekly office + out-of-office therapist assisted E/RP Intensive CBT (50 hours of daily CBT over 3 weeks)	Biweekly E/RP Partial hospital Inpatient hospital
Format	***Individual***	Group Individual + family therapy Behavioral family therapy
Number of Sessions	***13–20 sessions*** 7–12 sessions	20–50 sessions 3–6 sessions

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Guideline 3: Selecting A Specific Medication Strategy

Summary: Among the classes of medications, the serotonin reuptake inhibitors (SRIs) are by far the most effective for OCD and the experts recommend all five SRIs as first line treatments for OCD. If the patient does not respond to the average dose of an SRI, the experts recommend gradually increasing the dose to its maximum within 4–8 weeks from the start of treatment. When a patient is having a partial response to an average dose of an SRI, the experts suggest gradually increasing the dose to its maximum within 5–9 weeks from the start of treatment. They consider 8–13 weeks an adequate medication trial before changing medication or augmenting with another agent.

	Drugs*	Dosage Range (mg)	Average Daily Dose (mg)	No Response to Average SRI dose	Partial Response to Average SRI dose
First Line	Fluvoxamine Fluoxetine Clomipramine Sertraline Paroxetine	100–300 20–80 100–300 75–225 20–60	200 50 200 150 50	Push SRI to maximum dose in 4–8 weeks from the start of treatment	Push SRI to maximum dose in 5–9 weeks from the start of treatment

* Dosage ranges are rounded off to the nearest "pill dose." Dosages for individual patients may be larger or smaller, depending on the individualized dose-response curve. Medications are listed in order of the experts' mean scores.

Further recommendations:

The experts recommend switching to another SRI if there is no response after 4–6 weeks at a maximum dose.

Other treatments, including venlafaxine, MAOIs, and clonazepam, are considered third line and may be worth a try when the SRIs themselves have not proven helpful.

SRIs are more likely to be helpful for pathological doubt, aggressive obsessions and urges, and mental rituals than for slowness, hoarding, and tic-like symptoms.

Editorial Comment: When increasing the dose to the maximum, it is generally wise to wait 2–4 weeks between dose increases to allow sufficient time to establish a dose-response relationship. A few patients who show a partial response to medication and few side effects may benefit from doses substantially higher than those listed as the conventional maximum. The dose of medication for such patients should not be increased to high levels until at least 12 weeks of treatment have elapsed.

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Guideline 4: When There is Still Room for Improvement

Editors' note: Unfortunately, some patients do not respond adequately or at all to the initial treatment plan. Guideline 4A provides the experts' recommendations for what to do next when the initial treatment plan of CBT or SRI or a combination of the two has not produced satisfactory improvement. Guideline 4B provides recommendations concerning how long to wait before making changes in the treatment regimen. Strategies for patients who continue to have an inadequate response after several treatment trials are outlined in Guideline 5.

4A: Inadequate Response to First Line Treatment: What to Do Next

Summary: The experts recommend adding an SRI when patients have not responded well to CBT alone. When patients have not done well with medication management alone, the experts recommend either adding CBT or switching to another SRI. Thus, combined CBT and medication is the experts' preference for most patients who have not responded to an initial trial of either CBT or medication alone. In patients who have shown no response to combined treatment, the experts recommend switching SRIs and continuing CBT. In patients with a partial response to combination therapy, they recommend switching SRIs, providing more CBT, and possibly augmenting with another medication.

(*bold italics* = treatment of choice**)**

	Inadequate Response to CBT only		**Inadequate Response to SRI alone**		**Inadequate Response to Combined CBT/SRI**	
	No response	Partial response	No response	Partial response	No response	Partial response
First line	***Add SRI***	***Add SRI*** New CBT technique or intensity	***Add CBT*** Switch SRIs	***Add CBT*** Switch SRIs	Switch SRIs	Switch SRIs New CBT technique or intensity Augment meds

Second line	New CBT technique* or intensity† New CBT setting‡ or format§	New CBT setting or format	Augment meds§§ New CBT setting or format	Augment meds New CBT setting or format	Augment meds New CBT technique or intensity New CBT setting or format	New CBT setting or format

***New CBT technique: e.g., satiation, thought stopping, habit reversal, relaxation**

†New CBT intensity: additional CBT sessions or intensive CBT

‡New CBT setting: e.g., using a partial hospital or inpatient behavioral unit to conduct therapist-assisted E/RP

§New CBT format: e.g., family or group therapy

§§For details on specific augmentation strategies, see Guideline 5.

Editorial Comment: While the experts find the average efficacy of the five SRIs to be equal, individual patients may respond better to one SRI than another, so that sequential trials are necessary in patients who have not responded to any single SRI.

4B. When to Rethink Your Strategy If the Patient Is Having an Inadequate Response

Summary: The following table provides suggestions about how to time changes in treatment for patients who are having an inadequate response to the previous intervention.

Current Treatment Status	No Response	Partial Response
When to add medication for a patient who has started with CBT alone	For more severe OCD, give weekly CBT for 2 weeks before adding medication For milder OCD, give	For more severe OCD, give weekly CBT for 4 weeks before adding medication For milder OCD, give

	weekly CBT for 4 weeks before adding medication	weekly CBT for 7 weeks before adding medication
When to add CBT for a patient who has started with medication alone*	Try medication alone for 4–8 weeks before adding CBT	Try medication alone for 4–8 weeks before adding CBT
If the patient prefers to stay on CBT alone but has inadequate response after 6 sessions	Try 3–6 additional sessions	Try 4–10 additional sessions
If the patient has failed trials of 2–3 SSRIs	Consider a trial of clomipramine	Consider a trial of clomipramine

*** Editors' recommendation.**

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Guideline 5: Strategies for the Treatment-Refractory Patient

Summary: The experts have somewhat less agreement about what to do next in managing treatment-refractory patients (those who fail to respond to well-delivered sequential SRI trials combined with expert CBT). They recommend adding an augmenting medication, especially if the patient exhibits associated features (e.g., tics or a comorbid anxiety disorder) that might predict a positive response to augmentation. Second line recommendations are to try a new CBT setting, technique, or intensity, or to switch to another SRI or an MAOI. Finally, in patients with extremely severe and nonremitting OCD, IV clomipramine, neurosurgery,(internal capsulotomy) or ECT (if the patient is also depressed) may sometimes be considered.

	No response to CBT plus 3 SRIs trials ,*	**Partial response to CBT plus 3 SRI trials,***
First line	Augment with another medication	Augment with another medication
Second line	New CBT setting or format	New CBT setting or format

	New CBT technique or intensity Switch to another SRI Switch to MAOI	New CBT technique or intensity Switch to another SRI Switch to MAOI
Infrequently needed, but sometimes life saving interventions	Try IV clomipramine ECT if also depressed Neurosurgery	Try IV clomipramine

* Assumes one of the trials was clomipramine

Further recommendations:

There are a variety of augmentation strategies that can be tried in OCD, including clomipramine, clonazepam, conventional neuroleptics, buspirone, risperidone, and a second SSRI added to the first one. The editors suggest tailoring the choice of augmentation medications to the individual clinical presentation. Clomipramine may be useful in boosting the response of a patient treated with an SSRI who is not having an adequate response. Neuroleptics may be helpful for patients who are not having an adequate response to an SRI and who have a comorbid tic disorder; OCD symptoms such as compulsive touching that resemble tics; or comorbid schizotypy. Clonazepam may be a helpful augmentation agent for patients with a comorbid anxiety disorder.

While little empirical documentation exists, case studies and open trials support the same augmentation strategies for pediatric as for adult patients.

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Guideline 6: Treatment Strategies for the Maintenance

Phase

Summary: Once patients have responded to the acute phase of treatment for OCD, it is important to consolidate treatment gains during the maintenance phase. The experts recommend monthly follow-up visits for at least 3–6 months and consider rapid discontinuation of medications unacceptable. Booster CBT sessions may help reduce the risk of relapse when medication is withdrawn. The experts recommend considering long-term or lifelong prophylactic maintenance medication after two to four severe relapses or three to four mild to moderate relapses.

(***bold italics*** = treatment of choice)

	Visit schedule for first 3–6 months after acute treatment	**When to consider medication taper**	**How to discontinue medications**	**Long-term prophylactic maintenance medication**
Recommendations	Monthly visits	Not before 1–2 years	Gradual* with monthly follow up	After 2–4 severe relapses After 3–4 mild to moderate relapses
Also consider	Weekly visits Quarterly visits		Gradual* with monthly CBT booster sessions Medication visit only	

*We defined *gradual discontinuation* as decreasing the medication by 25% and waiting 2 months before again decreasing the medication, depending on patient response.

Further recommendation: The experts' replies reflect a tendency to recommend continuing medication for longer periods in patients who are not receiving CBT, probably reflecting the higher probability of relapse in patients withdrawn from medication who have not also received CBT.

Editorial Comments:

When patients are stable but still clinically symptomatic, they may be seen for medication maintenance or CBT booster sessions every 3

months, while patients in remission are seen yearly. Because, OCD is a lifetime waxing and waning condition, most OCD experts never end treatment, but leave the option open to return if OCD recurs.

Relapse prevention, including generalization training and booster sessions, especially when withdrawing medication, may increase the durability of CBT.

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Guideline 7: Minimizing Medication Side Effects

Summary: Since the overall efficacy of the different SRIs* is on average equal, tailoring the side effect profile to the patient's needs and preferences is an important way of selecting among them. The experts' ratings indicate that they believe that side effects differ most dramatically between the four SSRIs as a group and the tricyclic antidepressant, clomipramine (CMI), and that the SSRIs are generally better tolerated than CMI. Within the group of SSRIs, some side effects are more or less prominent with specific drugs (See Survey Question 18, p. **XX**).†

Problematic Side Effect‡	**Drug(s) Less Likely to Cause**	**Drug(s) More Likely to Cause**
Cardiovascular	SSRIs	Clomipramine
Sedation	SSRIs	Clomipramine
Insomnia	Clomipramine	SSRIs
Anticholinergic	SSRIs	Clomipramine
Weight gain	SSRIs	Clomipramine
Sexual	SSRIs (but still common)	Clomipramine

Akathisia	Clomipramine	SSRIs
Nausea/Diarrhea	Clomipramine	SSRIs

***SRI (serotonin reuptake inhibitor) refers to the five compounds clomipramine, fluoxetine, fluvoxamine, paroxetine, and sertraline; SSRI (selective SRI) refers to all but clomipramine.**

†Fluoxetine, which has a much longer half-life than the other SSRIs, may cause fewer withdrawal symptoms when the medication is stopped, but side effects and the risk of drug interactions may persist for a somewhat longer period of time.

‡Editors' comment: Side effects are usually dose and time dependent. More severe side effects are associated with larger doses and faster dosage increases involving a shorter time to maximum dose. Tolerance often develops over 6–8 weeks. Tolerance may be more likely to occur with some side effects (e.g., nausea) but not with other side effects (e.g., akathisia) of the SSRIs. Tolerance is less likely to occur with tricyclic side effects (e.g., postural hypotension; anticholinergic side effects).

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Guideline 8: Treatment of OCD Complicated by Comorbid Psychiatric Illness

Summary: Treatment of OCD is often complicated by the presence of other psychiatric disorders. Some comorbid disorders (e.g., tic or schizophreniform disorder) indicate the need for an additional treatment (e.g., a neuroleptic) that is augmentative for the OCD in addition to being a primary therapy for the comorbid disorder. In other cases, the treatments (e.g., stimulants for ADHD) target altogether different symptoms. The experts generally recommend parsimoniously combining treatments that are appropriate for the OCD and/or for the comorbid conditions. Therefore, in the table below, the term CBT includes cognitive-behavioral treatment for OCD as well as CBT elements appropriate for the comorbid conditions.

Comorbid disorder	First line	Second line
Panic disorder or social phobia	CBT + SSRI CBT alone	CBT + clomipramine CBT + SRI + BZD* CBT + MAOI +/- BZD
Depression	CBT + SRI	CBT alone CBT + MAOI CBT + SRI + BZD
Bipolar I or II (in remission on mood stabilizer alone)	CBT + mood stabilizer CBT + mood stabilizer + SRI	SRI + mood stabilizer
Schizophrenia	SRI + neuroleptic	CBT + SRI + neuroleptic
Tourette's Syndrome	CBT + SRI + conventional antipsychotic	CBT + SRI + risperidone or a -2 agonist CBT + SRI CBT alone
Attention-Deficit/Hyperactivity Disorder	CBT + SSRI + psychostimulant	CBT + clomipramine + psychostimulant CBT + SRI CBT alone
Disruptive Behaviors	SRI + CBT + family therapy SSRI + CBT	CBT + family therapy Clomipramine + CBT SSRI Clomipramine CBT alone

*BZD = benzodiazepine

Further recommendations:

In milder depressions, the experts recommend beginning with CBT/MED or MED alone. In more severe depressions,

the experts usually start with MED, although CBT/MED is also first line. In neither case do the experts recommend beginning with CBT alone.

When combining treatments, consider the impact of the comorbid condition. For example, the stage of illness (e.g., acute mania or schizophrenic psychosis) may make treatments for OCD unfeasible (CBT) or risky (an SRI).†

Remember that combining medications may dramatically increase the risk for drug-drug interactions. †

†Editors' recommendations

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Guideline 9: Treatment of OCD Complicated by Pregnancy or Comorbid Medical Illness

Summary: The experts recommend attempting to use CBT alone for patients with OCD who are pregnant or who also have medical complications, such as heart or renal disease, since the risk of drug therapy may outweigh the risk of the disorder in these cases. When the risk of OCD begins to rival the risk of the medical condition (e.g., a pregnant mother who will not eat because of contamination fears), then combined CBT and medication may become necessary.

(***bold italics*** = treatment of choice)

	Pregnancy	**Heart Disease**	**Renal Failure**
First line	***CBT alone***	CBT alone CBT + SSRI	***CBT alone*** CBT + SSRI
Second line	CBT + SRI	SSRI	SSRI

Further recommendations:

It is important to consider the potential for drug-drug interactions when choosing an SRI.*

The increased risk of cardiovascular side effects with CMI

as contrasted to the negligible risk with the SSRIs suggests that serial SSRI trials be conducted first in patients with heart disease.*

***Editors' recommendation**

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Guideline 10: Pharmacotherapy for OCD "Spectrum" Conditions

Summary: A variety of disorders share features with OCD and have been considered to be possible OCD spectrum disorders. There is, however, considerable disagreement regarding the extent to which patients with these disorders respond to treatments that are effective for OCD. Consistent with recent literature on this topic, the experts consider pharmacotherapy with an SRI to be a first line treatment only for body dysmorphic disorder and bulimia. The indications for most of these conditions must be considered highly preliminary since supporting data are limited.

	Responsiveness to SRI pharmacotherapy (listed in order of decreasing responsiveness)
First Line	Body Dysmorphic Disorder Bulimia
Second Line	Trichotillomania Hypochondriasis Picking skin Anorexia Self-mutilation Paraphilias Other impulse control disorders Gambling

	Shoplifting

Editorial comments:

When the spectrum disorders listed above are comorbid with OCD, they should be treated with interventions that are appropriate for the specific disorder at the same time as treatment for OCD is also being implemented.

Disorders that are substantially aversive (e.g., tinged with negative affects) are more likely to respond to an SRI than disorders that involve substantial reward such as the paraphilias or gambling.

Just as disorders that more closely resemble OCD are more likely to respond to SRI medication, they are also more likely to respond to E/RP and CT. Disorders such as trichotillomania and skin picking usually do best with habit reversal. Impulse control disorders, such as pathological gambling, do best with support groups and contingency management.

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Web site by David Ross, Ross Editorial Services, 5/17/97