General

Guideline Title

Practice guideline for the treatment of patients with obsessive-compulsive disorder.

Bibliographic Source(s)

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]

Guideline Status

This is the current release of the guideline.

The American Psychiatric Association reaffirmed the currency of the guideline in 2012.

Regulatory Alert

FDA Warning/Regulatory Alert

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- August 31, 2016 – Opioid pain and cough medicines combined with benzodiazepines : A U.S. Food and Drug Administration (FDA) review has found that the growing combined used of opioid medicines with benzodiazepines or other drugs that depress the central nervous system (CNS) has resulted in serious side effects, including slowed or difficult breathing and deaths. FDA is adding Boxed Warnings to the drug labeling of prescription opioid pain and prescription opioid cough medicines and benzodiazepines.

Recommendations

Major Recommendations

Each recommendation is identified as meriting one of three categories of endorsement, based on the level of clinical confidence regarding the recommendation, as indicated by a bracketed Roman numeral following the statement. Definitions of the categories of endorsement are presented at the end of the "Major Recommendations" field.

Psychiatric Management

Obsessive-compulsive disorder (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 [I]. 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 [I]. It is important to coordinate the patient's care with physicians treating co-occurring medical conditions, other clinicians, and social agencies such as schools and vocational rehabilitation programs [I]. 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 [I]. 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 [I].

Establishing a Therapeutic Alliance

Establishing and maintaining a strong therapeutic alliance is important so that treatment may be jointly, and therefore more effectively, planned and implemented [I]. 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 [I]. 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) [I]. 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 [I].

Assessing the Patient's Symptoms

In assessing the patient's symptoms with the aim of establishing a diagnosis using Diagnostic and Statistical Manual of Mental Disorders, Text Revision IV (DSM-IV-TR) criteria, it is important to differentiate the obsessions, compulsions, and rituals of OCD from similar symptoms found in other disorders, including depressive ruminations, the worries of generalized anxiety disorder, the intrusive thoughts and images of posttraumatic stress disorder, and schizophrenic and manic delusions [I].

Using Rating Scales

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]. Scales may also be utilized to rate other symptoms, such as depression or degree of disability.

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 details on the nature, extent, and response to all trials) [I].

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 [I]. In addition, the psychiatrist should evaluate how OCD has interfered with academic and vocational achievement as well as familial, social, and sexual relationships [I]. 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 [I].

The psychiatrist should consider whether the OCD is a manifestation of a general medical condition [I]; document current medical conditions, relevant hospitalizations, and any history of head trauma, loss of consciousness, or seizures [I]; and record the presence and severity of somatic or psychological symptoms that could be confused with medication side effects [I]. 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 [I]. Allergies or sensitivities to medications should be recorded [I]. 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 [I].

Establishing Goals for Treatment

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 [I]. 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 [I].

Establishing the Appropriate Setting for Treatment

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 [I].

Enhancing Treatment Adherence

To enhance treatment adherence, the psychiatrist should consider factors related to the illness, the patient, the physician, the patient-physician relationship, the treatment, and the social or environmental milieu [I]. 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 [II]. Many patients with OCD benefit from educational materials and access to support groups provided by the Obsessive Compulsive Foundation (www.ocfoundation.org). 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 [II]. 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 [I]. In describing cognitive-behavioral therapy (CBT), it is helpful to advise that it involves confronting feared thoughts and situations, though at a tolerable rate [I]. 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 [II].

Choosing an Initial Treatment Modality

In choosing a treatment approach, the clinician should consider the patient's motivation and ability to comply with pharmacotherapy and psychotherapy [I]. CBT and serotonin reuptake inhibitors (SRIs) are recommended as safe and effective first-line treatments for OCD [I]. 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 exposure and response prevention, 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 [II]. 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 [II]. Combined

treatment should be considered for patients with an unsatisfactory response to monotherapy [II], for those with co-occurring psychiatric conditions for which SRIs are effective [I], and for those who wish to limit the duration of SRI treatment [II]. In the latter instance, uncontrolled follow-up studies suggest that CBT may delay or mitigate relapse when SRI treatment is discontinued [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 [II].

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 [I].

Choosing a Specific Pharmacological Treatment

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 [I]. 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 selective serotonin reuptake inhibitors (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 [I]. 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 conditions [I].

Choosing a Specific Form of Psychotherapy

CBT that relies primarily on behavioral techniques such as exposure and response prevention (ERP) is recommended because it has the best evidentiary support [I]. Some data support the use of CBT that focuses on cognitive techniques [II]. 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) [III]. It may also be useful in addressing the interpersonal consequences of the OCD symptoms [II]. Motivational interviewing may also help overcome resistance to treatment [III]. Family therapy may reduce inter-family tensions that are exacerbating the patient's symptoms or ameliorate the family's collusion with symptoms [III].

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 1.h [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 [II], switching to another SSRI [II], or adding a pharmacological agent such as bupropion [II].

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 [I].

Implementing Cognitive-Behavioral Therapies

Cognitive-behavioral therapies 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 [I]. Five ERP sessions per week may be more effective than once-weekly sessions but are not necessarily more effective than twice-weekly sessions [II]. The number of treatment sessions, their length, and the duration of an adequate trial have not been established, but expert consensus recommends 13 to 20 weekly sessions for most patients [I]. 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 [II]. 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 [III] (see the Appendix in the original guideline document).

Changing Treatments and Pursuing Sequential Treatment Trials

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 [I]. 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 [I].

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 [I].

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 [II]. 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 [II]. Combined SRI and CBT treatment may be provided when the patient has a co-occurring disorder that is SRI-responsive [I] or has a partial response to monotherapy [II]. Combined SRI and CBT treatment may also reduce the chance of relapse when medication is discontinued [II]. Another option in the case of 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], monoamine oxidase inhibitors (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 [II]. 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 [III].

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.

Definitions:

[I] Recommended with substantial clinical confidence.

[II] Recommended with moderate clinical confidence.

[III] May be recommended on the basis of individual circumstances.

Clinical Algorithm(s)

A clinical algorithm is provided in the original guideline document for the treatment of patients with obsessive-compulsive disorder.

Scope

Disease/Condition(s)

Obsessive-compulsive disorder

Guideline Category

Evaluation

Treatment

Clinical Specialty

Psychiatry

Intended Users

Physicians

Guideline Objective(s)

To provide recommendations for the treatment of patients with obsessive-compulsive disorder

Target Population

Adult patients with obsessive-compulsive disorder

Interventions and Practices Considered

Evaluation/Management

Psychiatric evaluation and management including the following:

- Establish a therapeutic alliance by tailoring communication and allowing extra time and repetition
- Assess the patient's symptoms using the Diagnostic and Statistical Manual of Mental Disorders, Text Revision IV (DSM-IV-TR)

Consider rating severity of symptoms and co-occurring conditions using the Yale-Brown Obsessive Compulsive Scale (Y-BOCS), documenting hours with compulsive behavior, or recording actively avoided items/areas
Evaluate and enhance the safety of the patient and others (e.g., assess potential for self-injury, suicide, and aggressive behavior)
Perform complete psychiatric and medical assessment
Establish treatment goals
Establish appropriate setting for treatment
Enhance treatment adherence

Treatment

Consideration of patient's motivation and ability to comply with pharmacotherapy and psychotherapy in developing treatment plan
Pharmacotherapy
Selective serotonin reuptake inhibitors (SSRIs), including fluoxetine, fluvoxamine, paroxetine, sertraline
Clomipramine
Other anti-depressants, including venlafaxine, mirtazapine
Other medications, including antipsychotics, morphine sulfate, buspirone, pindolol, riluzole, D-amphetamines, tramadol, monoamine oxidase inhibitors (MAOIs), ondansetron

Psychotherapy
Cognitive behavioral therapy (CBT), including exposure and response prevention (ERP)
Psychodynamic psychotherapy
Motivational interviewing
Combination therapy
Other therapies, including transcranial magnetic stimulation (TMS), deep brain stimulation, intensive residential treatment, partial hospitalization, ablative neurosurgery
Implement a treatment plan including appropriate dosing of pharmacotherapy, strategies to manage side effects, scheduling of cognitive-behavioral therapy, changing treatments, and sequential treatments therapy
Discontinuing active treatment

Major Outcomes Considered

Symptoms of obsessive-compulsive disorder
Resistance to treatment
Response and remission rates
Degree of functioning vs. disability
Quality of life

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

2007 Guideline

Relevant literature was identified through a MEDLINE literature search using PubMed for articles published between 1966 and December 2004, using the keywords ("Obsessive-Compulsive Disorder"[Medical Subject Heading (MeSH)] OR "Compulsive Behavior"[MeSH]) OR ("obsession"[All Fields] OR "obsessional"[All Fields] OR "obsessions"[All Fields] OR "obsessive"[All Fields]) OR ("compulsion"[All Fields] OR "compulsions"[All Fields] OR "compulsive"[All Fields]). This search yielded 13,182 references, of which 10,756 were in the English language and had abstracts. Additional, less formal literature searches were conducted by American Psychiatric Association (APA) staff and individual members of the Work Group on Obsessive-Compulsive Disorder. The Cochrane databases were also searched for relevant meta-analyses.

2012 Reaffirmation

Relevant literature was identified through a computerized search of MEDLINE, using PubMed, for the period from 2004 to 2012, using the same terms and parameters that were used for the literature search performed for the 2007 guideline, except that the present search was limited to randomized controlled trials and meta-analyses. The search returned 958 articles, which were screened by two separate raters for relevance: 722 articles were excluded, and 236 articles were included for review by the expert committee.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus (Committee)

Rating Scheme for the Strength of the Evidence

Not applicable

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

This practice guideline was developed under the auspices of the Steering Committee on Practice Guidelines. The development process is detailed in "American Psychiatric Association (APA) Guideline Development Process," which is available from the APA Department of Quality Improvement and Psychiatric Services. The key features of this process with regard to this document include the following:

- A comprehensive literature review to identify all relevant randomized clinical trials as well as less rigorously designed clinical trials and case series when evidence from randomized trials was unavailable
- The development of evidence tables that summarized the key features of each identified study, including funding source, study design, sample sizes, subject characteristics, treatment characteristics, and treatment outcomes
- Initial drafting of the guideline by a work group that included psychiatrists with clinical and research expertise in obsessive-compulsive disorders
- The production of multiple revised drafts with widespread review (11 organizations and 68 individuals submitted significant comments)
- Approval by the APA Assembly and Board of Trustees
- Planned revisions at regular intervals

2012 Reaffirmation

The original authors of the 2007 guideline reviewed results of the literature search in relation to the recommendations of the 2007 guideline, evaluated the currency of those recommendations, and are in the process of writing a brief review of important studies.

Rating Scheme for the Strength of the Recommendations

Each recommendation is identified as meriting one of three categories of endorsement, based on the level of clinical confidence regarding the recommendation, as indicated by a bracketed Roman numeral following the statement. The three categories are as follows:

[I] Recommended with substantial clinical confidence

[II] Recommended with moderate clinical confidence

[III] May be recommended on the basis of individual circumstances

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Iterative guideline drafts are reviewed by the Steering Committee, other experts, allied organizations, American Psychiatric Association (APA) members, and the APA Assembly and Board of Trustees; substantial revisions address or integrate the comments of these multiple reviewers.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated.

The evidence base for practice guidelines is derived from two sources: research studies and clinical consensus. Where gaps exist in the research data, evidence is derived from clinical consensus, obtained through extensive review of multiple drafts of each guideline. In addition, each reference at the end of the original guideline document is followed by a letter code in brackets that indicates the nature of the supporting evidence, as follows:

> [A] *Double-blind, randomized clinical trial*. 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.
> [A-] *Randomized clinical trial*. Same as above but not double-blind.
> [B] *Clinical trial*. 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.
> [C] *Cohort or longitudinal study*. A study in which subjects are prospectively followed over time without any specific intervention.
> [D] *Case-control study*. A study in which a group of patients is identified in the present and information about them is pursued retrospectively or backward in time.
> [E] *Review with secondary data analysis*. A structured analytic review of existing data, e.g., a meta-analysis or a decision analysis.
> [F] *Review*. A qualitative review and discussion of previously published literature without a quantitative synthesis of the data.
> [G] *Other*. Textbooks, expert opinion, case reports, and other reports not included above.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate treatment of obsessive-compulsive disorder

Potential Harms

The most common side effects of the selective serotonin reuptake inhibitors (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.

Concerns have been raised about the potential for increases in self-harming or suicidal behaviors in individuals treated with antidepressant medications, including serotonin reuptake inhibitors (SRIs).

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.

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 patients treated with clomipramine at a dose of up to 300 mg/day for as many as 6 years).

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.

The side-effect burden of monoamine oxidase inhibitors (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

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

Side effects of cingulotomy include memory disturbance, apathy, urinary disturbances, headache, insomnia, and weight gain/loss

Contraindications

Contraindications

Morphine sulfate should be avoided in patients with contraindications to opiate administration, including a history of substance or prescription medication abuse, psychosis, mania, antisocial personality disorder, chronic obstructive pulmonary disease, or cardiovascular compromise.

Qualifying Statements

Qualifying Statements

The American Psychiatric Association (APA) Practice Guidelines 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 interpreted 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.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Clinical Algorithm

Mobile Device Resources

Quick Reference Guides/Physician Guides

Staff Training/Competency Material

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Identifying Information and Availability

Bibliographic Source(s)

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Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2007 (reaffirmed 2012)

Guideline Developer(s)

American Psychiatric Association - Medical Specialty Society

Source(s) of Funding

American Psychiatric Association (APA)

Guideline Committee

Work Group on Obsessive-Compulsive Disorder
Steering Committee on Practice Guidelines

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

Dr. Koran has received research grants from Forest Pharmaceuticals, Pfizer, Eli Lilly, Ortho-McNeil, Somaxon, and Jazz Pharmaceuticals. He has received honoraria from the Forest Pharmaceuticals Speakers Bureau and the Pfizer Speakers Bureau. He has received consultant fees from Cypress Bioscience. Dr. Hanna reports no competing interests. Dr. Hollander has received research grants from the National Institute of Mental Health, the National Institute of Neurological Disorders and Stroke, the National Institute on Drug Abuse, the Office of Orphan Products Development of the U.S. Food and Drug Administration, Pfizer, GlaxoSmithKline, Wyeth, Eli Lilly, Janssen, and Abbott. He has served on advisory boards for Forest Pharmaceuticals, Abbott, and Somaxon. Dr. Nestadt reports no competing interests. Dr. Simpson reports no competing interests. The Executive Committee on Practice Guidelines has reviewed this guideline and found no evidence of influence from these relationships.

Guideline Status

This is the current release of the guideline.

The American Psychiatric Association reaffirmed the currency of the guideline in 2012.

Guideline Availability

Electronic copies: Available from the American Psychiatric Association's Web site .

Print copies: Available from the American Psychiatric Press, Inc (APPI), 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901; (703) 907-7322; (800) 368-5777; Fax (703) 907-1091.

Availability of Companion Documents

The following are available:

- Treating obsessive-compulsive disorder. Quick reference guide. Arlington, VA: American Psychiatric Association; 2007 Jul. Available from the American Psychiatric Association (APA) Web site .
- American Psychiatric Association practice guideline development process. Arlington (VA): American Psychiatric Association. 2004; Available from the APA Web site . Also available in a PDA version.
- Koran LM, Simpson HB. Guideline watch (March 2013): practice guideline for the treatment of patients with obsessive-compulsive disorder. Arlington (VA): American Psychiatric Association; 2013 Mar. 22 p. Available from the APA Web site .

Print copies: Available from the American Psychiatric Press, Inc (APPI), 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901; (703) 907-7322; (800) 368-5777; fax (703) 907-1091

Additionally, a continuing medical education (CME) course is available online at the APA Web site .

Patient Resources

None available

NGC Status

This summary was completed by ECRI Institute on October 1, 2007. The information was verified by the guideline developer on October 31, 2007. This summary was updated by ECRI Institute on July 20, 2009 following the U.S. Food and Drug Administration advisory on Varenicline and Bupropion. This summary was updated by ECRI Institute on July 20, 2010 following the U.S. Food and Drug Administration advisory on Ultram (tramadol hydrochloride), Ultracet (tramadol hydrochloride/acetaminophen). This summary was updated by ECRI Institute on May 20, 2011 following the U.S. Food and Drug Administration advisory on antipsychotic drugs. This summary was updated by ECRI Institute on September 12, 2011 following the U.S. Food and Drug Administration advisory on Celexa (citalopram hydrobromide). This summary was updated by ECRI Institute on November 22, 2011 following the U.S. Food and Drug Administration (FDA) advisory on Zofran (ondansetron). This summary was updated by ECRI Institute on April 16, 2012 following the updated U.S. Food and Drug Administration advisory on Celexa (citalopram hydrobromide). This summary was updated by ECRI Institute on September 10, 2012 following the U.S. Food and Drug Administration advisory on Ondansetron (Zofran). The currency of the guideline was reaffirmed by the developer in 2012 and this summary was updated by ECRI Institute on October 16, 2012. This summary was updated by ECRI Institute on December 12, 2012 following the U.S. Food and Drug Administration advisory on Ondansetron (Zofran). This summary was updated by ECRI Institute on May 24, 2016 following the U.S. Food and Drug Administration advisory on Olanzapine. This summary was updated by ECRI Institute on June 1, 2016 following the U.S. Food and Drug Administration advisory on opioid pain medicines. This summary was updated by ECRI Institute on October 21, 2016 following the U.S. Food and Drug Administration advisory on opioid pain and cough medicines combined with benzodiazepines.

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