

# Obsessive-compulsive disorder and body dysmorphic disorder: treatment

Clinical guideline

Published: 29 November 2005

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## Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or service users. The application of the recommendations in this guideline are not mandatory and the guideline does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Local commissioners and/or providers have a responsibility to enable the guideline to be applied when individual health professionals and their patients or service users wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with compliance with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

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This guideline is the basis of QS53.

## Introduction

**Obsessive-compulsive disorder (OCD)** is characterised by the presence of either obsessions or compulsions, but commonly both. The symptoms can cause significant functional impairment and/or distress. An obsession is defined as an unwanted intrusive thought, image or urge that repeatedly enters the person's mind. Compulsions are repetitive behaviours or mental acts that the person feels driven to perform. A compulsion can either be overt and observable by others, such as checking that a door is locked, or a covert mental act that cannot be observed, such as repeating a certain phrase in one's mind.

It is thought that 1–2% of the population have OCD, although some studies have estimated 2–3%.

**Body dysmorphic disorder (BDD)** is characterised by a preoccupation with an imagined defect in one's appearance, or in the case of a slight physical anomaly, the person's concern is markedly excessive. BDD is characterised by time-consuming behaviours such as mirror gazing, comparing particular features to those of others, excessive camouflaging tactics to hide the defect, skin picking and reassurance seeking.

It is thought that 0.5–0.7% of the population have BDD.

The recommendations in this guideline were graded according to the quality of the evidence they were based on. The gradings are available in the [full guideline](#) and are not shown in this web version.

## Key priorities for implementation

### All people with OCD or BDD

- Each PCT, mental healthcare trust and children's trust that provides mental health services should have access to a specialist obsessive-compulsive disorder (OCD)/body dysmorphic disorder (BDD) multidisciplinary team offering age-appropriate care. This team would perform the following functions: increase the skills of mental health professionals in the assessment and evidence-based treatment of people with OCD or BDD, provide high-quality advice, understand family and developmental needs, and, when appropriate, conduct expert assessment and specialist cognitive-behavioural and pharmacological treatment.
- OCD and BDD can have a fluctuating or episodic course, or relapse may occur after successful treatment. Therefore, people who have been successfully treated and discharged should be seen as soon as possible if re-referred with further occurrences of OCD or BDD, rather than placed on a routine waiting list. For those in whom there has been no response to treatment, care coordination (or other suitable processes) should be used at the end of any specific treatment programme to identify any need for continuing support and appropriate services to address it.

### Adults with OCD or BDD

- In the initial treatment of adults with OCD, low intensity psychological treatments (including exposure and response prevention [ERP]) (up to 10 therapist hours per patient) should be offered if the patient's degree of functional impairment is mild and/or the patient expresses a preference for a low intensity approach. Low intensity treatments include:
  - brief individual cognitive behavioural therapy (CBT) (including ERP) using structured self-help materials
  - brief individual CBT (including ERP) by telephone
  - group CBT (including ERP) (note, the patient may be receiving more than 10 hours of therapy in this format).
- Adults with OCD with mild functional impairment who are unable to engage in low intensity CBT (including ERP), or for whom low intensity treatment has proved to be inadequate, should be offered the choice of either a course of a selective serotonin re-uptake inhibitor (SSRI) or more intensive CBT (including ERP) (more than 10 therapist hours per patient), because these treatments appear to be comparably efficacious.

- Adults with OCD with moderate functional impairment should be offered the choice of either a course of an SSRI or more intensive CBT (including ERP) (more than 10 therapist hours per patient), because these treatments appear to be comparably efficacious.
- Adults with BDD with moderate functional impairment should be offered the choice of either a course of an SSRI or more intensive individual CBT (including ERP) that addresses key features of BDD.

### Children and young people with OCD or BDD

- Children and young people with OCD with moderate to severe functional impairment, and those with OCD with mild functional impairment for whom guided self-help has been ineffective or refused, should be offered CBT (including ERP) that involves the family or carers and is adapted to suit the developmental age of the child as the treatment of choice. Group or individual formats should be offered depending upon the preference of the child or young person and their family or carers.
- Following multidisciplinary review, for a child (aged 8–11 years) with OCD or BDD with moderate to severe functional impairment, if there has not been an adequate response to CBT (including ERP) involving the family or carers, the addition of an SSRI to ongoing psychological treatment may be considered. Careful monitoring should be undertaken, particularly at the beginning of treatment.
- Following multidisciplinary review, for a young person (aged 12–18 years) with OCD or BDD with moderate to severe functional impairment if there has not been an adequate response to CBT (including ERP) involving the family or carers, the addition of an SSRI to ongoing psychological treatment should be offered. Careful monitoring should be undertaken, particularly at the beginning of treatment.
- All children and young people with BDD should be offered CBT (including ERP) that involves the family or carers and is adapted to suit the developmental age of the child or young person as first-line treatment.

## 1 Guidance

### 1.1 *Principles of care for all people with OCD or BDD and their families or carers*

#### 1.1.1 Understanding

1.1.1.1 People with OCD or BDD are often ashamed and embarrassed by their condition and may find it very difficult to discuss their symptoms with healthcare professionals, friends, family or carers. Healthcare professionals should help patients, and their families or carers where appropriate, to understand the involuntary nature of the symptoms by providing accurate information in an appropriate format on current understanding of the disorders from psychological and/or biological perspectives.

1.1.1.2 When assessing people with OCD or BDD, healthcare professionals should sensitively explore the hidden distress and disability commonly associated with the disorders, providing explanation and information wherever necessary. In particular, people with OCD who are distressed by their obsessive thoughts should be informed that such thoughts are occasionally experienced by almost everybody, and when frequent and distressing are a typical feature of OCD.

#### 1.1.2 Continuity of care

1.1.2.1 OCD and BDD are frequently recurring or chronic conditions that often affect some of the most intimate aspects of a person's life. Healthcare professionals should therefore ensure continuity of care and minimise the need for multiple assessments by different healthcare professionals.

1.1.2.2 Because OCD and BDD may occur across a person's lifespan, particular care should be given to the provision of appropriate care at all ages and a seamless transition between services aimed at specific ages, such as the transition from services for young people to services for adults.

1.1.2.3 Careful consideration should be given to the effective integration and coordination of care of people with OCD and BDD across both primary and secondary care. There should be clear, written agreement among individual healthcare professionals about the responsibility for monitoring and treating people with OCD and BDD. A written copy of this agreement should be given to

the patient. This should be in collaboration with the patient, and where appropriate:

- the Care Programme Approach (CPA) should be used
- the patient's family or carers should be involved
- healthcare professionals should liaise with other professionals involved in providing care and support to the patient.

### 1.1.3 Information and support

1.1.3.1 Treatment and care should take into account the individual needs and preferences of people with OCD or BDD. Patients should have the opportunity to make informed decisions about their care and treatment. Where patients do not have the capacity to make decisions, or children or young people are not old enough to do so, healthcare professionals should follow the Department of Health guidelines ([Reference guide to consent for examination or treatment \[2001\]](#)).

1.1.3.2 Good communication between healthcare professionals and people with OCD or BDD is essential. Provision of information, treatment and care should be tailored to the needs of the individual, culturally appropriate, and provided in a form that is accessible to people who have additional needs, such as learning difficulties, physical or sensory disabilities, or limited competence in speaking or reading English.

1.1.3.3 Healthcare professionals should consider informing people with OCD or BDD and their family or carers about local self-help and support groups, and encourage them to participate in such groups where appropriate.

### 1.1.4 Religion and culture

1.1.4.1 Obsessive-compulsive symptoms may sometimes involve a person's religion, such as religious obsessions and scrupulosity, or cultural practices. When the boundary between religious or cultural practice and obsessive-compulsive symptoms is unclear, healthcare professionals should, with the patient's consent, consider seeking the advice and support of an appropriate religious or community leader to support the therapeutic process.

## 1.1.5 Families and carers

- 1.1.5.1 Because OCD and BDD often have an impact on families and carers, healthcare professionals should promote a collaborative approach with people with OCD or BDD and their family or carers, wherever this is appropriate and possible.
- 1.1.5.2 In the treatment and care of people with OCD or BDD, family members or carers should be provided with good information (both verbal and written) about the disorder, its likely causes, its course and its treatment.
- 1.1.5.3 Assessment and treatment plans for people with OCD or BDD should, where appropriate, involve relevant family members or carers. In some cases, particularly with children and young people, when the symptoms of OCD or BDD interfere with academic or workplace performance, it may be appropriate to liaise with professionals from these organisations. Assessment should include the impact of rituals and compulsions on others (in particular on dependent children) and the degree to which carers are involved in supporting or carrying out behaviours related to the disorder.
- 1.1.5.4 If dependent children are considered to be at risk of emotional, social or mental health problems as a result of the behaviour of a parent with OCD or BDD and/or the child's involvement in related activity, independent assessment of the child should be requested. If this is carried out, the parent should be kept informed at every stage of the assessment.
- 1.1.5.5 In the treatment of people with OCD or BDD, especially when the disorder is moderate to severe or chronic, an assessment of their carer's social, occupational and mental health needs should be offered.

## 1.2 *Stepped care for adults, young people and children with OCD or BDD*

The stepped-care model draws attention to the different needs of people with OCD and BDD, depending on the characteristics of their disorder, their personal and social circumstances, their age, and the responses that are required from services. It provides a framework in which to organise the provision of services in order to identify and access the most effective interventions (see Figure 1).

### Figure 1 The stepped-care model

The [full guideline](#) contains Figure 1.

Stepped care attempts to provide the most effective but least intrusive treatments appropriate to a person's needs. It assumes that the course of the disorder is monitored and referral to the appropriate level of care is made depending on the person's difficulties. Each step introduces additional interventions; the higher steps normally assume interventions in the previous step have been offered and/or attempted, but there are situations where an individual may be referred to any appropriate level. The guidance follows the steps in the figure.

At all stages of assessment and treatment, families or carers should be involved as appropriate. This is particularly important in the treatment of children and young people with OCD or BDD where it may also be helpful to involve others in their network, for example teachers, school health advisors, educational psychologists, and educational social workers.

### 1.3 *Step 1: awareness and recognition*

Although the more common forms of OCD are likely to be recognised when people report symptoms, less common forms of OCD and many cases of BDD may remain unrecognised, sometimes for many years. Relatively few mental health professionals or GPs have expertise in the recognition, assessment, diagnosis and treatment of the less common forms of OCD and BDD.

- 1.3.1.1 Each PCT, mental healthcare trust and children's trust that provides mental health services should have access to a specialist OCD/BDD multidisciplinary team offering age-appropriate care. This team would perform the following functions: increase the skills of mental health professionals in the assessment and evidence-based treatment of people with OCD or BDD, provide high-quality advice, understand family and developmental needs, and, when appropriate, conduct expert assessment and specialist cognitive-behavioural and pharmacological treatment.
- 1.3.1.2 Specialist mental healthcare professionals in OCD or BDD should collaborate with local and national voluntary organisations to increase awareness and understanding of the disorders and improve access to high-quality information about them. Such information should also be made available to primary and secondary healthcare professionals, and to professionals from other public services who may come into contact with people of any age with OCD or BDD.

1.3.1.3 Specialist OCD/BDD teams should collaborate with people with OCD or BDD and their families or carers to provide training for all mental health professionals, cosmetic surgeons and dermatology professionals.

## 1.4 *Step 2: recognition and assessment*

### 1.4.1 OCD

1.4.1.1 For people known to be at higher risk of OCD (such as individuals with symptoms of depression, anxiety, alcohol or substance misuse, BDD or an eating disorder), or for people attending dermatology clinics, healthcare professionals should routinely consider and explore the possibility of comorbid OCD by asking direct questions about possible symptoms such as the following.

- Do you wash or clean a lot?
- Do you check things a lot?
- Is there any thought that keeps bothering you that you would like to get rid of but can not?
- Do your daily activities take a long time to finish?
- Are you concerned about putting things in a special order or are you very upset by mess?
- Do these problems trouble you?

1.4.1.2 In people who have been diagnosed with OCD, healthcare professionals should assess the risk of self-harm and suicide, especially if they have also been diagnosed with depression. Part of the risk assessment should include the impact of their compulsive behaviours on themselves or others. Other comorbid conditions and psychosocial factors that may contribute to risk should also be considered.

1.4.1.3 If healthcare professionals are uncertain about the risks associated with intrusive sexual, aggressive or death-related thoughts reported by people with OCD, they should consult mental health professionals with specific expertise in the assessment and management of OCD. These themes are common in people with OCD at any age, and are often misinterpreted as indicating risk.

## 1.4.2 BDD

- 1.4.2.1 For people known to be at higher risk of BDD (such as individuals with symptoms of depression, social phobia, alcohol or substance misuse, OCD or an eating disorder), or for people with mild disfigurements or blemishes who are seeking a cosmetic or dermatological procedure, healthcare professionals should routinely consider and explore the possibility of BDD.
- 1.4.2.2 In the assessment of people at higher risk of BDD, the following five questions should be asked to help identify individuals with BDD.
- Do you worry a lot about the way you look and wish you could think about it less?
  - What specific concerns do you have about your appearance?
  - On a typical day, how many hours a day is your appearance on your mind? (More than 1 hour a day is considered excessive.)
  - What effect does it have on your life?
  - Does it make it hard to do your work or be with friends?
- 1.4.2.3 People with suspected or diagnosed BDD seeking cosmetic surgery or dermatological treatment should be assessed by a mental health professional with specific expertise in the management of BDD.
- 1.4.2.4 In people who have been diagnosed with BDD, healthcare professionals should assess the risk of self-harm and suicide, especially if they have also been diagnosed with depression. Other comorbid conditions and psychosocial factors that may contribute to risk should also be considered.
- 1.4.2.5 All children and young people who have been diagnosed with BDD should be assessed for suicidal ideation and a full risk assessment should be carried out before treatment is undertaken. If risks are identified, all professionals involved in primary and secondary care should be informed and appropriate risk management strategies put into place.
- 1.4.2.6 Specialist mental health professionals in BDD should work in partnership with cosmetic surgeons and dermatologists to ensure that an agreed screening system is in place to accurately identify people with BDD and that agreed

referral criteria have been established. They should help provide training opportunities for cosmetic surgeons and dermatologists to aid in the recognition of BDD.

## 1.5 *Steps 3–5: treatment options for people with OCD or BDD*

Effective treatments for OCD and BDD should be offered at all levels of the healthcare system. The difference in the treatments at the higher levels will reflect increasing experience and expertise in the implementation of a limited range of therapeutic options. For many people, initial treatment may be best provided in primary care settings. However, people with more impaired functioning, higher levels of comorbidity, or poor response to initial treatment will require care from teams with greater levels of expertise and experience in the management of OCD/BDD.

Irrespective of the level of care, the following recommendations should be taken into account when selecting initial treatments for people with OCD or BDD. The specific recommendations on how to provide these treatments follow in the subsequent sections.

Regulatory authorities have identified that the use of SSRIs to treat depression in children and young people may be associated with the appearance of suicidal behaviour, self-harm or hostility, particularly at the beginning of treatment. There is no clear evidence of an increased risk of self-harm and suicidal thoughts in young adults aged 18 years or older. But individuals mature at different rates and young adults are at a higher background risk of suicidal behaviour than older adults. Hence, young adults treated with SSRIs should be closely monitored as a precautionary measure. The Committee on Safety of Medicine's Expert Working Group on SSRIs, at a meeting in February 2005, advised that it could not be ruled out that the risk of suicidal behaviour, hostility and other adverse reactions seen in the paediatric depression trials applies to use in children or young people in all indications. Consequently, the recommendations about the use of SSRIs for people of any age with OCD or BDD have taken account of the position of regulatory authorities.

### 1.5.1 Initial treatment options

#### Adults

The intensity of psychological treatment has been defined as the hours of therapist input per patient. By this definition, most group treatments are defined as low intensity treatment (less than 10 hours of therapist input per patient), although each patient may receive a much greater number of hours of therapy.

- 1.5.1.1 In the initial treatment of adults with OCD, low intensity psychological treatments (including ERP) (up to 10 therapist hours per patient) should be offered if the patient's degree of functional impairment is mild and/or the patient expresses a preference for a low intensity approach. Low intensity treatments include:
- brief individual CBT (including ERP) using structured self-help materials
  - brief individual CBT (including ERP) by telephone
  - group CBT (including ERP) (note, the patient may be receiving more than 10 hours of therapy in this format).
- 1.5.1.2 Adults with OCD with mild functional impairment who are unable to engage in low intensity CBT (including ERP), or for whom low intensity treatment has proved to be inadequate, should be offered the choice of either a course of an SSRI or more intensive CBT (including ERP) (more than 10 therapist hours per patient), because these treatments appear to be comparably efficacious.
- 1.5.1.3 Adults with OCD with moderate functional impairment should be offered the choice of either a course of an SSRI or more intensive CBT (including ERP) (more than 10 therapist hours per patient), because these treatments appear to be comparably efficacious.
- 1.5.1.4 Adults with OCD with severe functional impairment should be offered combined treatment with an SSRI and CBT (including ERP).
- 1.5.1.5 Adults with BDD with mild functional impairment should be offered a course of CBT (including ERP) that addresses key features of BDD in individual or group formats. The most appropriate format should be jointly decided by the patient and the healthcare professional.
- 1.5.1.6 Adults with BDD with moderate functional impairment should be offered the choice of either a course of an SSRI or more intensive individual CBT (including ERP) that addresses key features of BDD.
- 1.5.1.7 Adults with BDD with severe functional impairment should be offered combined treatment with an SSRI and CBT (including ERP) that addresses key features of BDD.

## Children and young people

- 1.5.1.8 For children and young people with OCD with mild functional impairment, guided self-help may be considered in conjunction with support and information for the family or carers.
- 1.5.1.9 Children and young people with OCD with moderate to severe functional impairment, and those with OCD with mild functional impairment for whom guided self-help has been ineffective or refused, should be offered CBT (including ERP) that involves the family or carers and is adapted to suit the developmental age of the child as the treatment of choice. Group or individual formats should be offered depending upon the preference of the child or young person and their family or carers.
- 1.5.1.10 All children and young people with BDD should be offered CBT (including ERP) that involves the family or carers and is adapted to suit the developmental age of the child or young person as first-line treatment.
- 1.5.1.11 If psychological treatment is declined by children or young people with OCD or BDD and their families or carers, or they are unable to engage in treatment, an SSRI may be considered with specific arrangements for careful monitoring for adverse events.
- 1.5.1.12 The co-existence of comorbid conditions, learning disorders, persisting psychosocial risk factors such as family discord, or the presence of parental mental health problems, may be factors if the child or young person's OCD or BDD is not responding to any treatment. Additional or alternative interventions for these aspects should be considered. The child or young person will still require evidence-based treatments for his or her OCD or BDD.

## 1.5.2 How to use psychological interventions

### Training

- 1.5.2.1 All healthcare professionals offering psychological treatments to people of all ages with OCD or BDD should receive appropriate training in the interventions they are offering and receive ongoing clinical supervision in line with the

recommendations in *Organising and Delivering Psychological Therapies* (Department of Health, 2004)<sup>[1]</sup>.

## Adults

- 1.5.2.2 For adults with obsessive thoughts who do not have overt compulsions, CBT (including exposure to obsessive thoughts and response prevention of mental rituals and neutralising strategies) should be considered.
- 1.5.2.3 For adults with OCD, cognitive therapy adapted for OCD may be considered as an addition to ERP to enhance long-term symptom reduction.
- 1.5.2.4 For adults with OCD living with their family or carers, involving a family member or carer as a co-therapist in ERP should be considered where this is appropriate and acceptable to those involved.
- 1.5.2.5 For adults with OCD with more severe functional impairment who are housebound, unable or reluctant to attend a clinic, or have significant problems with hoarding, a period of home-based treatment may be considered.
- 1.5.2.6 For adults with OCD with more severe functional impairment who are housebound and unable to undertake home-based treatment because of the nature of their symptoms (such as contamination concerns or hoarding that prevents therapists' access to the patient's home), a period of CBT by telephone may be considered.
- 1.5.2.7 For adults with OCD who refuse or cannot engage with treatments that include ERP, individual cognitive therapy specifically adapted for OCD may be considered.
- 1.5.2.8 When adults with OCD request forms of psychological therapy other than cognitive and/or behavioural therapies as a specific treatment for OCD (such as psychoanalysis, transactional analysis, hypnosis, marital/couple therapy) they should be informed that there is as yet no convincing evidence for a clinically important effect of these treatments.
- 1.5.2.9 When family members or carers of people with OCD or BDD have become involved in compulsive behaviours, avoidance or reassurance seeking,

treatment plans should help them reduce their involvement in these behaviours in a sensitive and supportive manner.

1.5.2.10 Adults with OCD or BDD with significant functional impairment may need access to appropriate support for travel and transport to allow them to attend for their treatment.

1.5.2.11 Towards the end of treatment, healthcare professionals should inform adults with OCD or BDD about how the principles learned can be applied to the same or other symptoms if they occur in the future.

### Children and young people

Psychological treatments for children and young people should be collaborative and engage the family or carers. When using psychological treatments for children or young people, healthcare professionals should consider the wider context and other professionals involved with the individual. The recommendations on the use of psychological interventions for adults may also be considered, where appropriate.

1.5.2.12 In the cognitive-behavioural treatment of children and young people with OCD or BDD, particular attention should be given to:

- developing and maintaining a good therapeutic alliance with the child or young person, as well as their family or carers
- maintaining optimism in both the child or young person and their family or carers
- collaboratively identifying initial and subsequent treatment targets with the child or young person
- actively engaging the family or carers in planning treatment and in the treatment process, especially in ERP where, if appropriate and acceptable, they may be asked to assist the child or young person
- encouraging the use of ERP if new or different symptoms emerge after successful treatment
- liaising with other professionals involved in the child or young person's life, including teachers, social workers and other healthcare professionals, especially when

compulsive activity interferes with the ordinary functioning of the child or young person

- offering one or more additional sessions if needed at review appointments after completion of CBT.

1.5.2.13 In the psychological treatment of children and young people with OCD or BDD, healthcare professionals should consider including rewards in order to enhance their motivation and reinforce desired behaviour changes.

### 1.5.3 How to use pharmacological interventions in adults

Current published evidence suggests that SSRIs are effective in treating adults with OCD or BDD, although evidence for the latter is limited and less certain. However, SSRIs may increase the risk of suicidal thoughts and self-harm in people with depression and in younger people. It is currently unclear whether there is an increased risk for people with OCD or BDD. Regulatory authorities recommend caution in the use of SSRIs until evidence for differential safety has been demonstrated.

#### Starting the treatment

1.5.3.1 Common concerns about taking medication for OCD or BDD should be addressed. Patients should be advised, both verbally and with written material, that:

- craving and tolerance do not occur
- there is a risk of discontinuation/withdrawal symptoms on stopping the drug, missing doses, or reducing the dose
- there is a range of potential side effects, including worsening anxiety, suicidal thoughts and self-harm, which need to be carefully monitored, especially in the first few weeks of treatment
- there is commonly a delay in the onset of effect of up to 12 weeks, although depressive symptoms improve more quickly
- taking medication should not be seen as a weakness.

#### Monitoring risk

- 1.5.3.2 Adults with OCD or BDD started on SSRIs who are not considered to be at increased risk of suicide or self-harm should be monitored closely and seen on an appropriate and regular basis. The arrangements for monitoring should be agreed by the patient and the healthcare professional, and recorded in the notes.
- 1.5.3.3 Because of the potential increased risk of suicidal thoughts and self-harm associated with the early stages of SSRI treatment, younger adults (younger than age 30 years) with OCD or BDD, or people with OCD or BDD with comorbid depression, or who are considered to be at an increased risk of suicide, should be carefully and frequently monitored by healthcare professionals. Where appropriate, other carers – as agreed by the patient and the healthcare professional – may also contribute to the monitoring until the risk is no longer considered significant. The arrangements for monitoring should be agreed by the patient and the healthcare professional, and recorded in the notes.
- 1.5.3.4 For adults with OCD or BDD at a high risk of suicide, a limited quantity of medication should be prescribed.
- 1.5.3.5 When adults with OCD or BDD, especially those with comorbid depression, are assessed to be at a high risk of suicide, the use of additional support such as more frequent direct contacts with primary care staff or telephone contacts should be considered, particularly during the first weeks of treatment.
- 1.5.3.6 For adults with OCD or BDD, particularly in the initial stages of SSRI treatment, healthcare professionals should actively seek out signs of akathisia or restlessness, suicidal ideation and increased anxiety and agitation. They should also advise patients to seek help promptly if symptoms are at all distressing.
- 1.5.3.7 Adults with OCD or BDD should be monitored around the time of dose changes for any new symptoms or worsening of their condition.

## Choice of drug treatment

### *Selective serotonin reuptake inhibitors (SSRIs)*

- 1.5.3.8 For adults with OCD, the initial pharmacological treatment should be one of the following SSRIs: fluoxetine, fluvoxamine, paroxetine, sertraline or citalopram<sup>[2]</sup>.
- 1.5.3.9 For adults with BDD (including those with beliefs of delusional intensity), the initial pharmacological treatment should be fluoxetine<sup>[3]</sup> because there is more evidence for its effectiveness in BDD than there is for other SSRIs.
- 1.5.3.10 In the event that an adult with OCD or BDD develops marked and/or prolonged akathisia, restlessness or agitation while taking an SSRI, the use of the drug should be reviewed. If the patient prefers, the drug should be changed to a different SSRI.
- 1.5.3.11 Healthcare professionals should be aware of the increased risk of drug interactions when prescribing an SSRI to adults with OCD or BDD who are taking other medications.
- 1.5.3.12 For adults with OCD or BDD, if there has been no response to a full course of treatment with an SSRI, healthcare professionals should check that the patient has taken the drug regularly and in the prescribed dose and that there is no interference from alcohol or substance use.
- 1.5.3.13 For adults with OCD or BDD, if there has not been an adequate response to a standard dose of an SSRI, and there are no significant side effects after 4–6 weeks, a gradual increase in dose should be considered in line with the schedule suggested by the Summary of Product Characteristics.
- 1.5.3.14 For adults with OCD or BDD, the rate at which the dose of an SSRI should be increased should take into account therapeutic response, adverse effects and patient preference. Patients should be warned about, and monitored for, the emergence of side effects during dose increases.
- 1.5.3.15 If treatment for OCD or BDD with an SSRI is effective, it should be continued for at least 12 months to prevent relapse and allow for further improvements.
- 1.5.3.16 When an adult with OCD or BDD has taken an SSRI for 12 months after remission (symptoms are not clinically significant and the person is fully functioning for at least 12 weeks), healthcare professionals should review with the patient the need for continued treatment. This review should consider the

severity and duration of the initial illness, the number of previous episodes, the presence of residual symptoms, and concurrent psychosocial difficulties.

1.5.3.17 If treatment for OCD or BDD with an SSRI is continued for an extended period beyond 12 months after remission (symptoms are not clinically significant and the person is fully functioning for at least 12 weeks), the need for continuation should be reviewed at regular intervals, agreed between the patient and the prescriber, and written in the notes.

1.5.3.18 For adults with OCD or BDD, to minimise discontinuation/withdrawal symptoms when reducing or stopping SSRIs, the dose should be tapered gradually over several weeks according to the person's need. The rate of reduction should take into account the starting dose, the drug half-life and particular profiles of adverse effects.

1.5.3.19 Healthcare professionals should encourage adults with OCD or BDD who are discontinuing SSRI treatment to seek advice if they experience significant discontinuation/withdrawal symptoms.

#### *Other drugs*

1.5.3.20 The following drugs should not normally be used to treat OCD or BDD without comorbidity:

- tricyclic antidepressants other than clomipramine
- tricyclic-related antidepressants
- serotonin and noradrenaline re-uptake inhibitors (SNRIs), including venlafaxine
- monoamine oxidase inhibitors (MAOIs)
- anxiolytics (except cautiously for short periods to counter the early activation of SSRIs).

1.5.3.21 Antipsychotics as a monotherapy should not normally be used for treating OCD.

1.5.3.22 Antipsychotics as a monotherapy should not normally be used for treating BDD (including beliefs of delusional intensity).

### 1.5.4 Poor response to initial treatment in adults

If initial treatment does not result in a clinically significant improvement in both symptoms and functioning, other treatment options should be considered. When additional treatment options also fail to produce an adequate response, multidisciplinary teams with specific expertise in OCD/BDD should become involved. Their role should include supporting and collaborating with those professionals already involved in an individual's care.

- 1.5.4.1 For adults with OCD or BDD, if there has not been an adequate response to treatment with an SSRI alone (within 12 weeks) or CBT (including ERP) alone (more than 10 therapist hours per patient), a multidisciplinary review should be carried out.
- 1.5.4.2 Following multidisciplinary review, for adults with OCD or BDD, if there has not been an adequate response to treatment with an SSRI alone (within 12 weeks) or CBT (including ERP) alone (more than 10 therapist hours per patient), combined treatment with CBT (including ERP) and an SSRI should be offered.
- 1.5.4.3 For adults with OCD or BDD, if there has not been an adequate response after 12 weeks of combined treatment with CBT (including ERP) and an SSRI, or there has been no response to an SSRI alone, or the patient has not engaged with CBT, a different SSRI or clomipramine should be offered.
- 1.5.4.4 Clomipramine should be considered in the treatment of adults with OCD or BDD after an adequate trial of at least one SSRI has been ineffective or poorly tolerated, if the patient prefers clomipramine or has had a previous good response to it.
- 1.5.4.5 For adults with OCD or BDD, if there has been no response to a full trial of at least one SSRI alone, a full trial of combined treatment with CBT (including ERP) and an SSRI, and a full trial of clomipramine alone, the patient should be referred to a multidisciplinary team with specific expertise in the treatment of OCD/BDD for assessment and further treatment planning.
- 1.5.4.6 The assessment of adults with OCD or BDD referred to multidisciplinary teams with specific expertise in OCD/BDD should include a comprehensive assessment of their symptom profile, previous pharmacological and psychological treatment history, adherence to prescribed medication, history of

side effects, comorbid conditions such as depression, suicide risk, psychosocial stressors, relationship with family and/or carers and personality factors.

1.5.4.7 Following multidisciplinary review, for adults with OCD if there has been no response to a full trial of at least one SSRI alone, a full trial of combined treatment with CBT (including ERP) and an SSRI, and a full trial of clomipramine alone, the following treatment options should also be considered (note, there is no evidence of the optimal sequence of the options listed below):

- additional CBT (including ERP) or cognitive therapy
- adding an antipsychotic to an SSRI or clomipramine
- combining clomipramine and citalopram.

1.5.4.8 Following multidisciplinary review, for adults with BDD, if there has been no response to a full trial of at least one SSRI alone, a full trial of combined treatment with CBT (including ERP) and an SSRI, and a full trial of clomipramine alone, the following treatment options should also be considered (note, there is no evidence of the optimal sequence of the options listed below):

- additional CBT or cognitive therapy by a different multidisciplinary team with expertise in BDD
- adding buspirone<sup>[4]</sup> to an SSRI.

1.5.4.9 For adults with BDD, if there has been no response to treatment, or the patient is not receiving appropriate treatment, more intensive monitoring is needed because the risk of suicide is high in people with BDD.

1.5.4.10 Treatments such as combined antidepressants and antipsychotic augmentation should not be routinely initiated in primary care.

### How to use clomipramine in adults

1.5.4.11 For adults with OCD or BDD who are at a significant risk of suicide, healthcare professionals should only prescribe small amounts of clomipramine at a time because of its toxicity in overdose<sup>[5]</sup>. The patient should be monitored regularly until the risk of suicide has subsided.

- 1.5.4.12 An electrocardiogram (ECG) should be carried out and a blood pressure measurement taken before prescribing clomipramine for adults with OCD or BDD at significant risk of cardiovascular disease.
- 1.5.4.13 For adults with OCD or BDD, if there has not been an adequate response to the standard dose of clomipramine, and there are no significant side effects, a gradual increase in dose should be considered in line with the schedule suggested by the Summary of Product Characteristics.
- 1.5.4.14 For adults with OCD or BDD, treatment with clomipramine should be continued for at least 12 months if it appears to be effective and because there may be further improvement.
- 1.5.4.15 For adults with OCD or BDD, when discontinuing clomipramine, doses should be reduced gradually in order to minimise potential discontinuation/withdrawal symptoms.

## 1.5.5 Poor response to initial treatment in children and young people

Current published evidence suggests that SSRIs are effective in treating children and young people with OCD. The only SSRIs licensed for use in children and young people with OCD are fluvoxamine and sertraline. When used as a treatment for depression, SSRIs can cause significant adverse reactions, including increased suicidal thoughts and risk of self-harm, but it is not known whether this same risk occurs with their use in OCD. SSRIs may be safer in depression when combined with psychological treatments (see the NICE guideline on [depression in children and young people](#)). Given that the UK regulatory authority has advised that similar adverse reactions cannot be ruled out in OCD, appropriate caution should be observed, especially in the presence of comorbid depression.

- 1.5.5.1 For a child or young person with OCD or BDD, if there has not been an adequate response within 12 weeks to a full trial of CBT (including ERP) involving the family or carers, a multidisciplinary review should be carried out.
- 1.5.5.2 Following multidisciplinary review, for a *child* (aged 8–11 years) with OCD or BDD with moderate to severe functional impairment, if there has not been an adequate response to CBT (including ERP) involving the family or carers, the addition of an SSRI to ongoing psychological treatment may be considered.

Careful monitoring should be undertaken, particularly at the beginning of treatment.

- 1.5.5.3 Following multidisciplinary review, for a **young person** (aged 12–18 years) with OCD or BDD with moderate to severe functional impairment, if there has not been an adequate response to CBT (including ERP) involving the family or carers, the addition of an SSRI to ongoing psychological treatment should be offered. Careful monitoring should be undertaken, particularly at the beginning of treatment.
- 1.5.5.4 For a child or a young person with OCD or BDD, if treatment with an SSRI in combination with CBT (including ERP) involving the family or carers is unsuccessful or is not tolerated because of side effects, the use of another SSRI or clomipramine<sup>[6]</sup> with careful monitoring may be considered, especially if the child or young person has had a positive response to these alternatives in the past. This should also be in combination with CBT (including ERP).

## 1.5.6 How to use pharmacological treatments in children and young people

In adults with OCD treated by medication, there is some clinical trial evidence regarding the onset of therapeutic response, the dose needed, the rate of increase of dose, the duration of treatment and the likelihood of relapse on discontinuation. Trials of these aspects have not been done in children and/or young people, but the following good practice for prescribing SSRIs or clomipramine is based on adult trials and clinical experience.

### How to use SSRIs in children and young people

- 1.5.6.1 An SSRI should only be prescribed to children and young people with OCD or BDD following assessment and diagnosis by a child and adolescent psychiatrist who should also be involved in decisions about dose changes and discontinuation.
- 1.5.6.2 When an SSRI is prescribed to children and young people with OCD or BDD, it should be in combination with concurrent CBT (including ERP). If children and young people are unable to engage with concurrent CBT, specific arrangements should be made for careful monitoring of adverse events and these arrangements should be recorded in the notes.

- 1.5.6.3 Children and young people with OCD or BDD starting treatment with SSRIs should be carefully and frequently monitored and seen on an appropriate and regular basis. This should be agreed by the patient, his or her family or carers and the healthcare professional, and recorded in the notes.
- 1.5.6.4 A licensed medication (sertraline<sup>[7]</sup> or fluvoxamine<sup>[8]</sup>) should be used when an SSRI is prescribed to children and young people with OCD, except in patients with significant comorbid depression when fluoxetine<sup>[9]</sup> should be used, because of current regulatory requirements.
- 1.5.6.5 Fluoxetine<sup>[10]</sup> should be used when an SSRI is prescribed to children and young people with BDD.
- 1.5.6.6 For children and young people with OCD or BDD who also have significant depression, the NICE recommendations for the treatment of childhood depression<sup>[11]</sup> should be followed and there should be specific monitoring for suicidal thoughts or behaviours.
- 1.5.6.7 Children and young people with OCD or BDD starting treatment with SSRIs should be informed about the rationale for the drug treatment, the delay in onset of therapeutic response (up to 12 weeks), the time course of treatment, the possible side effects and the need to take the medication as prescribed. Discussion of these issues should be supplemented by written information appropriate to the needs of the child or young person and their family or carers.
- 1.5.6.8 The starting dose of medication for children and young people with OCD or BDD should be low, especially in younger children. A half or quarter of the normal starting dose may be considered for the first week.
- 1.5.6.9 If a lower dose of medication for children and young people with OCD or BDD is ineffective, the dose should be increased until a therapeutic response is obtained, with careful and close monitoring for adverse events. The rate of increase should be gradual and should take into account the delay in therapeutic response (up to 12 weeks) and the age of the patient. Maximum recommended doses for children and young people should not be exceeded.
- 1.5.6.10 Children and young people prescribed an SSRI, and their families or carers, should be informed by the prescribing doctor about the possible appearance of

suicidal behaviour, self-harm or hostility, particularly at the beginning of treatment. They should be advised that if there is any sign of new symptoms of these kinds, they should make urgent contact with their medical practitioner.

- 1.5.6.11 Where children or young people with OCD or BDD respond to treatment with an SSRI, medication should be continued for at least 6 months post-remission (that is, symptoms are not clinically significant and the child or young person is fully functioning for at least 12 weeks).

#### **How to use clomipramine in children and young people**

- 1.5.6.12 Children and young people with OCD or BDD and their families or carers should be advised about the possible side effects of clomipramine, including toxicity in overdose.
- 1.5.6.13 Before starting treatment with clomipramine in children and young people with OCD or BDD, an ECG should be carried out to exclude cardiac conduction abnormalities.
- 1.5.6.14 For a child or young person with OCD or BDD, if there has not been an adequate response to the standard dose of clomipramine, and there are no significant side effects, a gradual increase in dose may be cautiously considered.
- 1.5.6.15 Treatment of a child or young person with OCD or BDD with clomipramine should be continued for at least 6 months if the treatment appears to be effective, because there may be further improvement in symptoms.

#### **Stopping or reducing SSRIs and clomipramine in children and young people**

- 1.5.6.16 In children and young people with OCD or BDD, an attempt should be made to withdraw medication if remission has been achieved (that is, symptoms are no longer clinically significant and the child or young person is fully functioning) and maintained for at least 6 months, and if that is their wish. Patients and their family or carers should be warned that relapse and/or discontinuation/withdrawal symptoms may occur. They should be advised to contact their medical practitioner should symptoms of discontinuation/withdrawal arise.

1.5.6.17 For children and young people with OCD or BDD, to minimise discontinuation/ withdrawal symptoms on reducing or stopping antidepressants, particularly SSRIs, the dose should be tapered gradually over several weeks according to the individual's need. The rate of reduction should take into account the starting dose, the drug half-life and particular profiles of adverse effects.

1.5.6.18 Children and young people with OCD or BDD should continue with psychological treatment throughout the period of drug discontinuation because this may reduce the risk of relapse.

### Other drugs

1.5.6.19 Tricyclic antidepressants other than clomipramine should not be used to treat OCD or BDD in children and young people.

1.5.6.20 Other antidepressants (MAOIs, SNRIs) should not be used to treat OCD or BDD in children and young people.

1.5.6.21 Antipsychotics should not be used alone in the routine treatment of OCD or BDD in children or young people, but may be considered as an augmentation strategy.

## 1.6 *Step 6: intensive treatment and inpatient services for people with OCD or BDD*

1.6.1.1 People with severe, chronic, treatment-refractory OCD or BDD should have continuing access to specialist treatment services staffed by multidisciplinary teams of healthcare professionals with expertise in the management of the disorders.

1.6.1.2 Inpatient services, with specific expertise in OCD and BDD, are appropriate for a small proportion of people with these disorders, and may be considered when:

- there is risk to life
- there is severe self-neglect
- there is extreme distress or functional impairment

- there has been no response to adequate trials of pharmacological/psychological/combined treatments over long periods of time in other settings
- a person has additional diagnoses, such as severe depression, anorexia nervosa or schizophrenia, that make outpatient treatment more complex
- a person has a reversal of normal night/day patterns that make attendance at any daytime therapy impossible
- the compulsions and avoidance behaviour are so severe or habitual that they cannot undertake normal activities of daily living.

1.6.1.3 A small minority of adults with long-standing and disabling obsessive-compulsive symptoms that interfere with daily living and have prevented them from developing a normal level of autonomy may, in addition to treatment, need suitable accommodation in a supportive environment that will enable them to develop life skills for independent living.

1.6.1.4 Neurosurgery is not recommended in the treatment of OCD. However, if a patient requests neurosurgery because they have severe OCD that is refractory to other forms of treatment, the following should be taken into consideration.

- Existing published criteria (such as Matthews and Eljamel, 2003<sup>[12]</sup>) should be used to guide decisions about suitability.
- Multidisciplinary teams with a high degree of expertise in the pharmacological and psychological treatment of OCD should have been recently involved in the patient's care. All pharmacological options should have been considered and every attempt should have been made to engage the individual in CBT (including ERP) and cognitive therapy, including very intensive and/or inpatient treatments.
- Standardised assessment protocols should be used pre- and post-operation and at medium- and long-term follow-ups in order to audit the interventions. These assessment protocols should include standardised measures of symptoms, quality of life, social and personality function, as well as comprehensive neuropsychological tests.
- Services offering assessment for neurosurgical treatments should have access to independent advice on issues such as adequacy of previous treatment and consent and should be subject to appropriate oversight.

- Post-operative care should be carefully considered, including pharmacological and psychological therapies.
- Services offering assessment for neurosurgical treatments should be committed to sharing and publishing audit information.

1.6.1.5 For children and young people with severe OCD or BDD with high levels of distress and/or functional impairment, if there has been no response to adequate treatment in outpatient settings, or there is significant self-neglect or risk of suicide, assessment for intensive inpatient treatment in units where specialist treatment for children or young people with OCD or BDD is available should be offered.

## 1.7 *Discharge after recovery*

1.7.1.1 When a person of any age with OCD or BDD is in remission (symptoms are not clinically significant and the person is fully functioning for 12 weeks), he or she should be reviewed regularly for 12 months by a mental health professional. The exact frequency of contact should be agreed between the professional and the person with OCD or BDD and/or the family and/or carer and recorded in the notes. At the end of the 12-month period if recovery is maintained the person can be discharged to primary care.

1.7.1.2 OCD and BDD can have a fluctuating or episodic course, or relapse may occur after successful treatment. Therefore, people who have been successfully treated and discharged should be seen as soon as possible if re-referred with further occurrences of OCD or BDD, rather than placed on a routine waiting list. For those in whom there has been no response to treatment, care coordination (or other suitable processes) should be used at the end of any specific treatment programme to identify any need for continuing support and appropriate services to address it.

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<sup>[1]</sup> Department of Health (2004) *Organising and Delivering Psychological Therapies*. London: Department of Health.

<sup>[2]</sup> Citalopram does not have a UK Marketing Authorisation for use in OCD in adults at the date of publication (November 2005).

<sup>[3]</sup> Fluoxetine does not have a UK Marketing Authorisation for use in BDD at the date of publication (November 2005).

<sup>[4]</sup> Buspirone does not have a UK Marketing Authorisation for use in BDD at the date of publication (November 2005).

<sup>[5]</sup> Refer to the Summary of Product Characteristics for details about appropriate dosage.

<sup>[6]</sup> Clomipramine does not have a UK Marketing Authorisation for use in OCD or BDD in children and young people at the date of publication (November 2005).

<sup>[7]</sup> Sertraline has a UK Marketing Authorisation for use in OCD in children 6 years and older at the date of publication (November 2005).

<sup>[8]</sup> Fluvoxamine has a UK Marketing Authorisation for use in OCD in children 8 years and older at the date of publication (November 2005).

<sup>[9]</sup> Fluoxetine does not have a UK Marketing Authorisation for use in OCD in children and young people at the date of publication (November 2005).

<sup>[10]</sup> Fluoxetine does not have a UK Marketing Authorisation for use in BDD at the date of publication (November 2005).

<sup>[11]</sup> Depression in children: identification and management of depression in children and young people in primary care and specialist services. [NICE guideline CG28](#).

<sup>[12]</sup> Matthews K, Eljamel MS (2003) Status of neurosurgery for mental disorder in Scotland. Selective literature review and overview of current clinical activity. *British Journal of Psychiatry* 182:404–411.

## 2 Notes on the scope of the guidance

All NICE guidelines are developed in accordance with a scope document that defines what the guideline will and will not cover. The scope of this guideline was established at the start of the development of this guideline, following a period of consultation.

This guideline is relevant to children, young people and adults diagnosed with OCD or BDD, to their families and carers, and to all healthcare professionals involved in the help, treatment and care of people with OCD or BDD. These include the following.

- Professional groups who share in the treatment and care of people diagnosed with OCD or BDD, including psychiatrists, clinical psychologists, mental health nurses, community psychiatric nurses, social workers, practice nurses, secondary care medical staff, paramedical staff, occupational therapists, pharmacists, paediatricians, other physicians and general medical professionals.
- Professionals in other health and non-health sectors who may have direct contact with or are involved in the provision of health and other public services for those diagnosed with OCD or BDD. These may include prison doctors, the police and professionals who work in the criminal justice and education sectors.
- Those with responsibility for planning services for people diagnosed with OCD or BDD and their carers, including directors of public health, NHS trust managers and managers in primary care trusts.

The guidance does not specifically address care and treatment not normally available on the NHS.

## 3 Implementation in the NHS

### 3.1 *Resource implications*

Local health communities should review their existing practice for OCD and BDD against this guideline. The review should consider the resources required to implement the recommendations set out in Section 1, the people and processes involved, and the timeline over which full implementation is envisaged. It is in the interests of people with OCD and BDD that implementation is as rapid as possible.

Relevant local clinical guidelines, care pathways and protocols should be reviewed in the light of this guidance and revised accordingly.

Information on the cost impact of this guideline in England is available on the NICE website and includes a [costing template](#) that local communities can use.

### 3.2 *General*

The Department of Health considers implementation of clinical guidelines to be a developmental standard and this will be monitored by the Healthcare Commission. The implementation of this guideline will build on the National Service Framework for Mental Health in England and Wales and should form part of the service development plans for each local health community in England and Wales.

This guideline should be used in conjunction with the [National Service Framework for Mental Health](#).

### 3.3 *Audit*

Suggested audit criteria are listed in Appendix D, and can be used to audit practice locally.

## 4 Research recommendations

The Guideline Development Group has made the following recommendations for research, on the basis of its review of the evidence. The Group regards these recommendations as the most important research areas to improve NICE guidance and patient care in the future. The Guideline Development Group's full set of research recommendations is detailed in the full guideline (see Section 5).

### 4.1 *Treatment of OCD and BDD among young people and young adults*

Appropriately blinded randomised controlled trials (RCTs) should be conducted to assess the acute and long-term efficacy (including measures of social function and quality of life), acceptability and the cost effectiveness of CBT and SSRIs, alone and in combination, compared with each other and with appropriate control treatments for both the psychological and pharmacological arms. These should be carried out in a broadly based sample of young people and young adults (for example, aged 12–25 years) diagnosed with OCD and BDD across a range of functional impairment (using minimal exclusion criteria). The trials should be powered to examine the effect of treatment for combined versus single-strand treatments and involve a follow-up of 1, 2 and 5 years. Any treatment received in the follow-up period should also be recorded.

### 4.2 *CBT treatment intensity formats among adults with OCD*

Appropriately blinded RCTs should be conducted to assess the efficacy (including measures of social function and quality of life), acceptability and the cost effectiveness of different delivery formats of CBT that include ERP for adults with OCD, including brief individual CBT using structured self-help materials, brief individual CBT by telephone, group CBT and standard individual CBT compared with each other and with credible psychological treatment that is not specific to OCD and BDD (such as anxiety management training) in a broadly based sample of people diagnosed with OCD across a range of functional impairment (using minimal exclusion criteria). The trials should be powered to examine the effect of treatment in different bands of severity or functional impairment and involve a follow-up of 1 and 2 years. Any treatment received in the follow-up period should also be recorded.

### 4.3 *CBT for adults with OCD who have not responded to treatment*

An appropriately blinded RCT should be conducted to assess the efficacy (including measures of social functioning and quality of life as well as OCD) of intensive versus spaced individual treatments (that include both ERP and cognitive therapy elements) compared with a

treatment-as-usual control in a broadly based sample of adults diagnosed with OCD who have not responded to one or more adequate trials of an SSRI or clomipramine and one or more trials of CBT (that included ERP). The trial should be powered to examine the relative efficacy of intensive versus spaced treatment and involve a follow-up of 1 and 2 years. Any treatment received in the follow-up period should also be recorded.

#### **4.4 *Screening for OCD and BDD***

Appropriately designed studies should be conducted to compare validated screening instruments for the detection of OCD and BDD in children, young people and adults. An emphasis should be placed on examining those that use computer technology and more age-appropriate methods of assessing both symptoms and functioning, taking into account cultural and ethnic variations in communication, and family values. For BDD, specific populations would include young people or adults who consult in dermatology or plastic surgery and those with other psychiatric disorders.

#### **4.5 *CBT for children and young people with OCD and BDD***

An appropriately blinded RCT should be conducted to assess the efficacy (including measures of social functioning and quality of life) and the cost effectiveness of individual CBT and CBT involving the family or carers compared with each other and with a credible psychological treatment that is not specific to OCD and BDD (such as anxiety management training) in a broadly based sample of children and young people diagnosed with OCD and BDD (using minimal exclusion criteria). The trial should be powered to examine the effect of treatment in children and young people separately and involve a follow-up of at least 1 year.

## 5 Other versions of this guideline

National Institute for Clinical Excellence commissioned the development of this guidance from the National Collaborating Centre for Mental Health. The Centre established a Guideline Development Group, which reviewed the evidence and developed the recommendations. The members of the Guideline Development Group are listed in Appendix B. Information about the independent Guideline Review Panel is given in Appendix C.

There is more information about [how NICE guidelines are developed](#) on the NICE website.

### 5.1 *Full guideline*

The full guideline [obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder](#), is published by the National Collaborating Centre for Mental Health; it is available from the NICE website.

### 5.2 *Information for the public*

NICE has produced [information for the public](#) explaining this guideline.

We encourage NHS and voluntary sector organisations to use text from this information in their own materials about OCD or BDD.

### 5.3 *Implementation tools*

This guideline is supported by several implementation [tools](#) available on our website:

- a national costing report
- a local costing template
- implementation advice
- a slide set.

## 6 Related NICE guidance

Computerised cognitive behaviour therapy (CCBT) for the treatment of depression and anxiety (2006) [NICE technology appraisal guidance 97](#)

Depression: management of depression in primary and secondary care (2004) NICE guideline CG23 [Replaced by [NICE guideline CG90](#)]

Depression in children: identification and management of depression in children and young people in primary care and specialist services (2005) [NICE guideline CG28](#)

Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care (2004) NICE guideline CG22 [Replaced by [NICE guideline CG113](#)]

## 7 Review date

The process of reviewing the evidence is expected to begin 4 years after the date of issue of this guideline. Reviewing may begin earlier than 4 years if significant evidence that affects the guideline recommendations is identified sooner. The updated guideline will be available within 2 years of the start of the review process.

## Appendix A: Grading scheme

All evidence was classified according to an accepted hierarchy of evidence that was originally adapted from the US Agency for Healthcare Policy and Research Classification (see Box 1). Recommendations were then graded A to C based on the level of associated evidence. This grading scheme is based on a scheme formulated by the Clinical Outcomes Group of the NHS Executive (1996).

### Box 1: Hierarchy of evidence and recommendations grading scheme

Level	Type of evidence	Grade	Evidence
<b>I</b>	Evidence obtained from a single randomised controlled trial or a meta-analysis of randomised controlled trials	<b>A</b>	At least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence level I) without extrapolation
<b>IIa</b>	Evidence obtained from at least one well-designed controlled study without randomisation	<b>B</b>	Well-conducted clinical studies but no randomised clinical trials on the topic of recommendation (evidence levels II or III); or extrapolated from level I evidence
<b>IIb</b>	Evidence obtained from at least one other well-designed quasi-experimental study		
<b>III</b>	Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies		

<b>IV</b>	Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities	<b>C</b>	Expert committee reports or opinions and/or clinical experiences of respected authorities (evidence level IV) or extrapolated from level I or II evidence. This grading indicates that directly applicable clinical studies of good quality are absent or not readily available
		<b>GPP</b>	Recommended good practice based on the clinical experience of the GDG.

Adapted from Eccles M, Mason J (2001) How to develop cost-conscious guidelines. *Health Technology Assessment* 5:16 and Mann T (1996) *Clinical Guidelines: Using Clinical Guidelines to Improve Patient Care Within the NHS*. London: Department of Health.

## Appendix B: The Guideline Development Group

### **Professor Mark Freeston (Chair)**

Professor of Clinical Psychology, University of Newcastle upon Tyne, Newcastle, North Tyneside and Northumberland Mental Health NHS Trust

### **Dr Tim Kendall (Guideline Facilitator)**

Co-Director, National Collaborating Centre for Mental Health, Deputy Director, Royal College of Psychiatrists Research Unit, Consultant Psychiatrist and Medical Director, Community Health Sheffield NHS Trust

### **Dr Jo Derisley**

Chartered Clinical Psychologist, Norfolk & Waveney Mental Health Partnership NHS Trust; Honorary Lecturer, University of East Anglia

### **Dr Naomi Fineberg**

Consultant Psychiatrist, Queen Elizabeth II Hospital, Welwyn Garden City

### **Ms Tracey Flannaghan**

Nurse in practice, CBT Department, Glenfield Hospital, Leicester

### **Dr Isobel Heyman**

Consultant Child and Adolescent Psychiatrist, Maudsley and Great Ormond Street Hospitals, Children's Department, Maudsley Hospital, London

### **Mr Richard Jenkins**

Systematic Reviewer (2003–2004) The National Collaborating Centre for Mental Health

### **Mr Christopher Jones**

Health Economist, The National Collaborating Centre for Mental Health

### **Ms Gillian Knight**

People with OCD, London

### **Dr Karina Lovell**

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**Dr Catherine Pettinari**

Senior Centre Project Manager, The National Collaborating Centre for Mental Health

**Ms Preethi Premkumar**

Research Assistant, The National Collaborating Centre for Mental Health

**Mr Cliff Snelling**

Carers of People with OCD, Northampton

**Dr Clare Taylor**

Editor, The National Collaborating Centre for Mental Health

**Mr Rowland Urey**

People with OCD, Oldham

**Dr David Veale**

Consultant Psychiatrist in Cognitive Behaviour Therapy, The Priory Hospital North London and the South London and Maudsley Trust; Honorary Senior Lecturer, Institute of Psychiatry, King's College London

**Ms Heather Wilder**

Information Scientist, The National Collaborating Centre for Mental Health

**Dr Craig Whittington**

Senior Systematic Reviewer, The National Collaborating Centre for Mental Health

**Dr Steven Williams**

General Practitioner, The Garth Surgery, Guisborough

## Appendix C: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring its quality. The Panel includes experts on guideline methodology, health professionals and people with experience of the issues affecting patients and carers. The members of the Guideline Review Panel were as follows.

**Dr Chaand Nagpaul (Chair)**

GP, Stanmore

**Mr John Seddon**

Patient Representative, Bolton

**Professor Kenneth Wilson**

Professor of Psychiatry of Old Age and Honorary Consultant Psychiatrist, Cheshire and Wirral Partnership NHS Trust

**Dr Paul Rowlands**

Consultant Psychiatrist, Derbyshire Mental Health Services Mental Health Care Trust

**Dr Roger Paxton**

R&D Director, Newcastle, North Tyneside and Northumberland Mental Health NHS Trust

**Dr Catriona McMahon**

Medical Head, Specialist Care, AstraZeneca

**Professor Shirley Reynolds**

Professor of Medicine, Health Policy and Practice, University of East Anglia

## Appendix D: Technical detail on the criteria for audit

### Possible objectives for an audit

One or more audits could be carried out in different care settings to ensure that:

- individuals with OCD or BDD are involved in their care
- treatment options are appropriately offered and provided for individuals with OCD or BDD.

### People that could be included in an audit and time period for selection

A single audit could include all individuals with OCD or BDD. Alternatively, individual audits could be undertaken on specific groups of individuals such as:

- people with OCD or BDD at a particular stage (for example, to study assessment)
- a sample of people with OCD or BDD from particular populations in primary care.

### Measures that could be used as a basis for an audit

Please see tables below.

<b>1. Possible objective for audit</b> To improve access to specialist OCD/BDD multidisciplinary healthcare across the individual's lifespan		
<b>Criterion</b>	<b>Exception</b>	<b>Definition of terms</b>

<p>Each PCT, mental healthcare trust, and children's trust that provides mental health services has access to a specialist multidisciplinary OCD/BDD team.</p> <ol style="list-style-type: none"> <li>1. Operational policies in each PCT, mental healthcare trust and children's trust that provides mental health services specify procedure for accessing specialist OCD/BDD team</li> <li>2. Specialist teams offer a liaison function to other mental health professionals</li> </ol>	<p>None</p>	<p>A specialist OCD/BDD team is able to conduct expert assessment, specialist cognitive-behavioural and pharmacological treatment and provide age-appropriate care</p> <p>A liaison function will aim to: increase skills in the assessment and evidence-based treatment of people with OCD or BDD; provide high-quality advice; aid understanding of the needs of family/carers and developmental needs</p>
<p><b>2. Possible objective for audit</b></p> <p>To decrease delays in the patient pathway for people who are re-referred for treatment of OCD/BDD</p>		
<p><b>Criterion</b></p>	<p><b>Exception</b></p>	<p><b>Definition of terms</b></p>
<p>People with OCD or BDD who have relapsed following successful treatment are seen by a healthcare professional as soon as possible if re-referred, and where there has been no response to treatment are appropriately supported.</p> <ol style="list-style-type: none"> <li>1. Operational policies indicate the re-referral pathway</li> <li>2. Operational policies indicate that care coordination or other suitable process is followed for people where there has been no response to treatment</li> </ol>	<p>Person with OCD or BDD refuses re-referral</p>	<p>None</p>
<p><b>3. Possible objective for audit</b></p> <p>To improve the initial treatment of adults who have mild OCD or BDD, or those who prefer a low intensity psychological treatment</p>		

Criterion	Exception	Definition of terms
<p>In their initial treatment, adults who have mild OCD or BDD, or those who express a preference, are offered a low intensity psychological treatment.</p> <ol style="list-style-type: none"> <li>1. Clinical notes indicate that people are informed of low intensity treatment options</li> <li>2. Clinical notes indicate the clinical outcome of low intensity interventions</li> </ol>		<p>Low intensity treatments (less than 10 therapist hours) include:</p> <ul style="list-style-type: none"> <li>• brief individual CBT (including ERP) using structured self-help materials</li> <li>• brief individual CBT (including ERP) by telephone</li> <li>• group CBT (including ERP) – note the patient may be receiving more than 10 hours of therapy in this format</li> </ul>

**4. Possible objective for audit**

To improve the treatment of adults who have been unable to engage with, or where there has been no response to, low intensity treatment

Criterion	Exception	Definition of terms
<p>Where adults have been unable to engage with low intensity treatment, or there has been no response to low intensity treatment, adults with mild OCD are offered more intensive treatment interventions.</p> <ol style="list-style-type: none"> <li>1. Clinical notes indicate that people have been informed of the possibility of intensive CBT (including ERP) or an SSRI</li> <li>2. Clinical notes indicate the clinical outcome of the intervention offered</li> </ol>		<p>More intensive treatment interventions include: a choice of either a course of an SSRI, or more intensive CBT (including ERP) (of more than 10 therapist hours per patient)</p>

**5. Possible objective for audit**

To improve the treatment of adults who have OCD with moderate functional impairment

Criterion	Exception	Definition of terms
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<p>Adults who have OCD with moderate functional impairment are offered the choice of either a course of an SSRI or more intensive CBT (including ERP).</p> <ol style="list-style-type: none"> <li>1. Clinical notes indicate that people have been informed of the possibility of more intensive CBT (including ERP) or an SSRI</li> <li>2. Clinical notes indicate the clinical outcome of the intervention offered</li> </ol>	<p>Children and young people</p>	<p>More intensive CBT (including ERP) means: more than 10 therapist hours per patient</p>
<p><b>6. Possible objective for audit</b> To improve the treatment of adults who have BDD with moderate functional impairment</p>		
<p><b>Criterion</b></p>	<p><b>Exception</b></p>	<p><b>Definition of terms</b></p>
<p>Adults who have moderate BDD are offered the choice of an SSRI or more intensive individual CBT (including ERP) or an SSRI.</p> <ol style="list-style-type: none"> <li>1. Clinical notes indicate that people have been informed of the possibility of intensive individual CBT (including ERP) or an SSRI</li> <li>2. Clinical notes indicate the clinical outcome of the intervention offered</li> </ol>	<p>Children and young people</p>	<p>CBT (including ERP) means: ERP that addresses key features of BDD.</p>
<p><b>7. Possible objective for audit</b> To improve the care of children and young people who have OCD with moderate to severe functional impairment and those who have OCD with mild functional impairment for whom guided self-help has been ineffective or refused</p>		
<p><b>Criterion</b></p>	<p><b>Exception</b></p>	<p><b>Definition of terms</b></p>

<p>Children and young people who have OCD with moderate/severe impairment or those with mild impairment where there is no response to guided self-help, or where guided self-help has been refused, will be offered CBT (including ERP) as the treatment of choice.</p> <ol style="list-style-type: none"> <li>1. Clinical notes indicate that the child/young person and the family/carer were informed of possibility of CBT</li> <li>2. Clinical notes identify the clinical outcome of CBT</li> </ol>	<p>Children and young people who refuse CBT (including ERP)</p>	<p>CBT (including ERP) means: treatment involving the family or carers and adapted to suit the developmental age of the child. Group or individual formats should be offered depending upon the preference of the child or young person and their family or carers</p>
<p><b>8. Possible objective for audit</b></p> <p>To improve the care of children (aged 8– 11 years) who have OCD or BDD with moderate to severe functional impairment if there has not been an adequate response to CBT (including ERP) involving the family or carers</p>		
<p><b>Criterion</b></p>	<p><b>Exception</b></p>	<p><b>Definition of terms</b></p>

<p>Children who have OCD or BDD where there has not been an adequate response to CBT (including ERP) attend a multidisciplinary review (with family/ carers) where the use of an SSRI is considered in addition to ongoing psychological treatment.</p> <ol style="list-style-type: none"> <li>1. Clinical notes indicate a multidisciplinary review occurred and identified that the use of an SSRI in addition to ongoing psychological treatment was explored in detail</li> <li>2. Clinical notes indicate that careful monitoring was carried out</li> <li>3. Clinical notes indicate the clinical outcome of the intervention offered</li> </ol>	<p>Children who respond to CBT (including ERP)</p>	<p>Children: aged 8–11 years</p> <p>Careful monitoring: being seen frequently on an appropriate and regular basis agreed by the patient, his or her family or carers and the healthcare professional, and recorded in the notes</p>
<p><b>9. Possible objective for audit</b></p> <p>To improve the treatment of young people (aged 12–18 years) who have OCD or BDD with moderate to severe functional impairment if there has not been an adequate response to CBT (including ERP) involving the family or carers</p>		
<p><b>Criterion</b></p>	<p><b>Exception</b></p>	<p><b>Definition of terms</b></p>

<p>Young people who have OCD or BDD where there has not been an adequate response to CBT (including ERP) attend a multidisciplinary review (with family/ carers) where the use of an SSRI is considered in addition to ongoing psychological treatment</p> <ol style="list-style-type: none"> <li>1. Clinical notes indicate a multidisciplinary review occurred and identified that the use of an SSRI in addition to ongoing psychological treatment was explored in detail</li> <li>2. Clinical notes indicate that careful monitoring was carried out</li> <li>3. Clinical notes indicate the clinical outcome of the intervention offered</li> </ol>	<p>Young people who respond to CBT (including ERP)</p>	<p>Young people: aged 12–18 years Careful monitoring: being seen frequently on an appropriate and regular basis agreed by the patient, his or her family or carers and the healthcare professional, and recorded in the notes</p>
<p><b>10. Possible objective for audit</b> To improve the treatment of children and young people who have BDD</p>		
<p><b>Criterion</b></p>	<p><b>Exception</b></p>	<p><b>Definition of terms</b></p>

<p>Children and young people with BDD are considered for CBT (including ERP) as first-line treatment.</p> <ol style="list-style-type: none"> <li>1. Clinical notes indicate that the healthcare professional responsible has discussed the need for CBT (including ERP) and an arrangement has been made</li> <li>2. Clinical notes indicate the clinical outcome of the intervention offered</li> </ol>	<p>Children or young people who refuse treatment</p>	<p>Children: aged 8–11 years.          Young people: aged 12–18 years.          CBT (including ERP) means: involving the family or carers and adapted to the developmental age of the child or young person</p>
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## About this guideline

NICE guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

The guideline was developed by the National Collaborating Centre for Mental Health. The Collaborating Centre worked with a group of healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

The methods and processes for developing NICE guidelines are described in [the guidelines manual](#).

We have produced [information for the public](#) explaining this guideline. Tools to help you put the guideline into practice and information about the evidence it is based on are also [available](#).

### Changes after publication

**October 2015:** Minor maintenance.

**April 2015:** Minor maintenance.

**October 2012:** Minor maintenance.

**January 2012:** Minor maintenance.

### Your responsibility

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have

regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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