OCD Treatment Guidelines

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

- SRIs include clomipramine and all of the selective serotonin reup- take 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 ritu- als and relief from distress.
- Cognitive techniques such as identifying, challenging, and modify- ing 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.

Reference

Koran, L. M., Hanna, G. L., Hollander, E., Nestadt, G., & Simpson, H. B. (2007). Practice guideline for the treatment of patients with obsessive-compulsive disorder. American Journal of Psychiatry. https://read.qxmd.com/journal/20277