Obsessive Compulsive Disorder (OCD) Clinical Guidelines*

Developed in collaboration with the mental health centers associated with NBHP and FBHP

DSM-5 Diagnostic Code: 300.3

Diagnostic Considerations:

1. **Review diagnostic criteria** in DSM-5:
   - Presence of obsessions and/or compulsions
   - The obsessions or compulsions are time consuming, cause significant distress or impairment in functioning
   - Specifiers:
     - Level of insight: with good or fair insight; with poor insight; with absent insight/delusional beliefs
     - Tic-related

2. **Understand the unique presentation of OCD.** When determining a diagnosis of OCD, consider that **obsessions** are unwanted, persistent thoughts, urges or images that the individual attempts to suppress or neutralize with some other thought or action. Obsession subtypes typically include: fear of contamination/disease, pathologic doubt, unacceptable behavior, somatic, need for symmetry, and failure. Although **compulsions** (internal mental rituals and/or external behaviors) provide the function of preventing or reducing distress, these behaviors only provide temporary relief, and not performing them markedly increases subjective anxiety. An example of a mental ritual is counting; examples of external behaviors include washing and checking. Be sure to identify existing mental rituals, as mental rituals are treated as compulsions, though it can be easy to confuse them with obsessive thoughts.

3. **Useful diagnostic tools** include the Yale Brown Obsessive Compulsive Scale (Y-BOCS), The Anxiety Disorders Interview Schedule for DSM-IV: Lifetime Version, The Florida Obsessive-Compulsive Inventory, and Obsessive-Compulsive Inventory-Revised (OCI-R) are also widely available. These tools can be used for diagnostic purposes or to assess progress in treatment (see resources for links to tools).

4. **Differential diagnosis** should include: obsessive-compulsive personality disorder, hoarding disorder or other OCD related disorders, depressive disorders, eating disorders, anxiety disorder due to a general medical condition, PTSD, ADHD, substance-induced anxiety disorder, Tourette's disorder, tic disorder, higher functioning autism spectrum disorders, hypochondriasis, and GAD. Differentiate depressive ruminations from obsessions by identifying thought content and resistance to such thoughts. Note that magical thinking is often a symptom OCD and does not necessarily indicate the presence of delusions.

5. **Assess for co-occurring behavioral health problems.** Research demonstrates that more than half of individuals with OCD have at least one additional disorder such as major depressive disorder, anxiety spectrum disorders, disruptive behavior disorders, tic disorders, learning disabilities, autism spectrum disorders, or eating disorders. Other obsessive-compulsive type disorders to consider include body dysmorphic disorder, trichotillomania, and habit problems (e.g., nail biting), although less common.

6. **The prevalence of OCD** in the United States is 1.2% annually. The age of onset for OCD is earlier for males than females, 6-15 years old and 20-29 years respectively. The adulthood incidence is slightly higher in females, though males are more affected in childhood. Onset of symptoms is generally gradual and course can be chronic without treatment.

7. **Assess for risk factors.** Traumatic events in childhood, such as physical and sexual abuse are associated with higher risk of OCD. Certain temperamental styles, including negative emotionality, internalizing symptoms and behavioral inhibition are possible risk factors. Family history of OCD also contributes to risk.

Understanding an individual's risk factors can illuminate potential triggers and help understand the constellation of symptoms. Risk factors can also impact treatment and prognosis.

8. Consider cultural factors. While there is substantial similarity of prevalence, course, and symptomology of OCD across cultures, there may be variation in the content of obsessions and compulsions. It is important to consider how an individual's culture shapes his/her understanding of their symptoms and view of treatment.

Treatment Guidelines:

1. Establish a strong therapeutic relationship in which the client feels safe and supported and willing to fully engage in the therapeutic process and commit to the difficult work that treatment will require. A strong rapport is essential when the clinician needs to challenge behavioral patterns and encourages clients to take risks, as is necessary with exposure based therapy.

2. **Assess regularly** for: suicidal risk, depressive symptoms, substance use/abuse, and psychosocial impairment. Understanding how symptoms impair daily functioning can help design exposure exercises based on those impairments. Though suicidal obsessions are common in OCD, less than 1% of people with OCD commit suicide.

3. The factors that influence treatment. Factors associated with a good prognosis include the following: 1) Milder symptoms; 2) Brief duration of symptoms; and 3) Good functioning before full onset. Co-occurring severe depression can inhibit treatment efficacy and needs to be treated prior to working on symptoms of OCD. It is important to intervene as early as possible to prevent worsening of the individual's condition. Regardless of a person's age at onset, the content of obsessions does not determine prognosis. Educating a client about how their unique history and genetic pre-disposition may have contributed to their symptoms can reduce self-blame.

4. **Exposure with Response Prevention (ERP),** a form of behavior therapy, is the best practice for the treatment of OCD. In this treatment, the individual is repeatedly exposed to the source of their obsession(s) while being prevented from engaging in the avoidance behavior (compulsion/ ritual). The source for one's obsessions may be related to his/her history, and can help understand the underlying fear network (such as a fear of contamination or a fear of losing control). Additionally, adding an imaginal exposure component, (i.e. describing catastrophic consequences or revisiting the experience in imagination), to the in vivo exposure can enhance long term outcomes. ERP has been shown to be more effective than relaxation or anxiety management training. It is essential that the clinician is familiar with the underlying principles of behavior therapy and is able to provide interventions accordingly. Recent studies also support the use of CBT and Acceptance and Commitment Therapy (ACT) in reducing the symptoms of OCD, especially when combined with exposure techniques. Supervision is recommended, unless well experienced with exposure based treatment.

5. Pharmacologic treatment, specifically**,** serotonergic medications, have been shown to be effective for OCD. However, no study has found clear, long term superiority for combined pharmacotherapy plus ERP over ERP alone. The symptom reduction with psychotropic medication can allow clients to tolerate the distress associated with ERP; thus, medication may be helpful in promoting readiness. Additionally, medications may be used to treat associated symptoms. (See medication algorithm)

6. Self-help or support groups provide persons with OCD the opportunity to share their challenges and achievements with others. Talking with a trusted friend or member of the clergy can also provide support, but it is not a substitute for care from a mental health professional.

7. Education for family and friends about how to be supportive without helping to perpetuate the symptoms should be included in the treatment plan. Through education, family and friends learn techniques such as patience and praise for small successes, such as completing exposure tasks. It is

important for family to support alternative strategies for coping with obsessive thoughts, as opposed to engaging in rituals. Family members should know that this is a very real and treatable condition.

*The Clinical Guidelines are meant to assist providers in making the best decisions about appropriate treatment in specific clinical circumstances. You are not required to follow them nor are you expected to be proficient in all of the therapeutic models described above. However, following the guidelines is one way to help ensure that your care is consistent with the most current research and best practices and that it is medically necessary.

References and Resources

American Psychiatric Association. Practice guideline for the treatment of patients with obsessive-compulsive disorder. Arlington, VA: American Psychiatric Association, 2007. Available online at http//www.psych.org/psych_pract/treatg/pg/prac_guide.cfm. Guideline watch updated 2013.

Abramowitz JS: *Getting Over OCD: A 10-Step Workbook for Taking Back Your Life.* New York, Guilford Press, 2009

Anthony, M., Swinson R: *When Perfect Isn't Good Enough: Strategies for Coping with Perfectionism.* Oakland, CA, New Harbinger Publications, 2009.

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Nathan, P.E. & Gorman, J.M. (2007). *A guide to treatments that work (3rd edition).* New York, NY: Oxford University Press, Inc.

Yadin E, Foa EB, Lichner TK: *Treating Your OCD With Exposure and Response (Ritual) Prevention: Workbook.* New York, Oxford University Press, 2012

Screening and Assessment Tools:

Yale Brown Obsessive Compulsive Scale (Y-BOCS): http://psychology-tools.com/yale-brown-obsessive-compulsive-scale/

The Florida Obsessive-Compulsive Inventory: http://ocdscales.org/

Obsessive-Compulsive Inventory-Revised (OCI-R): http://www.ocdtypes.com/oci-r-test.php