PRACTICE GUIDELINE FOR THE
Treatment of Patients With Obsessive-Compulsive Disorder

WORK GROUP ON OBSESSIVE-COMPULSIVE DISORDER

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STATEMENT OF INTENT

The 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.

This practice guideline has been developed by psychiatrists who are in active clinical practice. In addition, some contributors are primarily involved in research or other academic endeavors. It is possible that through such activities some contributors, including work group members and reviewers, have received income related to treatments discussed in this guideline. A number of mechanisms are in place to minimize the potential for producing biased recommendations due to conflicts of interest. Work group members are selected on the basis of their expertise and integrity. Any work group member or reviewer who has a potential conflict of interest that may bias (or appear to bias) his or her work is asked to disclose this to the Steering Committee on Practice Guidelines and the work group. Iterative guideline drafts are reviewed by the Steering Committee, other experts, allied organizations, APA members, and the APA Assembly and Board of Trustees; substantial revisions address or integrate the comments of these multiple reviewers. The development of the APA practice guidelines is not financially supported by any commercial organization.

More detail about mechanisms in place to minimize bias is provided in a document available from the APA Department of Quality Improvement and Psychiatric Services, "APA Guideline Development Process."

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GUIDE TO USING THIS PRACTICE GUIDELINE

The *Practice Guideline for the Treatment of Patients With Obsessive-Compulsive Disorder* consists of three parts (Parts A, B, and C) and many sections, not all of which will be equally useful for all readers. The following guide is designed to help readers find the sections that will be most useful to them.

Part A, "Treatment Recommendations," is published as a supplement to the *American Journal of Psychiatry* and contains general and specific treatment recommendations. Section I summarizes the key recommendations of the guideline and codes each recommendation according to the degree of clinical confidence with which the recommendation is made. Section II is a guide to the formulation and implementation of a treatment plan for the individual patient. Section III, "Specific Clinical Features Influencing the Treatment Plan," discusses a range of clinical considerations that could alter the general recommendations discussed in Section I.

Part B, "Background Information and Review of Available Evidence," and Part C, "Future Research Needs," are not included in the *American Journal of Psychiatry* supplement but are provided with Part A in the complete guideline, which is available in print format from American Psychiatric Publishing, Inc., and online through the American Psychiatric Association (http://www.psych. org). Part B provides an overview of obsessive-compulsive disorder (OCD), including general information on natural history, course, and epidemiology. It also provides a structured review and synthesis of the evidence that underlies the recommendations made in Part A. Part C draws from the previous sections and summarizes areas for which more research data are needed to guide clinical decisions.

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DEVELOPMENT PROCESS

This practice guideline was developed under the auspices of the Steering Committee on Practice Guidelines. The development process is detailed in "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 disorder
- 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

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"[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 APA staff and individual members of the Work Group on Obsessive-Compulsive Disorder. The Cochrane databases were also searched for relevant meta-analyses.

The summary of treatment recommendations is keyed according to the level of confidence with which each recommendation is made (indicated by a bracketed Roman numeral). In addition, each reference is followed by a bracketed letter that indicates the nature of the supporting evidence.

Part A

TREATMENT RECOMMENDATIONS

I. EXECUTIVE SUMMARY

A. CODING SYSTEM

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

B. EXECUTIVE SUMMARY

1. 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].

a. 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].

b. Assessing the Patient's Symptoms

In assessing the patient's symptoms with the aim of establishing a diagnosis using 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].

c. 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.

d. 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].

e. 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].

f. 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].

g. 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].

h. 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].

2. 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].

3. 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].

4. 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].

5. 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 I.B.1.h [I].

a. 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 4–6 weeks after starting medication, and some who will ultimately respond will experience little improvement for as many as 10–12 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].

b. 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 13–20 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 Appendix).

c. Changing Treatments and Pursuing Sequential Treatment Trials

First treatments rarely produce freedom from all OCD symptoms. When a good response is not achieved after 13–20 weeks of weekly outpatient CBT, 3 weeks of daily CBT, or 8–12 weeks of SRI treatment (including 4–6 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 aug-

mentation 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].

6. Discontinuing 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 [I]. Successful ERP should be followed by monthly booster sessions for 3–6 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.

II. FORMULATION AND IMPLEMENTATION OF A TREATMENT PLAN

The essential features of OCD identified in DSM-IV-TR are "recurrent obsessions or compulsions (Criterion A) that are severe enough to be time consuming (i.e., they take more than 1 hour a day) or cause marked distress or significant impairment (Criterion C)" (1, pp. 456–457). Obsessions are intrusive, persistent, unwanted thoughts, impulses, or images that give rise to marked anxiety or distress. Compulsions are physical or mental acts that the patient feels driven to perform in order to magically prevent some feared event, to undo some thought, or to reduce anxiety or distress.

Compulsive acts—also known as *rituals*—are carried out repetitively, excessively, and usually according to rules or in a rigid manner. Obsessions may occur spontaneously or be evoked by a feared environmental stimulus or event. Mental compulsions such as counting, praying, or reviewing actions, conversations, or lists are initiated by the patient willfully, with the aim of feeling safer or reducing anxiety or distress.

The most common obsessional themes are fears of being contaminated or spreading contamination, accidentally or purposely harming others, making a significant mistake, committing a religious offense or moral infraction, contracting a disease, and being considered homosexual or committing homosexual or pedophilic acts.

Hoarding, when a symptom of OCD, is not usually feared, though it may be regretted. Individuals with OCD may also obsess about orderliness or symmetry, lucky or unlucky numbers or colors, needing to know or remember, heterosexual acts, or bodily health. Obsessions are often accompanied by a feeling of doubt, uncertainty, or incompleteness that drives repetitive thought or action and are often colored by an inflated estimate of danger, an increased sense of responsibility, or a need for certainty or perfection.

A. PSYCHIATRIC MANAGEMENT

Psychiatric management of OCD is indicated when symptoms interfere with functioning or cause significant distress. Although transient OCD is found in community surveys, OCD seen in clinical practice is usually a chronic illness with a waxing and waning course. With appropriate treatment, OCD symptoms usually improve over weeks or months and may become mild or even subside into remission over months or years. Thus, treatment planning and psychiatric management will be iterative processes adapted to the patient's current status and response to previous interventions.

Psychiatric management encompasses a broad collection of professional actions and interventions designed to benefit the patient. These actions and interventions include providing the following:

- Pharmacotherapy and psychotherapy in the appropriate setting, as indicated by patient preference and clinical judgment;
- Guidance to the patient and involved family members about educational materials that are available in published form and on the Web (see Appendix); and
- Information about local support groups (see Appendix).

Psychiatric management should be offered throughout the course of illness at an intensity consistent with the patient's needs, capacities, and desires. The components of psychiatric management across the stages of illness are described in more detail below.

1. Establish a Therapeutic Alliance

As in all of medicine, the physician first attempts to establish and then to maintain a therapeutic alliance so that the patient's care is a joint endeavor. 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 treatments. It is important to tailor one's communication style to the patient's needs and capacities, along continua from detailed to general, from biologically to psychosocially framed, and from warm to neutral. Explaining symptoms in understandable terms is both encouraging and comforting to patients. The excessive doubting that is characteristic of OCD may require special approaches to building the alliance. For example, the clinician may need to allow the patient more time to consider treatment decisions and may need to repeat explanations (a limited number of times) and at several visits. Increased attention to excessive worry about medication side effects, perfectionism, or checking behaviors may be needed. Treatment of patients with OCD has a potential for transference and/or countertransference issues that may disrupt adherence and the therapeutic alliance. In building the alliance, the psychiatrist should also consider the patient's feelings and actions toward him or her, as well as why the patient has come to him or her specifically, and why at this point in time. What does the patient want and expect? How are these desires and expectations affected by the patient's cultural background, religious background, beliefs about the illness (its cause, effects, and mechanisms), and experience with past treatments?

2. Assess the Patient's Symptoms

The psychiatrist should assess the patient for symptoms of OCD, guided by the diagnostic criteria of DSM-IV-TR (Table 1).

OCD is likely to be underdiagnosed unless specific screening occurs (2). Screening questions might include some of the following: 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, or 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 in social activities?

As part of the assessment, the psychiatrist must differentiate obsessions, compulsions, and rituals from similar symptoms found in other disorders. Unlike obsessions, depressive ruminations are experienced as consistent with one's self-image or values. They often focus on past events but, like obsessions, may concern possible current or future negative events or anticipated failures. The subject matter of depressive ruminations usually concerns self-criticism, failures, guilt, regret, or pessimism regarding the future. Depressive ruminations do not elicit compulsive rituals. The worries of generalized anxiety disorder focus on real life problems and usually do not lead to compulsive rituals, although, as in OCD,

TABLE 1. DSM-IV-TR Diagnostic Criteria for 300.3 Obsessive-Compulsive Disorder

A. Either obsessions or compulsions:

Obsessions as defined by (1), (2), (3), and (4):

(1) recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress
(2) the thoughts, impulses, or images are not simply excessive worries about real-life problems
(3) the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action
(4) the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

Compulsions as defined by (1) and (2):

(1) repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly
(2) the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. **Note:** This does not apply to children.

C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.

D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder).

E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify if:

With Poor Insight: if, for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable.

Source. Reprinted from *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000. Copyright © 2000, American Psychiatric Association.

the sufferer may try to convince himself or herself that the fear is groundless or may check on the safety of loved ones. Generalized anxiety disorder may also present as a vague but troubling feeling of foreboding, whereas the obsessions of OCD always have clear content. The intrusive thoughts and images of posttraumatic stress disorder are replays of actual events, not anticipations of future events. Obsessions held with delusional conviction can be distinguished from schizophrenic and manic delusions by the absence of other signs and symptoms of these disorders. Moreover, delusional obsessions will have typical OCD content rather than content related to persecution, grandiosity, passivity experiences, or ideas of reference.

OCD can be differentiated from hypochondriasis by noting that the hypochondriacal fear or belief regarding serious disease arises from misinterpretation of ordinary bodily signs and symptoms. In OCD such fears arise from external stimuli—for example, a patient fearing he has contracted AIDS because he was served by a waiter wearing a bandage, possibly exposing him to blood. In addition, an individual with hypochondriasis does not have insight into the irrationality of his or her fears and behaviors, whereas some insight is usually present in OCD. In body dysmorphic disorder, the recurrent and intrusive preoccupations are limited to the fear or belief that one has a disturbing physical defect, when in reality the defect is nonexistent or slight. In anorexia nervosa and bulimia nervosa, the intrusive thoughts and irrational behaviors center on weight and its effects on self-evaluation. In contrast to the thoughts and urges of paraphilias, OCD-related sexual obsessions or images (e.g., fears

of homosexuality, images of having sex with a child) lead to avoidance behaviors, are morally abhorrent, and are resisted. Similarly, in OCD, obsessions regarding a sexual partner are experienced as alien to the self and are not accompanied by stalking behavior.

Differentiating urges to harm an infant that occur as postpartum symptoms of OCD from superficially similar symptoms of postpartum depression is critical. The OCD urges are not accompanied by depressed mood and are experienced as inconsistent with one's self, are resisted, or induce efforts to neutralize the urges through other behaviors. Although OCD rituals aimed at avoiding harming the infant may interfere with attachment or normal maternal behaviors and may require treatment, there is little risk of direct harm to the infant. In contrast, the impulses or ideas that arise in postpartum depression may be experienced as justified, may not be strongly resisted, and emerge from depressed mood and other signs and symptoms of major depression. In postpartum depression, taking steps to protect the infant may be necessary (3).

Differentiating compulsions from the complex vocal or motor tics sometimes seen in Tourette's disorder can be difficult. Tics, unlike compulsions, are neither preceded by thoughts nor aimed at relieving anxiety or preventing or undoing an external, undesired event (4). DSM-IV-TR (1, p. 108) defines a tic as "a sudden, rapid, recurrent, nonrhythmic, [and] stereotyped motor movement or vocalization." Tics are often preceded by premonitory sensations such as muscular tension and may involve repeating an action until an unpleasant, localized, physical tension or a sense of incompleteness is relieved (5, 6). Complex motor tics can take the form of arranging, ordering, touching, or making objects symmetrical (5). Repeating an action until "it feels right" (e.g., repeatedly closing a door until the right sound or sensation of closure is achieved) may be a complex tic or a compulsion, or reflect elements of both. Complex tics may be more likely in individuals with a personal or family history of motor or phonic tics; individuals with a history of hypersensitivity to sensations associated with scratchy fabrics, the touch of clothing labels, or to uneven shoelaces or socks; and individuals with co-occurring diagnoses of attention-deficit disorder or learning disorder (5).

Differentiating OCD from obsessive-compulsive personality disorder (OCPD) may also be difficult. In addition, OCD and OCPD may co-occur (7, 8). In fact, the greater prevalence of OCPD in first-degree relatives of OCD patients than of control subjects suggests the possibility of a genetic relationship between the two disorders (9). Although hoarding, scrupulosity, perfectionism, and preoccupation with rules, order, and lists may occur in both disorders, a number of factors may help distinguish OCD and OCPD. For example, in OCD, anxiety about feared consequences of forgoing compulsive behaviors is prominent, whereas in OCPD, the focus is on "doing things my way, the right way" (i.e., on the need for control). In OCD, perfectionism and preoccupation with rules is usually focal and limited to feared events; in OCPD these traits globally color the individual's attitudes and behavior. Fundamentally, the person with OCPD experiences the concerns and behaviors as part of the normal self and does not resist them but, to the contrary, considers them valued attributes. Despite the fact that OCPD traits often irritate companions or associates, the individual with OCPD has no desire to change these traits.

3. 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. The Y-BOCS Symptom Checklist lists 40 obsessions, 15 behavioral compulsions, 5 mental compulsions, and 9 miscellaneous compulsions.

The psychiatrist should consider using a rating scale such as the 10-item Y-BOCS scale (10, 12) to record baseline severity since this provides a way to measure response to treatment. The Y-BOCS rating can also be compared with the patient's and the family's impressions of severity. The Y-BOCS scale evaluates obsessions and compulsions separately and, for each of these two symptom dimensions, measures the time spent and the degrees of distress, interference with functioning, resistance to the symptoms, and success in resisting. The Y-BOCS may be found at the following Web sites: http://healthnet.umassmed.edu/ mhealth/YBOCRating-Scale.pdf or www.peaceofmind.com/ YBOCS.pdf. The Obsessive-Compulsive Inventory (11), a self-rated scale, may also be considered. A simpler measure is a visual analog scale in the form of a thermometer with the bottom labeled "no OCD symptoms" and the top labeled "incapacitating OCD symptoms." Encouraging the patient to use a self-rated scale will help him or her become a better self-observer and may aid in identifying factors that aggravate or ameliorate symptoms. If a rating scale is not used, the psychiatrist should document the patient's estimate of the number of hours per day spent in obsessing and in performing compulsive behaviors, and the degree of effort applied to trying to escape the obsessions (by distraction or accepting passive awareness, not by counter-argument) and to resisting the behaviors.

Recording items or situations that the patient actively avoids because of OCD also provides a useful baseline against which change can be measured.

The psychiatrist should consider recording co-occurring conditions and their effects on the patient's functioning. For monitoring depression, which is commonly present and may aggravate OCD symptoms, the clinician might also consider self-rated scales. These can be as simple as visual analog scales or scales measuring symptoms of interest using a "0 to 10" severity rating. Formal self-rated scales that may be useful include the Patient Health Questionnaire (PHQ-9) (13, 14), Beck Depression Inventory–II (BDI-II) (15), Zung Depression Scale (16), and the patient versions of the Inventory of Depressive Symptomatology (IDS) or the shorter 16-item Quick-IDS (QIDS) (17).

OCD symptoms may seriously impair self-care, interpersonal relationships, vocational ability, marital and family relationships, child-rearing capacities, and use of leisure time. Thus, it may be useful to include a rating of disability—for example, the self-rated, three-item Sheehan Disability Scale (SDS) (18, 19), which records disability in the domains of work, family, and social relationships. Some patients, however, may not accurately recognize the degree of their disability until after successful treatment. For most patients, OCD seriously impairs quality of life (20). A rating of the patient's quality of life, using a scale such as the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q) (21) or the more detailed World Health Organization Quality of Life Survey (WHOQOL-100) (22), can provide a broader measure of disease impact and of the results of treatment.

4. Evaluate 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. When these risks are present, it is important to arrange treatments that will enhance the safety of the patient and others. Although accurate prediction of dangerousness to self or others is not possible in a given individual at a given point in time, many factors have been associated with increased risk in groups of individuals and are, therefore, important to determine.

In assessing and estimating the patient's potential for self-injury or suicide, a number of factors should be taken into consideration. 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 (23, 24). In rare instances, self-injury can also be directly or indirectly associated with compulsive behaviors. Because increased risk of suicide attempts and suicide has been associated with specific psychiatric symptoms and disorders, the psychiatrist will also want to assess for hopelessness, agitation, psychosis, anxiety, or panic attacks, as well as the presence of mood or substance use disorders, schizophrenia, borderline personality disorder, or other disorders associated with heightened risk. Risk for suicide and for suicide attempts is also increased by a history of previous suicide attempts, including aborted attempts. Thus, if a patient has this history, the nature of those attempts and their potential lethality should be determined. It is also essential to determine whether the patient has had thoughts of death, self-harm, or suicide and the degree to which the patient intends to act on any such thoughts. If a patient has considered suicide, the extent of planning or preparation and the relative lethality of any planned suicide methods should be considered. The availability of the means for suicide, including firearms, should also be explored. Also relevant is any family history of suicide, recent exposure to suicide or suicide attempts by others, real or perceived lack of social supports, and recent losses, including impairments resulting from medical conditions. Cultural, religious, and ethnic factors can also modify suicide risk. Further information is available in APA's *Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors* (25).

The psychiatrist should also evaluate the patient's potential for harming others. This evaluation will include inquiring about whether the patient has had thoughts or urges to harm others and when these thoughts and urges have led to aggression toward others in the past. Such questioning should be sensitive to the fact that patients may fear thoughts, impulses, urges, or images related to harming others or to sexually abusing a child, even though these are experienced as alien to the self and true desires. Although acting on such impulses or thoughts has not been reported in OCD, the patient may fear loss of control and engage in extensive avoidance rituals. OCD symptoms can occasionally be associated with direct or indirect potential for harm to others. For example, OCD symptoms can interfere with parenting, leading the patient, for example, to avoid or neglect his or her children, to "clean" them inappropriately with bleach or other harmful substances, or to insist on inappropriate neatness. In such cases, the psychiatrist may have to work with the unaffected parent or social agencies to mitigate the effects of OCD symptoms on the patient's children. On rare occasions, individuals with OCD have become distressed and aggressive when others interfered with the performance of compulsive rituals. Finally, in assessing the potential for harm to others,

the psychiatrist should consider the possibility that aggressive behavior can be associated with co-occurring disorders such as substance use, impulse control, and personality disorders.

5. 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). Facets of the assessment that are of particular relevance to individuals with OCD are highlighted in Table 2.

At all phases of subsequent assessment, the psychiatrist should be alert for signs, symptoms, and history suggesting the possibility of co-occurring conditions. Particular attention should be given to mood disorders, since depressive disorders (27, 28) and bipolar disorder (29, 30) are more common in patients with OCD than in the general population. Careful exploration for family history for bipolar disorder is also important in view of the risk of precipitating hypomania or mania with anti-OCD medications.

Other anxiety disorders (panic disorder, generalized anxiety disorder, social phobia) are common in OCD patients (24, 31, 32) and may complicate treatment planning as described later in this guideline (Sections III.A.5 and III.A.6).

Tics are common in individuals with OCD. Conversely, OCD has been diagnosed in 28%–62% of individuals with Tourette's disorder (33). In patients with co-occurring OCD and Tourette's disorder, use of a rating scale such as the Yale Global Tic Severity Scale (YGTSS) (34) may be helpful. This scale provides anchor points for rating the number, frequency, intensity, complexity, interference, and impairment associated with motor and phonic tics.

Anorexia nervosa and bulimia nervosa may be more common in men and women with OCD than in the general population (24, 35). The prevalence of OCD appears to be elevated in patients with either anorexia nervosa or bulimia nervosa (36–38).

Evaluation should also include screening for alcohol or substance abuse or dependence. In some (31, 39) but not all studies (24), an increased risk of alcohol abuse and dependence has been noted. In addition, the presence of a substance use disorder will influence treatment planning (Section III.A.8).

Other disorders with elevated prevalence in OCD include certain impulse-control disorders, such as skin picking and trichotillomania. In children and adolescents with OCD, the prevalence of attention-deficit/hyperactivity disorder (ADHD) and of oppositional defiant disorder (ODD) is elevated (40). Since structured interview instruments lack modules for developmental disorders, the absence of prevalence data regarding ADHD in adult OCD patients may represent an error of omission. Given that about half of early-onset OCD patients with co-occurring ADHD will continue to have clinically significant ADHD symptoms in adulthood, assessing adult OCD patients for ADHD may be helpful. Assessment instruments include the Conners Adult ADHD Rating Scales (CAARS) (41) and the Wender Utah Rating Scale (WURS) (42), among others (e.g., see reference 43).

In assessing the past psychiatric history, a chronological history should be obtained of past psychiatric illnesses, including substance use disorders and treatment, and of hospitalizations. More specifically, the psychiatrist should attempt to document the longitudinal course of the patient's symptoms and their relationship to aggravating or ameliorating factors, including treatment. Details of the patient's past medication trials should be obtained to ensure that drug doses and trial durations have been adequate, to understand side effects and other factors influencing adherence, and to evaluate the degree of response. The nature, extent, and response to all trials of psychotherapy, including cognitive-behavioral therapy, should also be documented. When past medical records are accessible, these can be helpful in augmenting the treatment history provided by the patient. Past histories of psychiatric symptoms or co-occurring disorders will influence treatment planning and should also be elicited, such as alcohol or substance abuse or dependence (Section III.A.8), prominent fluctuations in mood (Section III.A.4), or panic attacks (Section III.A.5).

The general medical history should document any current general medical conditions, recent or relevant hospitalizations, and any history of head trauma, loss of consciousness, or seizures. The psychiatrist should also consider whether the OCD is a rare manifestation of a general medical condition (e.g., brain trauma, stimulant abuse, carbon monoxide poisoning, parkinsonism). Evaluation of such potential etiologies does not require screening with imaging studies (44), as these disorders are usually obvious from history and examination (33). Current medications and doses should be reviewed to determine potential pharmacokinetic and pharmacodynamic interactions with psychotropic drugs. Herbal or "natural" remedies must also be inquired about, along with hormonal therapies, vitamins, other over-the-counter medications, and other alternative or complementary treatments. Allergies and sensitivities to medications, including the nature of the patient's reaction, should be recorded. On careful exploration, reactions the patient describes as "allergies" will sometimes turn out to be unpleasant but manageable side effects. In performing the

TABLE 2. Highlights of the Psychiatric Evaluation in Obsessive-Compulsive Disorder (OCD)

- Assess the patient's current symptoms
- Consider rating symptom severity
- Evaluate the effects of symptoms on well-being, functioning, and quality of life
- Evaluate the safety of the patient and others
- Be alert to the presence of co-occurring conditions, especially
  - Depressive disorders
  - Bipolar disorder
  - Other anxiety disorders
  - Tics or Tourette's disorder
  - Eating disorders
  - Alcohol or substance abuse or dependence
  - Impulse-control disorders such as skin-picking, trichotillomania
  - Attention-deficit/hyperactivity disorder
- Record the past psychiatric history, especially
  - Course of symptoms
  - Treatment history, including hospitalizations and trials of medications and psychotherapies, with details of treatment adequacy, duration, response, and side effects
  - Past histories of co-occurring disorders that may influence treatment (e.g., mood or substance use disorders; panic attacks)
- Record the general medical history, especially
  - Current general medical conditions
  - Hospitalizations
  - History of head trauma, loss of consciousness, or seizures
  - Current medications, including hormonal therapies, herbal remedies, vitamins, other over-the-counter medications, and other alternative or complementary therapies
  - Allergies or drug sensitivities
- Elicit a review of systems, especially
  - Symptoms that could be confused with medication side effects
- Record the developmental, psychosocial, and sociocultural history, especially
  - Developmental transitions in childhood and adulthood
  - Capacity to achieve stable and gratifying familial and social relationships
  - Sexual history, including baseline dysfunction, nature of relationships, and impulsive or high-risk sexual behaviors
  - Educational and occupational history (including military history)
  - Primary support group and sociocultural supports (e.g., spouse/partner, children, other family and friends, community or faith-based organizations)
  - Potential psychosocial stressors (e.g., housing, finances, transportation, health care access, involvement with social agencies or the justice system)
  - Effects of OCD on schooling, work, and relationships
  - Role of social supports in facilitating treatment or in maintaining or exacerbating symptoms
- Record the family history, especially
  - OCD
  - Other psychiatric disorders (e.g., major depression, bipolar disorder, panic disorder, generalized or social anxiety disorder, substance use disorders)
  - Tics and/or Tourette's disorder
- Perform a mental status examination, especially

TABLE 2. Highlights of the Psychiatric Evaluation in Obsessive-Compulsive Disorder (OCD) *(continued)*

Appearance and general behavior, including degree of cooperation
Psychomotor abnormalities (e.g., tics, mannerisms, rituals, abnormal involuntary movements)
Thought process (e.g., circumstantiality)
Thought content (e.g., obsessions, compulsions, phobias, overvalued ideas, ideas of reference, delusions, suicidal or homicidal ideas)
Perceptual disturbances (e.g., illusions, hallucinations)
Sensorium and cognition
Insight (e.g., understanding of the irrationality of OCD symptoms; motivation and expectations for treatment)
Judgment, especially effects of OCD symptoms in day-to-day decision making

review of systems, the psychiatrist should record the presence and severity of somatic or psychological symptoms that could be confused with medication side effects.

In assessing the patient's developmental, psychosocial, and sociocultural history, the psychiatrist should review the stages of the patient's life, with attention to developmental transitions in childhood and adulthood and the patient's capacity to achieve stable and gratifying familial and social relationships. A sexual history will identify the nature of the patient's sexual relationships, including impulsive or high-risk sexual behaviors. It will also provide baseline information on patient concerns or sexual dysfunctions from which to judge potential side effects of psychotropic medications. An educational and occupational history (including military history) will help in evaluating the extent to which OCD symptoms have interfered with academic or vocational achievement. The psychiatrist should also assess the patient's primary support group and sociocultural supports (e.g., spouse/partner, children, other family or friends, community or faith-based organizations), as well as their possible role in facilitating treatment and in maintaining or exacerbating symptoms. Assessing the family's understanding of the patient's illness and of potential treatments is similarly important for treatment planning. Other specific information that may be relevant to the assessment of psychosocial stressors includes living arrangements; sources of income, insurance, or prescription coverage; access to transportation and health care; and past or current involvement with social agencies or the justice system.

In assessing the family history, the presence of OCD among family members is of interest for how it may affect the patient's expectations about the illness and its treatment. Although OCD is associated with genetic risk, the clinician should not expect concordance of specific OCD symptoms among siblings or across generations, with the possible exception of hoarding and ordering symptoms (45). A family history of other psychiatric disorders (e.g., major depression, bipolar disorder, panic disorder, generalized anxiety disorder, social phobia, substance use disorders) is also relevant, since it contributes to an increased risk of co-occurring disorders that may influence treatment choice. A family history of tics or Tourette's disorder suggests a need for careful exploration of these disorders in the patient, as their presence could influence treatment response.

The mental status examination involves the systematic collection and recording of data related to the patient's signs and symptoms of illness during the interview. The examination includes consideration of the patient's appearance and general behavior, including the patient's degree of cooperativeness. Psychomotor abnormalities (e.g., tics, mannerisms, rituals, abnormal involuntary movements) are also noted. The patient's mood should be assessed, since the presence of mood symptoms may alter cooperation with treatment or suggest a co-occurring mood disorder. In addition to specific obsessions and compulsions, other abnormalities in thought content (e.g., phobias, overvalued ideas, ideas of reference, delusions, suicidal or homicidal ideas) or thought process (e.g., circumstantiality) may be present. Perceptual disturbances (e.g., illusions, hallucinations) or disturbances in sensorium or cognition are less commonly observed and suggest the presence of a co-occurring disorder. Assessing the patient's degree of insight into the irrationality of the OCD symptoms and motivation and expectations of treatment is essential to treatment planning. Also crucial is the degree to which OCD is affecting judgment, as measured by OCD's effects on the patient's management of the ordinary decisions of daily life.

6. Establish Goals for Treatment

Marked clinical improvement, recovery, and full remission, if they occur, do not occur rapidly (46). 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). Treatment goals also include enhancing the patient's ability to cooperate with care despite

the frightening cognitions that are typical of OCD; anticipating stressors likely to exacerbate the condition and helping the patient develop coping strategies; providing assistance and support in dealing with stresses; monitoring the patient's psychiatric status and intervening as indicated; minimizing any adverse effects of treatment (e.g., medication side effects); and educating the patient and family regarding the disorder and its treatment. 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 uncertainty; and little or no interference of OCD with the tasks of ordinary living. However, some patients will be unable to reach these targets, despite the psychiatrist's and the patient's best efforts.

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. Consequently, the appropriate treatment setting will depend on a number of factors:

a. Hospital treatment (47) may be indicated by suicide risk, an inability to provide adequate self-care, danger to others, need for constant supervision or support, an inability to tolerate outpatient medication trials because of side effects, need for intensive CBT, the presence of medical conditions that necessitate hospital observation while medications are initiated, or by co-occurring conditions that themselves require hospital treatment, such as severe or suicidal depression, schizophrenia, or mania.
b. Residential treatment (48) may be indicated in individuals with severe treatment-resistant OCD, who require multidisciplinary treatment in a highly structured setting that permits intensive individual and group CBT as well as psychopharmacologic management with close monitoring of treatment adherence over a period of several months.
c. Partial hospitalization (49) may be indicated by a need for daily CBT and monitoring of behavior or medications or a supportive milieu with other adjunctive psychosocial interventions, or to stabilize and increase the gains made during a period of full hospitalization. Goals of treatment include restoring the patient's ability to function in daily life without intensive monitoring; reduction of symptoms to a level consistent with outpatient treatment; prevention of relapse; and maintenance and improvement of social functioning.
d. Home-based treatment may be necessary for patients with hoarding or, initially, for those with contamination fears or other symptoms so impairing that they cannot come to the office or clinic. Home-based treatment may also be indicated for individuals who experience symptoms primarily or exclusively at home.
e. Outpatient treatment is usually sufficient for the treatment of OCD, but the intensity may vary from daily psychotherapy, such as intensive CBT, to treatment less than once a week (after achieving substantial symptom reduction and stabilization).

8. 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 (50). The fears, doubting, and need for certainty that are characteristic of OCD can influence the patient's willingness and ability to cooperate and can challenge the physician's patience. Patients may, for example, obsess about possible medication side effects and, as a result, refuse pharmacotherapy. Cognitive and motivational effects of co-occurring conditions such as major depression must also be taken into account. Thus, it is useful to determine what the treatment will require of the patient and the way in which these requirements match his or her skills, resources, coping methods, priorities, and goals. Providing the patient and family with education (see Appendix) can be beneficial, because the patient's beliefs about the nature of the illness and its treatments will influence adherence. For example, it is important to inform patients about the delay between starting medication and experiencing substantial symptom relief, and the need for extended periods of medication taking (51).

Medication side effects can influence adherence. The patient's culture, however, may limit his or her willingness to report them (e.g., sexual side effects) or how discomfiting they are. Since effective medications differ both in side-effect profiles and in their adverse effects on a given patient, the psychiatrist has many options for responding to the patient's concerns and preferences. 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 will enhance adherence.

In describing CBT, the clinician should note that it involves confronting feared thoughts and situations, but at a tolerable rate. The therapist is a supportive coach, not a disciplinarian, and encourages behavior change and praises successes while validating the difficulty of confronting the OCD symptoms.

As with all psychotherapies, how the patient thinks, feels, and acts toward the clinician can decrease cooperation with CBT, the only psychotherapy with documented efficacy for OCD. For example, patients may

seek excessive reassurance or have difficulty committing to treatment options. These reactions can often be dealt with in the course of CBT. At other times, improving the patient's degree of cooperation may be best accomplished with another form of psychotherapy. Motivational interviewing (52) and other psychosocial interventions designed to enhance readiness for change may help to improve a patient's motivation for treatment. Clinician-related issues in the therapeutic alliance may also interfere with adherence and therapeutic success. Use of consultation can sometimes be helpful in resolving such impediments.

The psychiatrist should also consider the role of the patient's family and social support system in treatment adherence. Family members may be important allies in the treatment efforts (53). By contrast, family members may provide repeated inappropriate reassurance in efforts to reduce the patient's anxiety or inappropriately offer to do the patient's checking rituals so the patient can get more rest. The family or significant others may not understand that OCD is an illness that gives rise to the patient's compulsive behaviors. They may accuse the patient of being weak or "crazy" or may react to symptomatic behavior with inappropriate anger. They may also be adversely affected by rituals, such as excessive cleaning, or by the patient's insistence on avoiding "contaminated" places. Family therapy may be indicated to deal with hostility, dependency, or other family system issues. When a patient with OCD refuses or prematurely discontinues treatment, family members and others negatively affected by the OCD may benefit from therapy. Under these conditions, the goals of therapy may be to reduce the OCD's impact on the rest of the family and to teach family members how to support recovery from OCD.

Finally, practical issues such as treatment cost, insurance coverage, and transportation may need to be addressed. Pharmaceutical companies may provide free medications for patients with severe financial limitations, with the exact criteria differing from company to company. Information on patient assistance programs is available from the pharmaceutical company Web sites, from the Web site of the Partnership for Prescription Assistance (www.helpingpatients.org), and from Rx Assist (www.rxassist.org).

9. 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. All patients with OCD should be provided with information and access to educational materials explaining the nature of the disorder and the range of available treatments. Education will help destigmatize the illness and allow the patient to make more fully informed decisions about treatments. Education may also increase the patient's motivation and ability to cooperate in care. When appropriate, education should also be offered to involved family members. The appendix to this guideline contains lists of self-help books for patients with OCD and co-occurring OCD spectrum disorders (see also references 33, 54, 55), patient advocacy group Web sites that provide scientifically reliable information, Web sites that provide information on the use of medications in pregnancy and during breastfeeding, and scientifically reliable, broader mental health Web sites. All OCD patients should be made aware of the Obsessive Compulsive Foundation (www.ocfoundation.org), which provides both educational materials and access to support groups.

10. 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. For patients whose OCD symptoms or medications impair dental health, coordination with the patient's dentist will also be useful.

OCD-related functional impairments may involve family, social, academic, or occupational roles or financial problems. Consequently, under some circumstances, the psychiatrist may need to provide government agencies, schools, employers, and others with written documentation on the patient's behalf. For example, the psychiatrist may have to write to the federal Internal Revenue Service and state tax authorities to explain that a patient's hoarding or procrastination has prevented timely filing of income tax returns. A letter regarding special provisions for participation in or excuse from jury duty may also be appropriate. Students may need letters explaining the need for special dormitory living situations or academic accommodations. Employers may need help in understanding what accommodations are appropriate in light of the Americans With Disabilities Act (56), and referral to a state vocational rehabilitation agency or an occupational therapist may be indicated. For OCD of disabling severity, the psychiatrist must be willing to write to government agencies that control access to disability income, publicly financed health care, or government-supported housing.

OCD patients who are parents of young children may want advice regarding the genetic risk of OCD. The clinician may wish to refer these parents to a genetic counselor, but should be aware of the available data (Section IV.D). The psychiatrist should help patients concerned about the possibility of OCD in their children find cli-

nicians who can conduct an appropriate evaluation. (Educational materials for parents of children with OCD are included in the Appendix.)

B. ACUTE PHASE

1. 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. These 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, and preferences. Because most treatment studies have been of 3–4 months' duration, only limited data are available to guide long-term treatment decisions (Section II.C).

The evidence base for the form of CBT that relies primarily on behavioral techniques, such as ERP (57), is the strongest (58–60). Data also support the use of CBT that focuses on cognitive techniques aimed at identifying, challenging, and modifying dysfunctional beliefs (61–64) if these techniques are combined with behavioral experiments. However, some data suggest, and many clinical experts believe, that the most effective form of CBT for OCD integrates exposure, response prevention (behavior that results in not performing rituals), discussion of feared consequences and dysfunctional beliefs, and relapse prevention. There are few data from controlled trials to support cognitive therapy without ERP or behavioral experiments.

CBT alone, consisting of ERP, 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. The patient must be willing to do the work that CBT requires (e.g., regular behavioral homework).

An SRI alone is recommended for a patient who has previously responded well to a given drug or 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.

The available data suggest that combining an SRI and CBT consisting of ERP is more effective than monotherapy in some patients but is not necessary for all (65). Combined treatment should be considered for patients with an unsatisfactory response to monotherapy, for those with co-occurring psychiatric conditions for which SRIs are effective, and for those who wish to limit the duration of treatment with medication. In the latter instance, uncontrolled follow-up studies suggest that CBT consisting of ERP may delay or mitigate relapse when SRI treatment is discontinued (66–68). Combined treatment 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.

2. 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. Although meta-analyses (59, 69, 70) 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 SSRIs directly do not support this impression (Section V.A.1). Because the SSRIs have a less troublesome side-effect profile than clomipramine (see Section II.B.2.b), an SSRI is preferred for a first medication trial. Although all SSRIs (including citalopram and escitalopram) appear to be equally effective, individual patients may respond well to one and not to another. The reasons for this patient-specific response are unknown, and no demographic or clinical variables are sufficiently accurate predictors of treatment outcome to permit their use in selecting medications (71).

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. For example, paroxetine, the SSRI most associated with weight gain (72) and the most anticholinergic SSRI, would not be the first choice for patients with obesity, diabetes mellitus, constipation, or urinary hesitancy.

Another factor in choosing among medications is the degree to which they alter metabolism through the hepatic cytochrome P450 enzyme system or uridine 5′-diphosphate glucuronosyltransferases (UGTs), act at the P-glycoprotein transporter, or displace drugs tightly bound to plasma proteins (e.g., see references 73–76). Many interactions, however, reflect only in vitro data, and their clinical importance is not established. Citalopram, escitalopram, and sertraline (along with venlafaxine and mirtazapine) have few or no important known drug interactions. Web sites providing data on potential drug interactions include http://medicine. iupui.edu/flockhart and http://mhc.com/Cytochromes. For up-to-date clinical reports of interactions between specific SRIs and other

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

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

[a]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.
[b]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.
[c]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.
[d]Sertraline, alone among the SSRIs, is better absorbed with food.

medications, psychiatrists can consult the federal National Library of Medicine database at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?DB= pubmed, which is also accessible by entering the term "pubmed" in a search engine. Since there are very few serious risks associated with treatment with SSRIs (e.g., the risk of serotonin syndrome from adding an SSRI to an MAOI, tramadol, meperidine, or dextromethorphan [77, 78]), the psychiatrist will much more often have to consider the relative potential for specific SSRIs to interact with the patient's other medications, particularly given the higher doses of SSRIs that are often used in treating OCD.

Although no definitive data are available, the response of first-degree relatives to particular medications may be predictive of the patient's response because of genetic similarity. This is a subject, however, for future research.

a. Implementing Pharmacotherapy

The need to educate the patient about any medication recommended has been emphasized earlier. Table 3 displays suggested starting doses, known effective doses, maximum recommended doses, and maximum doses occasionally prescribed for each SRI. For most patients, the starting dose is that recommended by the manufacturer.

For patients who are worried about side effects, the medication can be started at half the listed dose or less, since many SSRIs (e.g., citalopram, escitalopram, fluoxetine, paroxetine, and sertraline) are available in liquid form or in pills that can be split. Lower initial medication starting doses and more gradual dose titration may also be needed in patients with co-occurring anxiety disorders, who may experience a transient worsening of anxiety symptoms. Experience with pharmacotherapy in the elderly indicates that lower starting doses of medication and a more gradual approach to dose increase are often advisable. 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. Available trial data suggest that higher SSRI doses produce a somewhat higher response rate and somewhat greater magnitude of symptom relief (79–82). Some patients, such as those who have had little response to previous treatments and are tolerating the medication well, may benefit from even higher doses than those shown in the last column of Table 3. In these instances, the patient should be closely monitored for side effects, including the serotonin syndrome. Moreover, patients who have not responded to a known effective dose after 10–12 weeks may respond at higher doses (83, 84). For this reason, 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 to evaluate results.

No evidence suggests that OCD treatment outcome is related to plasma levels of clomipramine (85), fluoxetine (86), fluvoxamine (87), or sertraline (82). However, these studies were not designed to identify whether rapid or ultra-rapid metabolizers of these medications were more likely to be nonresponders.

b. Managing Medication Side Effects

Unlike the SSRIs, clomipramine also blocks norepinephrine reuptake, muscarinic cholinergic receptors,

H_1 histamine receptors, and α_1-adrenergic receptors, as well as sodium channels in the heart and brain. Thus, 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 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 [88]). In view of clomipramine's less favorable side-effect profile, expert opinion favors one or more SSRI trials before trying clomipramine (89). Starting clomipramine at a dose of 25 mg/day or less will increase its early tolerability (90).

The most common side effects of the 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. A first step in managing any side effect is to consider whether lowering the drug dose may alleviate the side effect without loss of therapeutic effect. When this is not possible, specific interventions may be considered. Gastrointestinal distress can be minimized by starting with low doses; if mild queasiness or nausea occurs, it will usually disappear within 1–2 weeks at a constant dose. Insomnia may respond to the patient's taking the medication in the morning or to standard sleep hygiene measures, or may require addition of a sleep-promoting agent. Fatigue or sleepiness may respond to the addition of modest doses of modafinil (91). Cases of successful treatment of sweating have been reported with low doses of anticholinergic agents such as benztropine (92, 93), and with clonidine (94), cyproheptadine (95), and mirtazapine (96).

Few controlled trials have been published regarding the management of sexual side effects, which may affect one-third or more of patients (97). Management approaches include reducing the dose to the minimal effective dose; waiting for the symptom to remit (which clinical impression suggests may occur within 2 months in about 10% of patients); trying a once-weekly, one-day "drug holiday" before engaging in sexual activity; switching to another SSRI (which may relieve the sexual dysfunction but not control the patient's OCD); or adding a counteracting pharmacologic agent. The drug holiday approach may alleviate difficulties with erection or orgasm but not with libido. It is not effective for fluoxetine because of its long half-life (98) and may induce withdrawal symptoms if attempted with paroxetine or venlafaxine. Taking drug holidays more than once weekly risks a return of OCD symptoms. Case series and primarily uncontrolled studies report modest success in restoring libido, erection, and orgasm by addition of amantadine, bupropion, buspirone, yohimbine, Ginkgo biloba extract (99), ropinirole (100), or stimulants such as methylphenidate or dextroamphetamine. Adding bupropion has the best evidence base (101), but even this literature is mixed (102). Case series and uncontrolled studies report modest success in restoring erection or orgasm, but not libido, with cyproheptadine or mirtazapine (99). Controlled trials support the use of sildenafil, tadalafil, and vardenafil (103, 104) to restore erection and, in men (105) and women (106), to restore orgasmic ability.

Primarily on the basis of data in children and adolescents (Section III.B.4), concerns have been raised about the potential for increases in self-harming or suicidal behaviors in individuals treated with antidepressant medications, including SRIs. A meta-analysis in adults treated with SSRIs did not demonstrate increases in rates of suicide or suicidal thoughts, although there was weak evidence for an increase in self-harming behavior (107). A second meta-analysis noted an increase in the odds ratio for suicide attempts but did not report on the risk of other suicidal behaviors (108). However, interpretation of these results is difficult because of the confounds involved in calculating risks of suicide and other suicidal behaviors from meta-analyses (109). This is particularly true with regard to the use of antidepressants to treat OCD, because the majority of SSRI clinical trials involve depressed subjects, not subjects with OCD. In addition, studies using other methodologies, including a nested case–control study (110), a retrospective analysis of a large sample of computerized health plan records (111), and a large prospective effectiveness study in adult subjects with bipolar disorder (112), showed no increases in the likelihood of suicide or suicide attempts with antidepressant treatment. An additional nested case–control study also showed no increase in the risk of suicide but did note a small increase in the likelihood of self-harm (113). Although antidepressant treatment in adults does not appear to be associated with an increase in suicide, it is conceivable that side effects (e.g., anxiety, agitation, insomnia, irritability) may increase the chance of self-harming behaviors in some individuals (109). Thus, careful monitoring for such side effects, as well as for evidence of self-harming or suicidal thoughts or behaviors, is important, particularly in the early phases of treatment and after increases in antidepressant dose. Against these small risks, the benefits of antidepressant treatment must always be considered (114, 115).

SSRIs may be associated with increased intra-operative blood loss in patients also taking nonsteroidal anti-inflammatory drugs (116) and, along with clomipramine, may interact with anesthetics and opiate pain relievers. Patients should inform their surgeon and anesthesiologist if they are taking an SRI.

A drug discontinuation syndrome consisting most often of dizziness, nausea/vomiting, headache, and lethargy, but also including agitation, insomnia, myoclonic jerks, and paresthesias (117, 118), may occur if medication is suddenly stopped. The syndrome may occur after stopping any SRI but is most often seen after rapid discontinuation of paroxetine or the serotonin-norepinephrine reuptake inhibitor (SNRI) venlafaxine (117). Particularly for these latter medications, a slow taper over several weeks or more will minimize the likelihood of discontinuation symptoms. If symptoms do occur, raising the medication dose and slowing the taper may bring relief.

3. 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. 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). It may also be useful in addressing the interpersonal consequences of the OCD symptoms (119). Motivational interviewing may also help overcome resistance to treatment. As noted in Section II.B.1, the CBT variant that relies primarily on behavioral techniques such as ERP has the strongest evidence base (59, 60). Some data suggest that ERP is more effective if it integrates habituation with discussions of feared consequences and dysfunctional beliefs (120, 121) and with relapse prevention (122–125). For OCD patients without co-occurring depression, data from one large (N=122) randomized controlled trial suggest that intensive CBT consisting of ERP may be superior to clomipramine monotherapy (123, 126).

Data also support CBT that primarily utilizes cognitive techniques such as identifying, challenging, and modifying dysfunctional beliefs when these techniques are combined with behavioral experiments (64, 121, 127–129), which can resemble ERP depending on how they are done. In direct comparisons, CBT utilizing cognitive techniques and behavioral experiments had efficacy similar to CBT consisting of ERP that focused only on habituation. Whether incorporating cognitive techniques with ERP is more effective than either treatment alone is under investigation (122). Only case reports support attempting to treat OCD with cognitive therapy alone, without exposure or behavioral experiments (129, 130). No controlled trials have evaluated other psychosocial methods for treating OCD that have been used in clinical practice (e.g., the "brain-lock technique" [131], other mindfulness approaches, acceptance and commitment therapy).

4. 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 (135, 136) (for a summary of group and family therapy studies, see references 136, 137). One group has explored the delivery of behavior therapy by means of a self-instructional workbook that allows the patient to design and implement an individualized treatment plan. The patient couples the plan with a voice-activated telephone-response system accessible 24 hours a day to monitor and report progress (138, 139). The literature and expert opinion suggest that CBT sessions should be scheduled at least once weekly (63, 140). One study suggests that five sessions per week of CBT consisting of ERP may be more effective than once-weekly ERP sessions, but are not necessarily more effective than twice-weekly ERP sessions (141). The number of treatment sessions, their length, and the duration of an adequate trial have not been established, but expert consensus recommends 13–20 weekly sessions for most patients (140). More severely ill patients may require longer treatment and/or more frequent sessions. On the basis of clinical experience, clinicians should also consider booster sessions for more severely ill patients, patients who have relapsed in the past, and patients who show signs of early relapse. Finally, because the majority of treatment trials have been only 8–16 weeks long, the long-term persistence of treatment effects and the utility of periodic "booster sessions" require further study.

The psychiatrist may elect to conduct CBT or to refer the patient for this or another adjunctive psychotherapy. Psychiatrists wishing to utilize various forms of CBT are encouraged to pursue training through workshops, conferences, and other training programs. In addition, they can consult a number of treatment manuals (128, 142–146) or other publications (33, 147–149) or obtain consultation from a clinician specializing in the use of CBT. The psychiatrist initiating CBT should explain to the patient the nature of the treatment, including its here-and-now focus, the rationale underlying treatment procedures, and what the patient will be required to do. When resources for CBT are not available, the psychiatrist can suggest and supervise the use of self-help treatment guides (Appendix) and recommend support groups such as those accessible through the Obsessive Compulsive

Foundation (Appendix), although these interventions have not been subjected to controlled study.

At the start of therapy, the psychiatrist can use the Y-BOCS Symptom Checklist (10) to help the patient create a list of target symptoms, including obsessions, compulsions, and items or situations that are avoided because of OCD concerns. The patient ranks the listed items from least to most anxiety-provoking.

In CBT consisting of ERP, patients are taught to confront feared situations and objects (i.e., exposure) and to refrain from performing rituals (i.e., response prevention). Exposures may include in vivo confrontations (e.g., touching objects in public bathrooms) and imaginal confrontations of feared consequences (e.g., imagining becoming "dirty" from "contamination"). Exposures that provoke moderate anxiety are prescribed first, followed as quickly as tolerable by exposures of increasing difficulty. Moving at too slow a pace can diminish faith in the treatment and motivation to continue. Patients must face their fears for a prolonged period without ritualizing, allowing the anxiety or discomfort to dissipate on its own ("habituation"). The goal is to weaken the connections between feared stimuli and distress and between carrying out rituals and relief from distress.

As noted earlier, ERP can be combined with formal cognitive techniques aimed at dysfunctional beliefs (122). Dysfunctional beliefs in OCD include magical thinking (e.g., contamination by proximity), an inflated sense of responsibility for unwanted events, overestimations of the probability of feared events, the assumption that thoughts are morally equivalent to actions or inevitably lead to action ("thought-action fusion"), perfectionism, the belief that anxiety/ discomfort will persist forever, and the need for control. Whether ERP with cognitive therapy is superior to ERP alone is currently under investigation. However, many experts believe that integrating exposures (or behavioral experiments) with discussions of dysfunctional beliefs and feared consequences is likely to be the most effective treatment (120). Modifications of ERP that include formal cognitive techniques as well as other interventions have been suggested for OCD patients with certain symptoms (e.g., hoarding [150]) and those without overt rituals (e.g., see references 59, 149, 151).

5. 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. Patients should be seen as often as necessary for psychiatric management. They should be encouraged to telephone between visits if medication questions arise. If telephone calls become reassurance rituals, the physician should work with the patient and the patient's family to limit call frequency, using exposure (e.g., to the anxiety that prompts the urge to call) and response prevention (e.g., limiting calls), just as in treating any other ritual.

As noted earlier, symptom rating scales can sometimes be helpful for monitoring the response of OCD, co-occurring depression, or co-occurring anxiety disorders, or for keeping an objective record over time in those patients whose symptoms do not respond to initial treatments. Although use of scales is not expected in routine practice, keeping an objective record over time for patients who do not respond to initial treatments may be helpful.

6. 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. In clinical trials, OCD "responders" are variously defined as those whose Y-BOCS scores decrease by at least 25%–35% from baseline or who are rated much improved or very much improved on the Clinical Global Impressions–Improvement scale (CGI-I) (152). But even these degrees of improvement leave much room for additional gains. Thus, the psychiatrist must decide with the patient when, whether, and how to alter the treatment approach.

Deciding whether to alter the treatment approach will depend on the degree of suffering and disability the patient wishes to accept. Because illness can bring secondary gains (familial attention and caring and freedom from responsibilities), and because depressed mood can diminish hopefulness, the psychiatrist may have to address these issues when the patient is not well motivated to pursue further treatments despite limited improvement in his or her OCD. In the opinion of CBT experts, 13–20 sessions of weekly outpatient CBT with daily homework or weekday daily CBT for 3 weeks (about 50 hours, half therapist-guided, half homework) is an adequate dose after which next steps can be considered (140). With regard to SRIs, expert opinion supports changing medication strategy (switching or augmenting) after a trial of 8–12 weeks, with at least 4–6 weeks at the highest comfortably tolerated dose (140). However, some patients may respond simply to a longer period of continued treatment with the same medication (84). There is no apparent relationship between OCD treatment outcome and plasma levels of SRIs (82, 85–87).

When the outcome of initial treatment has been unsatisfactory, the psychiatrist should first consider the possible contribution of several factors: problems in the therapeutic alliance; interference by co-occurring conditions such as panic disorder, major depression, alcohol

TABLE 4. Factors to Consider at Each Treatment Step

Patient's motivation and ability to comply
Nature and severity of OCD symptoms
Co-occurring psychiatric disorders and their treatment
Presence/absence of suicide risk
Co-occurring medical disorders and their treatment
Likely drug side effects
If patient is a woman of childbearing age or is elderly
Patient's past treatment history
Stressors
Family or caregivers' involvement in symptoms
Cultural issues
Patient's preferences regarding treatment modality, acceptable risks, and expected benefits

or substance use disorders, or severe personality disorder; inadequate patient adherence to treatment; the presence of psychosocial stressors; the level of family members' accommodation to the obsessive-compulsive symptoms (153); and an inability to tolerate an adequate trial of psychotherapy or the maximum recommended drug doses. The psychiatrist should next consider extending or intensifying the psychotherapeutic or pharmacotherapeutic intervention. Figure 1 displays a treatment algorithm outlining potential next steps; Table 4 lists factors to be considered at each treatment step.

7. 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. The sequence of treatment trials shown in Figure 1 is based on expert opinion (e.g., reference 140 and contributors to this guideline).

Given the absence of definitive trial data, augmentation strategies might be preferred to switching strategies in patients who have had a partial response to the initial treatment. Modest evidence supports augmentation of SRIs with antipsychotic medications, including haloperidol (154), risperidone (155–157), quetiapine (158), or olanzapine (159). These trials report response rates in the range of 40% to 55%. Patients who do not respond to one antipsychotic augmenting agent may respond to another. A chart review study found that discontinuing successful augmentation after 1–12 months resulted in relapse for more than 80% (15/18) of patients, most within 2 months of discontinuation (160). Despite these promising data regarding antipsychotic augmentation in OCD, many questions about this treatment strategy remain unanswered, including the optimal dose for each drug, long-term tolerability, when and how to discontinue treatment, the drugs' relative augmentation efficacy, and the reasons that only some patients benefit. Further data are also needed on subsets of patients who may respond preferentially to specific augmentation strategies. For example, one study (154) suggests that augmentation with haloperidol helps only those patients with co-occurring tic disorders.

Modest evidence supports augmentation of SRIs with CBT (specifically, ERP) (161–163) and augmentation of CBT with SRIs (164, 165). Some studies have demonstrated no added benefit from combining SRIs and CBT (61, 123), but these findings are limited by high refusal and dropout rates and uncertainty about levels of treatment resistance (166, 167). Some evidence suggests that adding cognitive therapy to ERP may enhance the results, but this remains to be established. In the absence of definitive data, combination treatment is provided in clinical situations that include efforts to treat a co-occurring disorder that is SRI responsive, to augment a partial response to monotherapy (163), and to reduce the chance of relapse when medication is discontinued (67).

For patients who do not respond to their first SRI, expert opinion and clinical trial data support switching to a different SRI (85, 87, 168–171). However, the evidence does not allow one to predict the patient's chance of response to the new SRI. Clinical experience suggests that response rates to a second SRI trial are close to 50% but may diminish as the number of failed adequate trials increases. A switch to venlafaxine at doses ranging from 225 mg/day to 350 mg/day is supported by active comparator trials and open-label studies suggesting its effectiveness in treating OCD (171–173). A switch to mirtazapine is supported by one open pilot study and a double-blind discontinuation trial (174).

If the strategies described above are not effective, augmentation with other pharmacotherapies may also be considered. Expert opinion (140, 175) and three open-label studies (176–178) support clomipramine augmentation of SSRIs. If clomipramine is added, plasma levels of clomipramine and desmethylclomipramine should be assayed 2–3 weeks after reaching a dose of 50 mg/day, and the total plasma concentration should be kept below 500 ng/mL to avoid cardiac and central nervous system toxicity. Fluvoxamine most increases plasma clomipramine levels (178), but substantial increases may occur with fluoxetine and paroxetine. A screening electrocardiogram may be advisable in patients suspected of having heart disease or in patients over the age of 40. Pulse rate and blood pressure should be monitored as the dose of clomipramine is increased.

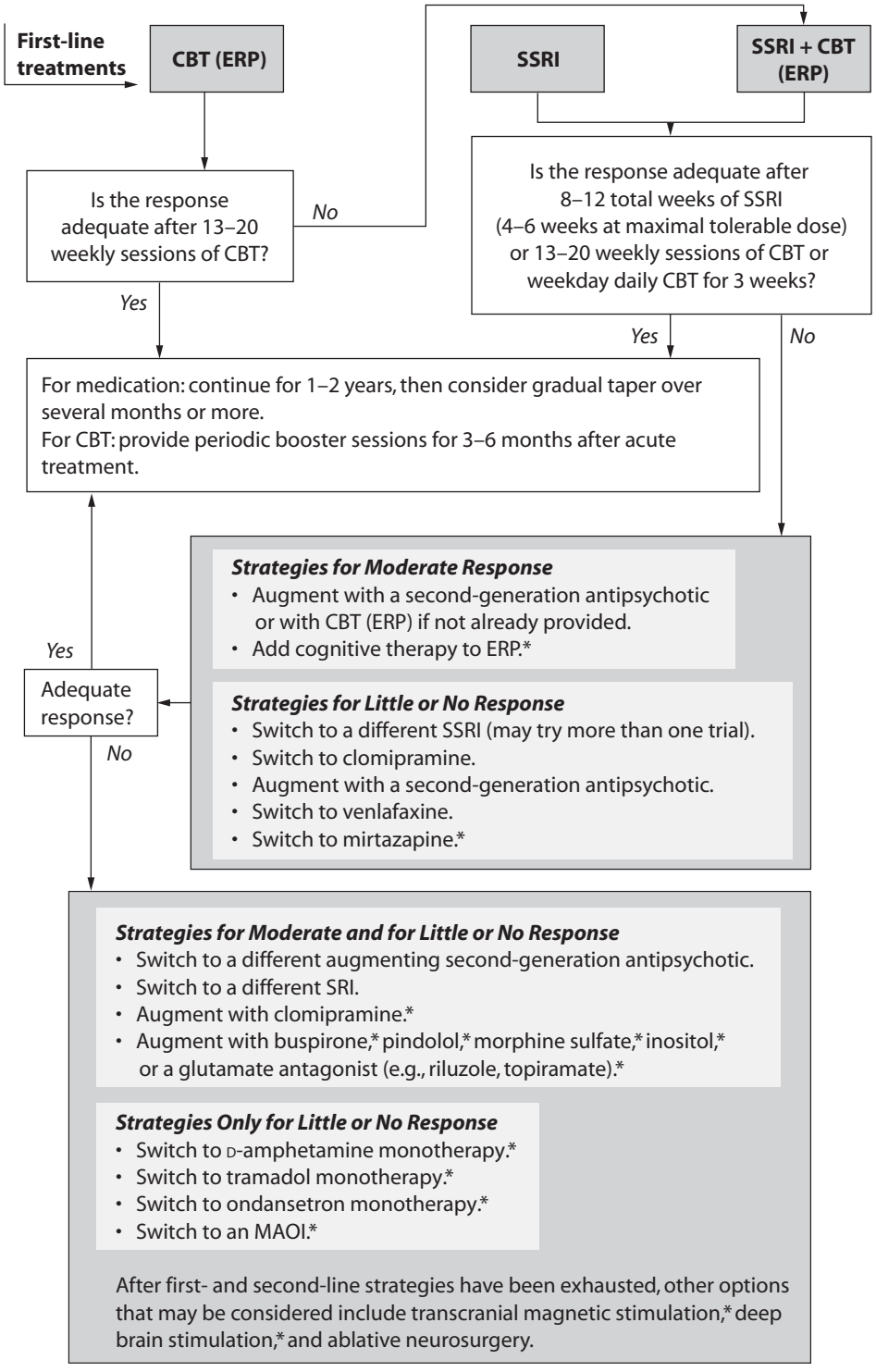

FIGURE 1. Algorithm for the Treatment of Obsessive-Compulsive Disorder (OCD)

Note. "Moderate response" means clinically significant but inadequate response.

*Treatment with little supporting evidence (e.g., one or few small trials or case reports or uncontrolled case series).

CBT=cognitive-behavioral therapy; ERP=exposure and response prevention; MAOI=monoamine oxidase inhibitor; SRI=serotonin reuptake inhibitor; SSRI=selective serotonin reuptake inhibitor.

Positive case reports exist for lithium augmentation, and positive case series have been reported for buspirone augmentation. However, small controlled but methodologically limited trials of lithium and buspirone augmentation have been negative. Adding pindolol 2.5 mg three times daily was effective in one small, double-blind, placebo-controlled trial (179) but not in another (180). A small, 12-week, open-label study reported that augmentation of SRIs with riluzole 50 mg two times daily was often helpful, but methodological limitations prevent confidence that the benefit was due to riluzole itself (180a). Small controlled augmentation trials with L-triiodothyronine and desipramine have produced generally negative results, and a double-blind, placebo-controlled trial found St. John's wort to be no better than placebo (181).

Adding once-weekly oral morphine sulfate 30–45 mg to various SSRIs with or without other augmenting agents was superior to placebo in a double-blind crossover study (182). However, 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. In addition, the psychiatrist should consider what precautions and documentation may be needed—for example, those described by the American Academy of Pain Medicine (www.painmed.org). In addition, positive case reports exist, along with a positive case series, for monotherapy with the weak narcotic agonist tramadol (183). And two small, double-blind, placebo-controlled, single-dose studies reported positive results for D-amphetamine 30 mg in unmedicated OCD subjects (184, 185). However, these drugs should be avoided in some patients (e.g., those with a history of alcohol or other substance abuse or dependence).

Other treatment strategies that are supported only by case series, case reports, or small open trials—literatures that are less likely to include negative experiences—include anticonvulsants, MAOIs, ondansetron, L-tryptophan, nicotine delivered via transdermal patch or chewing gum (186), and Kundalini yoga. For patients with severe treatment-resistant OCD, partial hospitalization (49, 187) and intensive residential treatment (48, 188,189) have been used.

Other somatic therapies should be considered only after first- and second-line treatments and well-supported augmentation strategies have been exhausted. With treatments such as these for which efficacy is uncertain, it is especially important to weigh the potential benefits against the side effects and other risks of therapy. For example, evidence for the use of electroconvulsive therapy (ECT) in OCD is limited to a single case series using a nonstandard form of ECT administration (190). In addition, ECT carries the risks of anesthesia and has side effects such as memory impairment. As a result, ECT cannot be recommended for the treatment of OCD but may be considered for treating co-occurring conditions for which it may be indicated (e.g., major depression, uncontrollable mania, and schizophrenia) (191–194). Transcranial magnetic stimulation (TMS) is associated with less potential for side effects, but evidence for its efficacy is limited. Deep brain stimulation (DBS), a reversible and adjustable neurosurgical intervention, has been reported to show efficacy in a few case series of individuals with severe, highly treatment-resistant OCD (195) but also has potential side effects.

The efficacy of ablative neurosurgery (anterior capsulotomy, limbic leucotomy, cingulotomy, and gamma-knife radiosurgery) in patients with severe, treatment-refractory, or intractable OCD has been evaluated in case reports and unblinded studies. Improvement rates have ranged from 35% to 50% (196–198). Although some studies report relatively high rates of improvement, the unblinded nature of these studies and the ongoing treatment of many patients limit interpretation of these results. In addition, potential adverse events range from personality changes, seizures, and hydrocephalus to transient mania and mild transient side effects such as urinary dysfunction. The recent development of less invasive (DBS) and non-invasive (TMS) procedures makes it harder to consider ablative neurosurgery as an alternative for highly treatment-resistant or intractable OCD. For the time being, DBS and ablative neurosurgical treatment for OCD should be performed only at sites with expertise in both OCD and these treatment approaches.

C. 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.

Four double-blind SRI discontinuation studies studied different SRIs, used different designs (e.g., length of observation and method of placebo substitution), and had different relapse definitions. These methodological differences have been associated with widely varying reported rates of relapse or discontinuation for insufficient clinical response after double-blind switch to placebo, ranging from 89% within 7 weeks to 24% within 28 weeks (80, 199–201). An open discontinuation study also

reported significantly higher 6-month, 1-year, and 2-year relapse rates for the patients whose SRI treatment was discontinued (177). Thus, rates of relapse appear to be increased after discontinuation of SRI treatment but cannot be precisely specified. Given these observations, discontinuation of pharmacotherapy should be carefully considered, and for most patients, continued treatment of some form is recommended.

A review of CBT studies consisting of ERP (202) concluded that about three-quarters of patients receiving ERP (with and without concomitant medication) were doing well at a mean follow-up of a little more than 2 years after the index treatment course. The studies' methodological limitations make this finding inconclusive. In addition, the relapse definition utilized in this review differs from those used in the SRI studies, precluding comparison of relapse rates.

A multi-site study (123) found that responders to intensive ERP (with or without concomitant clomipramine) had a significantly lower relapse rate and longer time to relapse after treatment discontinuation than responders to clomipramine alone (67). Post hoc analyses generally supported these findings, albeit with substantial variability in observed relapse rates (203), depending on the specific definition of relapse.

Together, these data suggest that the response to CBT consisting of ERP may be more durable, at least in the short run, than response to some SRIs after these treatments are discontinued. However, the observed differences could be explained by other factors, including differences in the intensity of treatment before discontinuation, the rate of medication taper, the subjects studied, the length of follow-up, and the relapse criteria.

III. SPECIFIC CLINICAL FEATURES INFLUENCING THE TREATMENT PLAN

Many of the clinical features that will influence the treatment plan have been mentioned in describing the choice of a treatment setting and methods of enhancing adherence. Additional features are described below.

A. PSYCHIATRIC FEATURES

In suggesting treatments for adults, the clinician should consider the patient's response to past treatments, including the benefits and side effects, and the patient's motivation and ability to adhere to pharmacotherapy and psychotherapy. As noted, educational efforts are a standard treatment element and enhance treatment motivation. An unstable or stressful living situation diminishes the chances of successful treatment and may require concomitant interventions such as family therapy.

Assessing the patient's degree of insight is useful because it may influence willingness to cooperate with treatment. The Brown Assessment of Beliefs Scale (204) and the Overvalued Ideas Scale (OVIS) (205) provide quantitative measures. Poor insight is associated with poorer response to SRIs in most studies (71, 206) but not all (207), and poorer response to CBT in some studies (208) but not others (209–211).

Patients appear to be less likely to benefit from medications, CBT, or combined treatment (212) if their predominant or only OCD symptom is hoarding (i.e., acquiring or accumulating items such as newspapers, magazines, books, packaging, old clothing, notes, and lists that are beyond reasonable need or of little objective value). Such individuals may be less responsive to treatment than patients with other symptom patterns because they usually demonstrate less insight, less distress, and therefore less motivation for change (45, 213–217). A recent study, however, found that OCD patients who hoard responded as well to pharmacotherapy as did OCD patients with other symptom types (218). Differences in the underlying neurobiology (219) or OCD-related genetics (220) of hoarding patients compared with nonhoarding patients may also play a role. Specific treatment programs that achieve benefit with hoarding patients have been described (33, 150, 221, 222) but not tested in controlled trials. The Appendix includes a helpful Web site (San Francisco Bay Area Resource & Internet Guide for Extreme Hoarding Behavior, Clutterers Syndrome, or Pack Rat Syndrome).

1. Chronic Motor Tics

Co-occurring chronic motor tics in the absence of Tourette's disorder have been shown to decrease the likelihood of response to fluvoxamine (154, 223) but not to clomipramine (224). Patients with OCD who do not respond to an SRI and have co-occurring tics may benefit from the addition of an antipsychotic drug (154, 225). Although tic onset or exacerbation during SSRI treatment is reported in isolated cases (226, 227), trials of SSRIs should not be withheld from OCD patients with co-occurring motor tics.

2. Tourette's Disorder

OCD co-occurring with Tourette's disorder can be treated with SRIs, which usually have little effect, either positive or negative, on the tic symptoms (225). When the OCD fails to respond after one or two adequate SRI trials, adding a first-generation (typical) or second-generation (atypical) antipsychotic drug in a low to modest dose may ameliorate both disorders (225).

3. Major Depression

Co-occurring major depression does not adversely affect the response of OCD to SRIs (71, 228). When the OCD responds well and the major depression does not, the clinician has many choices, none of which have been studied in large double-blind trials. As a result, it is reasonable to apply the treatment strategies outlined in APA's *Practice Guideline for the Treatment of Patients With Major Depressive Disorder* (192). These include using psychotherapies that are effective in treating depression (i.e., interpersonal psychotherapy, CBT, or short-term psychodynamic therapy), increasing the SRI dose, adding an antidepressant from another class, adding an augmenting agent, or, in patients with severe, treatment-resistant, or suicidal depression, utilizing ECT (191). In many trials of CBT (229–231), but not all (232), co-occurring major depression has been associated with a poorer OCD outcome. Severe depression clearly interferes with CBT (233). Thus, it may be useful to utilize antidepressant medication, and particularly SRIs, to treat co-occurring major depression before or during a trial of CBT.

4. Bipolar Disorder

Treatment of patients with both OCD and bipolar disorder should include measures to achieve mood stabilization before initiating treatment with agents, such as SRIs, that may induce or exacerbate hypomania or mania. Stabilizing the bipolar disorder may require a combination of medications, including lithium, anticonvulsants, and second-generation antipsychotic drugs (193). In bipolar OCD patients, SSRIs appear to be less likely than clomipramine to precipitate hypomania or mania (29). Potential drug interactions should be carefully considered when clomipramine, fluoxetine, fluvoxamine, paroxetine, or sertraline are considered for use in combination with these agents.

Episodic OCD, characterized by periods of markedly different symptom severity independent of OCD treatment, appears to be considerably more common in OCD patients with bipolar disorder (29). Thus, a history of episodic OCD should raise the psychiatrist's suspicion that co-occurring bipolar disorder may be present. Perhaps as a result of co-occurring bipolar disorder, patients with episodic OCD appear to be more likely to suffer from alcohol abuse or dependence, panic disorder, and agoraphobia (29), which will also require treatment.

5. Panic Disorder

Co-occurring panic disorder may respond to the SRI utilized to treat the patient's OCD (234) or to CBT for panic (235). When co-occurring panic disorder or a history of panic attacks is present, SRI treatment should be initiated at low doses, and the dose should be slowly titrated upward over a period of weeks, in order to avoid initiating or exacerbating panic attacks (234). Alternatively, the clinician can start an SRI at usual doses combined with a benzodiazepine at antipanic doses for the first month or so and then try tapering the benzodiazepine over a period of weeks (234).

6. Social Phobia (Social Anxiety Disorder)

Co-occurring social phobia may respond to the SRI utilized to treat the patient's OCD (236). However, in one small study, OCD patients with co-occurring social anxiety disorder experienced a poorer response to SSRI treatment than those without this condition (237). Large, double-blind, placebo-controlled studies support the effectiveness of escitalopram (238), fluoxetine (239), fluvoxamine (240), paroxetine (241), and sertraline (242), as well as venlafaxine (243) and clonazepam (244), in treating social phobia. Phenelzine, while effective, cannot be combined with SRIs because the combination is likely to cause the serotonin syndrome. Controlled trials suggest that social phobia also responds to cognitive-behavioral therapies (245).

7. Schizophrenia

The point and lifetime prevalences of obsessive-compulsive symptoms and of OCD in patients with schizophrenia are elevated (246–248). In patients with co-occurring schizophrenia, OCD or obsessive-compulsive symptoms may be present independently or may be precipitated or exacerbated by second-generation antipsychotic medications (249, 250). Clozapine is the second-generation antipsychotic most often reported to exacerbate obsessive-compulsive symptoms. However, case reports also describe this effect with risperidone (251), quetiapine (252), and olanzapine (253). Some patients with schizophrenia have insight into the irrationality of their obsessions and compulsions while lacking insight into their schizophrenic delusions. In other patients, the obsessions and delusions become illogically linked, as for example when the patient believes that obsessions have been inserted into his mind by an external force or that his compulsive rituals control world events. When clinically significant OCD or obsessive-compulsive symptoms are present independently, the psychiatrist must rely on clinical judgment in formulating a treatment plan, since no large, controlled trials have been conducted.

The patient's antipsychotic regimen should first be stabilized. A review of the treatment literature (254) suggests that SRIs are usually well tolerated and can be beneficial, but isolated reports of psychotic exacerbation exist. As with all use of combination pharmacotherapies, potential drug interactions must be borne in mind. Olanzapine monotherapy has been beneficial in two case series. Adding fluvoxamine has been helpful in two open trials, as has adding fluoxetine, paroxetine, or sertraline in individual cases. Case reports suggest that low doses of fluvoxamine (75–300 mg/day) and slow upward titration are indicated (254). When a second-generation antipsychotic drug induces obsessive-compulsive symptoms, they may disappear within a few weeks. If not, treatment options include adding an SRI, switching to another second-generation antipsychotic, or attempting a trial of CBT. No controlled trials exist to guide treatment planning, but reviewing the results of published cases (249, 254) may be helpful.

8. Substance Use Disorders

Because co-occurring alcohol or substance abuse or dependence can interfere with treatment adherence and response and bring risks of drug interactions, these disorders must be treated either before or while treating the patient's OCD. Several organizations have published guidelines to aid in treatment planning (255–257).

9. Autism and Asperger's Syndrome

Repetitive thoughts and behaviors are common in children and adults with autism or Asperger's syndrome. In a recent study that carefully distinguished stereotypic behaviors and idiosyncratic interests from obsessions and compulsions, only somatic obsessions and repetition rituals were more common in adults with OCD than in adults with high-functioning autistic spectrum disorders (258). An earlier study found that, compared with adults with OCD, adults with autistic disorder had significantly more ordering, hoarding, touching, and self-injurious behaviors (259). However, about half of the autistic individuals in that study were either intellectually impaired, mute, or both. Conversely, one study reported that about 20% of OCD patients have autistic traits (260). One study found the rate of OCD to be elevated in the parents of autistic children with extensive rituals and restricted interests (261).

The SRIs have been effective in treating the repetitive thoughts and behaviors associated with autism (262). In two studies with autistic children, clomipramine was more effective than either desipramine or placebo in reducing repetitive and compulsive behaviors (263, 264). One controlled study found fluvoxamine to be significantly better than placebo for decreasing repetitive behavior and aggression in adults with autistic disorder (265). In a randomized controlled trial in children with Asperger's syndrome, CBT was effective in reducing obsessive-compulsive symptoms and other forms of anxiety (266).

10. Personality Disorders

Although the majority of studies suggest that personality disorders are common in patients with OCD (267), the literature is mixed with regard to their impact on the outcome of pharmacotherapy and of CBT. Attempts to draw conclusions are hampered by methodological problems such as small sample sizes, retrospective study design, poorly defined outcome criteria, difficulties in valid ascertainment of these disorders (268), and differing diagnostic criteria and lengths of follow-up. Some personality traits (e.g., passive-aggressive) and disorders (e.g., borderline personality disorder) have been reported to interfere with adherence to treatment (269, 270). Other traits (e.g., the odd thinking style in schizotypal personality disorder) or particular disorders (especially schizotypal personality disorder [271, 272]) have been associated with poor outcome for unclear reasons in some, but not all, studies (269, 273). Thus, the presence of a co-occurring personality disorder should not prevent a trial of CBT and/or SRIs, but rather should alert the clinician to consider whether to provide additional treatments targeting the personality disorder. Obsessive-compulsive personality disorder, which may co-occur with OCD, has, for example, been noted in case reports to respond to psychodynamic psychotherapy or individual psychotherapy with an expressive emphasis (274–276), to CBT (277), and, in a case series, to SSRIs (278). Patients with OCPD may feel threatened by a lack of control in therapy, deny negative and painful feelings, intellectualize feelings, or resist becoming "dependent" on medications or therapy. Strategies to enhance the therapeutic work with these patients include respecting the patient's defenses, helping the patient accept his or her humanness, enlisting the patient's collaboration in treatment planning, and empathizing with the patient's feelings of shame and fear (119).

11. Neurological Conditions Inducing OCD

OCD or obsessive-compulsive symptoms not meeting DSM-IV-TR diagnostic criteria can be manifestations of a number of neurological conditions, including brain trauma, stroke, encephalitis, temporal lobe epilepsy, Prader-Willi syndrome, Sydenham's chorea, carbon monoxide poisoning, manganese poisoning, and neurodegenerative diseases such as Parkinson's disease and Huntington's disease (33, 279, 280). Treatment is first directed to the underlying neurological condition when this is possible. When OCD symptoms persist after treatment or stabilization of the underlying condition, isolated case reports suggest that treatment with an SRI

and/or CBT may be of some benefit. No controlled treatment trials have been conducted in patients with OCD induced by neurological conditions.

B. DEMOGRAPHIC AND PSYCHOSOCIAL FACTORS

1. Gender

Gender does not appear to influence the likelihood of treatment response in OCD (71). However, men and women may differ in their metabolism of psychotropic medications, including those used in treating OCD (281–283). In addition, premenstrual worsening of OCD has been reported in from 20% (284) to 42% (285) of women and may influence apparent treatment responses.

2. Ethnicity

Pharmacogenetic influences on the probability of therapeutic outcomes and adverse reactions to SRIs are beginning to be reported. Differences in neurotransmitter transporter and receptor genotypes are beginning to be implicated in predicting therapeutic response. In addition, differences in the prevalence of cytochrome P450 (CYP) slow, normal, extensive, and ultra-rapid metabolizers of psychotropic medications, and hence in pharmacokinetic contributions to rates of adverse events, are being associated with ethnicity (286). For example, data indicate that 13%–23% of Asians are CYP2C19 poor metabolizers compared with 2%–5% of Caucasians, and thus should receive about 60% of the average dose of clomipramine (287). CYP2D6 poor metabolizers may require lower doses of paroxetine, which is both an inhibitor and a substrate for this enzyme (287). In the future, identifying CYP genotypes through approaches such as gene chips, may help prevent adverse responses and metabolism-related treatment failures. Although the data are too sparse to support guidelines at present, psychiatrists should remain alert for helpful information.

3. Pregnancy and Breast-Feeding

For patients wishing to become pregnant, pregnant patients, and patients who are breast-feeding, CBT alone should be considered. Deciding whether to start or stop a psychotropic drug during pregnancy or breast-feeding requires making a risk-benefit assessment without having complete information. Risks to the well-being of the fetus, the infant, and the mother occur whether medications are started or stopped, since the mother's health will influence the pregnancy outcome and postpartum infant care. A model to integrate and weigh the decision-making elements in this situation has been proposed (288). In counseling the patient and her concerned others, the physician should provide clear summaries of the available data and, if desired, aid in obtaining more detailed data (289) and provide counseling over several sessions to help the patient come to terms with the uncertainty of the risks. Two helpful Web sites are listed in the Appendix. Consultation with the patient's obstetrician-gynecologist should be offered. Because OCD patients are often quite anxious, experience doubting, and can suffer from perfectionism or a need for certainty, helping the patient and her significant other reach an informed decision may take several sessions. Documentation of the information provided and the clinical rationale for the chosen treatment approach is advisable.

OCD symptom onset during pregnancy has been reported in 13% (285) to 39% (290) of women with OCD who have been pregnant. The severity of pre-existing OCD is usually unaffected by pregnancy but has been reported to worsen in from 8% (284) to 17% (285) of women with OCD who are pregnant and to improve in 14% (285).

The available data suggest that exposure to tricyclic antidepressants (TCAs), fluoxetine, fluvoxamine, paroxetine, or sertraline does not increase rates of intrauterine death (288, 291). Whether SRI exposure decreases birth weight or increases rates of premature delivery is unclear; the data are conflicting (292). Available data do not suggest increased rates of major malformations after in utero exposure to citalopram (293) or escitalopram (294); fluoxetine, sertraline, or TCAs (288, 295); or fluvoxamine (296). However, the FDA has determined that exposure to paroxetine in the first trimester of pregnancy may increase the risk for congenital malformations, particularly cardiac malformations (www.fda.gov/cder/drug/advisory/paroxetine200512.htm; accessed December 13, 2005). Consequently, at the FDA's request, the manufacturer has changed paroxetine's pregnancy category from C ("Risk cannot be ruled out") to D ("Positive evidence of human fetal risk").

A neonatal behavioral syndrome that includes central nervous system, motor, respiratory, and gastrointestinal signs may occur in neonates exposed to SRIs in the third trimester. Although monitoring of exposed neonates is warranted, this behavioral syndrome is usually mild and is manageable with supportive care, and disappears by 2 weeks of age (297). Some evidence also suggests an increase in the likelihood of persistent pulmonary hypertension of the newborn when the patient receives an SSRI during the third trimester (298). Since the severity of OCD symptoms may not rapidly increase when medication is tapered, tapering the patient's SRI dose during the last weeks of pregnancy may be considered.

The very limited data regarding long-term effects of exposure throughout pregnancy to TCAs or SSRIs do

not suggest an elevated risk of abnormalities in cognitive function, language, temperament, or general behavior between ages 15 and 71 months (299). In addition, one study found no evidence for developmental delay at up to 2 years of age associated with in utero exposure to TCAs, fluoxetine, sertraline, or paroxetine at varying times and for varying durations (295).

The pharmacokinetic, pharmacodynamic, and safety considerations in administering SRIs and other psychotropic drugs in pregnancy (and during breast-feeding) are reviewed elsewhere (300, 301). Although there are no data specific to OCD, increases in the SSRI dose have been needed in the early third trimester to maintain remission in major depression. The relative safety of administering first-generation antipsychotics, especially trifluoperazine and perphenazine, during pregnancy is supported by a large database (300). The data regarding second-generation antipsychotics consist only of case reports and case series totaling fewer than 100 children for any individual drug except clozapine, for which the total approaches 150 children. The FDA classifies all second-generation antipsychotics as pregnancy risk Category C ("Risk cannot be ruled out"), except clozapine, which is classified as Category B ("No evidence of risk in humans"). Benzodiazepines are apparently not associated with a significant risk of somatic teratogenesis, but the risk of neurobehavioral effects is unclear because of conflicting reports (300, 302). The reviewers recommend tapering these drugs before delivery when possible and using benzodiazepines in FDA Category C (i.e., clonazepam) or those with less potential for fetal accumulation (i.e., lorazepam and oxazepam).

The available data concerning the effects on the infant of maternal SRI ingestion during breast-feeding are derived from only a few hundred infants. The data suggest that the risk of contemporaneous, noticeable effects is quite low (300, 303). Cases of respiratory depression, hypotonia, poor feeding, irritability, and uncontrollable crying have been reported (303). There are no reports of long-term adverse effects of exposure, but in the absence of large, controlled trials or observational studies, caution remains in order. The American Academy of Pediatrics Committee on Drugs recommends that a nursing mother be informed that the infant will be exposed to maternal medications (304). No consensus exists regarding how best to measure infant exposure (305), but sertraline and paroxetine appear least likely to produce detectable or elevated infant plasma drug levels (303). Monitoring maternal or breast milk antidepressant levels is not recommended (303). Discarding the breast milk 8–9 hours after taking sertraline reduces infant exposure by a little more than 15% (305). Data helpful in evaluating the risks and benefits of taking other psychotropic drugs during breast-feeding are reviewed elsewhere (300, 306).

4. Children and Adolescents

In children and adolescents, treatment should often start with CBT or with a combination of psychotherapy and an SRI (307). Cognitive-behavioral approaches consisting primarily of ERP have been shown to be efficacious in children (308–310), and three SSRIs and clomipramine are FDA-approved for use in treating OCD in children (308, 311–313). Caution and frequent clinical monitoring are advisable when treating children and adolescents with SRIs because of the possibility of an increase in suicidal thinking or behaviors (314). However, using SRIs in treating children and adolescents with OCD or major depression may be necessary and should not be avoided when clinically indicated (315–320). As further information on the treatment of OCD in children and adolescents is beyond the scope of this guideline, the reader is referred to the practice parameter of the American Academy of Child and Adolescent Psychiatry (321).

5. The Elderly

No studies of treatment of OCD in the elderly have been published. Experience with pharmacotherapy of other psychiatric disorders in the elderly indicates that lower starting doses of medication and a more gradual approach to dose increases are often advisable in this age group. Advanced age may affect drug absorption, free drug concentration in plasma, the volume of distribution of lipid-soluble drugs (leading to an increased half-life), and renal excretion rates (322–324). Although hepatic CYP enzyme activity does not regularly diminish with age, decreases in liver mass or blood flow can lead to diminished rates of drug metabolism. For example, diminished hepatic blood flow in the elderly is associated with slower clearance of drugs metabolized by CYP3A4 (e.g., alprazolam, triazolam, sertraline, and mirtazapine). Older patients may also be more sensitive to adverse drug effects. In particular, elderly patients are more sensitive to anticholinergic effects of tricyclics, such as clomipramine, and of antipsychotic drugs. They are also more sensitive to the sedative, cardiac, autonomic, and weight-increasing side effects of these drugs. Because elderly patients are more likely to be taking medications for general medical conditions, the physician prescribing anti-OCD medications will more often have to consider potential pharmacokinetic and pharmacodynamic drug interactions in these patients (73, 76, 283) (Section II.B.2).

C. TREATMENT IMPLICATIONS OF CONCURRENT GENERAL MEDICAL DISORDERS

Co-occurring medical conditions and any medications being used to treat them must be considered when the psychiatrist is choosing pharmacotherapies for OCD. In particular, the effects of kidney and liver disease on drug metabolism and the potentials for pharmacokinetic and pharmacodynamic drug interactions must be reviewed. SSRIs would be preferred over clomipramine in a) patients with epilepsy, because of lower seizure risk; b) patients with cardiac arrythmias, congestive heart failure, or blood pressure abnormalities, because of relative cardiovascular safety; and c) patients who are overweight, because of a lesser likelihood of stimulating appetite. The psychiatrist should recall that SSRIs have been associated with cases of bradycardia, hypertension, hyponatremia, bleeding (325), easy bruising, nausea, diarrhea, constipation, changes in urination, extrapyramidal symptoms, and other symptoms that can be confused with manifestations of co-occurring medical conditions or treatments (33). SSRIs may be used in patients with migraine headaches who are taking triptans (326). Moreover, they may also be used in patients with Parkinson's disease, although there are isolated case reports of worsened motor functioning (327, 328). In patients with diabetes mellitus, it is important to select second-generation antipsychotics that are least likely to affect glucose metabolism and appetite (e.g., aripiprazole and ziprasidone) (194, 329). In all cases, the potential for interactions between the patient's medical and psychiatric medications should be reviewed.

APPENDIX: EDUCATIONAL RESOURCES FOR PATIENTS AND FAMILIES

The American Psychiatric Association does not vouch for or endorse the accuracy of the information contained in any of the publications or Web sites listed in this appendix at the time of writing or in the future, although they are believed to be generally trustworthy at the time of writing. The clinician should review a book or visit a Web site before recommending it to a patient.

RESOURCES FOR OCD

1. Baer L: Getting Control: Overcoming Your Obsessions and Compulsions. New York, Plume Books, 2000.
2. Baer L: The Imp of the Mind: Exploring the Silent Epidemic of Obsessive Bad Thoughts. New York, Plume Books, 2001.
3. Chansky RE: Freeing Your Child From Obsessive-Compulsive Disorder. New York, Crown, 2000.
4. Ciarrocchi JW: The Doubting Disease: Help for Scrupulosity and Religious Compulsions. Mahwah, NJ, Paulist Press, 1998.
5. Foa EB, Kozak MJ: Mastery of Obsessive-Compulsive Disorder: A Cognitive-Behavioral Approach: Client Kit. New York, Oxford University Press, 1997.
6. Foa EB, Wilson R: Stop Obsessing! How to Overcome Your Obsessions and Compulsions, 2nd ed. New York, Bantam, 2001.
7. Gravitz HL: Obsessive Compulsive Disorder: New Help for the Family. Santa Barbara, CA, Healing Visions Press, 1998.
8. Grayson J: Freedom From Obsessive Compulsive Disorder: A Personalized Recovery Program for Living With Uncertainty. New York, Penguin (Tarcher), 2003.
9. Greist JH: Obsessive-Compulsive Disorder: A Guide. Madison, WI, Obsessive-Compulsive Information Center, Madison Institute of Medicine, 2000.
10. Hyman BM, Pedrick C: The OCD Workbook: Your Guide to Breaking Free From Obsessive Compulsive Disorder, 2nd ed. Oakland, CA, New Harbinger Publications, 2005.
11. Munford PR: Overcoming Obsessive Checking. Oakland, CA, New Harbinger Publications, 2004.
12. Munford PR: Overcoming Obsessive Washing. Oakland, CA, New Harbinger Publications, 2005.
13. Neziroglu F, Bubrick J, Yaryura-Tobias JA. Overcoming Compulsive Hoarding: Why You Save and How You Can Stop. Oakland, CA, New Harbinger, 2004.
14. Neziroglu F, Yaryura-Tobias JA: Over and Over Again: Understanding Obsessive-Compulsive Disorder. San Francisco, Jossey-Bass, 1997.
15. Osborn I: Tormenting Thoughts and Secret Rituals. New York, Dell, 1999.
16. Penzel F: Obsessive-Compulsive Disorders: A Complete Guide to Getting Well and Staying Well. New York, Oxford University Press, 2000.
17. Purdon C, Clark DA: Overcoming Obsessive Thoughts: How to Gain Control of Your OCD. Oakland, CA, New Harbinger Publications, 2005.
18. Santa TM: Understanding Scrupulosity: Helpful Answers for Those Who Experience Nagging Questions and Doubts. Ligouri, MI, Ligouri Publications, 1999.
19. Schwartz JM: Brain Lock: Free Yourself From Obsessive Compulsive Disorder. New York, Harper Collins, 1996.
20. Steketee GS: Overcoming Obsessive-Compulsive Disorder: Client Manual. Oakland, CA, New Harbinger Publications, 1999.
21. Summers M (with Hollander E): Everything in Its Place: My Trials and Triumphs With Obsessive-Compulsive Disorder. New York, Penguin Putnam, 1999.
22. van Noppen B, Pato M, Rasmussen S: Learning to Live With OCD. New Haven, CT, Obsessive Compulsive Foundation, 2003.
23. Waltz M: Obsessive-Compulsive Disorder: Help for Children and Adolescents. Sebastopol, CA, O'Reilly Press, 2000.

Obsessive Compulsive Foundation

676 State St.
New Haven, CT 06511
Tel: 203-401-2070
www.ocfoundation.org

Obsessive-Compulsive Information Center

Information Centers
Madison Institute of Medicine
7617 Mineral Point Rd.
Suite 300
Madison, WI 53717
Tel: 608-827-2470
www.miminc.org/aboutocic.html

Scrupulous Anonymous

Offers a monthly newsletter for those with the religious/moral questioning form of OCD.

http://mission.liguori.org/newsletters/scrupanon.htm

San Francisco Bay Area Resource & Internet Guide for Extreme Hoarding Behavior, Clutterers Syndrome, or Pack Rat Syndrome
www.hoarders.org

American Academy of Child and Adolescent Psychiatry
Provides "fact sheets" for families about OCD, Tourette's disorder, anxiety disorders, and other disorders, as well as information about locating treating clinicians.

3615 Wisconsin Ave., NW
Washington, DC 20016-3007
Tel: 202-966-7300
Facts for Families database:
www.aacap.org/page.ww?section=Facts+for+Families&name=Facts+for+Families

RESOURCE FOR TIC DISORDERS

Tourette Syndrome Association, Inc.
42-40 Bell Blvd.
Bayside, NY 11361
Tel: 718-224-2999
www.tsa-usa.org

RESOURCES FOR PANIC DISORDER AND SOCIAL ANXIETY DISORDER

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Anxiety Disorders Association of America
8730 Georgia Ave.
Suite 600
Silver Spring, MD 20910
Tel: 240-485-1001
www.adaa.org

Anxiety Treatment and Research Centre
6th Floor, Fontbonne Building
St. Joseph's Healthcare, Hamilton
50 Charlton Ave., East
Hamilton, ON L8N 4A6
Canada
Tel: 905-522-1155
www.anxietytreatment.ca

SocialAnxietySupport.com
www.socialanxietysupport.com

RESOURCES FOR POSTTRAUMATIC STRESS DISORDER (PTSD)

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2. Matsakis A: I Can't Get Over It: A Handbook for Trauma Survivors, 2nd ed. Oakland, CA, New Harbinger Publications, 1996.
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U.S. Department of Veterans Affairs, National Center for Posttraumatic Stress Disorder
www.ncptsd.va.gov

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Autism Society of America
7910 Woodmont Ave.
Suite 300
Bethesda, MD 20814-3067
Tel: 1-800-3AUTISM
301-657-0881
www.autism-society.org

RESOURCES FOR ASPERGER'S SYNDROME

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RESOURCES FOR COMPULSIVE BUYING

1. Mellan O, Christie S: Overcoming Overspending: A Winning Plan for Spenders and Their Partners. New York, Barnes & Noble Books, 2004.

2. Wesson C: Women Who Shop Too Much: Overcoming the Urge to Splurge. New York, St Martin's Press, 1990.

Debtors Anonymous

General Service Office
P.O. Box 920888
Needham, MA 02492-0009
Tel: 781-453-2743
www.debtorsanonymous.org

RESOURCES FOR KLEPTOMANIA

Cleptomaniacs & Shoplifters Anonymous (CASA)

Terry S. / C.A.S.A.
P.O. Box 250008
Franklin, MI 48205
Tel: 248-358-8508
www.shopliftersanonymous.com

National Association for Shoplifting Prevention

380 N. Broadway
Suite 306
Jericho, NY 11753
Tel: 1-800-848-9595
www.shopliftingprevention.org

RESOURCES FOR PATHOLOGICAL GAMBLING

1. Blaszczynski A: Overcoming Compulsive Gambling: A Self-Help Guide Using Cognitive Behavioral Techniques. London, UK, Robinson, 1998.
2. Grant JE, Kim SW: Stop Me Because I Can't Stop Myself: Taking Control of Impulsive Behavior. New York, McGraw-Hill, 2003.
3. National Council on Problem Gambling and National Endowment for Financial Education: Personal Financial Strategies for the Loved Ones of Problem Gamblers. Greenwood Village, CO, National Endowment for Financial Educations, 2000.

Gamblers Anonymous

Provides limited information on problematic gambling and access to local meetings, which are modeled on the 12-step methods of Alcoholics Anonymous.

P.O. Box 17173
Los Angeles, CA 90017
Tel: 213-386-8789
www.gamblersanonymous.org

Council on Compulsive Gambling of New Jersey

Provides articles for the public, a directory of other state Councils on Compulsive Gambling, and links to related sites.

3635 Quakerbridge Rd.
Suite 7
Hamilton, NJ 08619
Tel: 1-800-GAMBLER
609-588-5515
www.800gambler.org

RESOURCES FOR NONPARAPHILIC SEXUAL DISORDERS

Sexaholics Anonymous

Provides publications and access to meetings across the United States, which are modeled on the 12-step program of Alcoholics Anonymous.

P.O. Box 3565
Brentwood, TN 37024
Tel: 1-866-424-8777
615-370-6062
www.sa.org

Sexual Addicts Anonymous

Provides access to publications and local chapter meetings.

P.O. Box 70949
Houston, TX 77270
Tel: 1-800-477-8191
713-869-4902
www.sexaa.org

Sexual Compulsives Anonymous (SCA)

Provides a list of meetings and a pen pal program controlled by SCA.

P.O. Box 1585
Old Chelsea Station
New York, NY 10011
Tel: 1-800-977-HEAL
212-606-3778
www.sca-recovery.org

Society for the Advancement of Sexual Health

Provides information about sexual compulsions, addresses of 12-step programs, and recommended readings.

P.O. Box 725544
Atlanta, GA 31139
Tel: 770-541-9912
www.ncsac.org/general/index.aspx

RESOURCES FOR TRICHOTILLOMANIA

1. Keuthen NJ, Stein DJ, Christenson GA: Help for Hair Pullers: Understanding and Coping With Trichotillomania. Oakland, CA, New Harbinger Publications, 2001.
2. Penzel F: The Hair-Pulling Problem: A Complete Guide to Trichotillomana. New York, Oxford University Press, 2003.

Trichotillomania Learning Center
207 McPherson St.
Suite H
Santa Cruz, CA 95060-5863
Tel: 831-457-1004
www.trich.org

INFORMATION ON THE USE OF MEDICATION DURING PREGNANCY AND BREASTFEEDING

California Teratogen Information Service and Clinical Research
Tel: 1-800-532-3749 (CA only)
610-543-2131
www.otispregnancy.org/ctis.html

Massachusetts General Hospital Women's Mental Health Program
www.womensmentalhealth.com

Motherisk.com
Database maintained by the Toronto Hospital for Sick Children

www.motherisk.com

RESOURCES FOR GENERAL INFORMATION ON MENTAL DISORDERS AND MEDICATIONS

National Institute of Mental Health (NIMH)
Public Information and Communications Branch
6001 Executive Blvd.
Room 8184, MSC 9663
Bethesda, MD 20892
Tel:1-866-615-6464
www.nimh.nih.gov/publicat/index.cfm

National Alliance on Mental Illness
Colonial Place Three
2107 Wilson Blvd.
Suite 300
Arlington, VA 22201
Tel: 1-800-950-6264
703-524-7600
www.nami.org

Mental Health America
2000 N. Beauregard St.
6th Floor
Alexandria, VA 22311
Tel: 1-800-969-6642
703-684-7722
www.nmha.org

National Library of Medicine
U.S. government online repository of articles published in peer-reviewed medical journals.

www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed

National Center for Complementary and Alternative Medicine (NCCAM), National Institutes of Health
Access to abstracts of peer-reviewed articles concerning complementary medicine.

NCCAM Clearinghouse
P.O. Box 7923
Gaithersburg, MD 20898
Tel: 1-888-644-6226
301-519-3153
www.nlm.nih.gov/nccam/camonpubmed.html

ConsumerLab.com
Tests herbal and vitamin products for purity and posts the results on the Web.

www.consumerlab.com

Mental Health Net
Features thousands of resources on the Internet.

www.mhnet.org

Kids Health
Features physician-approved health information about children.

www.kidshealth.org

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American Association of Suicidology
American College of Physicians
American Group Psychotherapy Association
American Mental Health Counselors Association
American Psychoanalytic Association
Anxiety Disorders Association of America
Association for Academic Psychiatry
Brazilian Research Consortium on OCD Spectrum Disorders
National Association of Social Workers

REFERENCES

The following coding system is used to indicate the nature of the supporting evidence in the references:

[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.

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