OCD Treatment Guidelines

These guidelines are intended to be used for informational purposes only and should not be used as a substitute for professional psychological advice, diagnosis, or treatment. Always cross-reference to established clinical standards.

Psychiatric management

Establish a therapeutic alliance.

The therapeutic alliance allows the psychiatrist to obtain the information needed to plan effective treatment. The alliance allows the patient to trust the physician and helps motivate adherence to collaboratively planned treatment.

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Assess the patient's symptoms.

The psychiatrist should assess the patient for symptoms of OCD, guided by the diagnostic criteria of DSM-IV-TR.

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Consider rating the severity of OCD and co-occurring symptoms and their effects on the patient's functioning.

Use of the Y-BOCS Symptom Checklist (10), which allows the recording of current and past symptoms, or the 18-item Obsessive-Compulsive Inventory (11) may be helpful. These scales may help document both the variety and the clustering of the patient's symptoms.

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Enhance the safety of the patient and others.

In individuals with OCD, as with all psychiatric patients, assessing the risk for suicide and self-injurious behavior, as well as the risk for harm to others, is crucial. Collateral information from family members or others can be helpful in assessing such risks.

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Complete the psychiatric assessment.

In completing the psychiatric assessment, the psychiatrist will usually include the elements of the adult general psychiatric evaluation as described in APA's Practice Guideline for the Psychiatric Evaluation of Adults, 2nd edition (26).

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Establish goals for treatment.

Marked clinical improvement, recovery, and full remission, if they occur, do not occur rapidly. Thus, persistent 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 (in family, social, work/school, home, parental, and leisure domains).

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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.

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Enhance treatment adherence.

Factors influencing adherence can be thought of as related to the illness, the patient, the physician, the patient-physician relationship, the treatment, and the social or environmental milieu.

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Provide education to the patient and, when appropriate, to the family.

Patients often have little knowledge of the nature, biology, course, and treatment of their disorders. Those with childhood onset of OCD may confuse symptoms with aspects of their innate selves.

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Coordinate the patient's care with other providers of care and social agencies.

The psychiatrist should coordinate the patient's care with physicians treating co-occurring medical conditions, with other clinicians, and with social agencies such as schools and vocational rehabilitation programs.

Acute phase

Choosing an initial treatment modality.

CBT and SRIs are recommended on the basis of clinical trial results as safe and effective first-line treatments for OCD. SRIs include clomipramine and all of the SSRIs. Whether to recommend a form of CBT, an SRI, or combined treatment will depend on a number of factors.

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Choosing a specific pharmacological treatment.

Clomipramine, fluoxetine, fluvoxamine, paroxetine, and sertraline, which are approved by the FDA for treatment of OCD, are recommended pharmacological agents.

1. Implementing pharmacotherapy
2. Managing medication side effects

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Choosing a specific form of psychotherapy.

CBT is the only form of psychotherapy for OCD whose effectiveness is supported by controlled trials. There are no controlled studies that demonstrate effectiveness of dynamic psychotherapy or psychoanalysis in dealing with the core symptoms of OCD.

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Implementing cognitive-behavioral therapies.

Cognitive-behavioral therapies have been delivered in individual, group (132–134), and family therapy sessions, with session length varying from less than 1 hour to 2 hours.

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Monitoring the patient's psychiatric status.

The frequency of follow-up visits after a new pharmacotherapy is initiated may vary from a few days to 2 weeks. The indicated frequency of visits 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.

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Determining when and whether to change treatments.

The physician's goals are always to reduce suffering and disability while minimizing the adverse effects of treatment. First treatments rarely produce freedom from all OCD symptoms.

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Pursuing sequential treatment trials.

When the patient has an inadequate response to the initial treatment and no interfering factor can be identified, the psychiatrist and patient must decide on next treatment steps without the benefit of data from controlled trials comparing all the possibilities.

Discontinuation of active treatment

Successful medication treatment should be continued for 1–2 years before considering a gradual taper by decrements of 10%–25% every 1–2 months while observing for symptom return or exacerbation. Successful ERP should be followed by monthly booster sessions for 3–6 months, or more intensively if response has been only partial.

Reference

American Psychiatric Association (2010). Practice guideline for the treatment of patients with obsessive-compulsive disorder. https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/ocd-1410197738287.pdf